For further information please contact Peter Reith, ☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
1.13. Edinburgh Shadow Health & Social Care Partnership - Minutes of the Meeting held on 16 August 2013

1.14. Midlothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 25 July 2013

1.15. West Lothian Health & Care Partnership Sub-Committee - Minutes of the Meeting held on 29 August 2013

1.16. West Lothian Health & Care Partnership Board - Minutes of the Meeting held on 13 August 2013

2. Items for Discussion (subject to review of the items for approval)
   (9:45am - 12:00pm)

2.1. Review of the Quality Report

2.2. Waiting Times Performance, Progress and Elective Capacity Investment

2.3. Medical Workforce Risk Assessment

2.4. Improving the Health and Well-being of Lothian’s Children and Young People - the NHS Lothian Children and Young People’s Strategy 2013 - 2020

2.5. Single Outcome Agreements & Local Delivery Plan

2.6. Strategic Planning Committee

2.7. Audit Scotland: Annual Report on the 2012/13 Audit

3. Date, Time and Venue of Next Meeting: Wednesday 23 October 2013 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

4. Resolution to take items in closed session

5. Minutes of the Previous Private Meeting held on 26 June 2013

6. Matters Arising

7. Violence and Aggression - Briefing

Meetings in 2013: 27 November 2013
   No December Meeting
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 24 July 2013 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

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

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

In Attendance: Dr D Caesar (Consultant in Emergency Medicine for item 60); Mr G Curley (Director of Operations / Facilities for item 64); Mr J Forrest (Director of West Lothian Community Health & Care Partnership); Mr P Gabbitas (Director of Health & Social Care, Edinburgh); Mr A Jackson (Associate Director of Strategic Planning for item 63); Professor A McMahon (Director of Strategic Planning, Performance Reporting & Information); Mrs C Potter (Associate Director of Finance, Representing the Director of Finance); Mr D A Small (Director of Health & Social Care, East Lothian); Mrs L Tait (Associate Director, Service Modernisation for items 61 & 62); Dr J Tomlinson (Consultant in Public Health Medicine for item 73); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications and Public Affairs).

Apologies for absence were received from Mrs S Goldsmith, Mr P Johnston, Mr B Peacock and Mr G Warner.

Declaration of Financial and Non-Financial Interest

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

58. Welcome to Members of the Public and Press

58.1 The Chairman welcomed members of the public and press to the meeting.
59. Minutes of the Meeting Held on 26 June 2013

59.1 The minutes were approved as a correct record subject to the following amendments:

- Sederunt – record Mrs Meiklejohn’s apologies

- Minute 42.1.3 delete ‘Mr Walker commented that’

- Minute 43.21 to read ‘Mr Walker commented would require to take …… Mrs McDowell concurred stressing the importance of making future decisions following consideration of relative funding choices within the context of an ever tightening financial envelope ……..’

60. Matters Arising

60.1 Medical Workforce Risk Assessment – The Chairman commented he felt this was an excellent paper which had been prepared in response to the discussion held at the previous meeting. He felt the paper provided an understanding of underlying causes rather than just symptoms. The paper also built on previous Boards papers discussed in May and June and reflected how the Board linked with National Workforce Planning through National Education Scotland and the South East and Tayside Regional Planning Group.

60.2 The Medical Director reported in respect of paediatrics that all rotas would be maintained over the summer period and into autumn. He provided an update on the recruitment process at Simpsons Memorial Maternity Pavilion, Royal Hospital for Sick Children and St Johns Hospital advising that the ultimate aim of providing an advanced Nurse Practitioner Service would occur in 2015 and in the meantime work continued to ensure the sustainability of the service.

60.3 The Board noted in respect of obstetrics and gynaecology that the Medical Director was concerned about the reliance on locums to maintain the middle grade rota. The Medical Director updated the Board on the intention to advertise for consultants and specialist doctors in this specialty simultaneously.

60.4 The Medical Director reported within accident and emergency medicine that 5 clinical fellows had been appointed with an additional 2 late entries yet to be interviewed which might further assist the position.

60.5 The Board noted from the paper the actions being taken around the Emergency Medical Workforce Plan, changes to St Johns Emergency Department staff models and changes to St Johns from 7 August which would be externally reviewed. The Medical Director highlighted in particular investments going into St Johns Hospital with specific reference to increases in the consultant resource.

60.6 Dr Caesar commented in respect of the timescale for other steps to influence the supply of a suitable Emergency Medicine workforce that this required to be considered within the context of the UK wide picture and would take time given pressures in accident and emergency medicine across the UK. It was noted a thorough review of this area was underway in England with Scotland playing into the
discussions and it would be through this route that the first steps forward would be taken. He commented that emergency medicine and associated training would need to expand rapidly. Dr Caesar advised that the service would continue to use appropriate routes of influence although it was difficult at this point to be specific about timescales.

60.7 Mrs Blair commented she appreciated the paper which had put the medical workforce position into context both from a Scottish and national context. She questioned however how realistic it was for Lothian to sustain the current model based on its own and Scottish Government assumptions as it was clear there was an imbalance in staff resources making it unrealistic to achieve a balance across all sites. She commented she was pleased to see that clinical and patient safety was at the forefront of current work as it should be. The Chairman concurred that these were valid points.

60.8 The Chief Executive advised that the Board paper described a number of processes. He commented that the Greenaway Review being carried out on a UK wide basis would look at the future of training with timescales starting to bite as early as 2014 if the recommendations of the review were accepted by the four nations. He reminded the Board that he and Professor Iredale had contributed to The Greenaway Review and fed back that Lothian’s contribution reflected the fact that across the UK training had focussed too early at sub specialist level.

60.9 The Board was advised by the Chief Executive that at a Scottish level the National Committee that he co-chaired was also active in this area and in particular in the move to service provision by trained doctors. He commented however that the reduction in trainee posts did not correlate with the need for an increase in alternative staff models. He commented as a result a number of front door specialty reductions had been paused in 2013. It was noted for the 2014 intake the Scottish Government had asked all regional planning groups to submit a case for some of the paused areas to receive additional trainees. The Chief Executive commented he expected to see real growth in trainee numbers in key specialities from 2014. He pointed out however the key issue was being able to recruit to these posts given there was currently a less than 40% fill rate for trainee posts.

60.10 The Chief Executive advised another key workstream was looking at the attractiveness of some career choices and the potential need to incentivise people to work in onerous specialities which often involved antisocial hours. The Chief Executive agreed with Mrs Blair that there was a need to resolve issues in the short term as well as setting a strategically sustainable long term future.

60.11 Councillor Toner questioned in respect of paediatrics how sustainable the long term position was from August onwards given the lack of middle grade trainees. The Medical Director reminded the Board the introduction of the advanced neonatal nurse practitioner role would provide the sustainable solution in future. He noted that the Tailored Workforce Support Team (TWST) report had been useful in respect of contingency arrangements in the interim. He stressed that like other specialties, paediatrics was a UK problem with it being likely it would be a few years before a fully sustainable solution was reached.
60.12 The Medical Director in response to Councillor Toner advised in respect of the impact in West Lothian of Community Child Staff Retiral that again this was part of a UK challenge and that the position in West Lothian was being supported.

60.13 Mr Walker advised he had found the paper both useful and alarming. He had concerns about timeframes for solutions and the lack of reference to when recommendations would be implemented, noting the Board had been advised for some time about the difficulties. He felt there was a need for various issues to be joined up. He was keen to learn what had happened within accident and emergency medicine to make it so unattractive to new applicants.

60.14 The Chief Executive reiterated the position since 2011/12 with numbers of trainee doctors noting the potential for increases in 2014, subject to Cabinet Secretary approval.

60.15 Dr Caesar commented even with an increase in recruitment there would still be a three year lag period before applicants reached the level of experienced decision makers. He advised in respect of attractiveness to candidates that in recent years there had been a change in peoples’ work / life balance expectations which had affected acute specialties in particular. He felt there was a need for a sustainable work balance to be written into the recruitment process. In addition it was noted there was currently a high level of sickness absence amongst senior staff.

60.16 The Chief Executive advised the provision of a sustainable workforce across the four key sites was a key issue in strategic planning terms and would be a key driver in the way services were configured in future. He commented in Lothian work had been done to concentrate specialist services on a single site in order to stop spreading resources too thinly.

60.17 Dr Caesar in response to Councillor Toner stressed that there had been no service reduction in accessing the emergency department at St Johns Hospital and updated the Board on the changes made to the overnight service including extended consultant presence in the department until 11pm and an increase in other staff availability. He advised any slight deficiency in the seniority of night doctors was supported by the hospital at night model. He reported that the consultant would remain on call out of hours with critical care hospital at night colleagues being committed to being available. In overall terms more people were now available to see patients overnight. Dr Caesar commented whilst he appreciated the anxieties in West Lothian he felt the current position represented the best solution. The Medical Director commented that as previously mentioned, the prospective audit would be important to ensure the population’s needs were being met.

60.18 Dr Caesar in response to a question from Councillor Toner about the redirection policy criteria advised a useful meeting had been held with the Scottish Ambulance Service to ensure they had appropriate information to treat patients which had previously been a difficulty. Dr Caesar advised in broad terms there had been no changes to the Diversion Policy.

60.19 Councillor Toner questioned the reasons for St Johns Hospital being less able to attract specialist doctors. The Medical Director advised the problem was not specific to St Johns.
60.20 Dr Williams commented that the emergency department had argued its case and received increased investment to meet immediate needs. He felt in the longer term work was needed to look at why people attended the accident and emergency and to make investment in other areas to ensure patients were seen in the most appropriate setting. The Chairman suggested this referred back to the overall strategic context.

60.21 Councillor Toner commented he could not support the current position in respect of emergency medicine although he would reconsider his position following the publication of the outcome of the audit referred to by the Medical Director.

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

61. Renewing NHS Values

61.1 The Chief Executive introduced a circulated paper commenting that the recommendations had evolved following a detailed process of engagement and consultation involving thousands of staff. He advised the values wording had been confirmed following input from Board members, the Area Clinical Forum, Area Partnership Forum and senior staff who had unanimously bought into the proposal. He advised the paper and its proposals linked critically to the corporate objectives and also to the exercise on transforming the management culture.

61.2 The Chief Executive commented that the paper set out the architecture for the way NHS Lothian would work in future. He stressed the links with the corporate objectives were important as they were promoting a set of values to drive the organisation in future.

61.3 The Chief Executive commented the paper discussed both the promotion of positive values and the addressing of negative behaviours which would need to be challenged. He reminded the Board the Bowles Report had been about creating a new culture and in that regard it was important to consider both sides of the coin. He felt this was a seminal paper which he was keen for the Board to embrace to allow the following key values to be delivered:

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality
- Team work

61.4 Mrs Tait advised that the paper outlined the importance of shared values among all those working in NHS Lothian reporting that the work had actually commenced pre Bowles in the context of improving patient experience through how staff engaged with patients. She commented as previously reported by the Chief Executive the values and behaviours had been developed following wide staff engagement.

61.5 The Board noted that NHS Scotland had published their 2020 Workforce Vision and had also issued a values statement which was reflected in the appendix to the paper. It was noted that NHS Lothian’s values had fed into the development of the national
values. Mrs Tait advised an internal validation exercise had been undertaken which had received a limited albeit positive response which had stressed the need for the organisation to be seen to be living the values.

61.6 Mrs Tait reported a workshop had been held in June to ensure senior buy-in at the top of the organisation to the process and outcomes. This had affirmed a desire to adopt explicit values and behaviours and the steps needed to make these real.

61.7 Mrs Tait drew attention to the examples of conduct which were not acceptable. It was noted however that some people found it difficult to challenge bad behaviour. She advised statements had been checked against Human Resources Conduct Policies. Mrs Tait drew the Board’s attention to the last page of the paper which detailed what staff can expect from the organisation in line with the National Staff Governance Standard.

61.8 The Board noted that the next step in the process was to arrange engagement sessions for service teams in order to ensure ongoing commitment to promoting our values.

61.9 The Chairman suggested there should be no debate about the principle of the values and vision as this had been developed as part of a process involving Board members. He felt the difficult part of the process would be the deployment and implementation of the recommendations with the Board ensuring this was done in a rigorous manner. He stressed that each person around the Board table needed to absorb and be personally committed to the demonstration of what it meant to provide leadership from the top.

61.10 Mrs McDowell congratulated colleagues on the work undertaken and commented she would be happy to agree the paper although in order for the Board to own and support the recommendations and act as a role model she would welcome the development of an implementation plan to be included in a separate Board seminar. The Chairman agreed this would be an appropriate way forward.

61.11 Mrs McDowell further commented in order to ensure the proper rollout and introduction of the implementation plan it would be important to ensure proper scrutiny through the Staff Governance Committee. The Employee Director supported these views advising that the recommendations had the almost unanimous support of staff side colleagues who were keen to learn of the implementation process. The Employee Director felt this would also be a key issue for the Area Partnership Forum Agenda. He reported approaches had been made from senior staffside colleagues who were keen to become ‘values champions’ and team up with senior managers to ensure proper implementation of the proposals.

61.12 Mr Brettell felt the paper and its recommendations were excellent and as previously reported the key issue would be implementation. He advised currently he could not personally quote by rote the vision and objectives of the organisation and felt moving forward a process of memorable, reinforcement and enforcement would be necessary as he was convinced some people would continue to do as they did at present with there being a need to think about how best to deal with this scenario. He advised his experience of similar processes suggested success happened when people who asked questions received appropriate and quick responses.
61.13 Dr Bryce commented it would be important not to over manage the process noting that challenging others was difficult for some people although it would be important to encourage people to speak out about things they were uncomfortable with. The Vice Chair concurred advising it would be important in future updates to the Board to receive live examples of difficult issues experienced including from Board members. She commented however that during site visits she saw examples of how these values were already in place and were working on a day to day basis and it would be important not to lose sight of this position.

61.14 Mrs Blair agreed commenting compassionate and committed care was already evident in many service areas. She was of the view that quick wins should be identified and implemented. There was also a need to make the process meaningful and in that respect language would be important as would be the sharing of good practice. Mrs Blair felt visibility would be important as she felt the Board was not visible within the organisation and the same might be true for some senior managers.

61.15 Mrs Meiklejohn advised it would be important to make linkages with Scottish Government cultural work as well as the Investors In People process to see whether values made a difference in areas such as sickness absence, conduct and whether people were happy at work. She suggested this would need to be informed through a process of proper evaluation. Mrs Meiklejohn appreciated the steps being proposed to address unacceptable behaviour and suggested this should be reflected in staff induction.

61.16 Mr Walker commented although he was supportive of addressing negative behaviours he had some worries about the proposal. He felt some people experienced significant challenges in speaking up and he felt the language in the paper was slightly threatening. He noted that the word ‘listen’ was not reflected in the proposal. He advised that the challenging and enforcement aspects around inappropriate behaviours was important and how this would be tackled should be part of the implementation plan and needed to be aligned to consequences for inappropriate behaviour.

61.17 The Director of Human Resources and Organisational Development in response to Mr Wilson advised that NHS Lothian currently had an assumption against compulsory redundancy and this was aligned to a local no detriment policy. He commented that the assumption was that these policies would remain in place and on that basis it was possible to include the statement about securing peoples employment status. The Chief Executive commented the statement had been drawn from the Scottish Government 2020 Vision although if national policy changed then this would need to be taken into account. However he felt within the current framework he was confident the commitment could be delivered.

61.18 The Board agreed the recommendations in the circulated paper noting the next steps would be to support the implementation of these values across all sites and services through a series of local engagement events and to ensure their communication and integration into all plans and priorities including the Strategic Clinical Framework.
62. **Strategic Planning – Next Steps**

62.1 The Director of Strategic Planning, Performance Reporting and Information updated the Board on the next steps in developing the strategic planning process including communication and engagement. It was noted that the next Board workshop was planned for 26 August.

62.2 The Board were reminded that the Strategic Plan was due to come to the Board in March 2014 with a lot of work underway not reflected in the Board paper. It was noted, for example, that workstreams had commenced around Unscheduled Care, Planned Care, Primary Care Framework engagement and the Cancer Service Plan. In addition plans were being put in place around the infrastructure and architecture to deliver the plan with interviews being held the following week.

62.3 The Board noted that the 26 August workshop would build on the 1 May event and would look at dependencies and interdependencies against a list of criteria for the priorities for the emerging plans.

62.4 The Board noted the progress being made in developing the Strategic Clinical Framework and Strategic Plan.

63. **Waiting Times Performance, Progress and Elective Capacity Investment**

63.1 The Medical Director apologised that some of the most up to date data for diagnostic surveillance, 18 weeks, Child and Adolescent Mental Health Service (CAMHS) and Psychological Therapies had been unavailable at the time of writing the paper. The Board received a verbal update on performance in these areas.

63.2 The Board noted at the end of June, 303 patients were waiting for procedures under the treatment time guarantee for over 12 weeks. The Medical Director reported on ongoing difficulties in capacity for ophthalmology which was now beginning to impact on numbers over 12 weeks, masking a general underlying improvement in areas such as neurosurgery and plastics.

63.3 The Medical Director advised 95.8% of patients treated in June had been seen within the 12 week waiting time guarantee. 338 patients waited over this threshold in the month of whom 190 had been admitted or no longer required treatment. A further 114 had dates identified or were with external providers to find a suitable date and 11 were unavailable. The Medical Director advised arrangements for the remaining 23 were being explored.

63.4 The Board were advised that the over 12 week outpatient position had improved in June to 2614. Neurology and Urology had seen improvements whilst colorectal, ophthalmology, chronic pain and rheumatology had not. The Medical Director reported the ophthalmology position would continue to be challenging.

63.5 The Medical Director advised that changes in reporting arrangements in future would make it difficult to compare past with present performance and this would be highlighted appropriately in the next Board report.
63.6 Mr Jackson provided a detailed explanation to the Board on the particular characteristics of the ophthalmology and colorectal performance. He commented there was a need to identify cases that could be treated differently including within the private sector in order to free up NHS Lothian pathways.

63.7 The Chief Executive commented in respect of the headline numbers that good progress was being made, with the difficulty being specifically around ophthalmology and colorectal services for the reasons explained by Mr Jackson. He commented work was underway to mitigate the position although he felt it was important the Board was specifically advised of the issues in these two specific specialties.

63.8 Mrs Meiklejohn welcomed the update advising that the Area Clinical Forum had been concerned about the number of targets and commented that this could lead to distorted priorities to meet these targets rather than based on clinical need.

63.9 Dr Williams suggested the position in ophthalmology was unusual and commented that community ophthalmologists would have the skills and experience to assist in this area. He suggested this option should be explored further before automatically moving down the private sector route. The Director of Strategic Planning, Performance Reporting & Information advised work was underway in this respect particularly around minor issues.

63.10 Mrs Meiklejohn commented there was a need to consider how outpatient appointments were followed up in future to include opportunities around telehealth.

63.11 Mr Walker suggested there was a need to present the data in future to highlight the general positive downward trend whilst not losing sight of the 2 challenging specialties. The Chief Executive concurred advising it was important not to demotivate the specialties who were performing well.

63.12 Mr Walker commented that the activity data was sparse and rudimentary. He felt there was a need to understand how the financial investment was reflected in activity both internally and externally. Mr Jackson undertook to test an appropriate format with Mr Walker outwith the meeting given this issue had been raised a number of times at the Finance & Resources Committee.

63.13 The Board agreed the recommendations contained in the circulated paper and noted the progress being made on waiting times and the proposed further investment to support sustainable delivery.

64. **Little France Campus Redevelopment**

64.1 Mrs Potter advised the Board was being asked to accept proposals from Consort for an amnesty from deficiency points for the supplemental agreements for additional beds, renal works and the Chancellor’s Building. It was noted that the proposal had been discussed at the June Finance & Resources Committee as well as at the last Private Board meeting with the key points being set out in the paper.

64.2 Mr Brettell recalled that the debate about the amnesty had been limited to a specific timeframe and quantum. Mr Curley explained the proposals in detail including
quantum and timeframes in respect of the three supplemental agreements. Mr Brettell commented that, whilst he had been unhappy with the Consort proposal during previous discussions, he and the rest of the Board had accepted they had little choice other than accept the proposals.

64.3 Mr Walker advised he supported the proposals as had the Finance & Resources Committee. He was concerned however that Consort might regard this as setting a precedent for future. He commented it would be important to stress to Consort that the current circumstances absolutely did not set such a precedent.

64.4 The Chief Executive suggested that the renal supplemental agreement did not set a precedent and referred to the five year cap on the amnesty period. He commented in respect of the future strategic plan that there was no doubt further additional work would be needed at the Royal Infirmary of Edinburgh. He reminded the Board although the Royal Infirmary of Edinburgh was only ten years old it had changed several times in that period with further significant work being proposed around unscheduled care and elective services and the deliverability of this work was a key criteria that needed to be considered.

64.5 Mrs Potter advised work to mitigate the impact on NHS Lothian was being progressed by creating a protocol with Scottish Futures Trust. The Chief Executive commented this was an area of work in progress and reminded the Board it had previously taken two years to transfer a car park and it was not possible in strategic terms to progress to such timescales in future.

64.6 The Board agreed the recommendation to accept the proposal at this time for the additional beds, renal works and the Chancellor’s Building and to instruct the Director of Finance to continue dialogue with Consort and their lenders with an objective of achieving betterment for future supplemental agreements.

65. Legionnaires Disease Outbreak in Edinburgh June 2012

65.1 The Director of Public Health & Health Policy advised that the report before the Board was the interim one on the June 2012 Legionnaires Disease Outbreak in Edinburgh. The report focussed on ongoing work and recommendations for the future.

65.2 The Board were reminded this had been a large outbreak with 1000 people having been investigated and treated in Primary Care. There had been 45 hospital admissions with 22 patients admitted to intensive care. The Board recorded their sympathy to the families of the four people who had died.

65.3 The Director of Public Health & Health Policy advised this outbreak had 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 the Lothian Unscheduled Care services had resulted in less morbidity and fewer deaths than in previous outbreaks of similar size.

65.4 The Board noted that work around new techniques and lessons learned were reflected as work in progress in the report which also included inputs from local
people. The Director of Public Health & Health Policy advised she was meeting with local general practitioners as well as writing to families affected offering to go through the report in more detail.

65.5 The Director of Health & Social Care, Edinburgh advised that the support from the NHS Lothian Public Health Department and Primary Care had been outstanding with the speed of reaction having been excellent. He suggested that the mortality rate reflected the speed of reaction. The Director of Public Health & Health Policy in respect to a query about parallels with lessons learned around pandemic flu commented there was a need to practise outbreak plans on an annual basis in order to ensure that resources could be deployed quickly. The Board were advised through regular exercises it would be possible to maintain and strengthen the infrastructure to ensure staff were trained and capable of doing their jobs efficiently under similar circumstances.

65.6 Councillor Henderson thanked the Director of Public Health & Health Policy for the report commenting that elected representatives would welcome the offer to meet with people affected by the outbreak. He commented there remained a frustration about the inability to identify the source of the outbreak.

65.7 The Board agreed the detailed recommendations outlined in the paper.

66.** Quality Report**

66.1 The Medical Director advised that the circulated paper represented the Quality Report for June 2013 and provided assurance on the quality of care NHS Lothian provided with a particular focus on child and maternal health clinical effectiveness. Exception reports were provided in respect of Stroke and *Clostridium Difficile*. It was noted that this was the final version of the current report which would be updated from September onwards.

66.2 The Medical Director commented in respect of forceps delivery that Lothian was an outlier with a higher rate than the rest of Scotland. It was noted there was no explanation available at this point for this position although work was underway to better understand the data.

66.3 The Board noted from the Medical Director that the information on readmission rates over six months was not yet available and was proving difficult to obtain. It was noted however that the new patient safety and quality arrangements being progressed by Dr S MacKenzie and supported by the site Director for St Johns Hospital and two St Johns Hospital Consultants would breath new light into this area. The Medical Director would report back on readmission rates as soon as reasonably practical once Dr MacKenzie fully engaged in his new role.

66.4 Mrs Blair noted that both the indicators around incident management and medicine reconciliation compliance had moved adversely. The Medical Director reported he was unaware of any particular reason for this and reminded colleagues that the data was reported on a trend basis and it was therefore perhaps too early to draw conclusions. An update would be provided in the new format of the Quality Report to be considered at the next meeting.
66.5 The Board agreed the recommendations contained in the circulated paper which updated on the quality of care provided to children and maternal health patients.

67. **Unscheduled Care**

67.1 The Nurse Director commented whilst reported performance was reasonable it was important to recognise there was more to do. It was noted arrangements for the festival period were in place to cope with the increase in the population and these were detailed in the circulated paper. The current focus was on planning for the forthcoming winter with the provision of additional beds in wards 109 and 209 at the Royal Infirmary of Edinburgh being part of that process. The Nurse Director advised consideration was being given to such capacity with a more detailed report being provided to a future meeting.

67.2 The Board noted that the Unscheduled Care Plan agreed by the Board at its previous meeting had been submitted to the Scottish Government with positive informal feedback having been received.

67.3 The Nurse Director advised the two most significant areas to be addressed were around step-down capacity and delayed discharges. It was noted that the Nurse Director, the Director of Finance and the Director of Health & Social Care, Edinburgh had started the process of evaluating all projects around unscheduled care looking in particular at the impact and outcome of investments. It was anticipated this process would be concluded during September.

67.4 The Director of Health & Social Care, Edinburgh provided the Board with a detailed update on what had been undertaken around supply and demand, delayed discharges and the provision of step-down beds. He advised in total terms the delayed discharge position had worsened slightly although the average length of delay had reduced. Step-down capacity was a new service with work being done around patients suffering from an alcoholic brain injury to ensure treatment in the most appropriate environment through the provision of a new care pathway.

67.5 The Director of Health & Social Care, East Lothian commented on the different issues experienced in East Lothian where there had been an increase in delayed discharges. He recognised the need to increase capacity with it being anticipated that this would be in place during September/October.

67.6 Mr Brettell welcomed the improved performance from the previous month and questioned whether this linked to the more stable position around elective capacity. The Nurse Director advised there were a number of reasons for the improved performance including less pressure on beds because of the summer season and a change in elective capacity requirements because of a reduction in activity due to summer holidays. It had also been reported that the site based management model had contributed to the increase in performance as had the reduction in Norovirus. It was noted however challenges still existed at the Royal Infirmary of Edinburgh because of the numbers and complexity of attendances.
67.7 Mr Walker questioned whether it would be possible to focus capacity on day cases in order to address elective issues. The Chief Executive commented this would be done although it was important to remember that the 12 week treatment time guarantee also related to inpatients and these were the types of issues the service had to continually address on a daily basis. He commented a more radical plan would be needed than had been the case in the past and this would include input from the community and social care sector.

67.8 Mr Walker sought an update in respect of the role of the old Royal Victoria Hospital beds moving forward and links with the winter period. The Nurse Director advised there were a number of issues around these beds which consisted off two wards and 40 patients who generally were delayed discharge patients. It had been agreed these beds would remain in place until wards 109 and 209 at the Royal Infirmary of Edinburgh came on stream. The Nurse Director advised work was underway to help existing patients move to more appropriate settings and it would be important not to fill the released beds with similar patients. She advised that four wards had been refurbished at the Royal Victoria Hospital with consideration being given to another two wards which would give six wards in total which would be important given the limited decant opportunities available elsewhere. It was noted that these moves also linked with the Western General Hospital Site Master Planning Process. Mr Walker commented he was heartened to hear that this capacity would be kept in place.

67.9 The Vice Chair commented on the need to be aware of the significance of the challenges and noted the need for Medical Workforce issues to be informed by this level of detail. She suggested a simple guide to the challenges and building blocks would be helpful. The Director of Strategic Planning, Performance Reporting & Information commented that the 26 August workshop would address some of these issues.

67.10 Mr Walker on behalf of the Board congratulated Mrs Hornett on her new role as Director of Unscheduled Care and commented he genuinely felt progress was being made in this complex area.

67.11 The Board noted the performance against the emergency care standard and the progress of the Unscheduled Care Group.

68. Performance Management

68.1 The Director of Strategic Planning, Performance Reporting & Information advised that the paper represented his regular report to the Board and provided highlights in respect of the Child and Adolescent Mental Health Service (CAMHS), psychological therapies and cancer performance.

68.2 Mrs Blair commented in terms of the Board role that this was about seeking assurance about how issues were being addressed when targets were not being met. She did not feel that the comments in the appendix to the paper addressed these issues and felt there should be distinct recommendations contained in future papers. The Director of Strategic Planning, Performance Reporting & Information undertook to take these comments into account. Mr Walker supported Mrs Blair’s comments noting that 11 out of the 23 targets were off trajectory although some of
these had been addressed elsewhere on the agenda. The Chairman commented on the need in future for a more holistic approach to be taken as referred to previously by the Chief Executive.

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

69. **Healthcare Associated Infection Update**

69.1 The Nurse Director advised it was her intention in future to link this report with the revised Quality Paper as described by the Medical Director. It was noted that the focus of the next Healthcare Governance Committee would be on Healthcare Associated Infection.

69.2 The Board noted that the Healthcare Environmental Inspectorate (HEI) report for the Royal Infirmary of Edinburgh had been published on 24 June 2013 identifying five requirements for which an action plan had been developed.

69.3 The Board noted the progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian.

70. **Financial Position to 30 June 2013**

70.1 Mrs Potter reported an overspend of £1.16m in June bringing the financial position for the first 3 months of the year to a £1.92m overspend. It was noted that overall for the year to date, the key issues impacting on the £0.67m baseline overspend were the anticipated pressures on clinical supplies for which financial plan funding was not yet allocated; the unanticipated overspend on GP prescribing, a net pressure within nursing and incremental drift pressures around Estates with further work underway to quantify this further.

70.2 The Board noted that the outcome of the Quarter 1 Review would be discussed both at the Joint Management Team and the Finance & Resources Committee and thereafter back to the Board in September. Mrs Potter commented on and emphasised the need for strong financial control and assured the Board this message continued to be emphasised. Mrs Potter advised the Board that the year end continued to project a balanced financial position.

70.3 Mrs Blair expressed disappointment at the June financial position especially in relation to slippage and efficiency savings. She noted the underspend in medical and dental staff and the overspend in all of the Community Health Partnerships and St Johns Hospital. Mrs Potter advised that the underspend in medical and dental services related to vacancies and the position in respect of Community Health Partnerships related to the reported prescribing position. Mrs Potter undertook to advise Mrs Blair offline about the position in relation to St Johns Hospital.

70.4 Dr Williams reminded the Board that it was not only General Practitioners who prescribed and that the reference should be changed to Primary Care Prescribing.
70.5 The Board noted the financial position to the end of June 2013 and the projected year end balanced financial position.

71. **Corporate Objectives to 2013/2014**

71.1 The Director of Strategic Planning, Performance Reporting & Information advised that since the objectives had been approved by the Board in May 2013, revisions had been made to a number of corporate objectives to reduce duplication and improve alignment to national policy and he explained these in detail to the Board.

71.2 The Board approved the revised Corporate Objectives.

72. **Integration of Adult Health and Social Care in Scotland Consultation**

72.1 The Director of Strategic Planning, Performance Reporting & Information provided an update report to the Board including progress with the legislative Bill which had issued and was undergoing Parliamentary scrutiny with an evidence call having issued. The date for responding to the consultation had been extended to 16 August following negotiation.

72.2 The Board noted that a helpful meeting had been held with colleagues from the Scottish Government earlier in the week about the Corporate Body Model.

72.3 The Director of Strategic Planning, Performance Reporting & Information advised that all of the local partners involved had signed up to integration.

72.4 Mr Ash questioned whether there would be an NHS Lothian response suggesting this might be difficult given the different Local Authority perspectives. He commented that the national CHP Group was also calling for evidence and he would therefore welcome advice on how to respond to the various calls for evidence.

72.5 The Director of Strategic Planning, Performance Reporting & Information reported that a joint response had been submitted to the initial consultation and this would be referenced in future responses stating that early views were still firmly held. It would be important that the response to the evidence call teased out what the new models would mean in respect of delegation of functions to new Boards with the Board Workplan Session on 5 and 11 September being used to better understand the implications. The Director of Strategic Planning, Performance Reporting & Information confirmed there would be a response from NHS Lothian which would seek synergies with other partners.

72.6 Mr Wilson commented where differences existed there would be a need to be clear about what the implications would be for NHS Lothian. The Chief Executive commented the Board workshops on 5 and 11 September would discuss these issues although the generality of the NHS Lothian response would confirm commitment to the principles of integration whilst recognising that the Bill raised issues requiring clarification where these differed from the consultation. The NHS Lothian response would therefore be about seeking clarification around governance, accountability and ownership.
72.7 Mr Ash asked that Community Health Partnership Chairs have sight of the draft response before it was submitted. The Chief Executive advised there would be four joint responses although the kernel would be a consistent NHS Lothian position restating the terms of the original response to the consultation seeking clarification around the previously discussed issues which he would be happy to share with CHP colleagues. It was noted that the September sessions would colour in the detail.

72.8 The Chief Executive reminded the Board that a two month extension had been negotiated. The Parliamentary Committee would be advised that NHS Lothian would provide what evidence they could with further submissions being made following the September sessions if the Committee were minded to accept that proposal.

72.9 The Board noted the update position.

73. Keep Well Annual Report 2012/2013

73.1 The Chairman welcomed Dr J Tomlinson, Consultant in Public Health Medicine to the meeting.

73.2 Dr Tomlinson reported that the Keep Well Programme had been expanded in 2012/13 in line with Government guidance including a wider geographical area and new eligible patient groups. The programme provided additional clinical results for patients living in the most deprived areas. It was noted local evaluation had been positive but the research study on which it was based used 25 year old follow up data to demonstrate benefit compared with a controlled area.

73.3 The programme had engaged successfully with population groups who found traditional services hard to use. The lessons learned from the successful methods of engagement would be adopted more widely in the provision of planned and anticipatory care. Dr Tomlinson reported that the Scottish Government had indicated dedicated funding would remain in place until 2015.

73.4 The Board noted that more work had been undertaken with the Prison Service with particular success noted at Addiwell. Success had also been evident in the substance misuse arena.

73.5 Mrs Mitchell questioned what the barriers were in respect of some GPs reluctance to participate in the Keep Well Programme. Dr Tomlinson commented the issue was sometimes around the timing of the request with general practitioners often having other issues on their agenda. She commented some general practitioners did not believe health and equality should be addressed within the Primary Care setting.

73.6 Dr Williams commented his practice had initially been involved in the pilot but was no longer involved largely because of the lack of evidence around benefit and issues around the evaluation process. He suggested the main question for the Board would be funding issues once the Scottish Government funding ceased as future investments would need to be evidenced based.
73.7 Mr Wilson commented part of the work in progress would need to be around improving the evaluation process. Dr Tomlinson advised whilst this might be difficult for individual Boards, the national evaluation would be undertaken led by Health Scotland with a report being produced before funding ceased in 2014/15.

73.8 Dr Bryce commended the Keep Well Project advising that it embodied the principle of shifting from treating illness to preventing illness in the first instance. There were clear opportunities for engagement with the third sector.

73.9 The Director of Public Health & Health Policy explained to the Board the method of evaluation to be adopted and the reasons for the model adopted which needed to build into World Health Organisation and national Government requirements. It was noted systematic evaluation would be undertaken locally where possible.

73.10 The Board noted the update report and agreed the recommendations contained within.

74. **Anti Bribery Statement from the Board**

74.1 The Board agreed the following Anti Bribery Statement.

74.2 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 the 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 partners. We will not work with others who do not share our commitments 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:

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)

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**.

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"
75. Healthcare Governance Committee Terms of Reference

75.1 The Board agreed the revised Terms of Reference for the Healthcare Governance Committee.

76. Schedule of Board and Committee Meetings for 2014

76.1 The Board agreed the schedule of Board and Committee meetings for 2014 noting that the Board would now meet monthly on the first Wednesday of the month rather than the fourth Wednesday. The detail of how to use the meeting dates would be discussed at the Board Workshop to be held immediately following the Board meeting.

77. Committee Minutes for Adoption

77.1 Audit and Risk Committee - minutes of the meeting held on 24 June 2013 - The Board adopted the minutes.

77.2 Finance and Resources Committee - minutes of the meeting held on 12 June 2013 - the Board adopted the minutes.

77.3 East Lothian Community Health Partnership Sub-Committee - minutes of the meeting held on 27 June 2013 - the Board adopted the minutes.

77.4 Edinburgh Shadow Health and Social Care Partnership Sub-Committee - minutes of the meeting held on 14 June 2013 - the Board adopted the minutes.

77.5 Midlothian Community Health Partnership Sub-Committee - minutes of the meeting held on 30 May 2013 - the Board adopted the minutes.

77.6 West Lothian Health & Care Partnership Board - Action Note of the meeting held on 25 June 2013 - the Board noted the action note.

78. Date and Time of Next Meeting

78.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 25 September in the Board Room, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

79. Invoking Standing Order 15.2

79.1 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.
NHS LOTHIAN

Board Meeting
25 September 2013

Director of Strategic Planning, Performance Reporting & Information

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.

- CAMHS: 144 people started treatment in July of which 121 (84%) were treated within 18 weeks (compared to our current target trajectory of 75%).
  - There are currently 1315 patients waiting for treatment of which, at the end of May, 269 (20%) had been waiting over 18 weeks.
  - The total number of people waiting for treatment has decreased by 36 patients from 1351 in June to 1315 in July

- Psychological Therapies: in July 67 people had a first treatment for a formal psychological therapy in July, of which 47 (70%) were seen within 18 weeks.
  - 999 people were still waiting for treatment for a psychological therapy at the end of July of which 357 (36%) had been waiting over 18 weeks.

- Cancer: performance on cancer waiting times in July was 62 days – 97.5%, and 31 days – 99.5%.

- Delayed Discharges: In August there were 161 patients whose hospital discharge was delayed.

- Stroke: performance has improved to 82%. Work continues to get back towards the national 90% standard.

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Alex McMahon
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1 Purpose of the Report

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

2 Recommendations

2.1 Receive this update on the current performance against 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 5th 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 took place on 30 August 2013, was 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 9 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:

- 144 people started treatment in July of which 121 (84%) were treated within 18 weeks (compared to our current target trajectory of 75%).

- There are currently 1315 patients waiting for treatment of which, at the end of May, 269 (20%) had been waiting over 18 weeks.
• The total number of people waiting for treatment has decreased by 36 patients from 1351 in June to 1315 in July

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.

In relation to treatment within 26 weeks:
• Of the 144 people who started treatment in July, 124 (86%) started treatment within 26 weeks.
• Of the 1315 patients currently waiting for treatment 92 (8%) had been waiting over 26 weeks at the end of July.

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

July performance:

• 67 people had a first treatment for a formal psychological therapy in July, of which 47 (70%) were seen within 18 weeks.

• 999 people were still waiting for treatment for a psychological therapy at the end of July of which 357 (36%) 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 and the Head of Psychologically therapies services have begun working with the Consultant Psychologists to ensure active management of waiting lists and a focus of those currently waiting the longest for psychological therapies.

Although there have now been two national publications on Boards performance in respect of both CAMHS and psychological therapies it is not possible at this early stage to measure in any meaningful like for like way re performance as Boards have been given the opportunity to adjust waiting times across a range of measures such as non-attendance. At the same time we are still introducing a number of adult services into the measurement for psychological therapies and this will be complete over the course of this calendar year. However based on performance information to date we appear to benchmark against the national position for the HEAT target for both measures and we are just ahead of our own trajectory as set with the Scottish Government.
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 July performance was 95.1%. This was a marginal improvement on June which was 95% but this is the third month in succession that NHS Lothian has performed at or just above the new trajectory of 95%. Plans have been agreed with the Scottish Government for how we will get back to 98% by September next year. In so doing our current trajectory would have us at 91% for July 2013 so we are, based on the information above ahead of this.

4.1.5 Flouride Varnish Applications (Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

Performance has reduced in the worst performing quintile from 10.41% to 8.18%. Over the last three months Childsmile in Lothian has recruited a large number of new staff, many of whom will be working with and encouraging dental practices to apply fluoride varnish. We have also recruited additional dental nurses so that additional nurseries can be included in the NHSL Childsmile fluoride varnishing programme. However, because the ISD stats report on two applications within one year, the improvements we have made locally will not begin to show through in the ISD stats for at least another year. It may not be until the November 2014 data is published that we see the difference our increased activity is making.

There was a serious national supply problem with fluoride varnish for the first few months of 2013. The product was unavailable for some months. And so many general dental practices had no fluoride varnish for the three months to the end of March 2013.

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

NHS Health Scotland is producing national marketing materials as part of the Refreshed Framework for Maternity Care. These will be customised with local contact details, and distributed locally to those identified as target groups.
4.1.7 Suicide Reduction (Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

There were 143 suicides in Lothian in 2012 (18.8% of the Scottish total). This is an increase on 2011 (128) and highest yearly total in the last 25 years. Under the new coding rules Lothian had a total of 162 suicides. The age-sex-standardised suicide rate per 100,000 population has increased from 12.7 in 2003 - 2007 to 14.7 in 2008 – 2012. The 2012 total is made up of 105 males and 38 females. Much of the variation in the Lothian figures over the last 5 years appears to be due to changes in male suicide. Female deaths from suicide have been between 30 and 38 in that period. This information will be used in a number of ways to support thinking but also into how we review each suicide and take lessons learned from it, and also in supporting families and staff.

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 July 2013 for NHS Lothian was:

- 62 days – 97.5%
- 31 days – 99.5%

NHS Lothian continues to perform well against the two standards and has been working with Scottish Government colleagues in looking at how whole patient treatment journeys can be measured. In relation to the two standards reported in this paper we continue to perform above the 95% standard set for Scotland.

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 August 2013 census

<table>
<thead>
<tr>
<th>Total ISD Delays (incl. x-codes)</th>
<th>Total Delays (Excel. 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>Average length of stay as a delayed discharge Days (non-x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>August</td>
<td>161 ↑</td>
<td>112 ↑</td>
<td>49 ↓</td>
<td>39 ↑</td>
<td>66 ↑</td>
</tr>
</tbody>
</table>

- 112 delays after X codes removed (129 July, 109 June, 121 May)
- 161 overall including X codes (179 July, 169 June, 183 May)
- 39 Patients delayed >4 wks (37 July, 27 June, 26 May, 17 April)
- 27 days is the average length of stay (22 July, 20 June, 18 May, 16 April)
- Zero Non-Lothian delays
- 49 X codes (50 July, 60 June, 62 May, 53 April)
- 318 Overall number of patients held on the delayed discharge data base on census day (349 July, 361 June, 342 May)

This is a better performance than the last three months in numbers delayed, but the length of delay/bed days lost is getting higher.
The table below sets out the delays by reason in colour, against the number of weeks for August

<table>
<thead>
<tr>
<th>Weeks delayed</th>
<th>Number delayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1-5</td>
<td>1</td>
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<tr>
<td>6-10</td>
<td>1</td>
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<tr>
<td>11-15</td>
<td>1</td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
</tr>
<tr>
<td>21-25</td>
<td>1</td>
</tr>
<tr>
<td>26-30</td>
<td>1</td>
</tr>
</tbody>
</table>

- Care Homes are the longer waits (blue and yellow), with residential the longest.
- Waiting on packages to go home (purple) are predominantly within 3-4 weeks, but if we miss that window its taking between 8-10 weeks. This is the more complex packages—often require overnight cover and double ups for staff during the day. These take longer to coordinated across the various providers
- Housing (pink) takes time and is a combination of patients/clients having to bid on lists that are issued weekly—and the interface across the Social Work-Housing and Hospital processes.
- Our performance against the 4 week target is improving at ground level in spotting the challenging cases earlier.

The Partnership numbers
- Edinburgh has 87 down on 91 in July—although those waiting over 4 weeks is up at 39.
- East with 21, which is a significant improvement over the last three months.
- Midlothian has 4 and all are less than two weeks
- West Lothian has Zero.
- The over 4 weeks (mostly Edinburgh) have moved our average length of stay to 27 days, up from 22 in July.

4.2.3 Stroke (Responsible Director: Nurse Director)

Performance has moved about improved from 79% in May to 74% in June to 82% in July. Weekly exception reports have focused the improvement of performance in other stroke standards but the availability of acute stroke beds continues to be the main factor in achieving this standard.

We will look to increase the capacity of the WGH integrated stroke unit to more effectively support these flows. An expansion of the cohort of outreach nurses to provide assertive day-to-day leadership to pull patients into our stroke units will be explored, and a daily pan-Lothian "huddle" will be established to help manage stroke flow at a clinical front-line level.
4.2.4 Emergency Bed Day Rate 75+yrs. (Responsibility 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.

4.2.5 Unscheduled Care (Responsibility Director: Director of Unscheduled Care)

The unscheduled care performance across Lothian for July was 95.6%.

It is anticipated that the August position will also exceed 95% which will be first time performance for two consecutive months have exceeded 95% since November 2011. SJH attained 98% for the month for the first time since September 2011.

Performance gains have in part been due to seasonal factors (eg reduced rates of norovirus) but have also been due to on-going work associated with site based management and the implementation of the workplan set out in the Local Unscheduled Care Action Plan (LUCAP) that was approved by the Board in June. The overall position remains challenging and significant further work is required to progressed planned initiatives (e.g. Step Down beds, Hospital at Weekend, opening of the additional beds at Royal Infirmary of Edinburgh) to ensure sufficient capacity for unscheduled care.

The LUCAP has now been reviewed by the Scottish Government who have provided very positive feedback on the plan submitted. The plan has been positively received and the Scottish Government have confirmed the release of funding to support the plan. A full year contribution of £1,022,317 has been approved for 2014/15 and 2015/16 with a part year effect of £681,545 allocated for 2013/14. This includes a contribution from the T10 fund. This amount will be augmented with a non-recurring allocation of £350,000 in recognition of the work
being deployed currently across NHS Lothian to stabilise the position. NHS Lothian will also receive a further £50,000 in recognition of the superior rating that the LUCAP submission achieved. These amounts are in addition to the £250,000 already allocated to support new A&E consultants. This will bring 2013/14 total allocation to £1,331,545. This resource will be considered by the Unscheduled Care Group along with Change Fund resources to ensure the prioritisation of existing proposals for improved flow and capacity.

The Unscheduled Care Group has set up an evaluation panel – which has met twice – whose role is to critically evaluate all the current investments with a view to reviewing these investments. This will also cover future planned investments and this work, along with a review of 2014/15 priorities will bring the financial projections for 2014/15 back into line with the Financial Plan.

The Unscheduled Care group is also working with the CHP/LA Partnerships to discuss the overall impact of Change Fund investments and this will be considered as part of the overall financial planning for 2015/16, the Change Fund having ended on 31/3/2015.

The UCG is also working closely with Partners to support the Lothian Winter Planning process and to consider the Primary Care Capacity plan. All of these matters being captured in the UCG Financial Outline.

**Revision to Unscheduled Care improvement trajectory**

Earlier in 2013 NHS Lothian submitted its Local Unscheduled Care Plan (LUCAP) to the Scottish Government. This outlined planned actions to achieve sustained improvement in unscheduled care services across NHS Lothian. The plan also included a proposed trajectory to reach 95% by September 2014. The LUCAP has been welcomed by the Scottish Government who have released funding accordingly for 2013/14 as well as 2014/15 and 2015/16. However the Scottish Government have requested that the trajectory be adjusted to demonstrate achieving 95% as an average level of performance at a Board level for October 2013-September 2014. The revised trajectory is shown below.
5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

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List of Appendices

Appendix 1: Performance Management Scorecard
### Health Improvement

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Lothian Milestones Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Officer</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Improvement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Healthy Weight - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14 (add: requirement that at least 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)</strong></td>
<td>Mar-14</td>
<td>11,686</td>
<td>Apr-13 to Dec-12</td>
<td>11,276</td>
<td>↑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Suicide Reduction - % of suicides per yr per 100,000 population</strong></td>
<td>2013</td>
<td>20%</td>
<td>2009-11</td>
<td>13.7%</td>
<td>2009-12</td>
<td>14.7%</td>
<td>30%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Smoking Cessation - to deliver universal smoking cessation services to achieve at least 11,886 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within Board SIMD areas over the period 2011/12 to 2013/14</strong></td>
<td>Mar-14</td>
<td>11,686</td>
<td>Apr-13 to May-13</td>
<td>8,650</td>
<td>↑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>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</strong></td>
<td>Mar-14</td>
<td>60%</td>
<td>2014/15</td>
<td>30.90%</td>
<td>2015/16</td>
<td>29.10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>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</strong></td>
<td>Mar-14</td>
<td>60%</td>
<td>2014/15</td>
<td>30.90%</td>
<td>2015/16</td>
<td>29.10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Detecting Cancer Early - of all those diagnosed with breast, colorectal and lung cancer, 20% are to be diagnosed while in the first stage of the disease</strong></td>
<td>Mar-15</td>
<td>29%</td>
<td>Baseline</td>
<td>22.60%</td>
<td>2013/14</td>
<td>0.24</td>
<td>80%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Reduce Carbon Emissions - % reduction year-on-year (Tonnes of CO2)</strong></td>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qtr 3, 12/13</td>
<td>6.07%</td>
<td>Qtr 4, 12/13</td>
<td>6.59%</td>
<td>5.91</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Reduce Energy Consumption - % reduction year-on-year (Energy GJ)</strong></td>
<td>Mar-15</td>
<td>-2.07%</td>
<td>Qtr 3, 12/13</td>
<td>1.49%</td>
<td>Qtr 4, 12/13</td>
<td>1.34%</td>
<td>1.88</td>
<td>↓</td>
</tr>
</tbody>
</table>

### Efficiency

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Lothian Milestones Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Officer</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster access to CAHIS - deliver 18 wks Referral to Treatment</td>
<td>Dec-14</td>
<td>0</td>
<td>May-13</td>
<td>1%</td>
<td>Jul-13</td>
<td>6%</td>
<td>75%</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>May-13</td>
<td>4%</td>
<td>Jul-13</td>
<td>6%</td>
<td>70%</td>
<td>↑</td>
</tr>
</tbody>
</table>

### Treatment Appropriate for Patient

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Lothian Milestones Current Period</th>
<th>Trend</th>
<th>Status</th>
<th>Lead Officer</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A&amp;E Attendances - rate of A&amp;E attendances per 100,000 population</strong></td>
<td>Mar-14</td>
<td>1,911</td>
<td>May-13</td>
<td>2,105</td>
<td>Jun-13</td>
<td>2,043</td>
<td>1,942</td>
<td>↓</td>
</tr>
<tr>
<td><strong>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</strong></td>
<td>Mar-15</td>
<td>0.24</td>
<td>Jun-13</td>
<td>0.25</td>
<td>Jul-13</td>
<td>0.38</td>
<td>0.28</td>
<td>↑</td>
</tr>
<tr>
<td><strong>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</strong></td>
<td>Mar-15</td>
<td>0.25</td>
<td>Jun-13</td>
<td>0.40</td>
<td>Jul-13</td>
<td>0.42</td>
<td>0.32</td>
<td>↓</td>
</tr>
</tbody>
</table>

Note: Where Target includes breakdown by quintiles, Trend uses bottom cell to calculate analysis.
### Reduction in emergency bed day rates for patients aged 75+

<table>
<thead>
<tr>
<th>Target</th>
<th>Mar-15</th>
<th>Jan-13</th>
<th>CEC 5457</th>
<th>Feb-13</th>
<th>CEC 5344</th>
<th>5,037</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian</td>
<td>3,143</td>
<td>5,981</td>
<td>6,014</td>
<td>5,924</td>
<td>5,223</td>
<td></td>
</tr>
</tbody>
</table>

*Based on rolling year - an SMOUG return, previous months’ totals subject to change as longer stay patients are discharged.*

Lothian continues on a downward trajectory month-on-month, distance to Scott Gov deadlines has reduced to 4.6% from 5.7% (January 2013). City of Edinburgh rates continue to fall ahead of trajectory, with Midlothian and East Lothian level, and West Lothian showing a slow fall. West continues to be the only council area below target.

**Milestones reduce by 0.3% month-on-month**

### Delayed Discharges

- **no people wait more than 28 days from April 2013, followed by a 14 day maximum wait from April 2013**

<table>
<thead>
<tr>
<th>Target</th>
<th>Apr-15</th>
<th>Jul-13</th>
<th>37</th>
<th>Aug-13</th>
<th>39</th>
<th>43</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduction in emergency bed day rates for patients aged 75+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Milestones

- **Milestones reduce by 0.3% month-on-month**

### Dementia Diagnosis

- **all people newly diagnosed with dementia will have a minimum of 90 days’ worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan**

### 4-hour A&E

- **95% of patients waiting less than 4 hours from arrival to admission, discharge or transfer for A&E treatment as a minimum**

<table>
<thead>
<tr>
<th>Target</th>
<th>Apr-15</th>
<th>Jun-13</th>
<th>99%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduction in emergency bed day rates for patients aged 75+</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Drug and Alcohol waiting times

- **90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery**

<table>
<thead>
<tr>
<th>Target</th>
<th>Standard</th>
<th>90%</th>
<th>Jan-Mar 2013</th>
<th>100.00%</th>
<th>April-June 2013</th>
<th>95.40%</th>
<th>90.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduction in emergency bed day rates for patients aged 75+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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&E, or referred from one of the national cancer screening programmes**

<table>
<thead>
<tr>
<th>Target</th>
<th>Standard</th>
<th>95%</th>
<th>Jun-13</th>
<th>95.00%</th>
<th>Jul-13</th>
<th>95.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduction in emergency bed day rates for patients aged 75+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Stroke Unit

- **90% of all stroke patients to be admitted to a stroke unit on day of admission or the day following presentation**

<table>
<thead>
<tr>
<th>Target</th>
<th>Ongoing</th>
<th>90%</th>
<th>Jun-13</th>
<th>74%</th>
<th>Jul-13</th>
<th>82%</th>
<th>80%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduction in emergency bed day rates for patients aged 75+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COMMITTEE MEMBERSHIPS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree to appoint Chris Stirling, Site Director at St John Hospital, to West Lothian Community Health & Care Partnership Sub-Committee.

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

2 Recommendations

2.1 It is recommended that the Board agrees to appoint Chris Stirling, Site Director at St John Hospital, to West Lothian Community Health & Care Partnership Sub-Committee.

3 Key Risk

3.1 If Chris Stirling is not appointed, the St John’s Hospital Site Director will not be represented on the West Lothian Community Health & Care Partnership Sub-Committee.

4 Risk Register

4.1 There are no implications for NHS Lothian’s Risk Register.

5 Impact on Inequality, Including Health Inequalities

5.1 Not required as this is an administrative matter.

6 Involving People

6.1 This proposal has been discussed with Chris Stirling and Councillor Frank Toner, Chair of the West Lothian Community Health & Care Partnership Sub-Committee is aware of the proposed appointment.

7 Resource Implications

7.1 There are no resource implications.

Peter Reith
Secretariat Manager
12 September 2013
peter.reith@nhslothian.scot.nhs.uk
SUMMARY PAPER - CORPORATE RISK REGISTER

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

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

<table>
<thead>
<tr>
<th>Para</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There are 19 risks currently being managed on the NHS Lothian Corporate Risk Register compared to 17 set out in the June 2013 Board paper; 12 of which have a risk level of high and 7 of medium level.</td>
</tr>
<tr>
<td>• The risk of Medical Workforce Sustainability has replaced the Sustainability of Paediatric &amp; Neonatal Services at St. Johns Hospital and highlights key service sustainability issues around Paediatrics, Emergency Medicine and Obstetrics &amp; Gynaecology.</td>
</tr>
<tr>
<td>• The new risks are Lack of Management Capacity (3531) and Data Quality (3486), both of which are high risks. Data Quality was highlighted in the June 2013 Board report as an emerging risk.</td>
</tr>
<tr>
<td>• One risk has been reduced – statutory equality duties, from Medium 6 to Medium 4.</td>
</tr>
<tr>
<td>• Table 1 illustrates minimum movement in risk grading over the last year.</td>
</tr>
<tr>
<td>• There is a strong correlation between the number of high risks and corporate objectives 6 and 8. The Board has stated it has a minimal risk appetite towards the delivery of objective 6 - staff and patient safety.</td>
</tr>
</tbody>
</table>
NHS LOTHIAN

Board Meeting
25 September 2013

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

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

2 Recommendations

2.1 Review the updated NHS Lothian Corporate Risk Register, highlights of which are contained in section 3.3 and summarised in Appendix 1.

3 Discussion of Key Issues

3.1 Corporate Risk Register – summary of key changes:

3.1.1 There are 19 risks currently being managed on the NHS Lothian Corporate Risk Register compared to 17 set out in the June 2013 Board paper; 12 of which have a risk level of high and 7 of medium level.

3.1.2 The risk of Medical Workforce Sustainability has replaced the Sustainability of Paediatric & Neonatal Services at St. Johns Hospital and highlights key service sustainability issues around Paediatrics, Emergency Medicine and Obstetrics & Gynaecology.

3.1.3 The new risks are Lack of Management Capacity (3531) and Data Quality (3486), both of which are high risks. Data Quality was highlighted in the June 2013 Board report as an emerging risk. Lack of Management Capacity has been highlighted before at a number of Board governance committees and in particular the Audit & Risk Committee.

3.1.4 Risk 2819, concerning non-compliance with statutory equality duties, has been reduced from a Medium 6 to a Medium 4 due to increasing controls and year on year improvement in Ethnicity Coding compliance and Rapid Impact Assessments.

3.2 Table 1 below provides a summary of the corporate risks and movement in risk grading over the last year. Appendix 1 provides additional details of each individual risk plus recent updates made. If you have an electronic version they have been embedded in the table below (please click on individual Datix risk). This table illustrates that there has been minimal movement in risk grading over the last year.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3531</td>
<td>New risk</td>
<td>High 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of Management Capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3486</td>
<td>New risk, May 2012</td>
<td>High 12</td>
<td></td>
<td>Risk opened 24/05/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3527</td>
<td>Medical Workforce Sustainability</td>
<td>High 16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New risk which replaces/incorporates: ID 1103 Paediatric Services at St John's Hospital, now closed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3480</td>
<td>Patient Safety (Safety Measures in monthly Quality Report SPSP reported January &amp; June 2013 to Board)</td>
<td>High 16</td>
<td>Date opened 13/02/2013</td>
<td>High 16</td>
<td>High 16</td>
<td>High 16</td>
</tr>
<tr>
<td>3189</td>
<td>Maintenance Backlog (Reported through Finance &amp; Resources Committee via Minutes)</td>
<td>High 15</td>
<td>High 15</td>
<td>High 16</td>
<td>High 16</td>
<td>High 16</td>
</tr>
<tr>
<td>1085</td>
<td>Public Protection (Child, Adult, MAPPA) (Standing item on HCG Committee. Reported to Board via Minutes)</td>
<td>High 16</td>
<td>Very High 20</td>
<td>High 15</td>
<td>High 15</td>
<td>High 15</td>
</tr>
<tr>
<td>3455</td>
<td>Health &amp; Safety (Reported at H&amp;S Committee, via Staff Governance Committee Minutes)</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>High 15</td>
<td>High 15</td>
<td>High 15</td>
</tr>
<tr>
<td>3328</td>
<td>Roadway / Traffic Management (Risk escalated from UHD 06/03/2013) (Reported at H&amp;S Committee, via Staff Governance Committee Minutes)</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
</tr>
<tr>
<td>3454</td>
<td>Patient Experience (Complaints reporting and National Person-Centred Programme reported to Board March 2013)</td>
<td>High 12</td>
<td>Date opened 13/02/2013</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
</tr>
<tr>
<td>1086</td>
<td>Litigation exposure (To be reported to August HCG Committee (2013) and to September Audit &amp; Risk Committee, to Board via Minutes)</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
</tr>
<tr>
<td>3211</td>
<td>Achievement of National Waiting Times Targets (Standing Board Agenda item under Performance Report)</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>3203</td>
<td>Unscheduled Care (Title changed from Delay Discharges Jan 2013) (On Board agenda under Performance Management)</td>
<td>High 10</td>
<td>High 10</td>
<td>High 10</td>
<td>High 10</td>
<td>High 10</td>
</tr>
<tr>
<td>2964</td>
<td>The Board does not achieve its financial targets each year on a sustainable basis. (Standing item on Board Agenda under Performance Management)</td>
<td>High 15</td>
<td>High 15</td>
<td>High 10</td>
<td>Medium 9</td>
<td>Medium 9</td>
</tr>
<tr>
<td>1076</td>
<td>Healthcare Associated Infection (Standing item on Board Agenda)</td>
<td>Medium 16</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
</tr>
<tr>
<td>1267</td>
<td>The Board’s Capital Plan cannot be delivered (Property Assessment Management Investment Programme 2013/14 – 2017/18 reported to March 2013 Board)</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
</tr>
<tr>
<td>1268</td>
<td>Equal Pay Claims (Reported at Staff Governance Committee via Minutes to Board)</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
</tr>
<tr>
<td>2812</td>
<td>Data Protection Act 1998 Compliance (Reported to HCG Committee and to Board via Minutes)</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
</tr>
<tr>
<td>1966</td>
<td>Preparedness in Emergency Planning (Reported via HCG Committee Minutes to Board)</td>
<td>Medium 12</td>
<td>Medium 8</td>
<td>Medium 8</td>
<td>Medium 8</td>
<td>Medium 8</td>
</tr>
<tr>
<td>2819</td>
<td>Non-compliance with statutory equality duties (Standing item on HCG Committee Agenda. Equality outcomes for 2013-17 reported to March 2013 Board)</td>
<td>Medium 6</td>
<td>Medium 6</td>
<td>Medium 6</td>
<td>Medium 6</td>
<td>Medium 4</td>
</tr>
</tbody>
</table>

### 3.3 Corporate Objectives 2013/14

The corporate risks have been set against the 2013/14 corporate objectives along with agreed risk appetite. There is a strong correlation between a number of risks and objectives 6 and 8 as illustrated in Table 2 below. There are also a number of risks, particularly around staff and patient safety that are high risk and have a minimum agreed risk appetite. It is however acknowledged there are significant inter-relationships between risks and across corporate objectives.
Table 2 - Summary of Objectives & Risk Level

<table>
<thead>
<tr>
<th>NHS Lothian Corporate Objectives</th>
<th>Very high risk</th>
<th>High risk</th>
<th>Medium risk</th>
<th>Low risk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: To transform the management culture of the organisation  * Risk Appetite – Cautious</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2: To plan and deliver the waiting times recovery plan to clear the backlog of patients and develop recurring demand/capacity equilibrium  Risk Appetite – Minimal</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3: To improve unscheduled care performance  Risk Appetite – Minimal</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4: To develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements  Risk Appetite – Open</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>5: Effective internal and external communications  Risk Appetite – Cautious</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6: To Improve Staff and Patient Safety  Risk Appetite – Minimal</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>7: Implementation of the Patient Centred Collaborative  Risk Appetite – Minimal</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8: To live within available financial resources, develop a sustainable financial plan and deliver the capital investment plan  Risk Appetite – Open</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>9: To protect health, improve health status and tackle health inequalities  Risk Appetite – Open</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10: To have a robust system of performance management and reporting aligned to delivery of government targets  Risk Appetite – Cautious</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>12</td>
<td>7</td>
<td>0</td>
<td>19</td>
</tr>
</tbody>
</table>

* Risk Appetite is defined as: Low Appetite – certainty of delivery and High Appetite – level of acceptance the objective is not delivered.

3.4 Governance Committees

The Healthcare Governance, Staff Governance and Finance & Resources committees are regularly reviewing risks pertinent to each committee and these risks are being used to inform committee assurance requirements.
4 Key Risks

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

5 Risk Register

5.1 Not applicable.

6 Impact on Health Inequalities

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

7 Resource Implications

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

Jo Bennett
Clinical Governance & Risk Manager
11 September 2013
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

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

<table>
<thead>
<tr>
<th>New Risk</th>
<th>ID</th>
<th>NHS Lothian Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Risk Owner</th>
<th>Assurance</th>
</tr>
</thead>
</table>
| 3531     |    | 1.Transform the management culture of the organisation | Lack of Management Capacity | There is a risk that management capacity, particularly in the acute sector and at executive level, will impact on developing and implementing robust plans to deliver key strategic objectives, or that operational management will be stretched to the extent that objectives are not met. | - Board reports on delivery of organisational objectives, risks and response.  
- Annual appraisals and mid-year reviews.  
- Review of organisational development needs including visible leadership at points of care.  
- Articulate organisational priorities to focus management efforts and identify areas of risk the organisation can tolerate in areas, particularly around internal audit recommendations.  
- Audit & Risk Committee commission internal audits and monitor recommendations and management actions.  
- Staff Governance Committee to lead on management capacity and capability from a governance perspective. | - Additional senior management capacity and workforce planning approved.  
- Fourth Director of Health & Social Care appointed and started  
- Melanie Hornett to do Director of Unscheduled Care and backfill identified  
- Director of Scheduled Care will in place by end Nov 2013.  
- Temporary management arrangements in acute division put in place (Aug/Sept 2013)  
- Need to assess management capability issues.  
- Need to assess layers of management  
- Report to go to September 2013 Audit & Risk Committee on achievements/ non-achievements of management actions against internal audit reports  
- Consideration being given to additional compliance monitoring. (Director of Finance – Internal Audit), (Director of HR&OD – OH&S) | Adequate but ineffective; control is properly designed but not being implemented properly | High 15 | Low 3 | Tim Davison | Staff Governance Committee |
<table>
<thead>
<tr>
<th>ID</th>
<th>NHS Lothian Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
</tr>
</thead>
</table>
| 3527| Medical Workforce Sustainability | Medical Workforce Sustainability           | There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian’s ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology. | - In response to a request from the SEAT Planning Board, a medical workforce risk assessment tool has been developed and initial implementation is nearing completion across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk.  
- For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group. This group will co-ordinate actions across Boards within SEAT and feed into the national medical workforce planning processes co-ordinated by NES/SG.  
- There is a monthly report taken to the Board updating on actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas.  
- For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures.  
- A medical workforce group is being established to co-ordinate medical workforce planning across specialties. | The risk assessment process is fit for purpose and has provided a higher degree of control through an improved understanding of the range of risks and their level of severity.  
- This process enables the Board to contain and minimise risks for those factors under its direct influence and to influence national decision making.  
- However, there are a number of factors outside the control of NHS Lothian which can be assessed but not directly controlled, e.g. international recruitment. |

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| 3486 | 6: Improve Staff and Patient Safety - Minimal Risk Appetite | Data Quality    | There is a risk that poor data quality impacts upon patient safety. Poorly entered data could lead to the incorrect information being extracted for patient management or performance reporting.                                                                                                                                       | - A Data Quality Steering Group has been established to identify and address risks associated with poor data quality. The actions being taken forward are: Induction training for all new staff.  
- Undergraduate training for Nurse and Drs, training for Bank Staff. TRAK refresher courses linked with SOP training for waiting times.  
- Reduce DNA for TRAK refresher courses. Address issues in Medical Coding. Communicate the importance of Data Quality to all staff. | June 2013: New risk identified and entered onto Datix.  
Reviewed July 2013: Risk grade/rating remains unchanged High/12 | Uncertain; impact of controls not known at this time and more work required to identify current situation | High 12                                                                                         | Medium 9                                                                                   | Alex McMahon          | Healthcare Governance Committee |
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| 3480 | Improve Staff and Patient Safety - Minimal Risk Appetite | Patient Safety | There is a risk that patient safety is compromised due to unreliable care and sub-optimal incident management leading to potential patient harm.  
  - The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to patient safety.  
  - Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response.  
  - The Patient Safety Programme reports to relevant governance committees of the Board setting out compliance with process and outcome safety indicators and includes external monitoring.  
  - Quality Improvement Strategy (2011-14) sets out a range of improvement programmes to improve safety and outcomes of care.  
  - Quality of care which includes patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit & Risk Committee and HCG Committee when appropriate. | July 2013: Risk reviewed.  
  Funding application submitted to ensure timely delivery of the HSMR and Harm Reduction Plan.  
  June 2013 Quality Report provides SPSP updated to the Board.  
  New programmes initiated including Maternity and Mental Health.  
  Risk grade/rating remains unchanged High/16 | Uncertain; impact of controls not known at this time and more work required to identify current situation | High 16 | High 16 | Medium 6 | Dr David Farquharson | Healthcare Governance Committee |
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| 3189 | Financial Resources and Plans - Open | Maintenance Backlog              | Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk. | • The backlog maintenance sum has been reported at circa. £140 million. The Property Asset Management Strategy (PAMS) 2013-2020 describes how this figure will be reduced by disposals and Reprovision Programme.  
• F&R have agreed to fund an initial £10 million expenditure on the high and significant risks over the next 18 months. A further £5m will be allocated until 2017/18 from the Board’s Capital Allocation to address backlog maintenance works.  
• A programme of works has commenced to undertake high and significant risks. The programme will continue into the financial year 2013/14. Within the Boards Capital Investment Plan a commitment of £5m has been allowed to continue the programme of works over a five year period.  
• An update of the PAMS for next year will log the affect upon the backlog maintenance and compliance figure  
• A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance.  
• A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years.  
• Rationalisation of the estate through planned disposals and termination of leases | July 2013: Risk reviewed. The revised BLM figure reported in the 2013 PAMS is circa £96.8m. Reduction due to a number of factors – capital investment, disposal, relocation of services, review of existing data in EAMS.  
A programme of works costing approximately £5.1m was completed March 2013. Planning and Procurement is underway for a programme of works to address the high and significant risks during 2013.14. and for future years  
The BLM programme of works for 2012/13 will be reflected in the PAMS and should provide a reduction in the cost.  
The Programme Board will oversee and agree priorities in line with Boards view on risk.  
4 Properties now being marketed. Leases now terminated.  
Risk grade/rating remains unchanged High/16. | Adequate but ineffective; control is properly designed but not being implemented properly | High 16 | Medium 4 | Alan Boyter | Finance & Resources Committee |
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| 1085 | 6 Improve Staff and Patient Safety - Minimal Risk Appetite | Public Protection (Child, Adult, MAPPA) | There is a risk of harm to individuals and to the Organisation's reputation because of increasing complexity of cases, reduced capacity of medical and nursing specialist services including the vacancy for the Designated Doctor for Child Protection and the limitations of the existing IM &T infrastructure. This has the potential to be a contributing factor in the occurrence of harm to a patient, public or member of staff. This may lead to adverse outcome for the organisation. | • A revised structure for Public Protection following a review in 2011 is now firmly embedded across NHS Lothian.  
• Designated leads for child and adult protection as well as the Multiagency Arrangements for Public Protection (MAPPA) are in place reporting directly by the Assistant Director for Public Protection to the Executive Director for Public Protection (Public Protection Framework attached).  
• The Public Protection arrangements are supported by range of robust policies, procedures and guidelines both interagency and health.  
• A comprehensive Public Protection training strategy is in place.  
• The governance arrangements for public protection are monitored by the Executive Lead through the relevant public protection action groups.  
• There are interagency structures in place across Lothian to ensure effective partnership working at operational and strategic level.  
• Processes are in place with health and interagency to investigate significant incidents and disseminate learning. | July 2013: Risk reviewed. The role requirements for Designated Doctor for Adult Support and Protection have been outlined and work is still required to identify a named individual who is able to undertake this commitment.  
The Revision of guidelines Protecting Children living in Families with Problem Substance Use have been completed and launched across Lothian in April and May 2013. The implementation of the guidelines commenced 1st June. The training programme is near completion and will be piloted in July/August 2013.  
Recruitment to the post of Doctor for Child Protection has been unsuccessful. Measures are still being explored to recruit to the post. A lead paediatrician for Edinburgh has been agreed and interim arrangements are in place to cover West Lothian.  
An internal Audit for MAPPA has just been completed with an overall rating of Satisfactory. The report highlighted the ongoing developments.  
The Assistant Director Public Protection is in the process of recruiting to the Operational MAPPA post. It is anticipated this post will be filled by end August 2013.  
Risk grade/rating remains High 15 | Uncertain; impact of controls not known at this time and more work required to identify current situation | High 15 | Medium 9 | Melanie Hornett | Healthcare Governance Committee |
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| 3455 | 6:Improve Staff and Patient Safety | Health & Safety | There is a risk of Corporate Prosecution by HSE under the Corporate Homicide Act or the H&S at Work Act Section 2, 3 and 33 or any relevant H&S regulations. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being. | • Closed loop Health & safety management system in place.  
• Robust H&S Committee structure.  
• H&S policies and procedures in place (attached document).  
• Competent specialist H&S advice in place. Robust Occupational Health Services. Learning lessons through incident investigation.  
• Director of Occupational Health & Safety/Occupational Physician delivers an annual report to the NHSL H&S Committee with specific actions within these reports. | July 2013: Risk reviewed. NHS Lothian has received a recent HSE Improvement Notice highlighting a material breach of legislation. In addition, the recent RoSPA Audit has highlighted current gaps in H&S Management systems.  
Risk grade/rating remains unchanged - High/15 | Adequate but ineffective control is properly designed but not being implemented properly | High (Target) | Alan Boyter | Staff Governance Committee |
| 3328 | 6:Improve Staff and Patient Safety | Roadways / Traffic Management | There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites | • Traffic surveys have been conducted across all hospital sites, and action plans have been prepared. High risk actions have been completed where funding has permitted  
• Actions include:  
  o segregation of vehicle and pedestrian traffic;  
  o walk ways;  
  o drop-off areas and disabled spaces;  
  o additional parking attendants.  
• Interim measures have been put in place to prevent illegal parking including temporary barriers and bollards  
• RIE Site Campus Group has been put in place to co-ordinate the re-provision of DCN & RHSC, including impact on activity on traffic management  
• Action plans have been revisited on a number of hospital sites and has resulted in additional high risk works being undertaken | July 2013: Risk reviewed. A Business Case has been developed for improvements at SJH. Recommendations and costs now received. Business Case required to be submitted.  
A further review of traffic management is ongoing on the WGH site following the recent fatality on site in Dec 12. A series of options has been proposed and a Capital submission is now being developed for submission.  
Risk grade/rating remains unchanged - High/12 | Uncertain, impact of controls not known at this time and more work required to identify current situation | High (Target) | Alan Boyter | Staff Governance Committee |
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| 3454 | 7. Implementation of the Patient Centred Collaborative - Minimal Risk Appetite | Patient Experience | There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times.                                                                                                                                                                                                                                                                                                                                                       | ▪ The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care.  
▪ Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response.  
▪ Quality Improvement Strategy (2011-14) set out a range of improvement programmes to improve patient experience and outcome of care.  
▪ Delivering Better Care structures in place to deliver Older People’s Action Plan and Vulnerable People’s Quality Improvement Framework, reported to the Board through the executive lead. These plans are informed by inspection reports produced by Healthcare Improvement Scotland and local audit and regular checklists i.e. PQI and mock CPAH.  
▪ The Delivering Better Care Hub has been established as a primary resource for nursing staff and where appropriate, other disciplines.  
▪ As part of the improving care to vulnerable people the rollout of a support manual with detailed information inclusive of a rapid patient essential care check sheet has been implemented within acute areas and planning now in place to roll out to community settings.  
▪ Quality of care is subject to Internal Audits and compliance with audit recommendations reported via Audit & Risk Committee and Healthcare Governance Committee.  
▪ A new national Person Centred Programme has been launched which NHS Lothian is taking part in, with the aim of capturing and responding to patient experience of care, including enhancing active involvement of patients in their care and co-production. This will be reported via governance committees of the Board. | July 13: Risk reviewed. DBHC Hub resource now established WGH site. Open days to be held in August. Vulnerable People’s Quality Improvement Framework updated and includes PCC reference. Critical friend review conducted and feedback expected July 13. Resource packs (manuals) have now been delivered to all in patient areas of acute service and 100 staff identified as key links. Work has started on refining this resource for primary care settings. Project Lead for person centred work appointed, commenced 24 June 13. Person Centred Reference Group created and work has commenced on determining local measures for this work. | High 12 | Medium 6 | Melanie Hornett | Healthcare Governance Committee | Uncertain; impact of controls not known at this time and more work required to identify current situation | High 12 |
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| 1086| 6 Improve Staff and Patient Safety - Minimal Risk Appetite | Litigation exposure | There is a risk of: High cost claims relating to both patient and staff experience. Risk of adverse publicity relating to initial incidents and time taken to resolve claims. Risk of ineffective learning leading to repeat incidents.  | • Operational SOPs are in place for the recording, investigation and reporting of claims.  
• Litigation and learning to be reported at the Audit & Risk Committee to inform assurance reporting.  
• Work ongoing with Clinical Governance Team and UHD  
• Corporate Nursing colleagues to develop a process for sharing lessons learned from claims, and follow-up of action plans - planned pilot process in WCDN being set-up.  
• Scottish Patient Safety Programme (SPSP) in place includes process outcome measures to improve safety and reduce harm related HAI surgical and medical process which are highlighted as issues in claims.  
• Patient Safety in Maternity Care initiated with internal and external reporting.  
• Health & Safety review initiated of NHS Lothian Health & Safety Management System.  
• Health & Safety Incident monitoring to Health & Safety Committee  
• Claims annual report to Health & Safety Committee which includes H&S claims. | July 2013: Risk reviewed.  
Annual Report submitted to HCG Committee in June 2013. Report to be submitted to Audit & Risk Committee September 2013.  
A review of litigation claims 2009 – 2013/14 highlighted maternity claims continue to be the high value claims due to the nature of the claims.  
Risk grade/rating remains High 12 | Satisfactory, controls adequately designed to manage risk and working as intended | High 12 | Low 2 | Dr David Farquharnson | Finance & Resources Committee |
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| 321 | 2. Plan and Deliver Waiting Times Recovery Plan - Minimal Risk Appetite | Achievement of National Waiting Times Targets | There is a risk of: Not achieving national waiting times targets (stages within the 18 weeks RTT pathway; 31/62 Cancer waiting times; treatment time guarantee;) for a number of reasons: Lack of core capacity in a number of specialties; Internal capacity not being utilised effectively; Risk of overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money. Lack of robust management process and staff capability to deliver consistent management of waiting lists. Risk of adverse publicity relating to failure to meet waiting times targets. | • Waiting Time Recovery and Sustainability Group meets weekly chaired by the Medical Director to ensure the delivery of in-patient/day case and out-patient activity to reduce the backlog. There is monitoring of the financial impact of the recovery plans. The performance against the Treatment Time Guarantee is monitored.  
• Development and implementation of a consistent approach to capacity planning is progressing with QUEST support.  
• Development of skills for demand and capacity planning and management across various staff groups in the organisation.  
• Development and implementation of booking processes which supports good waiting list management; and use of the 6-4-2-1 theatre scheduling system to make better use of theatre capacity.  
• Commissioned support for purchase of external capacity to ensure Value for Money.  
• Action plan with agreed timescales in place to address internal audit recommendations relating to the management of waiting times in NHS Lothian, supported by a delivery group chaired by the Director of Finance. This includes single management system for waiting time’s management, development of SOPs and a staff training programme to ensure consistency of approach. Progress report - Audit & Risk Committee, September 2013. | July 2013: Risk reviewed. Action plan with agreed timescales in place to address internal audit recommendations relating to the management of waiting times in NHS Lothian, supported by a delivery group chaired by the Director of Finance. Progress report - Audit & Risk Committee, September 2013.  
Risk grade/rating remains unchanged at High/12. | Satisfactory; controls adequately designed to manage risk and working as intended | High 12 | Low 1 | Dr David Farquharson | Finance & Resources Committee |
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<td>3203</td>
<td>Unscheduled Care - Minimal Risk Appetite</td>
<td>3: Improve Unscheduled Care Performance</td>
<td>Performance against the delivery of Unscheduled Care is primarily measured by the 4 hour Emergency Care Standard. Performance against this standard is a measure of the effectiveness of performance against the whole healthcare system. It reflects the effectiveness of patient flow through the system. Poor performance is evidenced by the number of breaches of the 4 hour standard, levels of overcrowding within Emergency Departments, the number of patients boarding (including the use of day surgery beds as overnight capacity), the need for elective cancellations due to capacity pressures, the number of delayed transfers of care (either from critical care and recovery to acute, acute to sub-acute or to non-hospital). It is understood that poor performance against these measures will have a direct and adverse impact on patient care. Whole system working involves GP's, SAS, Local Authorities, NHS24, LUCS, primary care and secondary care.</td>
<td>The Unscheduled Care Group is responsible for developing and implementing the unscheduled care strategy. The Group is co-chaired by the Director of Nursing and the Director of Health &amp; Social Care. The Group has developed a range of proposals which are being implemented including: • The development of new medical assessment models to improve senior consultant presence in the evening and weekends. • The development of models of care for older people to support admission avoidance and earlier discharge from hospital. • The development of increased capacity in social care services to reduce the number of patients with a delayed transfer of care for social reasons (including an additional 4,610 hours per week care at home for older people in the first nine months, a 12% increase). The weekly discharge target has now increased from 63 people per week to 72 people per week. • Effective Joint Working with Councils to progress the Integration agenda. • Investment in additional bed capacity (RIE ward 104, WGH ward 25, re-opening of RVH ward 1 and 2, Corstorphine). • Planned development of additional capacity on RIE site for assessment and ward bed capacity in line with demand. • Work on redesign to improve processes (e.g. admission avoidance with OPAT, development of ambulatory care pathways, more rapid pull of patients to wards). • Investment in senior supervisory nursing staff to support improved discharge planning including earlier in the day discharges to support patient flow. • Investment in staffing within Emergency Departments. • Focus on those patients waiting for packages of care of less than 14 hours; care at home as well as those on the rehabilitation list who could be supported at home. In addition we continue to focus on the reduction in the time to process complex cases, including guardianship applications. • The performance metrics in place through the Change Fund plans will be used to determine the impact and effectiveness of the interventions and will be reported through JMT and CH(C)IP Sub-committees. The Delayed Discharge team within NHS Lothian will closely monitor delays over 2012/13 to ensure they remain on trajectory and provide analysis to support any proposed changes required to address performance through JMT and the Board.</td>
<td>July 2013: Risk reviewed. In light of inability to recruit GP's to work in ED overnight in response to nationally driven reduction in EM trainees, additional recruitment initiated by NHSL for Clinical Development Fellows to provide overnight support for ED – specifically at SJH in ED from August 2013 as part of EM workforce plan. Additional ED consultant recruitment supported. Executive team focus working to mitigate impact and ensure all recruitment opportunities explored.</td>
<td>Inadequate; control is not designed to manage the risk and further controls &amp; measures required to manage the risk</td>
<td>High 10</td>
<td>Low 1</td>
<td>Melanie Hornett</td>
<td>Finance &amp; Resources Committee</td>
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| 1076 | Improve Staff and Patient Safety - Minimal Risk Appetite | Healthcare Associated Infection | Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital and further treatment requirements. Outbreaks and increased incidence of infection as well as harm to patient has the potential to adversely affect NHS Lothian through impact on capacity, patient flow and adverse publicity damaging the reputation of NHS Lothian. Factors that can contribute to a development of HAI are inadequate or no training, failure to comply with Infection Prevention and Control Policies and poor decontamination of reusable equipment. | • NHS Lothian has an Infection Prevention & Control Service to provide access to specialist knowledge. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid & East and West Lothian) established to cover both acute and community settings.  
• The UHS and CHP Infection Prevention and Control Committees are in place and report to board through LICAC.  
• IT based system in place to facilitate IPCN to monitor incidences of HAI within their clinical remits and to monitor for trends and patterns. SPSP have provided a collection of tools to support good practice to minimise potential for patient. IPCNs work collaboratively with clinical teams and bed management to provide advice and guidance on isolation and restriction of patient movements to balance the risk of transmission and impact on patient flow.  
• IPCNs communicate directly with clinical services, escalating as appropriate. SAB and CDI rates reported weekly and monthly through IPCT reports which are sent by email and available on intranet. At senior management level there is CMG/CMT and board papers. All incidences of SAB & CDI investigated, clusters of 2 or more investigated for links SBARs are provided. Systems are in place to escalate investigation. HAI Matrix utilised to identify reporting level HAILRT. Communications provide support to manage public release of information as required.  
• Packages of audits are in place to monitor standards and are linked to the National Standard Infection Control Precautions Chapter.  
• HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro and the Education Strategy is available on line.  
• There is a Decontamination Strategy Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment. | July 2013: Risk reviewed. 6 new actions have been implemented:  
• Membership of the UHS ICC is under review following reconstruction of Acute Services. - Requests for representation sent to site & service leads.  
• The HAI Clinical Audits are being adopted and moved to QIDS. - Anticipate completion 31 July 2013.  
• The Internal Auditors report dated 13 June 2013 identified:  
• gaps in compliance with mandatory HAI Education. - Action requirements to Dir. of Education.  
• gaps in compliance with hand hygiene audits and areas reporting below 96%. - notified Chief Nurses re improvement requirements.  
• that Infection Control Incidents within Datix were not always reviewed with the expected timeframes. - ensure that IC staff get appropriate Datix notification.  
• Clinical Risk Assessment for MRSA Screening was not undertaken in 47% and 25% did not have the appropriate screening undertaken. - HAI Lead notified Chief Nurses with a requirement to report progress through relevant QIT and ICC.  
Risk grade/rating remains unchanged at Medium 9 | Satisfactory; controls adequately designed to manage risk and working as intended | Medium 9 | Medium 6 | Alison McCallum | Healthcare Governance Committee |
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| 2964 | Financial Resources and Plans - Open | The Board does not achieve its financial targets each year on a sustainable basis. | The Board does not achieve its financial targets each year on a sustainable basis. There is a UK-wide reduction in public sector budgets, which in turn has significantly reduced the projected level of growth available to the NHS Board in the next few years. The Board is already in a challenging position, and receives an allocation less than the NRAC formula prescribes. The cost base is subject to inflationary factors which always exceed general rises in funding, which therefore makes efficiency savings a continuous necessity. | - The Board approves budgets at the start of the financial year.  
- Financial governance policies & procedures, such as SFIS and Scheme of Delegation are in place.  
- System of delegated budgetary control is in place.  
- A system of control to identify and monitor the delivery of LRP savings is in place.  
- A system of risk management is in place, and financial management risks are a formal category. These risks appear on risk registers throughout the organisation.  
- The Board is subject to external and internal audit, and there is a follow-up system in place to monitor the implementation of audit recommendations.  
- The Board has a formal committee structure, and a management structure to monitor performance.  
- The Director of Finance presents monthly finance reports to the Joint Management Team each month, as well as reporting to the Finance & Resources Committee and the Board.  
- The Director of Finance provides a formal review of the forecast year end financial outturn following month 3, month 6 and month 9 results, which incorporate a detailed analysis and consideration of all aspects of the financial position. | June 2013: Risk Reviewed.  
Financial targets delivered for 2012/13.  
Annual Accounts approved by the NHS Board on 25 June 2013.  
Unqualified external audit opinion  
Risk Grade/Rating remains Medium9 | Adequate but ineffective; control is properly designed but not being implemented properly | Medium 9 | Low 2 | Susan Goldsmith | Finance & Resources Committee |
<table>
<thead>
<tr>
<th>ID</th>
<th>NHS Lothian Corporate Objective</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Risk Owner</th>
<th>Assurance</th>
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</thead>
</table>
| 1267| 6: Financial Resources Plans    | The Board's Capital Plan cannot be delivered | There is a UK-wide reduction in public sector budgets, which in turn has significantly reduced the level of available capital funding. Revised national arrangements have been introduced through CEL 32 (2010): Arrangements for the Management of NHS Scotland Capital Resources after 2010/11. Amongst other things, the Board’s delegated limit has been reduced from £10m to £5m. The Board therefore has less capital funding, and less delegated authority. | • The Lothian Capital Investment Group, Joint Management Team and Finance & Resources Committee of the Board regularly review progress with major capital projects and the property & asset management programme overall.  
• The Director of Finance is the executive lead for the Property & Asset Management Strategy, which encompasses all aspects of the estate and infrastructure, and sets priority areas for investment. The PAMS has been presented to the F&R Committee for discussion, it remains an area of ongoing dialogue and aims to ensure connections with the Clinical Strategy. | June 2013: Risk Reviewed. The Board approved the Property & Asset Investment Plan.  
The investment plan for the current year is over committed at this time, but a review of all planned investments is underway.  
Discussion is required with SGH/CDN colleagues on the potential use of any slippage on the RH/CDN enabling works  
Risk grade/rating remains unchanged Medium 9. |
| 1268| 8: Financial Resources and Plans - Open | Equal Pay Claims                          | NHS Lothian should continue to work with the Central Legal Office and other Health Boards to clarify issues and potential costs relating to equal pay claims in the NHS in Scotland. There is a risk that the potential liability is not disclosed appropriately in the financial statements. | • The issue in regard to Equal Pay claims is still being managed on a Scotland wide basis, we are kept advised on developments from the Central Legal office.  
• A recent Employment Tribunal case in this area has limited the Board’s exposure to the period April to October 2004. However discussions are still ongoing at a national level with the Employment Tribunals Office and as no cases have yet been heard. | July 2013: Risk reviewed. No change to risk at this time.  
Risk grade/rating remains unchanged at Medium 9. | Uncertain; impact of controls not known at this time and more work required to identify current situation | Medium 9  | Low 2 | Medium 9 | Alan Boyter | Staff Governance Committee |
<table>
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<tr>
<th>ID</th>
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</table>
| 2812 | Improve Staff and Patient Safety - Minimal Risk Appetite | Data Protection Act 1998 Compliance | There is a risk that NHS Lothian breaches the Data Protection Act 1998 by accidental or unauthorised disclosure to third parties, of identifiable sensitive data relating to patients or staff. Disclosure of manual or electronic identifiable data could occur by accidental loss such as theft, or by failure to implement policy or appropriate control and security of, use and disclosure of personal data. Consequence of inappropriate disclosure are; distress to individuals, reputational damage to organisation, legal action or financial penalty up to £500,000. | • Staff training (induction and refresher).  
• Staff awareness (letter to all staff, team brief articles and roadshows).  
• Policy and Procedures including security and confidentiality.  
• Monitoring of potential inappropriate access to patient systems.  
• Monitoring of potential inappropriate use of e-Health tools including email and encrypted USB devices.  
• Audit and Incident review.  
• Procedure for subject access to records in line with Data Protection Act.  
Risk grade/rating remains unchanged - Medium 9. | Uncertain, impact of controls not known at this time and more work required to identify current situation | Medium 9 | Low 1 | Alison McCullum | Healthcare Governance Committee |
New Health, Improve Health Status & Health Inequalities - Open

Preparedness in Emergency Planning

NHS Lothian is a Category 1 responder under the Civil Contingencies Act 2004 and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005. There is a risk that insufficient preparedness for major incidents and other risks as detailed in the Community Risk Register and mandated by the legislation would mean a less than professional response leading to the Board not meeting the expectations of Lothian and Borders Emergency Planning Strategic Coordinating Group partner agencies and Scottish Government. At a national level there are risks associated with the current SCG reform and the transitional arrangements. These include:

1. Major (or combination of minor) emergencies/disruptive events divert resources from transition work meaning transition cannot be carried out in time.
2. Complexity or disagreement in development of new (national or local) arrangements leads to delay.
3. Financial/resource constraints result in responder agencies not engaging sufficiently with transition process.

1. NHS Lothian major incident plans, outbreak plans and Public Health SOPs and guidance on the management of incidents indicate management structures and accountability. 2. Internally, when appropriate, Emergency Planning matters are reported at several key meetings, including EMT, HG&RM and EPSAG. Additionally, HG&RM receives an annual report from the Emergency Planning Officer. Externally, through the Director of Public Health and Health Policy and the Emergency Planning Officer, NHS Lothian is represented at all Lothian and Borders Emergency Planning Strategic Coordinating Group (SCG) meetings at strategic, tactical and operational levels and the NHSScotland Resilience Forum at Scottish Government. 3. Incidents are reported to the above groups as required in some cases following multi-agency structured debriefings. The Emergency Planning Officer is a member of the SCG’s Risk Group which oversees the Community Risk Register. 4. Structured debriefs are held of major and other significant incidents with a view to capturing issues and learning points. Where required they will inform amendments to plans, policies and procedures. 5. NHS Lothian staff participate in emergency planning training and exercises at local, regional and national levels on a regular basis. The Emergency Planning Officer chairs the SCG’s Training and Exercising Working Group. 6. Under the NHS Lothian Scheme of Delegation the Director of Public Health and Health Policy is given the role of responsibility for and oversight of emergency planning functions. 7. NHS Lothian Corporate Communications has co-opted membership of the Emergency Planning Strategic Advisory Group where they can be kept up to date with local, regional and national emergency planning issues. 8. The next internal audit of Emergency Planning is programmed for 2014/15. 9. As a means of mitigating SCG reform risks, it is probable that existing SCG arrangements would be capable of extension for a period of time if required to ensure a continued robust response at strategic SCG level, in which NHS Lothian participates through the Chief Executive and the Director of Public Health and Health Policy. However, the importance of maintaining effective communications and dialogue on the changes and impact upon Health Boards – NHS Lothian, Borders, Forth Valley and Fife –, as Category 1 responders across the East hub can not be underestimated in resolving issues. The provision of early clarity on future SCG resourcing from Scottish Government will also assist in this regard.

June 2013: Risk reviewed. Recruit to Emergency Planning Officer post - an interview was held on the 22nd of May. An appointment was made following the interview. The successful candidate is due to start on post on the 23rd July 2013.

Risk grade/rating remain at Medium8
<table>
<thead>
<tr>
<th>ID</th>
<th>NHS Lothian Corporate Objective</th>
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<th>Adequacy of controls</th>
<th>Risk level (Current)</th>
<th>Risk level (Target)</th>
<th>Risk Owner</th>
<th>Assurance</th>
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</table>
| 6 | Improve Staff and Patient Safety - Minimal Risk Appetite | Non-compliance with statutory equality duties | Failure to comply with NHS Lothian policy on impact assessment by NHS Lothian services and departments may lead to adverse attention from the regulator, the Equality and Human Rights Commission. | • Impact assessment practice routine and resulting in 80-100 impact assessments annually.  
• Comprehensive quality assurance and monitoring systems in place.  
• Policy - the Board agreed in January 2006 that all new and revised policies and plans would be subject to impact assessment to determine their impact on disadvantaged groups, and to address any negative impacts.  
• A comprehensive impact assessment toolkit exists supported by training and guidance. Training - all staff receive training in equality and diversity at induction and through mandatory refresher e-learning.  
• Training is also delivered in impact assessment and diversity monitoring.  
• Monitoring systems: the Board and its subcommittees, and key management teams are monitored to ensure that they comply with impact assessment policy and paper authors are contacted where items require action or follow-up impact assessment.  
• All impact assessments completed are followed up within 6 months to ensure that the actions arising from the assessment are completed.  
• Governance: this work is overseen by the Health Care Governance Committee and Staff Governance Committee. | July 2013: risk reviewed.  
Controls update: Monitoring systems: the Board and its subcommittees, and key management teams are monitored to ensure that they comply with impact assessment policy and paper authors are contacted where items require action or follow-up impact assessment.  
Governance: this work is overseen by the Health Care Governance Committee and Staff Governance Committee.  
Some risk remains due to the possibility of adverse attention from the Regulator, arising from spending plans which have not been impact assessed.  
Risk grade/rating reduced to Medium4 (Minor impact, unlikely to occur). | Satisfactory; controls adequately designed to manage risk and working as intended | Medium 4 | Low 1 | Alan Boyter | Healthcare Governance Committee |
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.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>• Compliance with the evidence-based stroke standard for admission to Stroke Unit within one day of admission remains an issue (see graph 22).</strong></td>
<td>3.1</td>
</tr>
<tr>
<td><strong>• Maintaining the HEAT target for Clostridium Difficile infection remains a challenge (see graph 11).</strong></td>
<td>3.2</td>
</tr>
<tr>
<td><strong>• There has been an increase in incidents with harm (graph 8).</strong></td>
<td>3.3</td>
</tr>
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</table>

Jo Bennett  
Clinical Governance & Risk Manager  
11 September 2013  
Jo.bennett@nhslothian.scot.nhs.uk

Dr Elizabeth Bream  
Consultant in Public Health  
11 September 2013  
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Medical Director Quality Improvement  
11 September 2013  
Simon.Mackenzie@nhslothian.scot.nhs.uk
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for August 2013, to provide assurance on the quality of care NHS Lothian provides.

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

2 Recommendations

2.1 Review the quality dashboard to inform assurance reporting, (context and technical appendix are set out in Appendix 1) and note as a separate agenda item the Review of the Quality Report.

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 remains an issue (see graph 22). There are, however, improvements in Swallow Screen on day of admission (see graph 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). A more detailed Healthcare Associated Infections (HAI) paper is on this committee’s agenda.

3.3 There has been an increase in incidents with harm (graph 8). A review of these incidents highlights that there was no one type of incident driving this increase with the exception of falls with harm, which is also reflected in the Patient Falls with Harm graph (graph 18). The vast majority of these falls (77% n=20) were not in acute hospitals but in community hospitals and may reflect increasing awareness of reporting falls as a result of the rollout of Care Rounding in these hospitals, which includes training on falls prevention and incident reporting.
Quality Dashboard - August 2013 (dates for each data item stated in background charts)

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

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>20-day Complaints Response Rate *</td>
<td>Number of complaints *</td>
<td>Incident Management Key Performance Indicator *</td>
<td>Hospital Standardised Mortality Ratios for RIE, WGH &amp; St. John’s *</td>
<td>Hand Hygiene Compliance *</td>
<td>Incidents with harm *</td>
<td>Falls Prevention Compliance *</td>
<td>Inpatient Falls with Harm *</td>
<td></td>
</tr>
<tr>
<td>3-day Complaints Response Rate *</td>
<td></td>
<td>Peripheral Vascular Catheter Compliance *</td>
<td>Adverse Event Rate *</td>
<td>Early Warning Score Compliance *</td>
<td>C. Difficile Numbers *</td>
<td>Pressure Ulcer Compliance *</td>
<td>Inpatient Pressure Ulcers Grade 2 or above *</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicine Reconciliation Compliance *</td>
<td>Staph. Aureus Bacteraemia Numbers *</td>
<td></td>
<td>Number of Cardiac/Respiratory Patients 2222 Calls *</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Ambition: Effective</th>
<th>Outcome Measures</th>
<th>Process Measures</th>
<th>Quality Ambition: Effective</th>
<th>Process Measures</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls Prevention Compliance *</td>
<td></td>
<td>Pressure Ulcer Compliance *</td>
<td>Inpatient Falls with Harm *</td>
<td>Admission to stroke unit on day or day after admission*</td>
<td>Inpatient Pressure Ulcers Grade 2 or above *</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stroke Treatment Measure: CT Scan *</td>
<td>Nursing Medication Administration Incidents *</td>
<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>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>0.90</td>
<td>1.00</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>1.05</td>
<td>1.00</td>
</tr>
</tbody>
</table>

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.”

**Title:** 20-day Complaints Response Rate  *(Graph 1)*
**Numerator:** Percentage of complaints responses within 20 days
**Denominator:** Percentage of all complaints responses
**Goal:** 85% of complaints responded to within 20 days

**Title:** Number of Complaints  *(Graph 2)*
**Numerator:** Total number of complaints
**Goal:** Reduction in number of formal complaints

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

Data Source: Datix

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

Data Source: Datix

**Title:** 3-day Complaints Response Rate  *(Graph 3)*
**Numerator:** Percentage of complaints responses within 20 days
**Denominator:** Percentage of all complaints responses
**Goal:** 100% formal acknowledgement within 3 working days

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

Data Source: Datix
Quality Ambition: Safe

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

**Safe: Reduction in mortality**

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

**Outcome Measure**

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – Mar 2013  
(Chart 4)

Data Source: ISD (Quarterly)

**Outcome Measure**

Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – Mar 2013  
(Chart 5)

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

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

Data Source: Datix

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

**Title:** Percent compliance with hand hygiene (NHS Lothian Acute Hospitals)  
**Numerator:** The total number of opportunities in the sample where appropriate hand hygiene was conducted  
**Denominator:** The total number of opportunities in the sample. **N=6,600 per month**  
**Goal:** 95% Compliance

**Process Measure**

![Compliance with Hand Hygiene Chart](Chart)

**Outcome Measure**

**Title:** C. difficile associated disease rate against HEAT Target 2012-13  
**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.

![CDI Trend Chart](Chart)

**Data Source:** Local Audits (QIDS)
**Safe: Compliance with Peripheral Vascular Bundles**

| Title: | Percent compliance with PVC Bundle (NHS Lothian Acute Hospitals)  
(Graph 12) |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Numerator:</td>
<td>Total number of patients who have all elements of the PVC bundle in place</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total number of patients reviewed per month. n=1000</td>
</tr>
<tr>
<td>Goal:</td>
<td>95% Compliance</td>
</tr>
</tbody>
</table>

**Staph. aureus bacteraemias (SABs) rate against HEAT Target 2012-13  
(Graph 13)**

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal:</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Process Measure**

![Peripheral Vascular Cannula Bundle](image)

**Outcome Measure**

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

![Graph depicting SAB episodes over time](image)

- **Data Source:** Infection Control Team

---

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

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

Compliance with Medicines Reconciliation

Source Data: Local Audits (QIDS)

---

**Outcome Measure**

OUTCOME MEASURE TO BE DETERMINED
Quality Ambition: Effective

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

### Effective: Reduction in in-patient Falls - Delivering Better Care

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

### Patient Falls with Harm

<table>
<thead>
<tr>
<th>Title:</th>
<th>Patient Falls with Harm (Graph 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of falls reported with harm, moderate, major/ death</td>
</tr>
<tr>
<td>Goal:</td>
<td>20% reduction in inpatients falls and associated harm by March 2013.</td>
</tr>
</tbody>
</table>

**Process Measure**

**Outcome Measure**

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

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

**Title:** Percent compliance with the Pressure Ulcer Prevention CQI (NHS Lothian Acute Hospitals)  
(Graph 19)

**Numerator:** No. of patients fully compliant CQI

**Denominator:** Total no. of patients reviewed at risk of pressure ulcers per month  
n=546

**Goal:** 95% Compliance

---

**Title:** Number of Pressure Ulcers per month across NHS Lothian  
(Graph 20)

**Numerator:** Number of Grade 2 or above pressure ulcers

**Goal:** To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2014 (from one a day to none a day)

---

**Process Measure**

![Compliance with Clinical Quality Indicator: Pressure Area Care](image)

Data Source: QiDS

---

**Outcome Measure**

![Count of all pressure ulcers (Grade 2 and above) developed in NHS Lothian hospitals reported on Datix](image)

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

Graph showing the number of nursing medication incidents per month from April 2010 to July 2013. The graph highlights the baseline, median, extended median, and target levels. 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

Data Source: ISD

Title: Stroke Treatment Measures (Graph 23)

Numerator: Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission

Denominator: Number of patients admitted with initial diagnosis of stroke

Goal: 100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission

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

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](http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs)
SUMMARY PAPER - FINANCIAL POSITION TO 31 AUGUST 2013

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>3.1/3.2</td>
<td>The underspend of £0.9 in August, bringing the year to date position to £0.7m overspent, is driven by reprofiling of budgets and the release of reserves following the quarter 1 review. This does not represent an improvement in underlying trends.</td>
</tr>
<tr>
<td>3.3-3.5</td>
<td>The key drivers of the year to date position are prescribing, activity and case mix driven increases in clinical costs, offset by medical and dental vacancies.</td>
</tr>
<tr>
<td>3.8</td>
<td>Efficiencies of £7.7m have been delivered against the annual plan of £27.8m. However of the savings delivered year to date; only £5.6m 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>3.12-3.14</td>
<td>The cost of providing elective capacity to meet waiting times targets is currently in line with the year end forecast, however the mix of independent sector, other consultant and in house provision may vary from that envisaged, resulting in additional financial pressures.</td>
</tr>
<tr>
<td>2.1</td>
<td>The key challenges to delivering the forecast breakeven position are the investments in capacity required to address waiting times and unscheduled care pressures.</td>
</tr>
</tbody>
</table>

Susan Goldsmith
Director of Finance
19 September 2013
susan.goldsmith@nhslOTHIAN.scot.nhs.uk
FINANCIAL POSITION TO 31 AUGUST 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 August 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

2.1 The Board members are asked to note:

- Reprofiling of budgets and the release of reserves following the detailed quarter 1 review has given rise to an in month underspend of £0.9m, reducing the overspend for the first five months to £0.7m;
- This realignment reflects the quarter 1 review but does not represent an improvement in the underlying position; and
- Whilst we continue to forecast a breakeven position, delivering this presents a challenge to the organisation, with the main risks being the investments in capacity required to address waiting times and unscheduled care pressures.

3 Discussion of Key Issues

3.1 NHS Lothian is reporting an in month underspend of £0.9m reducing the cumulative overspend to £0.7m. This is summarised in table 1 below and a detailed analysis by expenditure type is attached as Appendix 1 and by operational unit in Appendix 2.

<table>
<thead>
<tr>
<th></th>
<th>In month</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline position</td>
<td>1,329</td>
<td>1,575</td>
</tr>
<tr>
<td>Outstanding efficiency savings</td>
<td>(474)</td>
<td>(2,240)</td>
</tr>
<tr>
<td><strong>Total under/(over) Spend</strong></td>
<td><strong>855</strong></td>
<td><strong>(665)</strong></td>
</tr>
</tbody>
</table>

3.2 Whilst a favourable position is reported in month, there is no change to the underlying trends. The in month movement largely arises from the reprofiling of budgets and the release of reserves following the quarter 1 review.
3.3 Vacancies across a number of specialties, including: obstetrics and gynaecology; paediatrics at St John’s; children’s community services; neonatal; mental health; and dental are the key contributor to the ongoing underspend on pay. Recruitment for all posts is being actively pursued.

3.4 Offsetting the pay position are a number of non pay pressures. The ongoing exercise to correctly align equipment and administration partly masks the underlying position but it is clear that changes in activity and case mix are leading to increased costs in a number of areas. Further work has been commissioned to better understand the drivers and the position will be closely monitored as the year continues. Specific areas recording increased costs include: clinical supplies in paediatric theatres and community services; the community equipment service in Edinburgh; and laboratories.

3.5 GP prescribing continues to show an in year pressure. Although volumes remain as forecast, medicines shortages are causing short term increases in prices, contributing to the year to date overspend of £1.1m. This is a temporary spike in as prices are expected to return to previous levels over the coming months. Further price reductions not anticipated in the budget will bring the overall GP prescribing position back in line with the £1.5m overspend forecast in the quarter 1 review.

3.6 Investment in capacity to deliver waiting times is a key feature of the quarter 1 review and 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.

3.7 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.

Efficiency & Productivity

3.8 For the period to 31 August, efficiencies (or Local Reinvestment Plans – LRP) of £7.7m have been delivered against the annual plan of £27.8m. This reflects a shortfall of £0.5m against the in month target bringing the cumulative under delivery to £2.2m.

3.9 Of the £7.7m delivered in the first five months of the year, only £5.6m has been delivered on a recurring basis. This level of shortfall, if not rectified before the year end, will have a material impact on the 2014/15 Financial Plan and the ability to fund service priorities.

3.10 Table 2 provides a summary of the in year position, with further detailed analysis of delivery against local targets and specific workstreams set out in Appendix 6.
Table 2: Efficiency and Productivity 2013/14

<table>
<thead>
<tr>
<th>Current Year</th>
<th>April - August</th>
<th>Q1 Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td><strong>Target</strong></td>
<td><strong>Actuals</strong></td>
</tr>
<tr>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
</tr>
<tr>
<td>Local</td>
<td>(6,640)</td>
<td>(2,468)</td>
</tr>
<tr>
<td>Workstreams</td>
<td>(12,896)</td>
<td>(3,777)</td>
</tr>
<tr>
<td>Centrally Held</td>
<td>(7,926)</td>
<td>(3,303)</td>
</tr>
<tr>
<td>Residual</td>
<td>(370)</td>
<td>(394)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(27,832)</td>
<td>(9,942)</td>
</tr>
</tbody>
</table>

3.11 Key points to note include:

- Across the specific workstreams prescribing and procurement savings are dependent on price changes and new contracts which are planned for later in the year;
- For the labs review to deliver on a recurring basis a decision needs to be taken on the relocation and investment in the blood sciences service, until this happens any savings will be on a non recurring basis from vacancies;
- The review of interventions of limited clinical value, has delivered some cash releasing savings, work continues to identify and measure efficiency gain and the potential to avoid future investment in additional capacity. This is complex and challenging and is not forecast to deliver savings in year:
- The timescales for delivery in outpatients has also slipped. The Patient Reminder System Pilot is due to be evaluated and, once a decision is made on the way forward, this will be reviewed; and
- The slippage on delivery of Local LRP across University Hospital Services and within Edinburgh CHP continues to be a key issue, in particular the level of non recurring savings. This needs to be addressed by the Management Teams with the support of programme management.

Waiting times

3.12 The additional expenditure on elective capacity to meet waiting times to the end of August is £12.5m. 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>Plan</td>
</tr>
<tr>
<td></td>
<td>Monthly Spend</td>
<td>YTD</td>
</tr>
<tr>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
<td><strong>£k</strong></td>
</tr>
<tr>
<td>Internal</td>
<td>7,905</td>
<td>12,957</td>
</tr>
<tr>
<td>Independent Sector</td>
<td>12,081</td>
<td>11,697</td>
</tr>
<tr>
<td>Other Contractors</td>
<td>4,921</td>
<td>2,096</td>
</tr>
<tr>
<td>Other NHS</td>
<td>2,642</td>
<td>3,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27,549</td>
<td>29,750</td>
</tr>
</tbody>
</table>
3.13 Projected spend for the year is £29.8m, a shortfall of £18.5m against the available funding. This deficit was previously reported to the Board and Joint Management Team who agreed a range of actions to reduce expenditure over the medium term.

3.14 Whilst no further variance is reported against this position at present, it should be noted that the mix of independent sector and other contractor and in house provision may change from that envisaged. Planned spend against independent sector and other contractors was anticipated to be weighted to the first half of the year, to provide bridging capacity in advance of internal recruitment and to support recovery of Waiting Times targets. Slippage against investment plans and deterioration of performance against Waiting Times standards indicate that it is likely that there will be a continued reliance on external capacity beyond the original timescales and work is currently underway to review requirements. Clearly this represents a risk to the forecast.

**Property & Asset Management**

3.15 A property & asset management investment programme of £71.4m has been agreed for 2013/14, of which £9.9m has been incurred to the end of August 2013. The planned over-commitment of £6.7m was reviewed as part of the quarter 1 review which saw the figure reduce to £5.5m. Since then, confirmation has been received from SGHSCD on some outstanding allocation queries, further reducing the over-commitment which now stands at £2.3m, a level which is anticipated to be achievable.

3.16 The plan and expenditure to date on individual schemes is set out in Appendix 4.

4 **Key Risks**

4.1 As in 2012/13, ongoing risks will continue to be managed. Examples include:

- Identification of further recurring LRP schemes to mitigate forecast shortfall in recurring delivery;

- Development and implementation of a process to identify and reinvest non-recurring resources;

- 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; and

- 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
19 September 2013
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List of Appendices

Appendix 1: NHS Lothian Income and Expenditure Summary August 2013
Appendix 2: NHS Lothian Summary by Operational Unit August 2013
Appendix 3: NHS Lothian Summary of Acute Activity August 2013
Appendix 4: NHS Lothian Property and Asset Management Investment Programme Summary August 2013
Appendix 5: Efficiency and Productivity Summary August 2013
## NHS Lothian Income and Expenditure Summary August 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>(147,210)</td>
<td>(64,878)</td>
<td>(65,269)</td>
<td>391</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(56,164)</td>
<td>(23,924)</td>
<td>(23,929)</td>
<td>4</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,451)</td>
<td>(1,434)</td>
<td>(1,486)</td>
<td>52</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(1,918)</td>
<td>(799)</td>
<td>(815)</td>
<td>16</td>
</tr>
<tr>
<td>Other income</td>
<td>(41,792)</td>
<td>(24,226)</td>
<td>(24,217)</td>
<td>(9)</td>
</tr>
<tr>
<td><strong>Sub Total Income</strong></td>
<td><strong>(249,534)</strong></td>
<td><strong>(115,262)</strong></td>
<td><strong>(115,716)</strong></td>
<td><strong>455</strong></td>
</tr>
<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,341,677)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>(1,591,211)</strong></td>
<td><strong>(115,262)</strong></td>
<td><strong>(115,716)</strong></td>
<td><strong>455</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>206,820</td>
<td>84,460</td>
<td>82,627</td>
<td>1,832</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>340,763</td>
<td>140,266</td>
<td>139,821</td>
<td>446</td>
</tr>
<tr>
<td>Allied Healthcare Professional</td>
<td>57,096</td>
<td>23,257</td>
<td>23,225</td>
<td>32</td>
</tr>
<tr>
<td>Support Services / Other</td>
<td>53,618</td>
<td>21,715</td>
<td>22,144</td>
<td>(430)</td>
</tr>
<tr>
<td>Health Science Services</td>
<td>35,337</td>
<td>14,316</td>
<td>13,636</td>
<td>680</td>
</tr>
<tr>
<td>Personal &amp; Social / Therapeutic</td>
<td>24,969</td>
<td>10,570</td>
<td>9,822</td>
<td>748</td>
</tr>
<tr>
<td>Management/Admin Staff</td>
<td>84,955</td>
<td>34,137</td>
<td>33,664</td>
<td>473</td>
</tr>
<tr>
<td><strong>Total Pay</strong></td>
<td><strong>803,557</strong></td>
<td><strong>328,720</strong></td>
<td><strong>324,940</strong></td>
<td><strong>3,780</strong></td>
</tr>
<tr>
<td>Non-Pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>98,423</td>
<td>40,568</td>
<td>40,638</td>
<td>(71)</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>72,382</td>
<td>31,979</td>
<td>32,524</td>
<td>(545)</td>
</tr>
<tr>
<td>Equipment</td>
<td>17,722</td>
<td>6,880</td>
<td>8,393</td>
<td>(1,513)</td>
</tr>
<tr>
<td>Other Non Pays</td>
<td>71,067</td>
<td>36,516</td>
<td>36,706</td>
<td>(190)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>126,334</td>
<td>50,115</td>
<td>51,222</td>
<td>(1,107)</td>
</tr>
<tr>
<td>GMS</td>
<td>120,243</td>
<td>45,290</td>
<td>45,370</td>
<td>(80)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>4,453</td>
<td>1,730</td>
<td>1,722</td>
<td>8</td>
</tr>
<tr>
<td>Property/Transport</td>
<td>49,887</td>
<td>18,356</td>
<td>19,011</td>
<td>(655)</td>
</tr>
<tr>
<td>Ancillary / Admin Costs</td>
<td>176,248</td>
<td>28,263</td>
<td>26,771</td>
<td>1,492</td>
</tr>
<tr>
<td><strong>Total Non-Pay</strong></td>
<td><strong>736,758</strong></td>
<td><strong>259,698</strong></td>
<td><strong>262,357</strong></td>
<td><strong>(2,660)</strong></td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td><strong>1,540,315</strong></td>
<td><strong>588,418</strong></td>
<td><strong>587,298</strong></td>
<td><strong>1,120</strong></td>
</tr>
</tbody>
</table>

**SUB TOTAL CORE BASELINE POSITION**                                       | **(50,896)**    | **473,157**   | **471,582**    | **1,575**      |

#### LRP

<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>(10,064)</td>
<td>(2,240)</td>
<td>0</td>
<td>(2,240)</td>
</tr>
</tbody>
</table>

**SUB TOTAL CORE POSITION**                                                | **(60,960)**    | **470,917**   | **471,582**    | **(665)**      |
### UNIVERSITY HOSPITALS SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Annual Budget £k</th>
<th>Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Services</td>
<td>151,947</td>
<td>63,026</td>
<td>63,753</td>
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### CHPs/CHCP/PCCO

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### CORPORATE BUDGETS

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### STRATEGIC BUDGETS

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<th>Variance £k</th>
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<th>LRP Variance £k</th>
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## NHS Lothian Summary of Acute Activity August 2013

### Clinical Services

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<tr>
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### Royal Infirmary Edinburgh Site

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### St John’s Hospital Site

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### Surgical Services Directorate

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### Western General Hospital Site

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### NHS Lothian Summary of Acute Activity August 2013

**Discharges**

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<tr>
<td><strong>Women Children &amp; Neuroscience</strong></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>3,565</td>
<td>3,712</td>
<td>664</td>
<td>786</td>
<td>709</td>
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<tr>
<td>Midwifery</td>
<td>808</td>
<td>826</td>
<td>181</td>
<td>185</td>
<td>160</td>
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<tr>
<td>Neurology</td>
<td>666</td>
<td>614</td>
<td>125</td>
<td>123</td>
<td>133</td>
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<tr>
<td>Neurosurgery</td>
<td>1,057</td>
<td>1,069</td>
<td>216</td>
<td>211</td>
<td>210</td>
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<tr>
<td>Obstetrics</td>
<td>5,254</td>
<td>5,052</td>
<td>1,097</td>
<td>1,029</td>
<td>1,050</td>
</tr>
<tr>
<td>RHSC sub-total</td>
<td>8,691</td>
<td>8,329</td>
<td>1,683</td>
<td>1,697</td>
<td>1,706</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>20,041</strong></td>
<td><strong>19,602</strong></td>
<td><strong>3,966</strong></td>
<td><strong>4,031</strong></td>
<td><strong>3,968</strong></td>
</tr>
</tbody>
</table>

*this includes independent sector activity

**Please direct queries on this report to Finance in the first instance.**
## NHS Lothian Property and Asset Management Investment Programme Summary
### August 2013

### INCOME

<table>
<thead>
<tr>
<th>Source</th>
<th>Q1 Forecast 2013 £k</th>
<th>Programme £k</th>
<th>Expenditure to month 5 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>SGHD Specific Funding</td>
<td>26,152</td>
<td>26,152</td>
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<tr>
<td>SGHD Formula Allocation</td>
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<td>25,107</td>
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<tr>
<td>Other Sources of Funding</td>
<td>4,602</td>
<td>4,710</td>
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<tr>
<td><strong>TOTAL SOURCES</strong></td>
<td><strong>52,221</strong></td>
<td><strong>55,969</strong></td>
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</table>

### EXPENDITURE

#### Capacity & Unscheduled Care

<table>
<thead>
<tr>
<th>Project</th>
<th>Q1 Forecast 2013 £k</th>
<th>Programme £k</th>
<th>Expenditure to month 5 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>1,685</td>
<td>1,685</td>
<td>2,027</td>
</tr>
<tr>
<td>Radiotherapy Phase 9</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>RIE Additional Beds &amp; Decant</td>
<td>4,274</td>
<td>4,326</td>
<td>365</td>
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<tr>
<td>Continuing Care Redesign</td>
<td>3,643</td>
<td>3,643</td>
<td>0</td>
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<tr>
<td>WGH Expansion of Ward 58</td>
<td>100</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Day Surgery Redesign</td>
<td>100</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>St John's Hospital MRI</td>
<td>989</td>
<td>989</td>
<td>62</td>
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<tr>
<td>Renal Review - WGH</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Labour Ward/ Maternity Unit (SJH)</td>
<td>1,397</td>
<td>1,397</td>
<td>209</td>
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<tr>
<td>Burns Unit (SJH)</td>
<td>241</td>
<td>241</td>
<td>221</td>
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<tr>
<td>Autism/Learning Disability Residential Support Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>12,429</strong></td>
<td><strong>12,481</strong></td>
<td><strong>2,883</strong></td>
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#### Investment in Primary Care Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>Q1 Forecast 2013 £k</th>
<th>Programme £k</th>
<th>Expenditure to month 5 £k</th>
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</thead>
<tbody>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>2,991</td>
<td>2,991</td>
<td>1,615</td>
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<td>Gullane Medical Centre</td>
<td>1,449</td>
<td>1,449</td>
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<tr>
<td>West End Medical Practice</td>
<td>3,235</td>
<td>3,235</td>
<td>717</td>
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<tr>
<td>Firrhill/Muirhouse/Blackburn</td>
<td>576</td>
<td>576</td>
<td>105</td>
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<tr>
<td>Ratho Health Centre Satellite</td>
<td>1,441</td>
<td>1,441</td>
<td>1</td>
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<tr>
<td>Tranent</td>
<td>1,282</td>
<td>1,282</td>
<td>9</td>
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<tr>
<td><strong>10,974</strong></td>
<td><strong>10,974</strong></td>
<td><strong>2,448</strong></td>
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#### Major Service Redesign/Redevelopment

<table>
<thead>
<tr>
<th>Project</th>
<th>Q1 Forecast 2013 £k</th>
<th>Programme £k</th>
<th>Expenditure to month 5 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Hospital for Sick Children and DCN</td>
<td>9,495</td>
<td>9,495</td>
<td>596</td>
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<tr>
<td>Lothian Asset Management Strategy</td>
<td>179</td>
<td>208</td>
<td>(3)</td>
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<tr>
<td>Royal Edinburgh Hospital</td>
<td>812</td>
<td>812</td>
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<tr>
<td>Greenbank Centre REH</td>
<td>470</td>
<td>470</td>
<td>40</td>
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<tr>
<td>REH Orchard Clinic</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Pharmacy Aspectic Unit WGH</td>
<td>132</td>
<td>132</td>
<td>0</td>
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<tr>
<td><strong>11,088</strong></td>
<td><strong>11,117</strong></td>
<td><strong>633</strong></td>
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#### Invest to Save

<table>
<thead>
<tr>
<th>Project</th>
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<th>Expenditure to month 5 £k</th>
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</thead>
<tbody>
<tr>
<td>Laboratory Equipment</td>
<td>352</td>
<td>352</td>
<td>95</td>
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<tr>
<td>Microbiology Automation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>352</strong></td>
<td><strong>352</strong></td>
<td><strong>95</strong></td>
<td></td>
</tr>
<tr>
<td>Q1 Forecast 2013</td>
<td>Programme</td>
<td>Expenditure to month 5</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td></td>
</tr>
<tr>
<td><strong>Compliance</strong></td>
<td></td>
<td></td>
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<tr>
<td>GDP dental premises</td>
<td>2,000</td>
<td>2,000</td>
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<tr>
<td>Endoscopy RIE</td>
<td>100</td>
<td>100</td>
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<td>Endoscopy WGH</td>
<td>609</td>
<td>609</td>
<td>21</td>
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<tr>
<td>Community Dentistry Decontamination</td>
<td>609</td>
<td>609</td>
<td>285</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>3,318</strong></td>
<td><strong>3,318</strong></td>
<td><strong>323</strong></td>
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<tr>
<td><strong>Rolling Programmes</strong></td>
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<tr>
<td>RIE Lifecycle Costs</td>
<td>4,721</td>
<td>4,721</td>
<td>1,884</td>
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<td>Projects under £250k</td>
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<td>1,500</td>
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<tr>
<td>Medical Equipment</td>
<td>4,000</td>
<td>4,000</td>
<td>231</td>
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<tr>
<td>E-Health Strategic Priorities</td>
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<td>Backlog maintenance</td>
<td>4,834</td>
<td>4,834</td>
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<td>CEEF</td>
<td>605</td>
<td>605</td>
<td>34</td>
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<tr>
<td>Purchase of Items for Cancer Treatments</td>
<td>269</td>
<td>454</td>
<td>0</td>
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<td>National PACS Refresh 2007-17</td>
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<td>129</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>18,058</strong></td>
<td><strong>18,244</strong></td>
<td><strong>2,911</strong></td>
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<td><strong>Donations</strong></td>
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<tr>
<td>Macmillan Centre SJH</td>
<td>487</td>
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<td>228</td>
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<tr>
<td>Mammography Upgrade WGH</td>
<td>139</td>
<td>139</td>
<td>28</td>
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<tr>
<td>Teenage Cancer Trust, WGH</td>
<td>822</td>
<td>822</td>
<td>452</td>
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<tr>
<td>Other Donations</td>
<td>0</td>
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<td>13</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>1,447</strong></td>
<td><strong>1,475</strong></td>
<td><strong>722</strong></td>
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<tr>
<td><strong>Completing Schemes</strong></td>
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<tr>
<td>Other completing 12/13</td>
<td>271</td>
<td>271</td>
<td>(55)</td>
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<tr>
<td><strong>TOTAL EXPENDITURE</strong></td>
<td>57,937</td>
<td>58,232</td>
<td>9,960</td>
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<tr>
<td>Total (over)/ under commitment</td>
<td>(5,716)</td>
<td>(2,263)</td>
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# NHS Lothian Efficiency and Productivity Summary August 2013

## APPENDIX 5

<table>
<thead>
<tr>
<th>WORKSTREAM</th>
<th>Current Year Target</th>
<th>April - August</th>
<th>Target £k</th>
<th>Actuals £k</th>
<th>Slippage £k</th>
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<tbody>
<tr>
<td>Facilities &amp; Infrastructure</td>
<td>(1,613)</td>
<td>(203)</td>
<td>(140)</td>
<td>(63)</td>
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<tr>
<td>Labs Review</td>
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<td>(490)</td>
<td>(299)</td>
<td>(191)</td>
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<tr>
<td>Management &amp; Administration</td>
<td>(748)</td>
<td>(260)</td>
<td>(280)</td>
<td>(20)</td>
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<tr>
<td>Pharmacy Redesign</td>
<td>(285)</td>
<td>(119)</td>
<td>(97)</td>
<td>(22)</td>
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<tr>
<td>WCN</td>
<td>(275)</td>
<td>(115)</td>
<td>(83)</td>
<td>(32)</td>
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<tr>
<td>Flow &amp; Capacity Management</td>
<td>(142)</td>
<td>(38)</td>
<td>-</td>
<td>(38)</td>
<td></td>
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<tr>
<td>Edinburgh Rehabilitation Bed Redesign</td>
<td>(300)</td>
<td>(56)</td>
<td>-</td>
<td>(56)</td>
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</tr>
<tr>
<td>Enhanced Recovery</td>
<td>(300)</td>
<td>(125)</td>
<td>-</td>
<td>(125)</td>
<td></td>
</tr>
<tr>
<td>Review in Interventions of Limited Clinical Value</td>
<td>(500)</td>
<td>(125)</td>
<td>(9)</td>
<td>(116)</td>
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</tr>
<tr>
<td>Outpatients</td>
<td>(1,537)</td>
<td>(374)</td>
<td>-</td>
<td>(374)</td>
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</tr>
<tr>
<td>Prescribing</td>
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<td>(1,352)</td>
<td>(1,246)</td>
<td>(106)</td>
<td></td>
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<td>Procurement</td>
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<td>(520)</td>
<td>(279)</td>
<td>(241)</td>
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<tr>
<td></td>
<td></td>
<td>(12,896)</td>
<td>(3,777)</td>
<td>(2,433)</td>
<td>(1,344)</td>
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<tr>
<td>LOCAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>(811)</td>
<td>(350)</td>
<td>(414)</td>
<td>64</td>
<td></td>
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<tr>
<td>East Lothian CHP</td>
<td>(406)</td>
<td>(120)</td>
<td>(113)</td>
<td>7</td>
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<tr>
<td>Mid Lothian CHP</td>
<td>(54)</td>
<td>(16)</td>
<td>(17)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>(186)</td>
<td>(65)</td>
<td>(54)</td>
<td>11</td>
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</tr>
<tr>
<td>Primary Care Other</td>
<td>(28)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>(343)</td>
<td>(48)</td>
<td>(104)</td>
<td>56</td>
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</tr>
<tr>
<td>Corporate Areas</td>
<td>(601)</td>
<td>(237)</td>
<td>(119)</td>
<td>(118)</td>
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<tr>
<td>University Hospital Services</td>
<td>(3,740)</td>
<td>(1,534)</td>
<td>(1,142)</td>
<td>(392)</td>
<td></td>
</tr>
<tr>
<td>Strategic Budgets</td>
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<td>(98)</td>
<td>(3)</td>
<td>(95)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6,640)</td>
<td>(2,468)</td>
<td>(1,966)</td>
<td>(502)</td>
</tr>
<tr>
<td>Centrally held</td>
<td>(8,296)</td>
<td>(3,697)</td>
<td>(3,302)</td>
<td>(395)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>(27,832)</td>
<td>(9,942)</td>
<td>(7,701)</td>
<td>(2,241)</td>
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</tr>
</tbody>
</table>
CUSTOMER RELATIONS AND FEEDBACK 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.

- Note the figures in relation to Complaints, especially those with the SPSO
  4.2 and 4.3

- Complaints regarding Staff Attitude are slowly reducing
  5.2

- Having a rigorous investigation process for re-opened complaints may prevent the complainant progressing their issues to the SPSO and, if it does, SPSO would be less likely to uphold or partially uphold the issue or issues as NHSL had carried out a second rigorous investigatory process.
  4.4 and 4.5

- Note a case from the SPSO for the Board’s attention
  7.11

Stuart R Wilson
Director of Communications & Public Affairs
11 September 2013
CUSTOMER RELATIONS AND FEEDBACK QUALITY REPORT

1 Purpose of the Report

1.1 The purpose of this report is to give an overview of the issues highlighted within the complaints, comments and feedback received within Quarter 1, 1 April to the 30 June 2013. The paper also outlines the changes within the Customer relations and Feedback Team (CRaF Team) handling complaints, its processes and reports progress toward developing a new process to fully address the recommendations within the Francis Report of February 2013.

1.2 The report also gives an insight in NHS Lothian’s interaction with the Scottish Public Services Ombudsman (SPSO) and highlights ongoing cases that have been reported to the SPSO.

1.3 Some examples of Patient stories taken from Patient Opinion are included below.

2 Patient Stories

2.1.1 An example of a negative patient experience given through the public website Patient Opinion is as follows:

“My daughter attended A&E at the Royal Infirmary of Edinburgh recently after an injury.

“The nurse who treated my daughter was unsympathetic, made her feel stupid and questioned the severity of her injury. The nurse’s manner was uncaring and at times insulting. The nurse questioned the advice that had been given by health professionals to my daughter before we came to the hospital to other staff in a disparaging manner.

No matter the severity of the illness or injury people deserve to be treated with respect, something this nurse clearly knows very little about.”

This issue has been picked up through our complaints process

2.2 An example of a positive patient experience given through the public website Patient Opinion in the last quarter is as follows:

“I went into the Day Surgery Unit at St John’s Hospital in Livingston for a tonsillectomy yesterday and was really impressed by the standard of care I received. Everything was
very efficient and I wasn’t kept waiting too long before the op. I was also very nervous as this was my first ever operation but the nurses, anaesthetist and surgeon could not have been nicer - the nurse who went into the operating theatre with me was a particular gem.

“The nurse in the recovery room was equally nice, and the nursing staff on the ward were all helpful and attentive and made sure my pain was under control after the op. They also made sure to give me advice about recovery and all the pain meds I needed before going home.”

This issue was forwarded to the relevant teams so that the praise could be passed on.

3 Recommendations

3.1 Note the figures in relation to complaints.

3.2 Note the highest numbers of issues identified in the Hot Topics category are easily resolvable and that there are a number of compliments contained within complaints figures (Appendix 8 – Compliments in Blue).

3.3 Note the progress of the Short Life Working Group to examine the future remit of the CRaF Team.

3.4 Note the latest cases from the SPSO.

4 Background

4.1 In March 2013 the Board received the first Quarterly Complaints Quality Report which outlined a rise from 3151 complaints in 2011 to 3842 in 2012. The June 2013 CRaF Team Quality Report showed that the other Territorial NHS Boards had experienced a similar rise in complaints and the main three reasons for complaining were the same regardless of the differences in the size and remit of the Boards.

4.2 NHS Boards produced and circulated their Annual Reports in mid-June 2013 at the same time the SPSO also produced an Annual Report. All Boards and the SPSO showed a rise in the number of complaints. The SPSO reported an overall 5% increase and predicts a further 10% increase next year. The Public Sector which saw the steepest rise in numbers of complaints were the Health Boards, at 28%. NHS Lothian’s Annual Report shows that the rise in complaints for NHS Lothian from 2011 to 2012 was 17%.

4.3 SPSO is also concerned that it is upholding 46% of the complaints it receives compared to 39% the previous year. Of the issues that the SPSO has looked at from NHS Lothian, 70% have been upheld or partially upheld. Appendix 9 shows a table of current ‘live’ SPSO cases with a small table showing the CMT/CHP who manage the area.
4.4 A Short Life Working Group has been set up and is examining the way ahead to alter the way that the CRaF Team work to ensure that it contributes to helping improve service delivery across NHS Lothian. It is envisaged that when this group concludes at the end of September 2013 that a more robust, objective investigation process will be proposed which will better identify action points within complaints. This type of process will be more likely to satisfy complainants that their issues has been rigorously investigated and addressed making them less likely to be dissatisfied and take their issue to the SPSO. If the complainant does proceed to SPSO, the added rigour of the investigative process will make it less likely that SPSO will uphold the issue.

4.5 As illustrated in Appendix 5, between 55% and 71% of complaints which have progressed to the SPSO had previously been re-opened at the Health Board level. This shows that, when the complainant remains dissatisfied at the end of the complaints process, the majority return to the Board asking for the complaint to be reconsidered before going to the SPSO which gives us another opportunity to re-investigate.

5 Summary of the current issues

5.1 As identified in the June 2013 paper and outlined again for Quarter 1 (1 April 2013 to 30 June 2013) in Appendix 1, the three most frequently complained about issues in NHS Lothian are again, “Clinical Treatment”, “Staff Attitude and Behaviour” and “Waiting Times”. These have been the issues most complained about for the past three years in all major management groups.

5.2 As can be seen in Appendix 1, Clinical Treatment and Waiting Times remain at a steady level. However, staff attitude is slowly reducing which is positive news. We will wait to see if this trend is continued.

5.3 In Appendix 2, the Clinical Treatment complaints for Quarter 1 are shown by Clinical Management Team. As pointed out in the June 2013 paper, this shows that the highest numbers of these complaints are in Medicine in the Royal Infirmary of Edinburgh (RIE). The reason for this is due to the high activity level in the Emergency Department. This number is further broken down to sub-category in Appendix 2A.

5.4 Appendix 2A shows that the highest sub-category of the Clinical Treatment complaints is ‘Co-ordination of Medical Treatment’ which reflects the hand over from Emergency Department to Combined Assessment to the Clinical Specialty to which the patient requires to be transferred. This is the most anxious and unsettling time for patients with an unexpected illness.

5.5 Appendix 3 shows that the highest number of Staff Attitude complaints are in the specialty of Ophthalmology.

5.6 Appendix 3A shows the sub-category of the complaints regarding Staff Attitude in Ophthalmology is Communication. In Appendix 8 – Hot Topics, we can see that there have been 55 complaints regarding the telephone system at the Princess Alexandra Eye Pavilion (PAEP) – highlighted in red in the table. The Clinical Team responsible is aware of these issues and are taking action which will hopefully see the figures reduced.
5.7 For Waiting Times complaints, Appendix 3 shows that the highest numbers of these complaints are again with the Head and Neck Clinical Team who also manage Ear, Nose and Throat (ENT). Clinics for ENT have also been affected by the problems with telephones at PAEP as the same staff members cover the switchboard in the Lauriston Building which hosts the ENT Out-Patient Clinics. The telephone system gives an option for the patient waiting to choose for their call to be transferred directly to the CRaF Team. As patients are normally calling to book, change or arrange an appointment, this is the reason for their complaint. As mentioned in the previous paragraph, this issue is being picked up by the Clinical Team.

6 CRAFT and the Complaints Process

6.1 A Triage Desk was created in the CRaF Team which commenced on Monday 17 June 2013. There are now two members of the Customer Relations Officer team taking all calls and Triaging new issues received by mail and e-mail. The objective for the Triage Team has been to resolve all issues within 48 hours rather than focus on the 20 day response target. If the issue is not resolved, they pass to a Customer Relations Officer who will seek a written response by day 20. The team’s other objective is to cover the workload for the Customer Relations Officers during absence. This arrangement has been working well and is due for formal review at the end of September 2013 where CMT/CHP staff and past complainants will be asked to attend.

6.1.1 The Triage Desk has reduced the workload and increased the efficiency of the team. Morale remains high and a further Development session for the CRaF Team is being arranged for October.

7 Scottish Public Services Ombudsman

7.1 In Quarter 1, NHS Lothian currently has 44 cases live with the SPSO (Appendix 9). Of those one has not been upheld, the SPSO has requested further information on four of them and 39 are ongoing in terms of investigation.

7.1.0 The majority of these cases relate to Surgery and Medicine at the RIE. A growing number, however, relate to prisons.

7.1.1 We have been asked by the SPSO to bring a particular case to the attention of Board Members. It concerns the upholding of a complaint regarding the treatment of Ms A and the associated recommendations and action plan required.

7.1.2 Ms A was forcibly transferred from Hospital 1 to Hospital 2 without any prior knowledge or explanation. She was also inappropriately told that she was being detained under the Mental Health Act but has no recollection of being detained. SPSO also highlighted that the manner in which Ms A was wrapped in a blanket and strapped to a trolley, causing severe bruising to her shoulders, was inappropriate and unreasonable.

7.1.3 Dr David Farquharson, Medical Director is leading on the actions to address the issues raised. A full report on this case is due to be reported to the Board on 21 October 2013 as this has been reported by the SPSO in Quarter 2. In summary:
• The patient was forcibly transferred from Hospital 1 to Hospital 2 without any prior knowledge or explanation of reasons – all matters should be discussed fully with patients, giving the rationale for decisions and the range of options available to them

• The patient was inappropriately told that she was being detained under the Mental Health Act but has no recollection of being detained – discussion should be undertaken in relation to the patient’s care and these should be clearly recorded

• The manner in which the patient was wrapped in a blanket and strapped to a trolley was unreasonable – When restraint is required this should be clearly documented both in the Board’s incident reporting mechanism and in the patient’s medical notes

• Ensure that all staff are aware of the requirements of the Mental Health legislation and adhere to the appropriate process

• Staff should ensure that physical examination is conducted on all patients who have been restrained

• This case and the actions taken should be considered at a meeting of the Lothian NHS Board by 21 October 2013

8 Key Risks

There would be a risk that NHS Lothian would not be able to deliver on the requirement from the SPSO to reduce the number of upheld complaints if it does not progress an internal investigation element to complaints handling.

9 Impact on Inequality, Including Health Inequalities

8.1 Any new process for handling complaints will be subject to a Rapid Impact Assessment to ensure it meets the necessary requirements in this area. This will be carried out during the formal review of the Triage process at the end of September 2013.

10 Resource Implications

10.1 Additional funding may be required for additional staff if the new system being considered by the SLWG is approved.

Stuart Wilson
Director of Communications and Public Affairs
11 September 2013

List of Appendices

Appendix 1: Total Complaint Number for Q1 (1 April to 30 June 2013) broken down into CMT/CHP.
Appendix 2: TREATMENT - Main Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP.

Appendix 2A: TREATMENT - Main Reason for Complaining Q1 (1 April to 30 June 2013) broken down into sub-category for the CMT with most complaints in this category – Medicine at RIE.

Appendix 3: ATTITUDE – Second Main Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP.

Appendix 3A: STAFF ATTITUDE – Second Main Reason for Complaining Q1 (1 April to 30 June 2013) broken down into sub-category for the CMT with most complaints in this category – Medicine at RIE.

Appendix 4: WAITING – Second Main Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP.

Appendix 4A: WAITING – Second Main Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP broken down into sub-category for the CMT with most complaints in this category – Ear, Nose and Throat.

Appendix 5: RE-OPENED COMPLAINTS – Percentage which then progress to the Scottish Public Services Ombudsman (SPSO).

Appendix 6: CLOSED COMPLAINTS by Outcome – Upheld, Partially Upheld, Not Upheld.

Appendix 7: UPHELD COMPLAINTS by Subject % Q1 (1 April to 30 June 2013)

Appendix 8: HOT TOPICS – Q1 (1 April to 30 June 2013)

Appendix 9: SPSO Current Live SPSO cases
Total Complaint Number for Q1 (1 April to 30 June 2013) broken down into CMT/CHP

APPENDIX 1

Complaint Issues by Quarter - Q1 2012/13 to Q1 2013/14
TREATMENT - Main Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP

APPENDIX 2

TREATMENT - Top reason for complaints raised against CMT/CHP - Q1 2013/14
**APPENDIX 2A**

**TREATMENT - Main Reason for Complaining Q1 (1 April to 30 June 2013) sub-category by Medicine at RIE**

TREATMENT highest number of complaints received by Issue - Analysis of MEDAS who received most complaints in this category - Q1 2013/14

<table>
<thead>
<tr>
<th>Reason</th>
<th>Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ordination of medical treatment</td>
<td>13</td>
</tr>
<tr>
<td>Error in performing a procedure</td>
<td>1</td>
</tr>
<tr>
<td>Poor nursing care</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Staff not observing patient</td>
<td>1</td>
</tr>
<tr>
<td>Wrong diagnosis</td>
<td>6</td>
</tr>
<tr>
<td>Wrong medicine given</td>
<td>1</td>
</tr>
<tr>
<td>No data</td>
<td>3</td>
</tr>
<tr>
<td>Lack of pain management</td>
<td>2</td>
</tr>
<tr>
<td>Wrong treatment given</td>
<td>1</td>
</tr>
</tbody>
</table>
APPENDIX 3

ATTITUDE – Second Top Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP

ATTITUDE - 2nd highest reason for complaints raised against CMT/CHP - Q1 2013/14
APPENDIX 3A

STAFF ATTITUDE – Second Top Reason for Complaining Q1 (1 April to 30 June 2013) broken down into sub-category for the CMT with most complaints in this category – OPHTHALMOLOGY

<table>
<thead>
<tr>
<th>Attitude and behaviour</th>
<th>Communication (oral)</th>
<th>Communication (written)</th>
<th>Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

ATTITUDE 2nd most number of complaints received by Issue - Analysis of MEDAS as the area with most complaints in this category - Q1 2013/14
WAITING – Second Top Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP

WAITING - 3rd highest reason for complaint by CMT/CHP - 2012/13
WAITING – Second Top Reason for Complaining Q1 (1 April to 30 June 2013) broken down into CMT/CHP broken down into sub-category for the CMT with most complaints in this category – Ear, Nose and Throat

WAITING 3rd most complaints received by Issue - Analysis of Ear, Nose & Throat as the area with most complaints in this category - Q1 2013/14
APPENDIX 5

RE-OPENED COMPLAINTS PERCENTAGE WHICH THEN PROGRESS TO THE SCOTTISH PUBLIC SERVICES OMBUDSMAN (SPSO)

Complaints referred to SPSO by Quarter - 2012/13 to 2013/14
CLOSED COMPLAINTS BY OUTCOME – UPHELD, PARTIALLY UPHELD, NOT UPHELD

Closed Complaints by Outcome Q1 2013/14

- **Upheld**: 68
- **Partly Upheld**: 115
- **Not Upheld**: 103
- **Transferred to another unit**: 2
- **Withdrawn**: 1
- **Conciliation**: 1
UPHELD COMPLAINTS BY SUBJECT %

Complaints upheld by Issue - Q1 2013/14

- Delays in/at: 37%
- Environment / domestic: 23%
- Other: 21%
- Procedural issues: 11%
- Staff: 4%
- Transport: 3%
- Treatment: 1%
- Waiting times for: 3%
## HOT TOPICS – Q1 (1 April to 30 June 2013)

<table>
<thead>
<tr>
<th>HOT TOPIC</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting times</td>
<td>153</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>130</td>
</tr>
<tr>
<td>Quality of care</td>
<td>126</td>
</tr>
<tr>
<td><strong>Excellent Care and Treatment</strong></td>
<td>88</td>
</tr>
<tr>
<td>Attitude and behaviour</td>
<td>66</td>
</tr>
<tr>
<td>Personal Care</td>
<td>63</td>
</tr>
<tr>
<td><strong>Phones (PAEP)</strong></td>
<td>55</td>
</tr>
<tr>
<td>Medication</td>
<td>38</td>
</tr>
<tr>
<td>Discharge</td>
<td>19</td>
</tr>
<tr>
<td>Phones</td>
<td>18</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>14</td>
</tr>
<tr>
<td>Care funding in Lothian</td>
<td>13</td>
</tr>
<tr>
<td>DELAY</td>
<td>11</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>11</td>
</tr>
<tr>
<td>Records</td>
<td>11</td>
</tr>
<tr>
<td>Car Parking</td>
<td>10</td>
</tr>
<tr>
<td>Administration</td>
<td>9</td>
</tr>
<tr>
<td>Environment</td>
<td>9</td>
</tr>
<tr>
<td>Diabetes Register</td>
<td>8</td>
</tr>
<tr>
<td>Cancellation</td>
<td>7</td>
</tr>
<tr>
<td>Death</td>
<td>6</td>
</tr>
<tr>
<td>Infection Control</td>
<td>6</td>
</tr>
<tr>
<td>Smoking</td>
<td>6</td>
</tr>
<tr>
<td>Catering</td>
<td>4</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>4</td>
</tr>
<tr>
<td>Patient Belongings</td>
<td>4</td>
</tr>
<tr>
<td>Website</td>
<td>4</td>
</tr>
<tr>
<td>Wheelchairs</td>
<td>4</td>
</tr>
<tr>
<td>Consultation</td>
<td>3</td>
</tr>
<tr>
<td><strong>Consultation (PAEP)</strong></td>
<td>3</td>
</tr>
<tr>
<td>Referral</td>
<td>3</td>
</tr>
<tr>
<td>Results</td>
<td>3</td>
</tr>
<tr>
<td>Safety</td>
<td>3</td>
</tr>
<tr>
<td>Staffing issues</td>
<td>3</td>
</tr>
<tr>
<td>Transfer</td>
<td>3</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>918</strong></td>
</tr>
</tbody>
</table>
### SPSO Quarter 1 (1 April to 30 June 2013) Cases

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Closed in Quarter 1 – NOT UPHELD</td>
</tr>
<tr>
<td>4</td>
<td>New - SPSO request for information</td>
</tr>
<tr>
<td>39</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>44</strong></td>
<td><strong>CURRENT TOTAL</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CMT/CHP</th>
<th>NUMBER OF CURRENT SPSO ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURGERY</td>
<td>10</td>
</tr>
<tr>
<td>MEDICINE – RIE</td>
<td>9</td>
</tr>
<tr>
<td>MEDICINE – WGH</td>
<td>2</td>
</tr>
<tr>
<td>MEDICINE - SJH</td>
<td>1</td>
</tr>
<tr>
<td>CLINICAL</td>
<td>SERVICES</td>
</tr>
<tr>
<td>Oncology</td>
<td>2</td>
</tr>
<tr>
<td>Dental</td>
<td>1</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>1</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1</td>
</tr>
<tr>
<td>EMCHP</td>
<td>1</td>
</tr>
<tr>
<td>Prisons</td>
<td>4</td>
</tr>
<tr>
<td>ECHP</td>
<td>1</td>
</tr>
<tr>
<td>WOMEN Gynaecology</td>
<td>1</td>
</tr>
<tr>
<td>Maternity</td>
<td>2</td>
</tr>
<tr>
<td>Children</td>
<td>1</td>
</tr>
<tr>
<td>Neurology</td>
<td>1</td>
</tr>
<tr>
<td>REAS</td>
<td>3</td>
</tr>
<tr>
<td>WLCHP</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>
BABY FRIENDLY STATUS IN NHS LOTHIAN

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 purpose of this report is to update the Board on actions being taken, and that require to be taken, to acquire Baby Friendly Status across Lothian and to seek endorsement for accreditation across Lothian as agreed by JMT.

  1.1

- The Board is recommended to endorse that all Lothian CH(C)Ps pursue UNICEF Baby Friendly Status, with a minimum Certificate of Commitment obtained by December 2013.

  3.1

- NHS Lothian currently remains the only Scottish Health Board without Baby Friendly accreditation of any community services.

  3.6

Sally Egan
Chair of Maternal and Infant Nutrition Group
4 September 2013
Sally.Egan@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
25 September 2013

Director of Strategic Planning, Performance Reporting & Information/Director of Public Health & Health Policy

BABY FRIENDLY STATUS IN NHS LOTHIAN

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on actions being taken, and that require to be taken, to acquire Baby Friendly Status across Lothian and to seek endorsement for accreditation across Lothian as proposed by the Joint Management Team.

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

2 Recommendations

2.1 Endorse that all Lothian CH(C)Ps pursue UNICEF Baby Friendly Status, with a minimum Certificate of Commitment obtained by December 2013.

2.2 Promote the principles and adoption of the UNICEF Baby Friendly Initiative throughout the organisation, as outlined in the NHS Lothian Infant Feeding Policy.

3 Discussion of Key Issues

3.1 In January 2011 the Scottish Government published Maternal and Infant Nutrition: A Framework for Action, which outlined actions required by NHS Boards and partner agencies to help ensure children have the best start in life and are ready to succeed. NHS Lothian has been allocated £320,000 per annum (confirmed until March 2014, although expected until March 2016) to implement this framework. Local implementation of the Framework is coordinated through the Maternal & Infant Nutrition Group, now chaired by the Child Health Commissioner and with representation from CH(C)Ps, Royal Infirmary Edinburgh, St John’s Hospital and the Directorate of Public Health and Health Policy. A Maternal & Infant Nutrition Group will be formed which will:

- Identify any issues with implementing the Baby Friendly Initiative across Lothian, address where possible and escalate where necessary
- Report on progress to the Executive Lead/Project Sponsor and Child Health Commissioner
- Ensure the Maternal & Infant Nutrition Group have the right information to coordinate local implementation of the Framework
- Ensure funding is being spent in line with delivery plans
- Co-ordinate returns to the Scottish Government

Membership of this group will include representation from the Directorate of Public Health and Health Policy, Strategic Planning Performance Reporting and Information, Finance and will have clear links with CH(C)Ps, Local Authorities and implementation leads.
3.2 This framework continues to be an integral part of a broad spectrum of early years policy and should therefore be considered alongside the Refreshed Maternity Framework, Antenatal Health Efficiency Access Treatment Target and work of the Early Years Collaborative. Improving breast feeding rates is a key strand that cuts across all these initiatives as infants who are breastfed have improved attachment with their mother, are at reduced risk of ear, respiratory, gastro-intestinal and urinary tract infections, allergic disease (eczema, asthma and wheezing), type 1 diabetes, are less likely to be overweight later in childhood.

3.3 Breastfeeding rates are low in Scotland and have been relatively static for the last decade. Lothian is above average but is largely buoyed by Edinburgh. In broad terms the positions of the CH(C)Ps, according to the Information Services Division’s 2011/12 figures are:

<table>
<thead>
<tr>
<th>CH(C)Ps,</th>
<th>East</th>
<th>Mid</th>
<th>Edinburgh</th>
<th>West</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>First visit % Breastfed (incl. mixed)</td>
<td>56.0</td>
<td>43.1</td>
<td>72.1</td>
<td>45.8</td>
<td>47.0</td>
</tr>
<tr>
<td>% exclusively breastfed</td>
<td>42.5</td>
<td>30.7</td>
<td>53.2</td>
<td>35.1</td>
<td>35.9</td>
</tr>
<tr>
<td>6-8 week % Breastfed (incl. mixed)</td>
<td>40.8</td>
<td>32.3</td>
<td>60.0</td>
<td>33.1</td>
<td>36.7</td>
</tr>
<tr>
<td>% exclusively breastfed</td>
<td>28.1</td>
<td>22.4</td>
<td>41.4</td>
<td>22.9</td>
<td>26.2</td>
</tr>
</tbody>
</table>

West Lothian’s breastfeeding rates are below national average on all but exclusive feeding at six to eight week with little change in the last ten years. East Lothian are above national average but rates are dropping. Midlothian are below the national average and all rates are dropping. Edinburgh is above average and improving for combined feeding but not exclusive feeding.

3.4 Within the Framework for Action, Baby Friendly Initiative is specifically mentioned as an indicator of achieving national outcomes and in helping improve breastfeeding rates. Since publication in January 2011, NHS Boards across Scotland have been working towards accreditation.

3.5 The Baby Friendly Initiative is a global UNICEF and World Health Organisation programme which awards the prestigious Baby Friendly status to healthcare premises that adopt evidence-based best practice standards. For maternity units there are the ‘Ten Steps to Successful Breastfeeding’ and for community healthcare premises there are the ‘Seven Point Plan for Sustaining Breastfeeding in the Community’. Best practice standards for neonatal units have also been developed and UNICEF United Kingdom will shortly implement an accreditation programme for neonatal units highlighted in Chief Executive Letter14 (2008) Health Promoting Health Service: Action in acute care settings. Baby Friendly status has been achieved in the Royal Infirmary Edinburgh, where they are fully accredited, and St John’s Hospital where they will undertake their Stage 2 assessment in spring 2014.

3.6 NHS Lothian currently remains the only Scottish Health Board without Baby Friendly accreditation of any community services. In the NHS Lothian Annual Review 2012 self assessment, we stated our intention to improve “Maternal and infant nutrition through a number of evidence based interventions, such as ensuring that all our sites meet UNICEF Baby Friendly standards, all staff are trained to support women, and reducing the socioeconomic and geographical gradient in breast feeding in the early post-natal period.”
3.7 On 15/7/2013, UNICEF presented to NHS Lothian’s Informal Directors on how the Baby Friendly Initiative promotes health and well-being to all babies. This was well received and it was agreed that the Director of Public Health and Health Policy will be the Project Sponsor for this work. A commitment was also made by Directors that CH(C)Ps will work towards achieving Baby Friendly status. Subsequently papers have been presented to all CH(C)P sub-committees and to the Joint Management Team, all recommending The pursuit of Baby Friendly Status and promotion of the principles of the Baby Friendly Initiative, as now recommended to the Board.

3.8 It is proposed that accreditation is pursued aligned to Community Planning Partnerships, with Edinburgh and West Lothian CH(C)Ps applying individually and East and Midlothian making a joint application. Central co-ordination will ensure pan Lothian policies and an aligned approach, whilst enabling CH(C)Ps to action appropriate solutions to local issues. This will also ensure that NHS Lothian can demonstrate evidence of progress towards implementation of the Maternal & Infant Nutrition Framework at the pace expected by the Scottish Government. To this end and following discussion at JMT, an Implementation Visit from UNICEF that would prepare CH(C)Ps and consider an action plan for accreditation was arranged for 18 September 2013.

3.9 To help support NHS Lothian achieve Baby Friendly status, an updated Infant Feeding Policy is now in place, developed by staff across NHS Lothian including in the Royal Infirmary Edinburgh and St John’s Hospital Maternity services, the four CH(C)Ps, the Directorate of Public Health and Health Policy, Strategic Planning, Finance and the Partnership Forum. An Assistant Strategic Programme Manager will also support CH(C)Ps with achieving accreditation.

4 Key Risks

4.1 If NHS Lothian does not implement the Baby Friendly Initiative, the main risks are that breastfeeding rates will not improve and as a result children will have poorer health outcomes and that NHS Lothian will continue to be the only NHS Board in Scotland that has no CH(C)Ps with Baby Friendly status.

4.2 From the time that NHS Lothian or individual CH(C)Ps register for Baby Friendly Status there is an associated timeline allowing a maximum duration between level assessments. Failure to meet the standards at the end of a stage leads to the requirement for a reassessment at additional and increased costs. This risk will be mitigated by the formation of the Maternal & Infant Nutrition Executive Group overseeing delivery, with an Assistant Strategic Manager post funded for three years to support this.

5 Risk Register

5.1 There are no risks to be recorded in the Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 A central strand of the Maternal and Infant Nutrition programme is to reduce health inequalities. Infant feeding patterns in Lothian are poorest in mothers from the most deprived areas. Younger mothers, who are living on a low income, in areas of
deprivation or those with fewer education qualifications, are less likely to take the recommended nutritional supplements prior to pregnancy and have a good diet during pregnancy. They are also less likely to breastfeed and more likely to introduce complementary foods earlier than recommended.

6.2 The findings of the Equality Diversity Impact Assessment are that BFI will have a strongly positive impact for many diverse groups and at worst a neutral impact for unaffected populations. The recommendations made accordingly are to review training and literature to ensure communication barriers have been removed.

7 Involving People

7.1 A Maternal Infant Nutrition Group with representation from Strategic Planning, the Directorate of Public Health and Health Policy, CH(C)Ps and the Maternity Units, have all been involved in driving this agenda and will continue to support NHS Lothian in achieving Baby Friendly status. CH(C)Ps Infant Nutrition groups’ membership includes Council and Third Sector colleagues. Patient and community involvement work is already established including through CH(C)Ps peer support programmes and the development of a Parents’ Guide to the NHS Lothian Infant Feeding Policy.

7.2 The Baby Friendly Initiative will also build on the existing breast feeding work which already has a strong public involvement element. Examples include: the City of Edinburgh using questionnaire feedback and focus groups to appraise ante natal and post natal sessions leading to a comprehensive report and suggestions on how to shape the service; West Lothian using anonymous surveying to assess ward based peer supporter and tailor availability to suit the requirement; East and Midlothian’s diverse Breast Feeding Friendly awards supporting the community by reaching a variety of public spaces including schools, cafes and hairdressers.

8 Resource Implications

8.1 UNICEF applies fees to accreditation are currently funded by Scottish Government

8.2 There are staff time resource implications associated with implementation of baby friendly status, such as ongoing monitoring, management and attending learning sessions. This will be minimised by:

- Training already being undertaken for all staff groups affected, unlikely to have significant additional implications if training is to be mandated
- A cohort of staff including Infant Feeding Advisers, Maternal & Infant Nutrition Leads and Strategic and Public Health already engaged in this work
- Scottish Government Maternal and Infant Nutrition funding is currently being considered to help alleviate start up costs
- National Institute for Clinical Excellence clinical guideline no. 37 concludes that over time the initial costs of acquiring baby friendly status including fees and resources, will lead to potential savings.

Sally Egan
Chair of Maternal and Infant Nutrition Group
11 September 2013
Sally.Egan@nhslothian.scot.nhs.uk
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.

- Progress against Health Efficiency Access Treatment Targets
  - *Staphylococcus aureus* Bacteraemia (SAB): there were 18 episodes of SAB in August 2013 compared with the 21 reported in July 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 19 episodes per month.
  - *Clostridium difficile* Infection (CDI): there were 41 episodes of CDI in patients aged 15 or over in August 2013, compared with 34 reported in July 2013. In order to achieve the target, NHS Lothian has to average no more than 22 episodes per month for the 24 month period, with a current average of 36 episodes per month.
  - In September 2013 Health Protection Scotland published revised Health Efficiency Access Treatment (HEAT) Targets
  - Norovirus outbreaks: NHS Lothian is seeing some early presentations of the start of norovirus season.
  - Hand Hygiene: NHS Lothian is achieving a hand hygiene compliance of 97% which exceeds the national compliance of 96%.
  - Surveillance of HAI in Scottish Intensive Care Units: local data demonstrates significant achievement in preventing healthcare associated infections in critically unwell patients in NHS Lothian.
  - Healthcare Environmental Inspectorate (HEI): The Inspectorate carried out an unannounced inspection at the Royal Hospital for Sick Children on 6/8/2013 with report anticipated to be published on 1/10/2013.
  - Antimicrobial Management Team: the Alert Antibiotic Policy is in operation at the Royal Infirmary of Edinburgh, Western General Hospital and St Johns Hospital. This policy supports appropriate use of selected broad-spectrum antibiotic agents.
  - Decontamination: the local dental decontamination unit at the Western General Hospital has been built and the washer disinfectors have been installed.

Fiona Cameron
Head of Infection Prevention and Control Services
10 September 2013
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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 implementation of the Escalation Policy for Non Compliance with Hand Hygiene.

3 Discussion of Key Issues

3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets

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

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

![Figure 3: Hand Hygiene Compliance Rate – August 2013](image3.png)
3.2 *Staphylococcus aureus* Bacteraemia: there were 18 episodes of *Staphylococcus aureus* Bacteraemia in August 2013 (1 Meticillin Resistant *Staphylococcus aureus*, 17 Meticillin Sensitive *Staphylococcus aureus*), compared to 21 in July 2013 (2 Meticillin Resistant *Staphylococcus aureus*, 19 Meticillin Sensitive *Staphylococcus aureus*). NHS Lothian’s new Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days by March 2015, with a current rate of 0.28 (updated to August 2013). In order to achieve the target, NHS Lothian has to average no more than 15 episodes per month for the twenty-four month period, with a current average of 19 episodes per month.

3.3 *Clostridium difficile* Infection: there were 41 episodes of *Clostridium difficile* Infection in patients aged 15 or over in August 2013, compared to 34 in July 2013. NHS Lothian’s new Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 total occupied bed days by March 2015 in patients aged 15 and over, with a current rate of 0.53 (updated to August 2013). In order to achieve the target, NHS Lothian has to average no more than 22 episodes per month for the twenty-four month period.

In September 2013 Health Protection Scotland published revised Health Efficiency Access Treatment (HEAT) Targets in response to the detection that the number of bed days used to calculate rates for *Clostridium difficile* Infection in patients aged 65 years had previously been artificially high. Once corrected will result in the published *Clostridium difficile* Infection rates for all NHS Scotland Health Boards being higher than in previous reports. However, it is important to note that there are no changes to the number of cases identified and reported; therefore the reductions in CDI numbers remain accurate. Following the revision, NHS Lothian’s revised target is to achieve a rate of 0.32 by March 2015 (previously 0.25).

3.4 Norovirus outbreaks: NHS Lothian is seeing some early presentations of the start of norovirus season with confirmed norovirus outbreak at St Johns Hospital. Preparations are in place for the new norovirus season with a winter planning meeting scheduled for the 17th of October 2013.

3.5 The 26th bi-monthly national hand hygiene audit report was published by Health Protection Scotland on 31st July 2013. This indicates that NHS Lothian is achieving a hand hygiene compliance of 97% which exceeds the national compliance of 96%. In August 2013, the Scottish Government Healthcare Associated Infection Policy Unit announced the National Hand Hygiene Campaign, including the collection, analysis and publication of bi-monthly hand hygiene data by Health Protection Scotland, will conclude on 25th September 2013 with the publication of the 27th bi-monthly Hand Hygiene Monitoring Audit Report. From October 2013, boards are expected to continue with monitoring and reporting of hand hygiene compliance with re-integration of compliance monitoring through local improvement programmes such as the Scottish Patient Safety Programme.

3.6 The third annual report on Surveillance of Healthcare Associated Infections in Scottish Intensive Care Units was published by Scottish Intensive Care Society Audit Group and Health Protection Scotland in August 2013. Infection surveillance data is collected at the Royal Infirmary Edinburgh Ward 118, Western General Hospital Ward 20 and St John’s Hospital Intensive Care Unit. The Hospital in Europe Link for Infection Control through Surveillance criteria are used to define
ventilator associated pneumonia, bloodstream infection and central venous catheter related bloodstream infection.

The primary purpose of data collection is for local improvement. Infection surveillance data is analysed and synthesised to inform clinical practice and improve patient outcomes. Improvements for practice are shared among the clinical teams. Local data demonstrates significant achievement in preventing healthcare associated infections in critically unwell patients in NHS Lothian.

3.7 Healthcare Environmental Inspectorate: The Healthcare Environment Inspectorate requested a 16 week action plan update for the unannounced Inspection at the Royal Infirmary of Edinburgh on 30 April-1 May 2013. This was returned to Inspectorate on 2 September 2013. The Inspectorate carried out an unannounced inspection at the Royal Hospital for Sick Children on 6 August 2013, with the final report anticipated to be published on 1 October 2013.

3.8 Antibiotic Prescribing Indicators: the target level for compliance within the Acute Services Antimicrobial Prescribing Guidelines and documentation of antibiotic indication is 95%. In clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is at or above the target level for the Royal Infirmary of Edinburgh and below target level for St Johns Hospital. Documentation of indication for antibiotic treatment was at or above the target level for all three acute sites. Compliance with the Surgical Prophylaxis Policy has dropped below target level at 83% compliance in the last month and administration of single dose antibiotic prophylaxis has remained above the target level at 100% compliance.

3.9 Decontamination: the local dental decontamination unit at the Western General Hospital has been built and the washer disinfectors have been installed. A site visit is planned and an update will be provided in the next report. The Scottish Prison Health Service transferred into the NHS domain in November 2011. A review of both prison Local Decontamination Units took place in 2011-12. It has been agreed that the workload from both prisons will be moved to the new Local Dental Decontamination Units at the Western General Hospital and St John’s Hospital once these are completed.

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.
- Failure to comply with hand hygiene increases the potential risk of transmission of infection.

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 September 2013
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List of Appendices

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

## Section 1 – Board Wide Issues

**NHS LOTHIAN**

### Staphylococcus aureus bacteraemia monthly case numbers

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# ST JOHNS HOSPITAL

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## *Clostridium difficile* infection monthly case numbers

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COMMUNITY HOSPITALS

The community hospitals covered in this report card include:

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

### Staphylococcus aureus bacteraemia monthly case numbers

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### Clostridium difficile infection monthly case numbers

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### OUT OF HOSPITAL INFECTIONS

#### Staphylococcus aureus bacteraemia monthly case numbers

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The draft minutes of the meeting held on the 4 September 2013 at the Royal Edinburgh Hospital are attached.

Key issues discussed included:

- **REH Phase 1 OBC** – following a visit to some areas of the hospital the Committee received an update on the progress of the project including the masterplanning, clinical strategy and financial modelling. In particular Committee members noted the planned reduction in bed numbers and the plans for community reprovision. It was agreed that assurance on these plans regarding timescale and cost would be provided in the OBC.

- **Step down beds** – the Committee received an update on the development of plans for these to be provided in Care homes. They were advised that an initial 43 beds will become available in a phased basis from October.

- **Financial position/LRP** – the Committee were given assurance on the delivery of breakeven for 2013/14 but noted the range of issues impacting on the financial position. In particular the Committee discussed progress on Efficiency and productivity (E&P), the links with the Clinical strategy and quality agenda, and requested a presentation on E&P at the next meeting.

- **Property and Asset Investment Programme 2012/13** – discussion focussed on the current year’s programme. The Committee noted the slippage on the enabling works for the RHSC/DCN and agreed the increased cost of £3.3m for phase 1 of the REH OBC.

Key issues on the horizon are:

- Royal Edinburgh Hospital OBC
- Development of the Committee’s Statement of Assurance needs
- Consideration of the Efficiency and Productivity programme
- Capacity plans for Scheduled Care
- Spending review 2014/15

George Walker, Chair

Susan Goldsmith, Executive Lead
Minutes of the Meeting of the Finance & Resources Committee held at 10:00 a.m. on Wednesday 4 September 2013 in The Boardroom, Mackinnon House, Royal Edinburgh Hospital, Morningside Place, Edinburgh.

Present: Mr G Walker (Chair); Mrs S Goldsmith; Mr B Houston; Mr P Johnston; Mrs K Blair; Professor J Iredale and Mr P Gabbitas.

In Attendance: Mr I Graham; Mr D Small; Mr A Milne (Item 26); Ms M Pringle; Mr P McKenna; Mr D Fitzpatrick (Item 26); Mr R Park (Item 26); Mr C Graham and Ms K Hart (observer).

Apologies for absence were received from Mr J Brettell; Councillor R Henderson; Professor A McMahon; Mrs C Potter; Mrs M Hornett; Mr J Forrest; Mr T Davison; Mr S Wilson and Dr D Farquharson.

The Chair welcomed members to the meeting and thanked Royal Edinburgh colleagues for arranging the day’s site tour. The Chair added that due to an incident at the Royal Infirmary of Edinburgh this morning some members might be called away during the meeting if necessary.

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. Mr I Graham declared that he was the Participants' Director of Hubco South East Limited.

26. Update on Royal Edinburgh Hospital Hub Project

26.1 Mr Milne and Mr Small gave a project update on the master plan and Phase 1 model, methodology and capital cost. The presentation covered the NHS Lothian overall site strategy, the clinical need for change; clinical overview; current and future bed numbers summary; capital cost movement; unitary charge and projected revenue consequences of phase 1; along with HUB governance and phasing details. The presentation also covered the overall site masterplan, showing massing of buildings, access to green space, access and transport proposals.

26.2 The Committee noted that the Outline Business Case (OBC) for Phase 1 would come to the October Committee Meeting. There was discussion on the reduction in the number of beds. It was noted that the reductions in adult beds were fully approved in the NHS Lothian mental health strategy. It was also noted that there was an agreed plan for reprovision of mental health rehabilitation beds in community provision through the Public Social Partnership (PSP). The committee sought further assurance in the OBC regarding the timescale and costs of this reprovision. Concern
was expressed about the reduction in older people’s assessment beds in light of demographic trends. It was noted that some of the current beds were occupied by people no longer being assessed and waiting for alternative services. The Committee acknowledged the model of care was being refined for certain services but overhauled for mental health rehabilitation. The committee noted reductions in bed numbers but asked for clarification on the progress community led schemes and how the service would cope with a reduction in assessment beds.

26.3 Mr Small noted the reduction in bed numbers had been an ongoing process for some time and the strategy reflected the continuing progress of the scheme. The Committee felt a demonstration of the reduction would be useful in terms of the OBC

26.4 Mr Gabbitas stated that he was responsible for the delivery of alternative provisions. Whilst the Committee were seeing reductions, they were not seeing the investment made in the alternatives. It was noted that the clinicians were on board with this model and that there are good relationships with the third sector in providing the alternatives.

26.5 There was discussion on single room provision; shared space; social interaction and sharing of other space. Mr Milne confirmed that in order to get the maximum efficiency from the building and provide external access and activities, the single banking had been felt to be the best option.

26.6 Mr Milne added that green space development costs had also been built into each phase along with the installation of ground source heat pumps underneath the reinstated Victorian gardens and other low carbon technology such as photovoltaic (solar) cells.

26.7 The Committee discussed the debt and interest related to the project. It was noted that in comparison to the RHSC/DCN project the interest was similar and was less than the Royal Infirmary of Edinburgh PFI. There was also discussion on the Phase 1 risks, including the complexity of the accounting and funding arrangements.

26.8 The Chair asked about local engagement with the project. Mr Milne stated that there had been meetings with local councillors, MSPs and the Community Council, with feedback being supportive. There was an issue around the removal of the bowling green but this would be addressed by providing activities elsewhere on site. Mr Small added that there had also been formal consultation meetings as part of master planning. The Committee noted that the onsite community gardens would also move and this may provide an opportunity to get local residents and school children involved in developing alternative provision. Mr Fitzpatrick stated that there was good engagement currently and that there was a volunteering scheme, the aim being not just the therapeutic benefits for patients, but that better public involvement and engagement reduces stigma.

26.9 Mr Fitzpatrick noted that a public Social Partnership would be formed to engage with the public and third sector parties regarding the green and art spaces. At the first public event on green space 88 people had attended representing 35 different local interest groups. The primary partners for the public social partnership on use of green space would come from this group, with the aim to look strategically at how to deliver therapeutic activities in the longer term.
26.10 The Committee noted that at the October Finance and Resources Meeting the Committee will be asked to approve purely Phase 1. The OBC will contain the required detail on financing and risks.

26.11 It was also suggested that this project could be an item for discussion at the next Board Chair/MSPs meeting. Mrs Goldsmith and Mr Houston would discuss this outwith the meeting.  

The Chair thanked Mr Small and his colleagues for the project update, site tour and presentation and they left the meeting

27. Minutes of the Previous Meeting

27.1 The previously circulated minutes of the Finance & Resources Committee meeting held on 12 June 2013 were approved.

28. Action Note

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

- **Statement of Assurance Needs** – It was noted that work on this remains outstanding. It was agreed that the October meeting agenda be managed to incorporate dedicated time to go over the Statement of Assurance Needs and that Mr A Payne be invited along to facilitate the discussion.

- **Clinical Strategy** – Mr Small reported that master planning meetings as part of work on clinical strategy had commenced; incorporating the Property and Asset Investment Programme

29. Matters Arising

29.1 **Update on Step Down Beds in Care Homes** - Mr Gabbitas reported on progress in the development of Step Down beds in care homes in Edinburgh. The key components with this work would be the change fund and unscheduled care strategy. It was noted that the delayed discharge target of no one waiting longer than four weeks in hospital would be dropping to two weeks next year. Mr Gabbitas stated that criteria had been drawn up with clinicians, aimed at people over 65, not requiring an acute medical intervention but who cannot go directly home.

29.1.1 Mr Gabbitas explained that from 1 October there would be new capacity of 43 beds available. These would be delivered through two providers, 20 beds initially from the external nursing home market and 23 beds from internal capacity, by converting beds at Edinburgh Council’s Silverlea Care Home. It was hoped that the number of externally provided beds would eventually increase.
29.1.2 The Committee noted that due to Care Inspectorate processes, the 43 beds would not be available all at once; four beds per week would come online, scaling up towards the end of October 2013.

29.1.3 There was discussion on Step Up Beds and whether both step up and step down beds could be provided in the same facility. Mr Gabbitas stated that his team had been reviewing the best step down facilities in the country and whilst intuitively step up and step down could be provided together, the practicalities of this were still not clear. There is a need for step up as well, but the clinical facilities and resources to deliver on that are not yet in place. The focus presently is on step down beds.

29.1.4 Mr Gabbitas added that there has been substantial engagement with acute clinicians regarding social care assessments. The critical thing with the new capacity is to achieve good flow and throughput as this is how success would be determined. Mr Gabbitas emphasised the importance of ensuring direct admission to a care home as the exception.

29.1.5 The Committee noted the paper. The Chair stated that the Committee would like to see some level of analysis at a future meeting.

Mr Gabbitas left the meeting.

29.2 Update on East Lothian Community Hospital - Mr Small stated that the East Lothian Community Hospital Business Case had been a long time coming; however NHS Lothian were committed to the development. Following an update request from the Cabinet Minister it was noted that the planned completion date for the new Hospital would be late 2017. The Committee noted that there was ongoing engagement with Capita at the moment and discussions on the data analysis regarding the scope of the services the Hospital would provide. Mr Small confirmed that the potential for having a Minor Injuries service on site was being looked at. The initial agreement for the Hospital would come to the December Finance and Resources Committee meeting.

29.3 Operation Triangle - Mr Small reported that there was no paper for this item given the ongoing dialogue. It is understood that a settlement offer has been made to the Central Legal Office which is currently being considered. In parallel to this, work on the fraud case and potential prosecution continue. The settlement and fraud case are being treated separately.

30. Governance

30.1. Financial Position to 31 July 2013 & Quarter 1 Review

30.1.1 Mrs Goldsmith drew the Committee’s attention to the final point on the summary document which stated “Across all Services, the detailed Quarter 1 review process has been completed. This indicates that the Financial Plan target of breakeven remains achievable.” Once the September results are received the Mid Year Review would take place.

30.1.2 She advised that delivery of the breakeven target was challenging this year given the level of planned change in relation to both scheduled and unscheduled care
capacity. The slippage on this investment was supporting delivery of waiting times, particularly in the independent sector. It was important to note that this year no further funding was being released. There would be the opportunity to take stock once the settlement for next year and the recurring position are known.

30.1.3 There was discussion on the slippage outlined in the paper and concerns over the ability to deliver recurring efficiency savings. It was noted that there was to be a Joint Management Team workshop in November to look at the efficiency programme.

30.1.4 The Chair suggested that it would be helpful for the Committee to hear from the Efficiency and Productivity Group. The recent Strategic Session for Board Members included a very good presentation from Orthopaedic Surgery on the work they are doing in relation to efficiency and productivity. The question of how this work could be shared across all surgical specialties was raised.

30.1.5 Mrs Goldsmith stated that it would be helpful to bring a short presentation to the Committee about the work being undertaken on Efficiency and Productivity. The Committee noted that a project office under strategic planning was being established to support efficiency and productivity but there was a need for sharing of good work to be embedded culturally into the organisation.

30.1.6 The Chair stated that the Committee should be championing the sharing of good ideas that have a positive impact on efficiency and productivity.

30.1.7 The Committee noted the recommendations in the paper and agreed that there should be a presentation on this at a future meeting and would leave it to Mrs Goldsmith to take this forward.

30.2. Property and Asset Investment Programme 2012/13

30.2.1 Mr I Graham gave an update on the programme for the current year. It was noted that in terms of numbers, the existing over commitment programme had reduced; however there remained some risks around delivery due to timing issues, slippage and the Sick Kids/DCN enabling works. Key areas to highlight were backlog maintenance and the Sick Kids/DCN work.

30.2.2 There was discussion on Primary Care revenue funded projects and the challenges involved in delivering the Partnership Centres Bundle: Blackburn, Firrhill & North-West Edinburgh. There was also discussion on the opportunity for integration of any lessons learned from the recently completed Wester Hailes project.

30.2.3 The Committee noted that in relation to the Asset Management Strategy, the draft Scottish Government Review had been circulated and appeared to show improvement across the piece.

30.2.4 The Chair stated that that it was good to see the quality strategy work coming to fruition, there was now a better view emerging of joined up working.

30.2.5 Mr I Graham confirmed that work on the Royal Infirmary of Edinburgh Additional Beds (Wards 109b and 209b) had been signed off by Consort and was now
underway. The Committee discussed the next stage of modernising maternity services at St John’s Hospital and the best use for Ward 20. Mr I Graham stated that this would be an example to be used for the Master Planning exercise.

30.2.6 The Committee noted the expenditure for the first quarter of the year on the agreed capital plan and also the progress of ongoing projects to date and the overall programme of planned activity for the coming year.

30.2.7 Mr I Graham also asked the Committee to specifically note the increase to the New Project Request in the sum of £3,317,000 and the base number for the Royal Edinburgh Hospital as outlined in the previous presentation.

30.2.8 Mr I Graham thanked Ms Pringle and Mr McKenna for their work and input to the programme.

31. Any Other Competent Business

31.1 Items for October Meeting
   - Statement of Assurance Needs - Mr A Payne
   - Efficiency and Productivity Group Presentation – Ms J Smith

32. Date and Time of Next Meeting

32.1 It was noted that the next meeting of the Committee would be held at 9:00 a.m. on Wednesday 9 October 2013 in Meeting Room 7, Waverley Gate, 2 – 4 Waterloo Place, Edinburgh.
1.0 Key Issues Discussed

1.1 In addition to the information included in the minutes of the HCG meeting I would draw Boards attention to the following items.

1.2 Interdependency of matters discussed at the Board committees (item 25.1)

The HCG committee requested assurances from the Staff Governance Committee via the Chair.

These related to oversight of the processes for monitoring numbers, grades and the uptake of continuous professional development and training of NHSL staff. Work is in progress to identify the relevant data sources and makes these accessible and visible to the relevant committees of governance (Staff Governance) which can then provide ‘comfort’ on these areas to the HCG committee.

This item is one example of how our governance oversight spans more than one committee structure.

It is an important area for the Board because our ability to ‘ensure we can deliver safe effective and person-centred health and social care to meet the needs of the people of the Lothians’ (Clinical Strategic Framework 2013-20) depends on the workforce delivering that care and our responsibility to staff outlined in the Staff Governance Standard (4th Edition); The Standard requires all NHS Boards to demonstrate that staff are ‘appropriately trained and developed’.

1.3 Scottish Response to the Independent Review of the Liverpool Care Pathway (item 26.1)

The HCG requested a short update on the Scottish Government response to the recently published report by Baroness Julia Neuberger


There have been a number of public concerns and adverse media coverage about the use of the Liverpool Care pathway after this report was published and we were advised that measures were in place to reassure NHSL patients and families involved in end of life care situations. This included a direct approach to allow patients and families to raise matters of concern about adverse publicity and help to allay anxieties and ensure patients were fully informed. We anticipate a Scottish Government review of the End of Life Care Pathway by the end of 2013. All staff were updated on the Scottish position by the Medical and Nurse Director.

1.4 Person Centred Care (item 29.3)

Nurse Director updated committee on the national work being undertaken on Person Centred Care and outlined the way data would be collected and collated in ways that would offer quantifiable data about the patient experience of care delivery. This is a significant
item for the Board to note as we need to more fully understand the care experience from the user’s perspective to achieve our stated aims in the Clinical Strategic Framework.

2.0 Issues for future consideration

We await the publication of the Vale of Leven Enquiry later this year. http://www.valeoflevenhospitalinquiry.org/

Dr Morag Bryce
Chair of the Healthcare Governance Committee
August 2013
Chair's Welcome and Introductions

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

Members were reminded that they should declare any financial 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.

23. Patient Story

23.1 Mrs Hornett read out a letter sent by the parent of a patient who was cared for in Intensive Care Areas in the Western General Hospital, the Royal Infirmary of Edinburgh and the Rachel House Hospice. The letter praised the fact that a number of different areas had worked well together to provide a very good service.

24. Committee Cumulative Action Note and Minutes from Previous Meeting (4 June 2013)

24.1 The minutes of the meeting held on 4 June 2013 were approved as a correct record.
24.2 The updated cumulative action note had been previously circulated.

24.3 Chair’s Update

24.3.1 A report had been previously circulated. Dr Bryce noted that the minutes from the Dental Division Executive would now be submitted to the Committee. Dr Bryce would discuss with the Chair to find out its remit.

24.3.2 Dr Bryce noted the concern of the Audit and Risk Committee of the possibility of a cumulative affect when several unrelated audit results were ‘satisfactory’ only. The Committee agreed to take note of this but felt that any actions should be taken forward by the Audit and Risk Committee. Dr Bryce agreed to update the Chair of the Audit and Risk Committee. MB

25. Matters Arising

25.1 Assurance Needs from Staff Governance to Healthcare Governance Committees

25.1.1 Mr Joyce noted that a Staff Governance Committee Workshop had recently been held where some main issues were highlighted.

25.1.2 Mr Joyce noted that the Scottish Government had asked the Area Partnership Forum to take action to improve the use of eKSF among NHS Lothian employees. The Staff Governance Committee was looking at ways to improve access to computers for training by clinical staff as a large amount of training was now available only online. Once results of the staff survey were published more work may be done on smaller staff surveys in particular areas to determine the level of staff satisfaction.

25.1.5 Mrs Hornett noted that a review of staffing levels which began in anticipation of the Francis report was in progress and would report to the Board.

25.1.6 Dr Bryce advised that Chairs of Board Committees met with the NHS Lothian Chairman monthly where assurance required regarding identifying overlaps between the remits of different Committees was given.

25.1.7 In response to a query about who eHealth was accountable to, Mrs Hornett advised that it would report to various Committees depending on the specific issue, but that the Director of Strategic Planning had responsibility for the service. Mrs Hornett agreed to clarify this with Prof McMahon. MH

25.2 Spiritual Care Service Level Agreements

25.2.1 A report had been previously circulated outlining the background for the service level agreement in place between NHS Lothian and the Roman Catholic Church.

25.2.2 In response to a query from Ms Garrod, Mrs Hornett explained that the spiritual care team existed to provide care for all patients, staff and relatives, but that the agreement with the Roman Catholic Church was to enable the very specific needs of a specific religious group to be met. The report showed that that an impact
assessment had been carried out and had found that this need merited funding for the service level agreement. This would be regularly reviewed.

25.2.3 In response to a query from Cllr Toner, Mrs Hornett explained that in cases where patients were part of a particular Roman Catholic Church, their own priest may be requested but would not always be available; hence the need for an on-call service. Mrs Hornett agreed to find out the number of referrals to the Chapaincy Team and to the Roman Catholics.

25.3 Accountable Items Incidents update

25.3.1 Miss Gillies advised that Dr Nikki Maran had undertaken a review of an incident where a swab had been left in a patient. This followed two previous similar incidents in the same theatre and a further incident where a patient fell from the operating table. Miss Gillies advised that the full report would be submitted to the Committee when available.

25.3.2 Miss Gillies noted that the review covered a number of areas, one of which was that the surgeon had used smaller swabs than would usually be used for the kind of operation, meaning that over 100 swabs were required. This would make accounting for these items more difficult.

25.3.3 It was noted that although in England the term ‘never event’ was used for this sort of incident, it was known that incidents did happen. Miss Gillies had discussed the issue with the Theatre Manager at NHS Salford which was very highly regarded for its strong focus and success in patient safety, and had been informed that there was an average of one ‘never event’ per month in NHS Salford.

25.3.4 Dr Williams emphasised that patients should reasonably expect to be safe when in the care of the NHS. Mr Joyce also stated that the number or size of swabs should not negate the need to count them all and ensure none were left in the patient. Miss Gillies noted that one problem could be an over emphasis on a final count, when earlier counts were as important.

25.3.5 Dr Mackenzie noted that both human factors and system factors were involved in such incidents; human factors could not be eliminated, but the system must be made as robust as possible to reduce the risk of incidents.

25.4 Procurement from Private Sector for Waiting List Initiatives Internal Audit

25.4.1 An extract of the audit report had been previously circulated and the cover paper was distributed in hard copy at the meeting. Mrs Hornett noted that prior to the procurement of external organisations to carry out the services of the NHS to reduce waiting times, NHS Lothian had carried out visits to determine the suitability of organisations not used before. The audit raised the question as to whether it was the responsibility of NHS Lothian to do this.

25.4.2 Mrs Hornett noted that it was the responsibility of Healthcare Improvement Scotland (HIS) to inspect and regulate non NHS healthcare organisations. It was noted that if NHS were to undertake visits this would include setting up a group which may not have the correct expertise to carry out a job which was already been done by HIS.
25.4.3 It was agreed that it would not be appropriate for NHS to carry out assurance visits and that assurance should be gained from HIS. Dr Williams emphasised that assurance that the HIS assessment was recent, robust and face-to-face would be needed. Mrs Hornett agreed that as patients were likely to be referred to these organisations until NHS Lothian’s capacity had been increased, a process needed to be built up. It was also noted that this decision would not preclude visits by NHS Lothian if it was felt necessary due to any concerns, which would then be raised with Healthcare Improvement Scotland.

25.4.4 It was noted that any service level agreement could specify which incidents should be escalated to the Board, and that it should be patient centred and focus on outcome.

25.4.5 Prof McCallum noted that another issue raised by the internal audit was that of sending patient notes to external organisations who were carrying out care. Advice had been given on mitigating risks, making it clear that any technical risk of transferring notes should not overcome any clinical risk. This would also include allowing access to TRAK. It was agreed that it would be inappropriate not to allow use of medical notes including those held electronically, and that security and auditing measures were already in place for anyone using electronic systems.

25.4.7 Mrs Hornett noted that item 3.2 of the circulated paper showed the management actions agreed to cover the areas highlighted in the report. The Committee accepted the recommendations put forward in the paper.

25.5 Summary of Healthcare Governance Minutes

25.5.1 Dr Bryce noted the Board’s request that a summary be submitted with each set of minutes to highlight specific areas of importance.

26. Emerging Issues

26.1 Response to Independent Review on the Liverpool Care Pathway

26.1.1 Dr Bryce welcomed Ms Fife and Ms Brooks Young to the meeting. Mrs Hornett explained that following the report published in England about the Liverpool Care Pathway, Dr Farquharson and herself had issued a letter to all clinical staff advising them to continue working with the Liverpool Care Pathway while awaiting a position statement from the Scottish Government.

26.1.2 Ms Fife noted that Lothian care homes had been given funding by Macmillan Cancer Support to implement the Liverpool Care Pathway, but it had been further agreed to change the emphasis to end of life care. Community services were continuing to offer the Liverpool Care Pathway but explaining to patients and relatives about the recent media coverage.

26.1.3 Ms Brooks Young noted that in acute areas concerns with the Liverpool Care Pathway had mostly occurred during the transition period between a high level of intervention and end of life care. It was emphasised that even when not using the Liverpool Care Pathway the standard of care should follow the main principle of good and frequent communication between clinicians, patients and relatives.
26.1.4 Ms Fife advised that following the report published in England, the Scottish Government were carrying out a review of the Liverpool Care Pathway with a report expected by the end of 2013. In the meantime it was expected that all areas already using the Pathway would continue to do so. Mrs Hornett agreed to circulate the letter from the Scottish Government which outlined this.

26.1.5 In response to a query from Cllr Toner, Ms Fife explained that when care according to the principles of the Liverpool Care Pathway was offered, this was discussed first with patients and relatives. The decision would not be made by the clinician to start on the Pathway without agreement from the patient and their relatives. Ms Brooks Young noted that training on this was being arranged.

26.1.6 Ms Fife noted that a redesign of the cancer care services would be announced in the next few weeks, which could cause further media anxiety.

27. Risk Register

27.1 A report had been previously circulated. Ms Bennett noted that it had been agreed that medical workforce would be added as a risk. This would include Obstetrics and Gynaecology and St John’s Paediatrics and would be relevant to both the Healthcare Governance and the Staff Governance Committees. A new risk regarding the capacity of managers in acute areas would also be discussed at the Risk Management Committee.

27.2 As there had been significant improvements in stroke care standards, this risk would be merged with the unscheduled care risk, but this decision would be reconsidered if further improvements were not made. Mr Glover noted that the risk of non-compliance with statutory equalist duties had been downgraded over time as controls became more robust, and it was hoped that eventually this could be taken off the register.

27.6 Mr Wilson suggested that risks highlighted in internal audit reports, including the one on external providers previously discussed, should be included in the risk register. Ms Bennett noted that this could be discussed and that it would be useful to circulate the full audit report on external providers along with the paper submitted to the Joint Management Team as this may give assurance that the risks highlighted were under control.

27.7 Mr Houston emphasised that there should be a simple procedure whereby risks highlighted by an internal audit report would be automatically discussed and if appropriate added to the risk register for the relevant Committee. Dr Bryce agreed to discuss this with the chair of the Audit and Risk Committee and Ms Bennett agreed to take the issue to the Risk Management Group.

27.8 In response to a question from Cllr Toner regarding the patient experience risk, Ms Bennett advised that this was not in reference to a specific incident but an ongoing issue highlighted by surveys and patient feedback.

28. Healthcare Governance Workshop Feedback and Next Steps

5
28.1 The workshop feedback had been previously circulated; the covering paper was distributed in hard copy at the meeting. Ms Bennett noted that understanding of patient experience and values and culture of staff was felt to be a key area in the remit of the Healthcare Governance Committee.

28.2 Prof McCallum noted that some professional advisory committees reported to the Healthcare Governance Committee, and asked how their advice fitted into the Healthcare Governance Committee’s remit as they were not assurance groups. Mr Houston advised that the Board were considering changes as to how advisory committees related to Board Committees. Mrs Hornett noted that advice from advisory committees could support assurance given by directors.

28.3 Mr Houston noted that he would like some of the subjects discussed at the Healthcare Governance Committee to be discussed at the Board. Dr Bryce welcomed this.

28.4 The Committee agreed the recommendations presented in the paper.

29. **Person Centred Care**

29.1 **Ethnicity Coding Performance and Use of Ethnicity Data**

29.1.1 A report had been previously circulated. Mr Glover reported that after several years of significant work NHS Lothian was now the leading Board in Scotland for collecting patient ethnicity information in inpatient, outpatient and Accident and Emergency areas. There had been consistent sustainable improvement in all major areas. The approach taken by NHS Lothian for recording this information was regarded as best practice, and information collected compared well with the leading English Boards. Clinical areas were encouraged to consider the information collected to inform service design and service redevelopment.

29.1.2 Dr Bryce welcomed this report and thanked Mr Glover and his team for their hard work to bring compliance to this high standard.

29.2 **Rapid Impact Assessment Performance and Annual Audit**

29.2.1 A report had been previously circulated. Mr Glover explained that the Rapid Impact Assessment was a tool used to predict how a policy or change might affect patients of all backgrounds. The process used by NHS Lothian was robust and based on work started in 2005/6 NHS Lothian was now the leading Board in Scotland for carrying out rapid impact assessments on its policies.

29.2.2 The Equality Impact Assessment Steering Group had increased the number of impact assessments carried out each year and unlike any other public organisation was able to monitor actions generated by the assessments and ensure that these were completed.

29.2.3 The group also tried to ensure that all papers submitted to Committees were compliant with equality standards and had increased the number of papers assessed each year.
29.2.4 Ms Garrod noted that the UK Government was considering ending the requirement for public sector organisations to use rapid impact assessments although organisations had stated that they were useful tools which improved care. Prof McCallum emphasised the need to recommend to the Board that NHS Lothian continued to use this tool which was instrumental in reducing stigma and allowing care in all areas which was clinically and culturally appropriate. Mr Houston agreed that this was a vital part of the remit of NHS Lothian and that he would recommend that the tool continued to be used even if it was no longer a statutory requirement.

29.3 Person-Centred Care

29.3.1 A report had been previously circulated. Appendix 2 of the report was distributed in paper copy during the meeting. Mrs Hornett noted that the paper outlined the national work currently in progress on the collection, collation and presentation of information about patient experience. Dr Bryce noted that data collected according to the framework outlined in Appendix 2 of the report would be useful for covering the assurance remit of the Healthcare Governance Committee.

29.3.2 Prof McCallum noted that information included in the framework could be collected in a number of different places for each area and asked how it could be collated effectively. Ms Bennett noted that the Quality Improvement Teams across the organisation already gathered a lot of this information but that there was currently no group collating this. Mr Houston welcomed the paper showing how person-centred care could be measured. Mrs Hornett noted that much of the work outlined was already ongoing as part various local as well as organisational programmes; the method of measurement was new.

29.3.3 Ms Scott Macfarlane emphasised the importance of communication with outpatients while the patient was at home. Ms Bennett noted that this was included in the programme and would be part of the culture review.

29.3.4 Ms Garrod emphasised the importance of including Health and Social Care and Local Authorities in work on person-centred care.

29.3.6 Mrs Hornett advised that with the funding allocated a programme manager had been appointed but emphasised that work would be done throughout all areas and should be considered part of everyday work rather than as a separate programme.

30. Safe Care

30.1 Contextualising Healthcare Associated Infection

30.1.1 Dr Bryce welcomed Dr Willocks to the meeting. Dr Willocks gave a presentation on Healthcare Associated Infection (HAI) Epidemiology and Policy in Scotland which outlined the reasons for reduction in healthcare associated infection from 10% in 2005 to 4.9% in 2011 reported by the national HAI point prevalence surveys of these years, and looked at reductions in specific areas of audit including *Clostridium difficile*, *Staphylococcus aureus* Bacteraemia and caesarean section surgical site infections. Dr Willocks gave an overview of what improvements had been put in place and what new challenges were emerging, including increase in *Escherichia coli* and antimicrobial resistance.
30.1.2 Ms Bennett noted that a Catheter Associated Urinary Tract Infection (CAUTI) Bundle was currently on trial in primary care areas with the aim of reducing the risk of catheter related infections.

30.1.3 Miss Gillies noted that work was ongoing to improve awareness about resistant organisms in Accident and Emergency areas; front door staff had been asked to identify patients who had been hospitalised abroad and were therefore at higher risk of being colonised with a resistant organism. Prof McCallum noted that the update on Carbapenemese Producing Enterobacteriaceae at item 10.4 of the agenda was also relevant.

30.1.4 Cllr Toner noted that media coverage about the increase of antimicrobial resistant organisms being due to the amount of antibiotics prescribed could cause confusion when patients were prescribed antibiotics for an infection. Dr Willocks noted that patients should take the full course of antibiotics if prescribed, but should not expect to be prescribed them where they would be of no benefit.

30.1.5 Ms Meiklejohn asked whether any system changes were required to reduce the risk of resistant organisms spreading. Dr McCallum noted that significant improvement in overall infection rates had been seen in Intensive Care Units and the Renal unit where systematic evidence based approaches had been used over time to reduce risk of causing or spreading infection. Mrs Hornett emphasised that the real challenge was not to increase numbers of infection control nurses and cleanliness champions but to ensure that all clinical staff and all staff working with patients were using the correct approach with regard to infection control.

30.2 Healthcare Associated Infection Update

30.2.1 The update report had been previously circulated. Mrs Hornett noted that an unannounced Healthcare Associated Environment Inspectorate team had arrived at the Royal Hospital for Sick Children that day.

30.2.2 In response to a question from Dr Williams, Mrs Hornett agreed to check how wound infection data from primary care was collected to ensure that data was complete.

30.3 Evidence of Correlation between Hand Hygiene, Cleaning Compliance and Healthcare Associated Infection

30.3.1 Mrs Hornett noted that information on hand hygiene compliance audit results had been collected for each ward by the Infection Prevention and Control Team for some time, and there was no direct correlation between areas with high rates of healthcare associated infection and areas with poor compliance with hand hygiene.

30.3.2 Mrs Hornett explained that if a member of staff failed to comply with hand hygiene procedure during an audit, feedback would be given immediately. An escalation procedure was in place for repeated non-compliance. Dr McCallum noted that clinical staff took turns to carry out hand hygiene audits to improve awareness and reduce bias. The audit covered a number of elements including compliance, technique and uniform policy.
30.4 Improving Management and System Learning from Significant Adverse Events

30.4.1 A paper had been previously circulated. Ms Bennett noted that there had been positive feedback on the culture and understanding of staff about the procedures of learning from incidents through Quality Improvement Teams. Miss Gillies noted that work needed to be done on ensuring feedback was given to both patients and staff during and after incident investigations.

30.4.2 The Committee expressed their thanks for Ms Bennett and her team’s hard work in leading NHS Lothian to this positive position. Mr Warner noted that work needed to continue to ensure improvements made reduced the occurrence of incidents.

31. Effective Care

31.1 Quality Report

31.1.1 The report had been previously circulated. Dr Bryce noted that Ms Gormley, had noted prior to the meeting her feeling that the quality report was technical and difficult to read. Ms Bennett noted that the content and presentation of the report was under review as a result of workshop feedback. The aim of the report was to make a range of quality indicators visible at a glance.

31.1.2 Dr Williams noted that the part of the report at item 3.6.2 describing pregnancy screening for Down’s Syndrome was misleading as it indicated a false positive rate but the result of the screen indicated whether the baby was at high risk of having Down’s Syndrome, and not whether the baby had the condition; a ‘high risk’ baby born without the condition would therefore not be a false positive.

32. Other Minutes: Exception Reporting Only

The Committee noted the minutes from the following meetings:

32.1 Organ Donation Sub-Group, 25 July 2013

32.1.1 Dr Williams noted that there had been discussion at the meeting about the Human Transplantation (Wales) Bill passed by the Welsh Assembly which legislated for an ‘soft opt-out’ organ donation register which would be implemented by 2015. This meant that a person would be deemed to have given consent unless they had ‘opted out’ during their lifetime or their family could provide information after their death that they would not have wished to have their organs donated.

32.1.2 Dr Williams noted that it was not evident that an ‘opt-out’ system would increase the number of donors; the experience in Spain had been an increase in the number of donors but this was felt to be the result of a range of legislation. In Australia there was concern that the ‘hard opt-out’ system implemented had led to a decrease in the number of donors.

32.1.3 The Organ Donation Sub-Group had agreed that as NHS Lothian had the highest ‘opt-in’ rate in Scotland, no change to an ‘opt-out’ system was currently required.

32.2 Clinical Management Group, 14 May 2013
32.3 Lothian Infection Control Advisory Committee, 12 March 2013, 11 June 2013
32.4 NHS Lothian Health and Safety Committee, 28 May 2013
32.5 Area Drug and Therapeutics Committee, 5 April 2013, 7 June 2013
32.6 Divisional Dental Executive, 25 April 2013, 20 June 2013

33. Exception Reporting Only

The Committee noted the following items for information:

33.1 Information Governance Annual Report;
33.2 Update on Carbapenemase-Producing *Enterobacteriaceae* Strategy;
33.3 Lothian Infection Control Advisory Committee Annual Report;
33.4 Actions Taken to Reduce SAB in NHS Lothian;
33.5 Public Protection Update;
33.6 Complaints Report: Quarter 4

33.6.1 Ms McGuinness noted that the Customer Relations and Feedback Team was putting systems in place to focus positively on patient feedback. A triage team was now answering around 60 calls per day. A short life working group had been set up to consider how to investigate some of the complaints made by patients using a more person-centred approached. Ms McGuinness noted that there had been improvement in some of the areas indicated in the report in the last quarter.

33.7 Quality Improvement Team Annual Report;
33.8 Better Blood Transfusion; Training Update Report;
33.9 East of Scotland Renal Transplan Service Annual Report;

34. Date of Next Meeting

34.1 The next meeting of the Healthcare Governance Committee would be held from 9.00 am – 11.30 am on Tuesday 1 October 2013 in Room 8, Second Floor, Waverley Gate.

34.2 A further meeting in 2013 would take place on 3 December 2013.
Summary of the Staff Governance Committee Meeting of 31 July 2013

Key Issues Discussed

Staff Governance Action Plan for 2013/14
The Staff Governance Action Plan for 2013/14 was approved by the Committee and forwarded to the Scottish Government.

Management Culture Steering Group
The transfer of the work of the Management Culture Steering Group to the Staff Governance Committee was approved and will now be monitored through the Staff Governance Committee.

Issues on the Horizon
This was a shortened business meeting to allow a Needs Assurance Workshop with the Staff Governance Committee to take place. The output from this session will be written up and presented to the Staff Governance Committee at their next meeting on 30 October 2013.

Alex Joyce
Employee Director
11 September 2013
Minutes of the Meeting of the Staff Governance Committee held at 9.30am on Wednesday 31 July 2013 in Meeting Room 7, Waverley Gate, 2 - 4 Waterloo Place, Edinburgh.

Present: Mr A Joyce (Chair); Mr A Boyter; Dr D Farquharson; Councillor D Grant; Mr B Houston; Mrs J McDowell; Mr S McLauchlan; Mrs A Meiklejohn; Mrs A Mitchell; Mr L Turner; Mr G Warner and Mr R Wilson.

In Attendance: Ms J Bennett; Dr L Bream; Dr M Bryce; Mr J Glover; Dr C Kalman; Mrs R Kelly; Mr A Payne and Mr P Reith.

Apologies for absence were received from Mrs M Hornett.

The Chair welcomed Ms Bennett, Dr Bream and Mr Payne who would be facilitating the Assurance Needs Workshop taking place at the conclusion of the formal Committee business.

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.

13. Minutes of the Previous Meeting

1.1 The minutes of the previous Staff Governance Committee meeting held on 29 May 2013 were approved as a correct record.

14. Staff Governance Action Plan 2013/14

14.1 Mrs Kelly introduced the previously circulated Staff Governance Committee Action Plan for 2013/14 and reminded the Committee that, as reported at the previous meeting, all NHS Boards had been asked to produce a Staff Governance Committee Action Plan for submission to the Scottish Government by the end of May 2013.

14.2 The Committee noted that NHS Lothian had sought, and received, an extension of this deadline to the end of July in order to incorporate actions from the Human Resources Strategy, Bowles Report, Investors in People and Healthy Working lives. This had been done and a deliverable Action Plan had been completed in the format prescribed by the Scottish Government.

14.3 Mrs A Mitchell queried why there were no updates on any of the actions and Mrs Kelly explained that that, whilst progress had already been made on a number of
the actions, the Action Plan first had to be agreed by the Committee and submitted to the Scottish Government. Updates would then be provided to subsequent Staff Governance Committee meetings.

14.4 The Committee agreed to approve the Staff Governance Action Plan 2013/14 for submission to the Scottish Government.

15. **Management Culture Steering Group**

15.1 Mrs Khindria introduced a previously circulated report recommending that the work of the Management Culture Steering Group be transferred to the Staff Governance Committee.

15.2 The Committee noted that the Management Culture Steering Group had been established by the then Chairman of NHS Lothian in May 2012 to agree and oversee the work that required to be taken forward to address the concerns in regard to the culture and behaviours within NHS Lothian. The then Board Chairman was required by the Scottish Government Health Department to establish the group in order to address the concerns that had been raised in the D.J Bowles report, the PCW report on Waiting Times and the Critical Incident report into Waiting Times.

15.3 It was noted that concern had been expressed by some members of the Board about the status, transparency and accountability of the Steering Group and the position had been reviewed following the appointment of a new Board Chairman. Although it had been a requirement from Scottish Government Health Department that there was a group established to address the concerns raised, this could be integrated into the Board’s committee structure. It was therefore proposed that the Management Culture Steering Group be dissolved and the work programme be transferred to the Staff Governance Committee, with the exception of the development needs of the Corporate Management Team which would be reviewed and monitored by the Remuneration Committee and the Chief Executive as part of the normal appraisal arrangements.

15.4 Mr Boyter advised the Committee that the Programme Manager for this work would attend the Staff Governance Committee and report on progress. For the workstreams currently being progressed work streams overlapped in some areas and they required to be mainstreamed to ensure an efficient use of resources. It was, therefore, the intention to develop a single organisational development programme.

15.5 Mrs McDowell questioned whether the inaccurate statement in the Committee’s Annual Report, that the Management Culture Steering Group reported to the Staff Governance Committee, had been corrected. Mr Boyter advised that the Steering Group had been established by the Cabinet Secretary outwith the Board’s normal reporting structure and the purpose of this report was to bring the reporting arrangements into line with the Board’s normal governance procedures.

15.6 The Chair sought confirmation that the Cabinet Secretary acquiesced with these proposals and Mr Boyter advised that whilst the proposals had been discussed
with the Cabinet Secretary’s office, he would formally notify the Scottish Government of the Committee’s proposed course of action.

15.7 The Committee agreed that the work of the Management Culture Steering Group should be transferred to the Staff Governance Committee; that the responsibility for reviewing the development needs of the Corporate Management Team should be transferred to the Remuneration Committee and the Chief Executive and that an integrated work programme Organisational Development plan which took into account the management cultures priorities be developed.

16. **Date of Next Meeting**

16.1 It was noted that the next meeting of the Committee would be held on Wednesday 30 October 2013 at 9.30am in Meeting Room 7, Waverley Gate Edinburgh.

The meeting closed at 9:50 a.m. and the Assurance Needs Workshop commenced.
Shadow Health and Social Care Partnership 16 August 2013 – Summary

Matters Arising
- An email clarifying the situation prior to the legal formalities being in place for the Partnership was noted.

Reflections on Partnership visits
- The programme of visits was endorsed and positive feedback given as to their usefulness.

Communicating the Partnership message
- A presentation on a proposed visual identity for the partnership and the reasoning behind their development was discussed. The main strapline and partner logos were retained to assist in public facing recognition and trust, with the “working together” element being used repeated throughout.
- Some consultation had already taken place, together with research and input from a number of professional and advisory bodies. Strong colours and icons/symbols were used rather than photographs. Further feedback will be sought as the branding develops, with revision anticipated as the work progresses.

Integration Programme Status Report
- The July status of the programme overall was still “amber”, due to uncertainties arising from the published Bill. However, the plan was still to aim for April 2015 establishment of the legal partnership, and an updated draft critical path was presented covering the 2 key (statutory) areas that were required in order to achieve this timetable.
- Risks around the mismatch of the bill and policy intentions were highlighted, and the “red” status of the internal savings required by CEC also discussed and it was agreed following an update that this could be reduced to ‘amber’. Further information on both partners’ budget processes was requested in order to clarify their impact on the partnership’s aligned budgets. Susan Goldsmith and Hugh Dunn are to be invited to the next business meeting.

Public Bodies (Joint Working) (Scotland) Bill - Evidence
- A paper was presented for information highlighting the Council’s response to the draft Bill, which had recently been approved by the Corporate Policy and Strategy Committee. In summary the response highlighted the main areas of the policy as being very welcome, but the mismatch with the bill created a number of concerns around scope, local accountability, ministerial powers and remedial measures.
- It was noted that the draft NHS response had also highlighted many of the same issues.
ICT Strategy

- A joint presentation on current and future opportunities for integrated ICT was given. This covered the foundations being built and in place across both organisations, including the sharing of some data and secure email, and recent developments in sharing infrastructure (e.g. at the Wester Hailes Healthy Living Centre). Further locations for accessing systems across organisational boundaries were anticipated in the next 12 months.
- The new ICT strategy in the Council was explained in terms of the outcomes based approach being taken, and the progress being made by current/past pilots on the shared Portal for TRAK/SWIFT and the Lync/Communicator tool were highlighted.
- The importance of good information governance was stressed, both for clinical and administrative data.
- The need for better cross-partnership communication with staff about ICT developments was discussed.
- It was agreed to provide links between intranets to assist in better information sharing.
- A specific ICT strategy for the Partnership is to be produced. An update report on developments was requested for the next meeting.

Service User and Carer Engagement

- A report on the appointment of non-voting service user/carer membership of the Partnership was presented and recruitment agreed.
- Details of the post(s) and requirements were presented, together with the support that would be given to the successful candidate(s).
- It was noted that this would be an interim arrangement, pending any further statutory guidance on membership of the Partnership that may come from the Scottish Government during the progress of the Bill.
- Further work on the level of remuneration would be undertaken as part of the recruitment process.
- Inclusion of consultation evidence was requested for future performance reports to the Partnership.

Partnership Performance Overview

- A report was presented summarising performance across the Health and Social Care Partnership, together with an update on progress towards the development of a joint performance framework.
- Out of the 176 measures currently listed, 37 already had targets developed, with 19 being met or exceeded. A request for information on the actual target figures to be included in the narrative was made, together with better readability of the multi-page appendix.
- Information on three specific topics was given in further detail as part of the report, and positive feedback given on the general approach to the report, currently in its second iteration.

Aligned Budget Monitoring

- The 3 month position on the partnerships’ combined net budget of £486m for 2013/14 was presented. Efficiency savings were also highlighted and are currently on track to deliver a total of £4.6m across the partnerships services.
- A number of demography investments were described which aim to improve outcomes.
• The revenue budget current positions were stated, with CEC predicting a balanced position and NHS highlighting some budget pressures and potential overspends.

Health Inequality Framework and Action Plan
• A presentation on tackling health inequalities was given, supported by a report on the proposed Framework and Action Plan from the Health Inequality Standing Group.
• The background to this agenda was explained, together with how it links with the Partnerships’ agreed H&SC strategic framework and Edinburgh’s SOA.
• The importance of case management being joined up across agencies, particularly around the 20% of most deprived populations, was emphasised, as was the prevention and early intervention agenda.
• Some good examples of existing services were highlighted, where outreach and engagement has enabled multiple “life-wrecking” aspects of a person’s situation to be addressed and led to better outcomes for them.

Professional Advisory Committee
• A brief update on the PAC was given, together with some issues raised in the forum, including lack of membership/representation of the integration programme sub-groups.
• The main purpose of the PAC was restated as professionals ‘having the right conversations together in the same room’.
Minute of Meeting

Edinburgh Health and Social Care Partnership
NHS Lothian Headquarters, Edinburgh, 16 August 2013

Present:-
Councillor Ricky Henderson (Chair)
Shulah Allan (Vice Chair)
Councillor Elaine Aitken
Councillor Norman Work
Wanda Fairgrieve
Robert Wilson
Richard Williams

Also present :- Non Voting Members – Kirsten Hey, Tim Montgomery

In attendance:- Carl Bickler, Monica Boyle, Steve DiPonio, Lynda Cowie, Susanne Harrison, Claudette Jones, Simon Goundray, Tim Montgomery, Ian Robertson, Gordon Scott and the Programme Team.

Apologies:- Kay Blair, Peter Gabbitas, Dr Ian Mackey, Ella Simpson, Michelle Miller and Dorothy Hill.

1 Welcome and Introduction

The Chair welcomed everyone to the meeting.

2 Minutes

Decision

To approve the minute of the Shadow Health and Social Care Partnership of 14 June 2013 as a correct record.
3 Matters Arising

3.1 Partnership Agreement

To note the clarification from Tim Davidson that decisions of the Partnership Board would require the sanction of each parent body until delegated authority levels have been agreed.

Decision

Noted

4 Visits

The Convener advised that the visits undertaken by the Partnership had been very well received by the members. The next visit would be to the Astley Ainslie Hospital on Friday 14 September

Decision

To note the update and that further details of the next visit would be issued in due course.

5 Communicating the Partnership Message

Cath Cassidy and Simon Goundray gave a presentation on Communicating the Partnership Message – Developing an identity for Edinburgh’s Health and Social Care Partnership.

Cath Cassidy outlined the work that had been undertaken so far to establish a visual corporate identity for the Partnership. It was intended to use the strapline “working together for a caring, healthier, safer Edinburgh” and incorporate it into information booklets for each service. Simon Goundray advised that the vision had been interwoven throughout using symbols and icons. Consultation was currently ongoing with all interested parties and would be reported back to the partnership in due course.

Decision

1) To note the presentation, and

2) that members feedback views to Cath Cassidy, City of Edinburgh Council.

(Reference – presentation, submitted)
6 Integration Programme Status Report

The integration status report for the period to July 2013 was presented. The report included the Reason for Status table RA(G) together with the risks associated, an action plan, key milestones and the programme critical path.

The current status of the programme overall was amber.

Decision

1) To note the status report.

2) To note that the report on the Aligned Budget Monitoring three month position which was on the agenda for this meeting confirmed that the risk associated with the Council’s financial targets could be reduced to amber status.

3) To invite Hugh Dunn and Susan Goldsmith to present to the next formal meeting of the Board in October on matters associated with financial preparations for integration.

(Reference – report by the Programme Team, submitted.)

7 Public Bodies (Joint Working) (Scotland) Bill – Response by the City of Edinburgh Council

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.

The City of Edinburgh Council’s response to the Bill was presented for the information of the Partnership.

Decision

To note the response.

(Reference – report to the City of Edinburgh Council’s Corporate Policy and Strategy Committee, submitted)
8 ICT Strategy

Claudette Jones and Ian Robertson gave a joint presentation on the current position with the ICT Health and Social Care Integration.

The presentation outlined the following:-

- what had been achieved so far,
- how ICT could support the journey to integration;
- the external engagement to date and
- key core components for Partnership working.

Decision

1) To note the presentation
2) To ask the ICT sub-group to prepare a strategy for the Partnership
3) To note that a progress report would be presented to the next meeting of the Partnership
4) That the Intranet systems of each organisation be integrated as soon as possible
5) That the Council’s representative on the Harris Portal governance board provide (a) a timescale for the planned roll-out of the portal across co-located office accommodation and (b) information on whether the portal would encompass housing colleagues
6) That communications on ICT plans and developments affecting staff be improved.

(Reference – Presentation, submitted)

9 Service User and Carer Engagement

The Partnership had previously agreed in principle to appoint a non-voting member to provide a generic service user and/or carer perspective to discussions.

Details of the nature of the role, recruitment procedures and remuneration and support were provided.

Decision

1) To approve the recruitment of service user/carer members as set out in the report by the Chief Social Work Officer

2) To request the Chief Social Work officer, in conjunction with Sub-Group members and the Communications and Engagement Manager, to progress the appointments.

(Reference- report by the Chief Social Work Officer, submitted)

10 Performance Overview

A summary was provided of performance across the Health and Social Care Partnership together with an update on progress towards the development of a performance framework to support the Health and Social Care Partnership.

Decision

1) To note the ongoing work to develop a performance framework to support the Health and Social Care Partnership

2) To note the performance report for June 2013, and

3) To note that future reports would contain narrative in relation to what targets were being measured.

(References – report by the Chief Social Worker, submitted.)

11 Aligned Budget Monitoring – Month Three Position

The three month aligned budgetary position of the Partnership was presented. The joint financial plan outlined a Partnership budget in 13/14 of £486m with a combined efficiencies target of £4.6m.

Decision

1) To note the additional activity associated with the additional invested.

2) To note that plans were in place to deliver efficiency targets, and

3) That a more detailed report would be submitted to the next meeting of the Partnership.

(References – report by the Head of Older People and Disability Services, submitted.)
12 Poverty and Inequality

(a) (Presentation)

David White and Paul Hambleton gave a presentation on tackling poverty and inequalities in the city which was a key objective of Public Service reform.

The presentation covered the following:

- Why is tackling inequality crucial for health and social care?
- Edinburgh Health Inequality Framework and Action Plan
- Who should act? Partnerships in Edinburgh
- Who should act? How to lead strategic action

During discussions the following points were raised and responded to:

- This was the most important agenda and illustrated the need for the Partnership
- How do we coordinate staff working in these areas
- Familiarisation training and an exchange of knowledge would be undertaken within the next 6 months
- The need to engage with local communities
- The importance of case management
- The need to engage with people who are unwilling
- The need to focus less on assessments and more on quality of work and outcomes

Decision

To note the presentation and that regular progress reports would be submitted to the Partnership.

(Reference –presentation, submitted)

(b) Health Inequalities Framework and Action Plan

The integrated framework and action plan to tackle health inequalities from 2013-2016 was presented. The plan established a basis for the Partnership’s responsibility for tackling health inequality in the city, including the role of the strategic partnership within community planning.
The report recommended the endorsement of a strategic and integrated approach to reducing health inequality, which had been developed through the Health Inequality Standing Group, formed by the Community Health Partnership.

**Decision**

1) To endorse the Framework and Action Plan to tackle health inequality proposed by the Health Inequality Standing Group

2) To delegate to the Health Inequality Standing Group responsibility to continue dialogue with main partners and partnerships in the city in the context of the Framework and Action Plan to focus impacts on health inequality, through both mainstream services and joint approaches

3) To note that progress reports on the Action Plan would be submitted in due course.

(Reference – report by the Social Strategy Manager Co-Chair, Health Inequality Standing Group, submitted)

(c) **Health Inequalities in Scotland – An Audit Scotland National Study**

The City of Edinburgh Council had referred a report on Health Inequalities in Scotland – An Audit Scotland National Study to the Partnership for information and comment. A number of recommendations were proposed to help the development of Edinburgh’s response to health inequality in the light of the study.

**Decision**

To note the report.

(Reference – report from the Health, Wellbeing and Housing Committee of City of Edinburgh Council, submitted)

13 **Professional Advisory Committee**

Dr Carl Bickler gave an update on the establishment of the Professional Advisory Committee which was set up to give good clinical advice to the Partnership.

The two key issues to be addressed were IT and the need for teams to have an integrated approach. A presentation would be given to the Partnership in due course.
Decision

To note the update and that a further presentation would be given to the Partnership in due course.
Children & Young People’s Strategy Presentation

- The ML Sub Committee was attended by Mike Massaro-Mallinson who provided a presentation on the above.

Items for Discussion

- **Integration of Health & Social Care**
  The Sub-Committee considered a verbal report at the meeting given by DAS/EMc.

  The Midlothian Shadow board has now been developed. This existing CHP Sub Committee still continues to have the governance of health issues until the Shadow Board takes over formal responsibility.

  From 1 August EMc and DAS take up their new posts. Interim Management arrangements are to be in place from this date until April 2014. There are plans to establish an interim joint management team in Midlothian. Current proposals are to have a Head of Health Services reporting to the Joint Director, one in East and one in Midlothian. This has implications for a number of posts and individual discussions are being held.

  The ML Shadow board have had two meetings. Julie Gardiner (JG) and Sue Edmond (SE) have been involved around the voice of patients and carers and a process has now been developed for a service user and patient carer representative to be identified for the Shadow Board.

  A tour of Midlothian has been organised for the Shadow Board and will be happening soon. The next meeting will focus on financial resources across the partnership. Finance colleagues from both NHS and Midlothian Council will be involved in this event.

  A very successful event was held recently that brought together clinicians/professionals working across Midlothian to get the views from different clinical groups on how we can ensure that integration delivers better outcomes for patients/people who use services.

  The Management team will be focusing in the coming months on the implementation of proposals for a single dementia service, the development of plans for the Fraility project and an integrated learning disabilities service.

  It was confirmed that the recruitment process for the carer representative for the shadow board is now in place and if members wish to view the information, please contact Julie Gardner directly. Closes 1st August for nominees. There will be three members on the interview panel.

  It was asked if there would be discussion on health inequalities in the Shadow Board meetings and if so will the shadow board consider an opportunity in an advisory way for a representative to attend these meetings. Further consideration will be given to how we best ensure that the Shadow Board maintains a focus on this agenda.
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. The purpose of this report was to provide a progress update, since May 2013, on support for breastfeeding in Midlothian and primarily, for developing the Community Public Health Nursing workforce to meet the requirements of UNICEF’s Baby Friendly Initiative (BFI).

**Carers Forum:**
The Sub Committee considered a report which had been circulated in advance of the meeting.
Highlights included the new carer’s centre in Hardengreen has been secured and the team are hoping to move in September with a launch circa October 2013.

**Public Partnership Forum:**
The Sub Committee considered reports which had been circulated in advance of the meeting.
Highlights included that a review of what the PPF have achieved and what they still have to achieve is being planned. A Physical Disabilities open event was held and attended by PPF Members.

Peter Johnston
Chairman, Midlothian CHP
23 August 2013
NHS LOTHIAN

MIDLOTHIAN COMMUNITY HEALTH PARTNERSHIP

Minutes of the meeting of the Midlothian Community Health Partnership Sub-Committee held on Thursday 25th July 2013 at 2pm in The Council Chambers, Midlothian House, Dalkeith.

Present: David Small, General Manager, Midlothian Community Health Partnership (DAS)
Councillor Catherine Johnstone, Midlothian Council Representative (CJ)
Sue Edmond, PPF Representative (SE)
James Coghill, Public Partnership Representative (JG)
George Wilson, Voluntary Sector Representative (GW)
Mandy Mackinnon, Health Promotion Manager (MMac)
Peter Quinn, PPF Representative (PQ)
Andrew Duffy, Pharmacy Representative (AD)
Eibhlín 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)
Mike Porteous, Assistant Head of Finance on behalf of LH (MP)
Marlene Gill, PPF Representative (MG)
Alison MacDonald, Chief Nurse, Midlothian Community Health Partnership (AXM)

Apologies: Peter Johnston, Chairman, East Lothian & Midlothian CHPs (PJ)
Dr Tony Moffoot, Consultant Psychiatrist Midlothian (AMo)
Michael Pearson, Director of Operations, Royal Infirmary of Edinburgh (MPe)
Tom Welsh, Joint Futures Manager, Midlothian Council (TW)
Rob Packham, Interim AHP Manager, EL & ML CHPs (RP)
Patsy Eccles, RCN Representative, NHS Lothian (PE)

In Attendance: Wendy Michael – Minutes (WM)
Brian Brockie, Head of Physiotherapy on behalf of Rob Packham (BB)
Mike Massaro-Mallinson, Strategic Programme Manager, NHS Lothian (MMM)

1.0 Apologies and Welcome

Catherine Johnstone (CJ) noted the apologies as above and chaired today’s meeting on behalf of Peter Johnston (PJ)

Declaration of Interest
None were noted at this meeting.

1.1 Children & Young People’s Strategy Presentation

Mike Massaro-Mallinson (MMM) gave a presentation on the above.

An electronic copy of the presentation will be forwarded to the Committee.

Currently there is a confusing policy landscape with new policy and programmes, e.g. Children’s Bill and Early Years Collaborative
This creates significant NHS challenges

There is also learning from the new Children’s Services Inspections to take into account.

The outcomes of the strategy review were that NHS Lothian will have an improved understanding of the health needs of children and young people in Lothian. This will assist with the gradient in health outcomes being reduced, with health care accessible and appropriate to all children and their families, delivered proportionately to need. There will be an improved, earlier approach in place to support the needs of vulnerable children and young people and there will be opportunities brought by the integration of children’s services and the reprovision of the Royal Hospital for Sick Children.

Every child will have access to high quality healthcare; children with disabilities will have their additional needs met. NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population and children, young people and their families will be involved in decisions that affect their health.

There will be robust governance and performance improvement arrangements in place for overseeing implementation of this strategy.

EMC asked if the strategy addressed the needs of young carers. MMM replied that NHS Lothian Carer’s strategy will be aligned with this. Julie Deegan-wood is writing the paragraph for the strategy around Young Carers as Julie leads this for NHS Lothian.

SE asked how the public consultation will be done. MMM replied that there will be three public consultation events; Edinburgh, West Lothian and East Lothian and Midlothian. The project team are also looking to do tailored presentations for specific groups and would be grateful for suggestions. Survey monkey may also be used.

DAS asked if the project team intended to bring the final version back to the CHP Sub Committee for consideration. MMM replied that yes, they would submit the final draft of the strategy post consultation circa January 2014. **ACTION**

JG mentioned that in terms of the consultation with the carers network that the GIRFEC group may not actually capture them all.

MMc asked what will be the role of the integrated partnership in relation to the of this strategy. EMc replied that the existing CHP Sub Committee will have a continuing governance role until such time as the Shadow Board comes into affect.

MMM highlighted that areas of transition are important and the focus on integrating Adult Health & Social Care will support this.

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2.0 **Minutes of the Previous Meeting held 30th May 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 EMc/DAS.

The Midlothian Shadow board has now been developed. This existing CHP Sub Committee still continues to have the governance of health issues until the Shadow Board takes over formal responsibility.

From 1st August EMc and DAS take up their new posts. Interim Management arrangements are to be in place from this date until April 2014. There are plans to establish an interim joint management team in Midlothian. Current proposals are to have a Head of Health Services reporting to the Joint Director, one in East and one in Midlothian. This has implications for a number of posts and individual discussions are being held.

The ML Shadow board have had two meetings. Julie Gardiner (JG) and Sue Edmond (SE) have been involved around the voice of patients and carers and a process has now been developed for a service user and patient carer representative to be identified for the Shadow Board.

A tour of Midlothian has been organised for the Shadow Board and will be happening soon. The next meeting will focus on financial resources across the partnership. Finance colleagues from both NHS and Midlothian Council will be involved in this event.

A very successful event was held recently that brought together clinicians/professionals working across Midlothian to get the views from different clinical groups on how we can ensure that integration delivers better outcomes for patients/people who use services.

The Management team will be focusing in the coming months on the implementation of proposals for a single dementia service, the development of plans for the frailty project and an integrated learning disabilities service. TM asked about the partnership lead for the new Management Team. Discussion will be held out with this meeting to clarify.

JG confirmed that the recruitment process for the carer representative for the shadow board is now in place and if members wish to view the information, please contact JG directly. Closes 1st August for nominees. There will be three members on the interview panel.
MMc asked if there would be discussion on health inequalities in the Shadow Board meetings and if so will the shadow board consider an opportunity in an advisory way for a representative to attend these meetings. EMc said that the previous event on health inequalities had established the importance of this agenda for the Shadow Board. Further consideration will be given to how we best ensure that the Shadow Board maintains a focus on this agenda. **ACTION**

**Decisions**

The Committee welcomed the update.

### 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 and the Homeopathy Review.

The Midlothian Partnership continues to maintain its excellent performance in relation to delayed discharge with no one delayed in a short stay bed and only 6 delayed discharges with no one waiting more than the national target of 4 weeks.

Homeopathy section from the Sub Committees previous minutes were submitted to the Strategic planning Lead.

At its meeting on 26th June Lothian NHS Board decided to cease, from 1st April 2014, the provision of the homeopathy service in Lothian and referrals to the Glasgow service. All current service users will be offered a clinical review. A meeting with staff is to be held on 30th July. An action plan is being prepared.

**Decisions**

The report was noted by the Committee.

#### 6.2 Staff Governance Report

The Sub Committee considered a verbal report given at the meeting.

There is currently no up to date data due to system changes, however there should be no issues for Midlothian on Sickness Absence figures given the previous percentages noted against the national target.

**Decisions**

The verbal report was noted.

#### 6.3 Finance Report

The Sub Committee considered a report which had been circulated in advance of the meeting.
The purpose of the report is to advise Midlothian Sub-Committee of the
financial position to 30th June 2013.

The committee were asked to note the overall financial position as
presented.

The CHP is reporting an underspend of £19,000 for the 3 months to 30th
June 2013.

The CHP is reporting an underspend for the 3 months within Core
Services. This is largely as a result of vacancies, particularly in AHP and
Community Nursing services. Recruitment is underway to fill many of these
posts and this level of underspend is not expected to continue.

The CHP is delivering the majority of its LRP target recurring. A small
unachieved balance is being met on a non recurring basis pending
identification of suitable schemes to meet the target recurring.

Decisions

The report was noted.

6.3.1 LRP Midlothian Template

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

The purpose of this report is to provide further detail on the Midlothian
CHP LRP Schemes for 2013/14 and update the Midlothian CHP Sub-
Committee on progress in delivering the overall target.

Members of the Sub Committee were recommended to note the detail
relating to the individual savings schemes identified to date and note the
progress made in delivering the overall target on a recurring basis

The overall target for the Midlothian CHP Local Work stream is £52,000.
There is an additional Management & Administration target of £6,000,
giving a total target for the CHP of £58,000.

Budgets are reviewed annually and budgets no longer being used for their
specific purpose are being given up for LRP.

DAS advised that the gap of £11k will be manageable.

Decisions

The report was noted.

6.4 Chief Nurse Report

The Sub Committee considered reports which had been circulated in
advance of the meeting.
Midlothian Public Health/ Health Visiting Services
New Team Managers have been appointed to both the East and Midlothian teams. Both are experienced Team managers and will be welcome additions to the team. The Team manager for Midlothian will be Anne Wilson and it is hoped she will take up post around the 19th August.

Midlothian Community Hospital
Loanesk ward, are currently looking at the way they deliver end of life care. They are currently working with Shirley Fife to develop a model of care that is nurse led, this is in the early stages of development, it is hoped that this can be rolled out across East and Midlothian.

Healthcare Technician Pilot programme
This programme has been well received however the pilot phase has now concluded. There is work ongoing in order that we use the learning from the pilot to enhance the knowledge and skills of all our Healthcare Support Workers. This may now also be extended to Domestic Service Staff. A final meeting is to be held to discuss this.

Community Mental Health Teams
Work is continuing with the Dementia Demonstrator Site, taking forward proposals for a single service in conjunction with Midlothian Council.

Professional lines and accountabilities for the nursing structure will be included in the report for the next meeting of the ML CHP Sub. Including the development of an advanced practitioner role in health visiting

GW asked about the structures. AXM happy to continue to develop and will issue formal communication.

TM asked if the healthcare technician pilot training will be lost and what will it now be used for. AXM advised that there is to be one more meeting of this group and further discussions will be held around existing trained staff.

Decisions

The report was noted.

6.5 Clinical Director Report
The Sub Committee considered reports which had been circulated in advance of the meeting.

The Midlothian Community Health Partnership Sub Committee were recommended to consider how the X-ray service at MCH might be improved and note the information regarding the recent clinical engagement event.

X-ray services have been available at Midlothian Community Hospital since the Hospital opened in August 2010. The service was initially provided for 2 days per week excluding school holidays. MCHP provided funding to meet costs for school holiday cover and the service is now covered 52 weeks of the year.

The service provided at the MCH site is proving more convenient for some patients than other x-ray sites in Lothian, on most days more plain x-rays
are carried out at MCH than at any of the other Lothian site. The radiologist regularly has to direct patients to other sites.

HR has discussed this with radiology management. The Committee were asked to support HR seeking an improved service for patients at MCH X-ray department by increasing the hours.

SE stated that the PPF supported the option of an improved service at their meeting held last week. They did discuss doing a user survey of patients using the service to ask why they attended this hospital. HR added that the Radiology management are very happy to work with this around staffing, if it can be funded. It was suggested that it should be progressed but on a pilot basis. HR said that could be considered.

6.5.1 X-Ray Services
For noting by the Committee.

Decisions
The reports were noted.

6.6 AHP Manager’s Report
The Sub Committee considered a report which had been circulated in advance of the meeting. Brian Brockie (BB) attended the meeting on behalf of Rob Packham (RP).

The purpose of the report was to update and brief members on AHP Performance and developments.

BB highlighted the work ongoing with AHP Seven Day working which now has a programme of work that continues with a more formal constitution being developed to ensure achievement of NHS Lothian goals.

Recruitment and Service Pressures
BB reported a challenge to service delivery in MSK Out Patient Physiotherapy with 9 staff unavailable through illness or planned absence. Contingency plans in place and waiting times under control. General practices have been informed and the service is also working with Anthea Fraser to progress the replacement post for development of Telehealth strategy.

DAS reassured the Sub Committee around the Physio Therapy risk that all avenues had been explored for a solution and he will progress this to the Director for AHP Services, NHS Lothian. If this issue has not resolved it may have to be looked at again in September.

SE asked about delays for patients. BB advised the service is sitting at circa 14 weeks.

Arts Therapies
Job descriptions have now been submitted for matching under Agenda for Change.
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.

The Draft Primary Care Strategy should be available for the Sub Committee meeting in September 2013.

The Phlebotomy proposal will be a universal approach for patients at home. This has been agreed by GP Forums and are now working towards implementation of this for a single approach in each CHP area. A follow on discussion will be held in Midlothian.

MMc asked if bowel screening has been on the agenda of this group. Proposal that it becomes an enhanced service for GPs for patients with disabilities. HR is aware that this is being developed and has been in contact with practices looking for GPs to take part.

6.7.1 – PCJMG Minutes 09.05.13
For noting by the Committee.

6.7.2 – PCFG Notes of 04.04.13
For noting by the Committee, previously reviewed and noted at the 30th May Meeting.

Decisions

The verbal report was noted.

6.8 Joint Health Improvement Partnership (JHIP)

6.8.1 MJHIP Breast Feeding

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

The purpose of this report is to provide a progress update, since May 2013, on support for breastfeeding in Midlothian and primarily, for developing the Community Public Health Nursing workforce to meet the requirements of UNICEF’s Baby Friendly Initiative (BFI).

The CHP Sub Committee was recommended to note the training targets set locally by Midlothian’s Integrated Children’s Service Manager for 2013/14 and note the existing resource to deliver training, provide support and complement this work locally.

A discussion paper was presented to the CHP Sub-committee in May 2013 regarding (a) the declining breastfeeding rates in Midlothian; (b) the requirement for Community Public Health Nursing staff to be trained to UNICEF’s Baby Friendly Initiative (BFI) standards. This paper provides an update on developing and supporting the Public Health Nursing workforce.
in Midlothian to support breastfeeding. Recent and renewed discussions have resulted in the Integrated Children’s Service Manager setting local targets as follows:

1. All Midlothian Staff Nurses and Nursery Nurses will be trained to BFI standards by the end of 2013/14.
2. Two to three Health Visitors in each cluster will be trained to BFI standards

Decisions

The report was noted.

7.0 Carers Forum

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

JG highlighted that the new carer’s centre in Hardengreen has been secured and the team are hoping to move in September with a launch circa October 2013.

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.

SE highlighted that a review of what the PPF have achieved and what they still have to achieve is being planned. A Physical Disabilities open event has been held. MG said it is hoped to get more people involved and to ensure that what is being planned, is being carried out.

EMc said that feedback from colleagues who attended this event was very positive. In particular people valued the support that they received through their engagement with informal support groups. As we begin to focus more on self management of health conditions these support groups will have an important contribution to make.

Decisions

The report was noted.

8.1 Minutes from PPF 25.05.13

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**

David Small is now to be removed from this Committee from the 1st August 2013.

10.0 **AOCB**

10.1 No issues were raised.

**Date and Time of Next Meeting**

Thursday 26th September 2013 at 14:00 in the Council Chambers, Midlothian House, Buccleuch Street, Dalkeith
### West Lothian CHCP Sub-Committee 29 August 2013

<table>
<thead>
<tr>
<th>MEETING</th>
<th>KEY ISSUES</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>Presentation on Single Outcome Agreement (SOA) - Early Years</td>
<td>Noted presentation and that draft SOA has been signed off by Scottish Government.</td>
<td></td>
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<tr>
<td>Children and Young People’s Strategy - presentation</td>
<td>Noted vision, principles and outcomes.</td>
<td></td>
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<tr>
<td>Baby Friendly Status</td>
<td>Agreed participation in UNICEF implementation visit and promotion of UNICEF Baby Friendly initiative.</td>
<td></td>
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<tr>
<td>Breast feeding rates</td>
<td>Endorsed the programme of activities to improve breast feeding rates in West Lothian.</td>
<td></td>
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<tr>
<td>Health Improvement Fund Allocation</td>
<td>Noted plans for project evaluation and agreed to support developing plans for future allocation.</td>
<td></td>
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<tr>
<td>Health and Homelessness update</td>
<td>Noted progress.</td>
<td></td>
</tr>
<tr>
<td>TADP update</td>
<td>Noted success in achieving HEAT A11 target and review of the joint commissioning plan.</td>
<td></td>
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<tr>
<td>PPF update</td>
<td>Noted action plan and agreed briefing paper to be brought regarding participation / engagement structures in light of legislative change.</td>
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Minutes of the West Lothian Sub Committee held on 29th August 2013, 1400 – 1600, Strathbrock Partnership Centre.

Present

Frank Toner (FT) Chair, West Lothian CHCP
Jim Forrest (JF) CHCP Director
Jane Houston (JH) Partnership Lead
Jane Kellock (JK) Senior Manager, Children & Early Intervention
Marion Christie (MC) Head of Health / General Manager, WLCHCP
James McCallum (JMc) Clinical Director
Gill Cottrell (GC) Chief Nurse
Jennifer Scott (JS) Head of Social Policy, WLC
Julie Cassidy (JC) Public Involvement Co-ordinator
Margaret Douglas (MD) Deputy Director, Public Health, NHS Lothian
Alison Mitchell (AM) Non-Executive Member, NHS Lothian
Lindsay Seywright (LS) Assistant Principal, West Lothian College
Alan Bell (AB) Senior Manager, Community Care Support & Services
Lorraine Gillies (LG) Community Planning Development Manager Services
John Richardson (JR) PPF Representative
Ann Marie Carr (AMC) Customer Service Manager, Housing Need
Sally Egan (SE) Associate Director, Child Health Commissioner
Jim Gallacher (JG) Chief Executive Officer, Voluntary Sector Gateway Services

Apologies

Moira Niven (MN) Depute Chief Executive
Claire Kenwood (CK) Assoc. Clinical Director
Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
Pat Donald (PD) Acting AHP Manager
Michaela Kerr (MK) Police Scotland Representative

In Attendance

Marjory Brisbane (MB) CHCP Administrative Manager

1. APOLOGIES
As above.

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

3. ANY OTHER BUSINESS FOR TODAY
No other business notified.

4. DECLARATION OF INTEREST
FT declared he is chair of the CHCP and non executive member of NHS Lothian.

5. DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE
The minutes of the meeting held on 23rd May 2013 were approved as being an accurate record.
6. CONFIRMATION OF ACTION POINTS
   Actions Points confirmed

7. MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING
   Noted minutes of 14/05/13.

8. MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP
   Noted minutes of 09/05/13

9. MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT
   No minutes available

10. SINGLE OUTCOME AGREEMENT (SOA) – EARLY YEARS
    JK gave a presentation on Early Years. JK confirmed the reporting cycle to the Sub Committee will be based around the Single Outcome Agreement. LG confirmed the draft SOA has now been signed off by the Scottish Government. JK gave an overview of all the indicators influencing Early Years. Future reporting to the Sub Committee will not include all indicators only those require particular attention.

    LS offered the support of West Lothian College re the engagement of pregnant students regarding the promotion of breast feeding. LS to discuss with JK.

    JR requested a summary report of the indicators to take to the PPF.

11. CHILDREN AND YOUNG PEOPLE’S STRATEGY - PRESENTATION
    SE gave a presentation on the Children and Young People’s Strategy. The Sub Committee were asked to consider the strategy prior to it returning to NHS Lothian Joint Management Team. The Sub Committee were asked to consider and comment on the vision, principles and outcomes of the strategy.

    JH raised a concern about the strategy taking West Lothian down a different route they are currently working towards. LG commented the strategy has been mapped across areas with the single outcome agreement with the involvement of Mike Massaro-Mallinson, and Donna Milne.

    JS will take the strategy to the children and families management group and invite Mike and Donna to attend. The strategy is underpinned by GIRFEC which is well embedded in West Lothian, giving the assurance this strategy will not change but support the work in West Lothian.

    The recommendations were noted.

12. BABY FRIENDLY STATUS
    SE talked to the paper giving the Sub Committee an update on actions being taken or that require to be taken to acquire baby friendly status in West Lothian.

    Continued support from chief nurses is required to carry out the training programme for staff. Resources are available to backfill posts. JH raised a concern regarding the additional pressure this would add to staff. Assurance was given that West Lothian was not starting with a zero base as regular training programmes had been carried out and this would bring previous and current work together in a structured way.

    The recommendations were agreed by the Sub Committee and the chair requested this report is taken to the CHCP Board for consideration.
13. **% OF NEW BORN EXCLUSIVELY BREAST FED AT 6 – 8 WEEKS – UPDATE ON PROGRESS**

GC talked to the paper asking the Sub Committee to note the programme of activities/interventions currently being undertaken in West Lothian to improve breast feeding rates.

GC highlighted the positive work being carried out by the peer supporters, giving evidence those women who have contact with a breast feeding supporter breast feed for longer. There are currently 20 active breast feeding supporters in West Lothian.

Work is already underway to support the UNICEF Baby Friendly Status in West Lothian.

The Sub Committee endorsed the activities being undertaken. The chair requested the report be taken to the CHCP Board.

14. **HEALTH IMPROVEMENT FUND ALLOCATION**

MD talked to the paper updating the Sub Committee on the use of the Health Improvement Fund in West Lothian to advise on plans for evaluation of the projects and to seek support in developing plans for future allocation.

The allocation of the funding was broken in to three areas.

- Continuation of funding to Eatright West Lothian at the same level of £75,000 per year for 2014/15, increasing to £85,000 for 2015/16 and 2016/17
- Continuation of funding to West Lothian on the Move at the same level of £75,000 per year for 2014/15, increasing to £85,000 for 2015/16 and 2016/17
- One further year of funding for Together for Health totalling £20,000 in 2014/15, with the project subsumed within Eatright and West Lothian on the Move thereafter.

The Sub Committee noted the first 2 options and approved the 3rd option dividing the funding and supporting the successful approaches.

15. **HOMELESSNESS - UPDATE**

AMC talked to the paper updating the Sub Committee of the ongoing work in respect of Health and Homelessness, through the progress of the Homelessness Strategy.

There has been continued improvement over the last few years with a fall in people presenting as homeless, in particular a major success in the reduction of presentation of repeating homeless. There has also been an increase of permanent accommodation.

JH raised a concern regarding the introduction of the bedroom tax and the added stress on health of people having to move out of homes that they have local support and lived in all their lives.

LS commented on the increased level of students presenting as homeless. West Lothian has always had a high level of under 25’s presenting as homeless.

JG asked if there was a log of ex forces personnel who present as homeless. AMC confirmed this information is available and will send to JG.

The Sub Committee noted the paper.

16. **TOBACCO, ALCOHOL, DRUGS PARTNERSHIP (TADP) - UPDATE**

AB talked to the paper updating the Sub Committee on the performance of the West Lothian Tobacco, Alcohol and Drugs Partnership (TADP) against the HEAT A11 target set by the Scottish Government.
Through the co-delivered Breakaway Recovery Drop-in service for access to specialist treatment and support the HEAT A11 target has been met with 90% of clients waiting no longer than 3 weeks from referral to receiving treatment.

A review is taking place of the TADP joint commissioning plan.

The Sub Committee noted the paper.

17. **PUBLIC PARTNERSHIP FORUM FOR HEALTH AND CARE - UPDATE**

JC talked to the paper updating the Sub Committee of the progress the PPF have made in regards to achieving objectives 3 and 4. Objective 3 - ensuring equality and diversity is reflected in all of its work and the work of the CHCP. Objective 4 - actively identifying and put in place resources to support WLCHCP achieve its objectives.

JC highlighted a particular issue with the links to Edinburgh and Lothian Racial Equality Council (ELREC) with the loss of a staff member.

The Sub Committee were asked to agree a 6 monthly reporting cycle.

The future of the PPF was discussed with the dissolution of CH (C) P’s ending the existing statute for Public Partnership Forums to exist. The chair requested a briefing paper to be brought to the Sub Committee with a note of the changes/development when this information is available.

The reporting cycle was agreed to as and when required.

18. **ANY OTHER COMPETENT BUSINESS**

No other business was discussed

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

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

17.10.2013
05.12.2013
06.02.2014
10.04.2014
05.06.2014

Meeting closed at 4pm.
<table>
<thead>
<tr>
<th>MEETING</th>
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<tbody>
<tr>
<td>West Lothian CHCP Board 13 August 2013</td>
<td>Keep Well Annual report</td>
<td>To continue to support the delivery of the Keep Well programme and engagement with participating practices.</td>
</tr>
<tr>
<td>Blackridge Medical Practice</td>
<td></td>
<td>To note and support the appointment of Dr Russell-Smith.</td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td></td>
<td>Progress noted.</td>
</tr>
<tr>
<td>Care Governance</td>
<td></td>
<td>Noted the success of West Lothian TADP in achieving the HEAT A11 target. Noted joint inspection of adult (older people) services.</td>
</tr>
<tr>
<td>Self-Directed Support</td>
<td></td>
<td>Noted West Lothian response.</td>
</tr>
<tr>
<td>Director’s Report</td>
<td></td>
<td>Agreed that future reports to CHCP Board should include Risk Register identifier numbers where appropriate. Congratulated Mother and Baby Unit at St John’s on accreditation as “excellent” by the Perinatal Quality Network.</td>
</tr>
</tbody>
</table>
MINUTE of MEETING of the WEST OTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD held within THE STRATHBROCK PARTNERSHIP CENTRE, BROXBURN on TUESDAY 13 AUGUST 2013

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

Apologies – Janet Campbell

In Attendance – Jim Forrest (CHCP Director), Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), Gill Cottrell (Chief Nurse, NHS Lothian), Carol Mitchell (Assistant Director of Finance, NHS Lothian), Alan Bell (Senior Manager – Communities and Information, West Lothian Council), Jill Derby (Service Development Officer, West Lothian Council)

Apologies - Julie Cassidy (Public Involvement Coordinator, NHS Lothian), Lynne Hollis (Associate Director of Finance, NHS Lothian), James McCallum (Clinical Director, NHS Lothian); John Richardson (PPF)

1. DECLARATIONS OF INTEREST

(a) Frank Toner declared a non-financial interest as the council’s appointment to the Board of NHS Lothian as a Non Executive Director.

(b) In relation to Agenda Item 12(a) (Clinical Governance - Blackridge Medical Practice Vacancy), Ed Russell-Smith declared that he had been selected to take over the vacant practice unit.

2. MINUTE OF MEETING OF THE BOARD – 25 JUNE 2013

The Board approved the minute of its meeting on 25 June 2013 as a correct record.

In relation to the second decision noted in relation to Item 07 on page 653 (Risk Management), the Board noted that the scoring had been checked and no inconsistency had been found, although the scoring would be liable to change as circumstances changed, in particular the effect of recent draft legislation on the need for such an agreement.

3. CHCP BOARD RUNNING ACTION NOTE

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

Decisions

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

2. In relation to Item 2, to agree that the survey instrument and survey information need only be supplied to John Richardson and not other Board members, with the item thereafter to be deleted from the Running Action Note.

3. To update and amend the Running Action Note accordingly.

4. DIRECTOR’S REPORT

The Board heard a report by the CHCP Director updating the CHCP Board on
key areas of work in which the partnership had been involved since the last meeting of the Board.

- The inclusion of Risk Register identifier numbers on Board reports where appropriate.
- The accreditation of the Mother and Baby Unit
- Suicide Prevention Week activities
- The publication of issue 24 of West Life
- Care Accolade award to the Chill Out Zone
- The launch of the Home from Hospital service
- Publication of the CHCP Induction Pack

The West Lothian CHCP Risk Register (with objectives) was contained in Appendix 1 to the report, and the West Lothian CHCP Induction Pack in Appendix 2.

Decisions

To note the information provided and in particular:-

(a) To note and agree the change to future reports to the Board to include Risk Register identifier numbers.

(b) To congratulate the Mother and Baby Unit at St John's Hospital on its accreditation as “excellent” by the Perinatal Quality Network.

5. KEEP WELL ANNUAL REPORT

The Board considered a report (which had been circulated) by the Head of Health Services presenting the Keep Well Annual Report 2012/13 to the Board and which was contained in the appendix to the report.

The report explained the history and purposes of the programme, and the way in which it was delivered in West Lothian. It highlighted aspects of the annual report, as follows:-

- 549 people from West Lothian received initial health checks in 2012/13; an additional 45 people attended for annual review (previously identified as being at high risk of cardiovascular disease); 56 of those receiving a health check in West Lothian were carers
- 58 people were referred on to other health improvement services, including smoking cessation, exercise and weight management.
- Positive feedback from West Lothian Drug and Alcohol Service (WELDAS) team and substance misuse teams in West Lothian, both have started to refer patients to Keep Well who are seen in their practices.
- Homeless hostel postcodes will be added to Blackburn and Dedridge
surgeries list where patients will register, this will enable them to be invited to the practice for their Keep Well check.

- Gypsy/Travellers in West Lothian, no permanent site but manager of this service linking with Keep Well now about roadside camps

**Decisions**

1. To support the continuation of the delivery of the Keep Well programme within West Lothian, in line with national recommendations.

2. To continue to support engagement with participating general practices.

**6. CLINICAL GOVERNANCE – BLACKRIDGE MEDICAL PRACTICE VACANCY**

The Board considered a report (which had been circulated) by the Clinical Director highlighting that Dr Edward Russell-Smith had been appointed to Blackridge Medical Practice from 1 November 2013, and the measures that had been put in place to ensure continued access to primary medical services for patients on the Blackridge list in the meantime.

The report gave background information about the vacancy and the successful application of Ed Russell-Smith to take over the practice. It went on to advise that there was a three month gap before Dr Russell-Smith took it over, and so interim arrangements had been made to ensure continued access for patients on the practice list. Those arrangements included the part-time employment of an experienced practice manager; the recruitment of locums; the provision of emergency telephone triage and consultation services by neighbouring practices; liaison with unscheduled care services and community services; and provision of information to patients.

**Decisions**

1. To note and support the appointment of Dr Russell-Smith.

2. To support the recruitment and continuity measures in place to ensure continued access to primary care services for patients on the Blackridge list.

**7. FAMILY NURSE PARTNERSHIP**

The Board considered a report (which had been circulated) by the Chief Nurse updating the Board on the work of the Family Nurse Partnership (FNP).

The report explained the importance of understanding how early relationships and experiences shape the infant brain and set the pattern for psychological and cognitive development and subsequent adult health. Changing knowledge as to how early childhood was viewed had brought pregnancy and infancy to the forefront of preventive health care and early intervention. There was now an imperative for intervening in pregnancy and the first years with programmes of sufficient intensity that work for the most vulnerable families.

It advised that the Scottish Government’s approach had been set out in the documents Equally Well, Early Years Framework and Achieving Our Potential, supporting a move away from crisis management to prevention. The Family Nurse Partnership, a licensed programme that was developed in the USA by Professor David Olds at the University of Colorado, supported that approach, and NHS Lothian had been awarded the first FNP test site licence in Scotland to
deliver FNP.

The report went on to explain how the FNP had been operating in the Edinburgh CHP since 2010, and advised that it had been expanded to test the service in West Lothian CHCP on 1st March 2013. There was an aspiration to continue to expand the service in order to offer a fully sustained service to all eligible clients across NHS Lothian. The expansion plan was on target with an aim to offer a continuous service from April 2015. The expansion plan would allow FNP to be mainstreamed within a single system service delivery approach.

Decisions

1. To note the progress of the programme and the extension plan to offer the service to all eligible clients across Lothian.

2. To note that a different programme was in place through the Early Years/Early Intervention Change Fund for those clients not eligible for the Family Nurse Partnership programme.

8. CARE GOVERNANCE - HEAT A11 PROGRESS/PILOT JOINT INSPECTION OF ADULT (OLDER PEOPLE) SERVICES

The Board considered a report (which had been circulated) by the Head of Council Services advising the Board of progress made by West Lothian Tobacco, Alcohol and Drug Partnership (TADP) to achieve the HEAT A11 target, and the pilot joint inspection of Adult (Older People) Services.

The report explained that the HEAT A11 target set by the Scottish Government stated that by March 2013, 90% of clients should wait no longer than three weeks from referral to receiving appropriate drug or alcohol treatment that supported their recovery. Local services in West Lothian had therefore established a co-delivered Breakaway Recovery Drop-in service for access to specialist treatment and support, involving 5 drop-in clinics spread across West Lothian jointly delivered by staff from NHS Lothian, the Social Work Addictions Team and WLDAS (West Lothian Drug and Alcohol Service), and from September 2012, the Cyrenians’ Recovery Service. An additional CPN post had also been funded by the West Lothian Tobacco, Alcohol and Drug Partnership (TADP) to help increase capacity in the system. Implementation of the drop-in model had helped reduce waiting times and increase capacity. West Lothian TADP successfully achieved the HEAT A11 target in January 2013 and had sustained this performance.

The report went on to provide information about the first full pilot joint inspection being carried out in West Lothian CHCP by the Care Inspectorate and Healthcare Improvement Scotland. It explained the make-up of the inspection team and that a set of performance indicators had been developed to form the basis for the inspection and to assist health and social care partnerships in evaluating their own performance and to provide an inspection model. The draft report was expected to be available in the near future and would be reported to the Board in due course.

Decisions

1. To note the success of the TADP in achieving the HEAT A11 target.

2. To note the information provided in relation to the joint inspection of Adult (Older People) Services.
9. RESPONSES TO CONSULTATIONS PUBLISHED BY THE SCOTTISH GOVERNMENT IN RELATION TO SELF-DIRECTED SUPPORT (SDS)

The Board considered a report (which had been circulated) by the Head of Council Services informing the Board that in April 2013 the Scottish Government had published a series of consultation documents relating to the Social Care (Self-Directed Support) (Scotland) Act 2013 and to Self-Directed Support, and of the West Lothian responses to these consultations.

The report summarised the meaning of SDS, the legislative framework and the statutory duties imposed on the council, details of all of which had previously been reported to the Board. It advised that the Scottish Government had issued draft regulations, directions and guidance for consultation. The council had sent responses, and the consultation documents and responses were contained in the three appendices to the report. The key elements were:-

- The need for much greater detail in relation to Children’s Services and SDS
- The need for greater inclusion and acknowledgement of the role of professional assessment and judgement and the potential use of discretionary powers
- Changes to the ‘exceptional circumstances’ rule in relation to the employment of close relatives
- Issues relating to capacity, safeguarding and risk enablement
- The role of the NHS in SDS in light of health and social care integration
- The need for more detail and definition in relation to proposals to waive charges to carers
- The financial implications of the implementation of SDS as outlined within the draft Statutory Guidance
- The financial implications of the waiving of charges to carers adopting a position that any additional costs to the council should be met by the Scottish Government

Decisions

1. To note the Scottish Government consultations in relation to the Social Care (Self-Directed Support) (Scotland) Act 2013, draft Regulations and draft Guidance.

2. To note the West Lothian responses to these consultations contained in the appendices to the report.

10. 2012/13 REVENUE BUDGET- MONITORING REPORT AS AT 30 JUNE 2013

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services providing a joint report on financial performance in respect of West Lothian Community Health and Care Partnership (WLCHCP) based on figures for the period to 30 June 2013.
The report advised that the anticipated out-turn for the CHCP council services for the financial year was for break-even, and that the same position was forecast for the CHCP Health Services.

The report outlined the reasons for the forecast positions and the anticipated pressure areas for the council and NHS Lothian elements of the budget. It advised that there was an overspend of £105,000 in the financial year to date and the report explained the variances. The report concluded by summarising the budgeted expenditure for the West Lothian Health and Social Care Change Fund.

The Board was asked to note an error at the bottom of page 4 of the report.

Decisions

1. To note that the last sentence on page 4 of the report under “Other Services” had been included in error and should be disregarded.

2. To note that service managers were taking management action to address areas of financial pressure within their own service area to ensure spend was contained within the budget available.

11. RESOURCE TRANSFER MONITORING REPORT TO 30 JUNE 2013

The Board considered a report (which had been circulated) by the Head of Council Services providing details of phased expenditure incurred in the period to 30 June 2013. The Period 3 resource transfer monitoring report was contained in the appendix.

The Board was advised that the council had invested £1.62 million of the total £6.52 million resource transfer monies to the end of June 2013 and had maintained a zero delayed discharge position in the first three months of the financial year.

In the course of discussion it was suggested and agreed that the work in achieving a zero delayed discharge position was more accurately described as work by the CHCP partners and not solely by the council.

Decisions

1. To agree that the investment and achievement in relation to delayed discharge figures were more properly by the CHCP as a whole rather than the council alone.

2. To agree that future reports to the Board on the same subject would reflect that.

3. To note as a result that the CHCP partners have invested £1.62 million of the total £6.52 million resource transfer monies to the end of June 2013 and have maintained a zero delayed discharge position in the first three months of the financial year.

12. FREQUENCY OF FINANCIAL REPORTING

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services proposing that the frequency
of financial reporting to the Board changed in line with the revised approach to budget monitoring within Council for 2013/14.

The report explained that the Council had introduced a revised approach to budget monitoring for 2013/14 and following discussion with NHS Lothian Finance and senior managers, it was proposed that the CHCP also adopt a risk based approach to budget monitoring and financial reporting. There were many relatively stable and low risk areas of the CHCP budget and the changes proposed would ensure that time was prioritised to high risk budget areas, particularly those driven by demographics, needs led pressures and other external factors.

The changes proposed were expected to result in the following:-

- A comprehensive monitoring of all areas of the CHCP budget would be reported to the Board based on the position at periods 4, 6 and 9. The CHCP budget monitoring report would be presented to the Board meetings that followed the outcome of the period 4, 6 and 9 monitoring. This would be consistent with the frequency of monitoring reports prepared for the Council’s Corporate Management Team and also Council Executive.

- In addition, a final outturn report for the CHCP budget would also be reported to the Board following the year end. In total, there would be four financial reports provided to the Board each year, essentially relating to a quarterly monitoring update and a final outturn report.

- The focus of budgetary control throughout the year would be on material risk areas of the budget. Risk areas would be agreed with budget holders and these areas would be closely reviewed on a monthly basis. An update on these areas would form part of the reports that were to be provided to the Board.

- In the event that a overspend arose in the overall CHCP budget as a result of these risk areas, this would be reported to the next Board meeting regardless of whether a monitoring report was due. This would ensure the Board were made aware of an overspend against the budget as soon as possible and could consider any action required.

It was considered that the proposed changes would enhance the monitoring of identified risk areas while still continuing to provide the necessary level of reporting to the Board on the overall CHCP budget.

The CHCP Director confirmed that senior management would continue to monitor the budget position as they do just now, and that where judged to be necessary reports would be brought to the Board to inform members of any particular pressures or unexpected developments.

Decisions

1. To agree the changes to financial reporting as outlined in the report, in particular that reporting to the Board in future would happen after periods 4, 6 and 9 and financial year end.

2. To note that officers would continue to monitor budgets and spending on a monthly basis and would bring exception reports to the Board as and when they were judged to be required.
13. **STAFF GOVERNANCE**

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services updating the Board on staff issues within the CHCP, in relation to Modernising Social Care, measles, mumps and rubella vaccination, Delivering Better Care (DBC) Hub, and Information Governance Policies.

**Decision**

To note the information provided in relation to:-

- Modernising Social Care - Model Office Update
- Measles, mumps and rubella vaccination
- Delivering Better Care (DBC) Hub
- Information Governance Policies
SUMMARY PAPER – REVIEW OF THE 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.

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- The Quality Report has been reviewed within the context of the Board Francis Workshop, NHS Lothian’s Quality Aims and Best Practice from a range of publications such as Berwick and Keogh reports.

- Within the context of the above, the report recommends a number of measures that should be continued with an emphasis on outcome measures (Table 1).

- Additional measures are set out in Table 2 and include delayed discharges, key waits plus staff and patient experience.

- The existing rolling programme of clinical effectiveness measures across care pathways, including primary care, will be reviewed and proposed changes reported to the Board in March 2014.

- Reporting of quality at different levels of the organisation will be reviewed and strengthened.

- The presentational aspects of the report will be reviewed with micro charts being used in the first instance.

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Medical Director Quality Improvement
11 September 2013
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NHS LOTHIAN

Board Meeting
25 September 2013

Medical Director

REVIEW OF THE QUALITY REPORT

1 Purpose of the Report

1.1 This report advises the Board on the changes proposed to the Quality Report to provide enhanced assurance on the quality of care provided by NHS Lothian.

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

2 Recommendations

2.1 Approve the proposed changes to the Quality Report and the commitment to further development;

2.2 Approve the development of quality reporting and scrutiny at other levels in the organisation;

2.3 Support training for Board Members in the use of Quality Data for Improvement.

3 Discussion of Key Issues

3.1 The Board workshop on the Francis Recommendations, the Risk Appetite & Tolerance Workshop and the Healthcare Governance Workshop on assurance needs identified that Board members require:

- Routine and timely assurance reporting on patient and staff experience;
- A focus on outcome measures, with process measures being reviewed at the relevant sub-committee of the board;
- Enhanced integration with the performance report and other stand-alone reports on quality;
- A greater focus on triangulation of data within the quality report with other information such as that obtained during walkrounds, culture surveys and external reports/reviews.
- A better breadth of coverage, including primary care.

3.2 In response to the above and within the context of best practice a review of the existing quality report was carried out taking account of the following.

- Principles used to develop the existing quality report and how the report links to Lothian’s quality aims;
- Best practice recommendations, by considering:
  - The Francis report;¹

¹ The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013.
The Keogh Review;\(^2\)
- A promise to learn- a commitment to act; The ‘Berwick report’;\(^3\)
- The Health Foundation report ‘The measuring and monitoring of safety’
- The information assessed by the boards of some high reliability health organisations (HROs);

- Review of existing measures, including criteria for removing measures and adding other measures;
- Identification of key quality operational effectiveness measures that currently sit within the performance report that may warrant monthly reporting within the Quality Report;
- Consideration of reporting at other levels in the organisational to enhance assurance, and;
- Presentational aspects of the report.

3.3 Principles used to develop the existing quality report

The quality report has aimed to provide a system-wide report on the three dimensions of quality that are the focus of the NHS Scotland Healthcare Quality Strategy; safe, effective, person-centred care.

The principles used in the initial development of the quality report were drawn from a variety of sources\(^4\) and were as follows:

1. The measure should reflect system, i.e. NHS Lothian level;
2. The measure should be important/relevant for scrutiny at board level; such measures will be supported by a larger number of less ‘high level’ measures at more local level including at a more local governance level;
3. The measure should be valid, i.e. measure what it says it does;
4. The measure may be an outcome measure (e.g. mortality rate) or a process measure for an evidence-based intervention (e.g. QOF indicator for hypertension);
5. There should be some method of assessing how Lothian compares, either to an agreed standard (for example HIS or Royal College) or against a national or international comparator. These data should also be available.

Additional principles for the effectiveness measures (currently included at every other Board meeting) were as follows:

6. If relevant, measures should include mortality and/or survival;
7. If relevant, national audit results should be included;
8. If relevant and possible, measures should reflect effectiveness of care delivered across the system i.e. care in hospital and in the community;

The effectiveness measures sections were selected to reflect the major national disease-area priorities (CHD, stroke, diabetes, cancer, mental health, child and

\(^2\) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Professor Sir Bruce Keogh KBE, July 2013.
\(^4\) The King’s Fund, 2010. Getting the measure of quality: opportunities and challenges.
maternal health). The first two years of the Quality Report included a wider range of effectiveness data, but these largely reflected the data that were available (e.g. where there are national audits) rather than necessarily the data we would want.

As the quality report has evolved, additional consideration has also been given to including, wherever possible, time trend data so that overall board members are able to ascertain the answers to three simple questions:

- How is Lothian doing?
- How does Lothian compare?
- Is Lothian getting better?

The quality report currently contains a mixture of measures, including process measures from improvement programmes such as SPSP and Delivering Better Care, which do not all reflect conventional assurance measures.

3.4 Links to Lothian’s Quality Aims

The report has aimed to link to NHS Lothian’s over-arching quality aims. The Quality Improvement Strategy (2011-14) sets out what Lothian is trying to achieve as:

- Reduced mortality;
- Reduced avoidable harm;
- Improved patient experience;
- Delivery of evidence-based care;
- Safely reducing cost and improving productivity.

The current quality report does address some, although not all, of these. The Strategic Clinical Framework includes two aims which relate broadly to the quality of care NHS Lothian delivers:

- Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients;
- Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting.

There is as yet no corresponding measurement framework.

3.5 Best Practice Recommendations

The Francis Report, Keogh Report, Berwick report and Health Foundation Report were detailed ‘one off’ examinations. They were not a template for regular Quality Reports but they all refer to the information that should be considered by Boards and a strong consensus on best practice emerges. This has informed this review of NHS Lothian Quality Report.

- Quality should be the top of the Board agenda. The report needs to support this.
- All three domains (safety, patient experience, effectiveness) must be considered.
- Boards need training in understanding data and should be scrutinising it to look for opportunities for improvement rather than simply for reassurance.
• Boards should have a Chief Quality Officer with appropriate knowledge and skills to lead this work.
• Assessing quality remains extremely challenging. There is no single measure of safety or any other dimension, nor is there any combination, that can provide complete assurance. Hence multiple measures are required.
• The emphasis should be to stimulate improvement. Berwick described ‘zero harm’ as a worthy aspiration but said that the correct goal was ‘continual reduction’. He advises using quantitative targets with caution: they may be a means but are not an end.
• It is essential to verify the data and processes reported. Sir Bruce Keogh’s reviews made extensive use of data to inform their inspections, but regularly found that there was a discrepancy between reported measures and the true state when wards were directly inspected.
• Transparency: The ‘Berwick report’, like the Francis report, recommends a transparent approach to data reporting and emphasises that aggregated data may mask important variation within organisations. It highlights that leaders should seek out variation within their organisations and the need for more detailed analysis at local level which should act as ‘early warning signals’. The suite of indicators recommended at sub-organisation level is in Appendix 2
• Emphasis on listening to, and working with patients.

There is no Board which is recognised as having an exemplar report on quality of care. Quality reports from a small number of organisations generally recognised as having a reliable approach to improving quality have been obtained and reviewed. The themes emerging from these papers are similar to those already mentioned. One aspect of the reports that may merit consideration in quality reporting and reflects our current approach to reporting of clinical effectiveness measures is the importance of reporting pathways which includes presenting data on mortality, compliance with evidence-based care pathways, readmissions and length of stay for each of these.

3.6 Review of current measures

In light of the feedback from the Board and from the best practice described above, it is clear that some of the process measures should be removed. Similarly, the person-centred and the effectiveness components need to be strengthened. In addition, the individual quality measures have been reviewed to assess whether:

• The data are still understood to be robust;
• The measure still reflects the most appropriate measure for the dimension of quality being assessed.

It is proposed that measures are removed from the report if either of these are not the case. In addition, it is proposed that measures are removed if:

• For process measures, if the measure has been stable and meets the required standard (e.g. hand hygiene has been consistently above the required 95% for >6 months).

Application of these criteria gives the results as shown in Appendix 3. For the majority of measures suggested for removal, monitoring will continue elsewhere.
The measure would be re-instituted into the quality report if there were an adverse change in the measure or in a related measure.

Within the context of the above, it is suggested that the following measures remain in the report as set out in Table 1. All of these measures relate to risks on the Corporate Risk Register from Patient Experience and Safety to Unscheduled Care.

Table 1: Measures in existing quality report that are recommended should continue to be reported

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Rationale</th>
<th>Corporate Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred</td>
<td>• Complaints</td>
<td>These are currently the only (proxy) measures of patient experience in the quality report. The process measures (response times) don't directly drive the outcome measure. These are acknowledged weaknesses of the report. A separate quarterly report on complaints, including themes and responses is also reported to the board to provide detailed assurance</td>
<td>1/7</td>
</tr>
<tr>
<td>Safe</td>
<td>• HSMR</td>
<td>Corporate objective and national aim to reduce HSMR best practice reports.</td>
<td>6</td>
</tr>
<tr>
<td>Safe</td>
<td>• Number of incidents associated with serious harm</td>
<td>Key quality indicator as set out in best practice reports.</td>
<td>6</td>
</tr>
<tr>
<td>Safe</td>
<td>• C. Difficile rate</td>
<td>Key quality indicator. (These are also reported in detail in the HAI report.)</td>
<td>6</td>
</tr>
<tr>
<td>Safe</td>
<td>• S. Aureus bacteraemia rate</td>
<td>Key quality indicator. (These are also reported in detail in the HAI report.)</td>
<td>6</td>
</tr>
<tr>
<td>Safe</td>
<td>• Cardiac/respiratory arrests</td>
<td>SPSP national target. These are small numbers (20-30/month for the 3 main acute sites) so these data must be interpreted with some caution.</td>
<td>6</td>
</tr>
<tr>
<td>Safe</td>
<td>• Falls with harm</td>
<td>NHS Lothian improvement target. Fundamental standard of care.</td>
<td>6</td>
</tr>
<tr>
<td>Safe</td>
<td>• Number of pressure ulcers per month</td>
<td>These are small numbers so these data must be interpreted with some caution. Fundamental standard of care.</td>
<td>6</td>
</tr>
<tr>
<td>Effective</td>
<td>• Stroke</td>
<td>The lack of improvement in these data is a potential cause for concern.</td>
<td>10</td>
</tr>
<tr>
<td>Effective</td>
<td>Standardised surgical readmission rate within 7 days</td>
<td>These data are reported in the Scottish Government Scorecard quarterly. The other measures in the scorecard are already part of the quality or performance reports. This should remain as reported nationally and illustrates at present that NHS Lothian is an outlier for both length of stay and readmissions rate.</td>
<td>3</td>
</tr>
</tbody>
</table>
In addition to the above, it is suggested that the following measures are added to the report, including operational effectiveness measures which are currently in the performance report as these measures have a direct impact on patient experience and outcome of care. They will also support the further triangulation of data and reflect risks currently identified on the NHS Lothian Corporate Risk Register.

In addition to the above, it is suggested that the following measures are added to the report, including operational effectiveness measures which are currently in the performance report as these measures have a direct impact on patient experience and outcome of care. They will also support the further triangulation of data and reflect risks currently identified on the NHS Lothian Corporate Risk Register.

Table 2 – Additional Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Rationale</th>
<th>Corporate Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred</td>
<td>Patient experience</td>
<td>These are currently being developed as part of the person-centred care programme. These will be incorporated into the quality report in 2014</td>
<td>1/7</td>
</tr>
<tr>
<td>Person-centred</td>
<td>Staff experience: Sickness absence levels</td>
<td>Sickness absence is proposed as a proxy measure.</td>
<td>1/7</td>
</tr>
<tr>
<td>Effective and patient centred</td>
<td>Delayed Discharges</td>
<td>Currently in Performance Report and reflects the interface between Health &amp; Social Care.</td>
<td>3</td>
</tr>
<tr>
<td>Effective and patient centred</td>
<td>Cancer waits</td>
<td>Key Performance Target</td>
<td>10</td>
</tr>
<tr>
<td>Effective and patient centred</td>
<td>62 days from diagnosis to treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective and patient centred</td>
<td>A&amp;E 4-hour waits</td>
<td>Key Performance Target</td>
<td>3</td>
</tr>
</tbody>
</table>

Appendix 4 summarises the proposed measures that should be retained, removed and amended. It is acknowledged that further work is needed, and that the report will continue to evolve. The most important omission is primary care measures. These need to be further developed and this work will be initiated through the Primary Care Forward Group with the intention to complete by March 2014. Measures of Patient Centred Care
will be developed through the Person Centred Care Programme and incorporated into the report when available.

3.7 Clinical Effectiveness Measures

Given the recommended focus on effectiveness measures by a number of external reviews including Francis and Berwick, it is proposed that detailed effectiveness measures sections continue to be reported to the Board. However, the content of these will be reviewed with the relevant clinicians, including primary care colleagues, with any changes reported to the Board in March 2014.

3.8 Links to quality reporting at other levels of the organisation

To enhance quality improvement it is essential that quality is reported and scrutinised at all levels of the organisation \(^2,3\). It is proposed that the systems for doing this are reviewed and strengthened. This will support improvement and also provide additional assurance to the Board that the information which it receives has been validated and acted upon.

3.9 Presentational aspects

The need for Boards to have the ability to scrutinise data to identify opportunities for improvement was highlighted by the reports. Key to this is how the data are presented. For most measures time series presentations are recommended and are already in use. For measures where time series data are not yet available, discussions/work is ongoing to progress this. It is proposed to offer training in the interpretation of data to Board Members. Micro charts will be used to allow summary information to be provided on a single page.

3.10 Links to risk appetite and tolerance work

An output of the Risk Appetite & Tolerance Workshop in May 2013 was to complete in the first instance the appetite and tolerance for agreed quality measures. It is suggested that this should be undertaken for measures in the revised Quality Report as it would inform exception reporting at Board level. Appendix 5 sets out the agreed risk appetite against delivery of organisational objectives and these will inform the setting of Appetite and Tolerance to individual quality measures as set out in the revised Quality Report.

4 Key Risks

4.1 The Board does not receive adequate assurance on the quality of care NHS Lothian provides.

5 Risk Register

5.1 The Quality Report informs assurance needs of the Board and 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

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. Discussions have been initiated with NHS Lothian’s Health Intelligence Unit how this can be delivered in an efficient and timely manner.

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11 September 2013
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List of Appendices

Appendix 1: Francis, Keogh and Berwick Report Recommendation in relation to information
Appendix 2: Berwick Report diagram
Appendix 3: Proposed removal of measures in current report
Appendix 4: Summary of changes to core measures in Quality Report (Dashboard)
Appendix 5: Board Approved Risk Appetite - June 2013
Relevant Summary information from The Francis Report, Keogh Report, Berwick Report

These three reports all considered the NHS in England and some of the recommendations are specific to that structure. The general points are however highly relevant.

Francis report recommendation in relation to information

Chapters 5 (mortality statistics) and 26 (information) are particularly relevant.

It was identified that failure to share and act upon relevant information lay at the heart of the failure of the system to detect the scale of the deficiencies at the Trust.

Some areas which may merit consideration are as follows:
- The importance of both director level and service line sign off of information;
- The role of a Chief Information Officer/equivalent at board level to include ensuring that clinicians are fully involved in data collection.
- For provider organizations, the requirement for:
  - Effective real-time information on the performance of each service against patient safety and minimum quality standards;
  - Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction.
- The importance of patient feedback and of it being available in as near to real time as possible.
- Improving quality accounts so they are more consistent and balanced (i.e. not focused on good areas) and also that they are subject to external audit/assurance. In NHS England Trusts must publish Annual Quality Accounts and the following are now mandatory
  - SHMI;
  - Patient-reported outcome scores for groin hernia surgery, varicose vein surgery,
  - hip replacement surgery and knee replacement surgery;
  - Emergency readmission with in 28 days of discharge;
  - Responsiveness to inpatients’ personal needs;
  - Percentage of staff who would recommend the provider to friends or family needing care;
  - Percentage of patients risk assessed for venous thrombo-embolism;
  - Rate of patient safety incidents and percentage resulting in death or serious harm.

Available at: www.midstaffspublicinquiry.com
Keogh Report
This was a detailed review of 14 Trusts based on a review of large amounts of data and site based inspections. It produced action plans for each Trust but identified general themes for the entire NHS in England summarised in eight Quality Ambitions. Three of these (1,2,6) are particularly relevant to information reporting:

1. Demonstrable progress towards reducing avoidable deaths.
2. Boards and leaders use data confidently and competently for forensic pursuit of quality improvement
3. Patients, carers, members of public as vital and equal partners
4. Patients and clinicians will have confidence in quality assessments by CQC
5. No hospital will be an island
6. Nurse staffing levels and skill mix appropriately reflect caseload and are transparently reported
7. Junior doctors seen as clinical leaders of today as well as tomorrow
8. Recognize impact of happy and engaged staff on patient outcomes and make this a key part of quality improvement strategy.

A promise to learn – A commitment to act (The Berwick Report)

This was also written for the English NHS but Professor Berwick argues that the messages are relevant for all four UK countries. Amongst the issues that he identified were:

Incorrect priorities do damage: The Mid Staffordshire tragedy and wider quality defects in the NHS seem traceable in part to a loss of focus by at least some leaders on both excellent patient care and continual improvement as primary aims of the NHS (or to a misinterpretation by providers of the intent of leaders). In some organisations, in the place of the prime directive, “the needs of the patient come first”, goals of (a) hitting targets and (b) reducing costs have taken centre stage. Although other goals are also important, where the central focus on patients’ falters, signals to staff, both at the front line and in regulatory and supervisory bodies, can become contaminated. Listening to and responding to patients’ needs then become, at best, secondary aims. Bad news becomes unwelcome and, over time, it is too often silenced. Under such conditions organisations can hit the target, but miss the point.

Warning signals abounded and were not heeded: Information on the deterioration of the quality of care at Mid-Staffordshire was abundant. It appeared in both narration (complaints from staff, carers and patients) and quantitative metrics (such as significantly high adjusted mortality rates compared with rates throughout England). Loud and urgent signals were muffled and explained away. Especially costly was the muffling of the voices of patients and carers who took the trouble to complain but whose complaints were too often ignored.
Improvement requires a system of support: The capability to measure and continually improve the quality of patient care needs to be taught and learned or it will not exist. The NHS needs a considered, resourced and driven agenda of capability-building in order to generate the capacity for continuous improvement. That investment in human development is absolutely necessary if, when alarms ring as they did in Mid Staffordshire, people with their hands on the steering wheel are to have the knowhow to diagnose and fix the problems. The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.

Fear is toxic to both safety and improvement: Fear impedes improvement in complex human systems. Time and again, we see the harvest of fear in the Mid Staffordshire story, a vicious cycle of over-riding goals, misallocation of resources, distracted attention, consequent failures and hazards, reproach for goals not met, more misallocation and growing opacity as dark rooms with no data came to look safer than ones with light. ‘Better not to know’ became the order of the day. A symptom of this cycle is the gaming of data and goals: if the system is unable to be better, because its people lack the capacity or capability to improve, the aim becomes above all to look better, even when truth is the casualty.

He made recommendations in relation to training, transparency and measurement as follows:

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals’, including managers and executives.

6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.

7. Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
## Box 5

Illustrating some of the suite of indicators that should be used by NHS organisations to assess safety improvement and variation. This data must be considered at ward/unit or other appropriate sub-organisational level in order to reveal the variation within an organisation.

<table>
<thead>
<tr>
<th>At sub-organisational level</th>
<th>At sub-organisational level</th>
<th>At sub-organisational level</th>
</tr>
</thead>
<tbody>
<tr>
<td>The perspective of patients and their families</td>
<td>Measures of harm</td>
<td>Measures of the reliability of critical safety processes</td>
</tr>
<tr>
<td>Information on practices that encourage the monitoring of safety</td>
<td>Information on the capacity to anticipate safety problems</td>
<td>Information on the capacity to respond to and learn from safety information</td>
</tr>
<tr>
<td>Data on staff attitudes, awareness and feedback</td>
<td>Mortality rate indicators</td>
<td>Staffing levels</td>
</tr>
<tr>
<td>Data on fundamental standards</td>
<td>Incident reports</td>
<td>Incident reporting levels</td>
</tr>
</tbody>
</table>

## Proposed removal of measures in current report

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Rationale for removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Process measure: percentage of incidents with major harm or death and/or graded as very high or high risk fully closed within 60 working days of being reported.</td>
<td>The measure does not have a direct impact on the corresponding outcome measure (number of incidents associated with serious harm). This is reported to the Healthcare Governance Committee.</td>
</tr>
<tr>
<td>Safe</td>
<td>Outcome measure: adverse event rate from monthly random sample case note review.</td>
<td>The initial SPSP target has been achieved. The monthly random sample case note review is stopping in order to allow a move to more focused local case note review (in line with good practice).</td>
</tr>
<tr>
<td>Safe</td>
<td>Process measure: Percentage compliance with hand hygiene.</td>
<td>Target achieved &gt; 6months. Features in HAI report.</td>
</tr>
<tr>
<td>Safe</td>
<td>Process measure: compliance with PVC bundle.</td>
<td>Stable, although not at compliance of 95%. May not be the most appropriate measure for the corresponding outcome measure, the SAB rate (note that the process measure has been stable for &gt;1 year, but the SAB rate has not). This will be included in the six monthly SPSP update.</td>
</tr>
<tr>
<td>Safe</td>
<td>Process measure: compliance with EWS bundle</td>
<td>Stable, although not at compliance of 95%. Not the most appropriate measure for the corresponding outcome measure. This will be included in the six monthly SPSP update.</td>
</tr>
<tr>
<td>Safe</td>
<td>Process measure: Percentage of patients with medicines reconciliation performed.</td>
<td>These data reflect one pilot ward and are not sufficient to provide assurance at board level. These data are reported through SPSP. It is proposed to consider reinstating this measure when there is adequate spread of this project.</td>
</tr>
<tr>
<td>Safe</td>
<td>Process measure: percentage compliance with falls CQI</td>
<td>The national reporting of CQIs is under review. Falls are reported through the ward scorecard. There are some concerns about the validity of these data.</td>
</tr>
<tr>
<td>Safe</td>
<td>Process measure: percentage compliance with pressure ulcer CQI</td>
<td>As above.</td>
</tr>
<tr>
<td>Safe</td>
<td>Process measure: Reduction in nursing medication incidents</td>
<td>This should be removed as the target is under review.</td>
</tr>
</tbody>
</table>
### Quality Dashboard – Summary of Changes

**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**
  - Standardised Surgical Readmission rate within 7 days
  - Standardised Surgical Readmission rate within 28 days
  - Standardised Medical Readmission rate within 7 days
  - Standardised Medical Readmission rate within 28 days
  - Average Surgical Length of Stay – Adjusted
  - Average Medical Length of Stay – Adjusted

- **+ Additions**
  - Staff Experience
  - Patient Experience
  - Staff Absence Levels
  - Delayed Discharges Occupied Bed Days
  - Cancer Waits 62 Days from Diagnosis to Treatment
  - A&E 4 Hour Wait
The matrix used which went from no appetite to seeking was based on the following premise:-

- Low appetite = certainty of delivery, High appetite = level of acceptance that the objective is not delivered.

**Output Session One**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>1. Transform Management Culture</td>
<td></td>
</tr>
<tr>
<td>2. Deliver Waiting Times Recovery Plan</td>
<td></td>
</tr>
<tr>
<td>3. Improve Unscheduled Care</td>
<td></td>
</tr>
<tr>
<td>4. Cohesive Strategic Plan</td>
<td></td>
</tr>
<tr>
<td>5. Effective Internal / External communications</td>
<td></td>
</tr>
<tr>
<td>6. Improve patient and staff safety</td>
<td></td>
</tr>
<tr>
<td>7. Implement Person Centred Programme</td>
<td></td>
</tr>
<tr>
<td>8. Suitable Financial Plan and Delivery</td>
<td></td>
</tr>
<tr>
<td>9. Health Improvement / Inequalities</td>
<td></td>
</tr>
<tr>
<td>10. Robust Reporting of Performance Targets</td>
<td></td>
</tr>
</tbody>
</table>
WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

SUMMARY PAPER

The key points of the paper are summarised here.

<table>
<thead>
<tr>
<th>Point</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both 31 day and 62 day performance on Cancer waiting times are above the 95% standards during July.</td>
<td>5</td>
</tr>
<tr>
<td>During August, 92% of patients were seen with the treatment time guarantee. A total of 519 patients subject to the standard were remaining at the end of the month. Of these, 200 have been treated or removed and 185 have a date for admission or at with external providers for treatment. The resolution for those remaining is being sought.</td>
<td>6.1</td>
</tr>
<tr>
<td>Including those inpatients and daycases not covered by the treatment guarantee, overall numbers over 12 weeks fell due to improved numbers in ophthalmology and neurosurgery.</td>
<td>6.3</td>
</tr>
<tr>
<td>Outpatients over 12 weeks increased in August to 4663. The position is outlined in the 5 specialties with the most patients over standard.</td>
<td>7</td>
</tr>
<tr>
<td>The final position at the end of August is not available for 18 weeks, psychological therapies, diagnostics and surveillance. Provisional information is given for the last two areas.</td>
<td>4  8- 10</td>
</tr>
<tr>
<td>Performance on the 26 week referral to treatment for Child and Adolescent Mental Health standard is below the 90% expected, at 86%</td>
<td>10</td>
</tr>
</tbody>
</table>
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 It is recommended that the Board receives this update on performance and progress on inpatient, outpatient and other waiting times.

3 Changes in Reporting

3.1 July’s Board paper highlighted that the sourcing and compilation of waiting times figures would alter for performance from July 2013 onwards for outpatients and inpatients. This is the first board paper since the change was made.

3.2 The rationale for the recent change is two-fold. Historically the information provided to the board was sourced from the National Data Warehouse and used to populate the monthly management information return required from Boards by the Scottish Government’s Health Department. This return was used as the basis for the reporting to the Board.

3.3 The Health Department revised the arrangements for this return from July, encompassing new requirements due to the introduction of the treatment time guarantee. This changed the scope of the return and introduces some discontinuities.

3.4 Moreover, when considering the Local Access Policy in May, Board members agreed to move the reasonable offer period from 7 days to 14 days to date of appointment. This decision affects how the waiting time clock is calculated and introduces the best practice outlined in national guidance into the Board.

3.5 This change has been implemented locally in Trak to cover patients with a standard less than six weeks at the start of August. However exploration of the equivalent change in the National Data Warehouse has not proved successful. As such, performance information provided to the Board will be drawn principally from Trak rather than national systems, as has been the case since early 2012.
3.6 The discontinuities impact primarily on overall assessment of list size and unavailability due the inclusion of cataract, cardiac and dental data.

4 18 Weeks Referral to Treatment Standard

4.1 The table below shows the recent trend to the end of July for combined performance for admitted and non-admitted pathways against the 18 week referral to treatment standard. A level of 90% compliance is expected in performance against this standard. It is a composite measure which incorporates stages of treatment covered elsewhere in the paper. The challenges reporting in the outpatient and inpatient position at reflected in the shortfall against this standard also.

4.2 The figures for August are not available at the time of writing. An update will be provided at the board if available.

<table>
<thead>
<tr>
<th>Table 1 – Trend in 18 Week Performance and Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance</td>
</tr>
<tr>
<td>Performance</td>
</tr>
<tr>
<td>Measurement</td>
</tr>
</tbody>
</table>

4.3 Performance for 18 weeks is assessed using an algorithm to join together stages of the pathway to assess total journey time for patients. Lothian’s measurement figure was been stable since late 2011 while other Boards’ levels have improved. Steps to improve this aspect are being pursued by Analytical Services.

5 Cancer

5.1 As also featured in the Performance Management report at this meeting, cancer waiting times show that performance in July 2013 for NHS Lothian was, against the 95% standards set:

- 62 days – 97.5%
- 31 days – 99.5%

5.2 NHS Lothian continues to perform well against the two standards and has been working with Scottish Government colleagues in looking at how whole patient treatment journeys can be measured.

6 Inpatients and Daycases

6.1 During August, 92% of patients were seen with the treatment time guarantee. A total of 519 patients subject to the standard were remaining at the end of the month. Of these, 200 have been treated or removed and 185 have a date for admission or at with external providers for treatment. The resolution for those remaining is being sought.

6.2 A further 144 patients not covered by guarantee were also waiting over 12 weeks at the end of month. Overall this was a slight improvement on the previous month and illustrated in Figure 1, with the key specialties also identified in Table 2.
Figure 1 - Inpatients waiting over 12 weeks

Table 2 - Trend in Principle Specialties over 12 weeks

<table>
<thead>
<tr>
<th></th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
<th>Jul-13</th>
<th>Aug-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>13</td>
<td>36</td>
<td>45</td>
<td>264</td>
<td>189</td>
</tr>
<tr>
<td>Urology</td>
<td>52</td>
<td>99</td>
<td>112</td>
<td>126</td>
<td>131</td>
</tr>
<tr>
<td>ENT</td>
<td>6</td>
<td>27</td>
<td>28</td>
<td>31</td>
<td>59</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>80</td>
<td>63</td>
<td>66</td>
<td>76</td>
<td>86</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>94</td>
<td>84</td>
<td>68</td>
<td>78</td>
<td>62</td>
</tr>
<tr>
<td>Colorectal &amp; General Surgery</td>
<td>63</td>
<td>40</td>
<td>37</td>
<td>37</td>
<td>41</td>
</tr>
<tr>
<td>Others</td>
<td>73</td>
<td>92</td>
<td>74</td>
<td>71</td>
<td>95</td>
</tr>
<tr>
<td><strong>Total &gt; 12 weeks</strong></td>
<td><strong>381</strong></td>
<td><strong>441</strong></td>
<td><strong>430</strong></td>
<td><strong>683</strong></td>
<td><strong>663</strong></td>
</tr>
</tbody>
</table>

6.3 As Table 2 indicates, the positive movement over August was due primarily to an improvement in the ophthalmology position, assisted by a fall in neurosurgery. Adverse movements were seen in a number of areas, most notably ENT.

6.4 Table 3 outlines the trend in list size and unavailability. The introduction of discontinuities from July 2013 highlighted in section 3 should be noted.

Table 3 - Inpatient List Size and Unavailability

<table>
<thead>
<tr>
<th></th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
<th>Jul-13</th>
<th>Aug-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td>6703</td>
<td>6673</td>
<td>6489</td>
<td>7768</td>
<td>7812</td>
</tr>
<tr>
<td>Unavailable</td>
<td>1128</td>
<td>1287</td>
<td>1302</td>
<td>1204</td>
<td>1117</td>
</tr>
<tr>
<td>Total Waiting List Size</td>
<td>7831</td>
<td>7960</td>
<td>7791</td>
<td>8972</td>
<td>8929</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
<td>14.4%</td>
<td>16.2%</td>
<td>16.7%</td>
<td>13.4%</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

1 This table has updated on 26th September to reflect actual position reported in text.
6.5 Table 4 outlines the patient choice codes active at the end of August. No preferences for location were recorded.

<table>
<thead>
<tr>
<th>National Specialty</th>
<th>Patient Advised - requests specific consultant</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic Surgery</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Urology</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>General Surgery</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>18</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

6.6 A number of specialties are considered in more detail below. A number of specialties, including Orthopaedics, General Surgery (excluding colorectal) and Vascular Surgery, which had patients waiting in excess of 12 weeks a year ago, have been reporting very minimal breaches of Treatment Time Guarantee compliance breaches for many months now. Those breaches that do occur can usually be attributed to working close to the 12 week time limit and a resultant lack of sufficient “headroom” to rearrange admissions following short notice cancellation.

**Ophthalmology Inpatients**

6.7 As described in recent board meetings, difficulties identifying staffing for see and treat sessions in the spring caused the pathway to be paused with the estimated loss of over 200 cases. This was further exacerbated by the ward refurbishment and theatre maintenance, which took place in midsummer, and affected a further 100 cases. The theatre capacity is now recovered and the see and treat sessions are now operational again.
6.8 These falls in capacity can be seen impacting on the overall size of the waiting list in recent months. Board members will note that the number on the list is now falling and the reduction in the number of patients waiting over 12 weeks continues.

6.9 Cataracts account for approximately 60% of the inpatient/daycase activity and approximately 14% of new outpatient activity. The activity transferred to the independent sector is primarily cataract activity as this is high volume and relatively less complex and represents lower clinical risk compared to other sub-specialty conditions such as strabismus (squint). The service is continuing to switch its internal capacity identified for cataracts to other areas where there are higher waits. It is anticipated that the use of the independent sector in Ophthalmology will continue into 2014/15.

6.10 In recognition of the pressures being experienced in the ophthalmology service, additional management resource has been committed to allow the implementation of a number of high impact improvements to both the inpatient and outpatient pathways, such as single waiting lists, pooled lists, creation of return waiting lists and improved quantification of DCAQ at a sub-specialty level, alongside the appointments of 3 consultants.

ENT Inpatients

6.11 Both adult and paediatric ENT are having increasing difficulties achieving the 12 week standard. While, prior to this Easter, adult services – with the support of external providers – were reducing the overall waiting list for the last few months the specialty’s activity has fallen behind the demand for the services, due primarily to lower level of activity being delivered than historically – related in part to annual leave and complexity. Paediatric services also have shown a longstanding imbalance, with increased number of patients seen in outpatient clinics identified as
requiring surgery. The imbalance between demand and capacity in the specialty is currently being assessed and will be completed by the end of this month.

6.12 ENT is anticipated to continue to have difficulties in the coming period, particularly for those surgeons specialising in head and neck procedures. Additional capacity will be identified internally and externally to minimise the delay to patients and a clear timebound action plan available following the DCAQ exercise concluding at the end of this month.

Urology Inpatients

6.13 The urology inpatient waiting list has been reducing from a peak of 324 patients waiting over 12 weeks in November 2012 to its current level of 132. Despite the recent rise in those waiting over 12 weeks, this equates to a 59% reduction. This has been achieved through a variety of measures including new and locum consultants, internal waiting list initiatives and the use of external activity.

6.14 In order to tackle the challenging subspecialty queues, two replacement Consultants have been appointed specifically to provide additional capacity in these areas. The most recent appointment has just commenced work.

6.15 Progress has been slower than was originally planned but there have been two episodes of long term sickness absence among the Consultant team, one of which is ongoing. This has eroded some of the benefits from the additional post agreed last August.

6.16 Despite that, general urology patients are being offered dates within 12 weeks but there is an ongoing pressure in complex pathways for endourology and reconstructive (joint incontinence) subspecialty queues. An action plan is in place
to address the specific pressures in these sub-specialties using a combination of core consultant staff and suitably trained NHS consultants from outside Lothian.

6.17 Reliance in the medium term is expected on the independent sector and additional non-core internal capacity. This will reduce the number of patients waiting for treatment but also permit the continued reduction of numbers seeking outpatient appointments.

**Colorectal Inpatients**

*Figure 5 – Colorectal Waiting List and Activity*

6.18 As the graph above illustrates, the colorectal waiting list is reducing in number. There remains however a number of sub-specialty / complex cases in colorectal surgery which are still waiting in excess of the 12 week TTG timeline.

6.19 Although a number of patients continue to wait in excess of 12 weeks the vast majority (82%) of colorectal patients are booked within their TTG date. Those patients who are not treated within target are primarily for reasons related to complexity of procedure or for the reason that a specific surgeon requires to undertake the operation.

6.20 A combination of external providers and internal additional capacity has been employed to help improve the inpatient position in Colorectal. An additional consultant was appointed and commenced in June 2013. They will contribute in the region of 250 inpatients and daycases per annum which will support the ability to sustain the delivery of 12 weeks following clearance of the backlog.

6.21 Ongoing use of additional capacity will be required in the medium term to accommodate the conversion from the additional outpatients seen to reduce waits in those areas. It is anticipated that this remaining backlog of specialist in-patient cases will have been cleared by the end of the calendar year.
6.22 The service has been managing a significant number of patients who had been on the waiting list as breaches for a long time whilst also dealing with routine monthly demand.

6.23 The service has utilised external capacity where possible for patients. For patients requiring complex procedure, i.e. complex breast or ear reconstruction, there had been no suitable alternative capacity with external providers. As a result, patients continued to be booked into future months capacity, which then had an impact on the capacity available for new patients being added to the waiting list each month. The service has now confirmed that one external provider can now provide capacity for some complex patients. This will release some capacity in coming months.

6.24 In addition to provide further capacity it has been agreed to extend theatre sessions for plastics sessions on a Monday to Thursday. The recruitment of staff to support this is now underway.

6.25 It is expected that the additional capacity with external providers and extending theatre sessions will allow plastics to meet month on month demand.

7 Outpatients

7.1 The number of outpatients waiting over 12 weeks at the end of July is provisionally placed at 4663. This is in the process of being ratified.

7.2 The graph below shows the change in the number over 12 weeks reported since April last year, with the 5 largest specialties by volume currently identified separately. Three of the five have an increased number of patients waiting over 12 weeks.
weeks in recent months – Ophthalmology, Rheumatology and Gastroenterology. The remaining two - urology and colorectal surgery are reducing.

7.3 The position in each of these 5 specialties is outlined below. The fluctuation in the “others” category will be noted. These are primarily long waits in pain management in Edinburgh CHP, which started to be reported in recent months, waits at the Edinburgh Dental Institute, particularly for Oral Medicine, and within the Department of Clinical Neurosciences, where numbers over 12 weeks are gradually reducing.

Figure 6 – Trend in Outpatients over 12 weeks

Table 5 – Trend in Outpatients over 12 weeks – Key Specialties

<table>
<thead>
<tr>
<th></th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
<th>Jul-13</th>
<th>Aug-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>161</td>
<td>199</td>
<td>353</td>
<td>893</td>
<td>1108</td>
</tr>
<tr>
<td>Colorectal &amp; General Surgery</td>
<td>483</td>
<td>592</td>
<td>611</td>
<td>754</td>
<td>651</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>215</td>
<td>303</td>
<td>360</td>
<td>417</td>
<td>587</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>111</td>
<td>137</td>
<td>135</td>
<td>187</td>
<td>394</td>
</tr>
<tr>
<td>Urology</td>
<td>528</td>
<td>490</td>
<td>359</td>
<td>324</td>
<td>381</td>
</tr>
<tr>
<td>Others</td>
<td>743</td>
<td>1026</td>
<td>796</td>
<td>1280</td>
<td>1542</td>
</tr>
<tr>
<td><strong>Total &gt; 12 weeks</strong></td>
<td><strong>2241</strong></td>
<td><strong>2747</strong></td>
<td><strong>2614</strong></td>
<td><strong>3855</strong></td>
<td><strong>4663</strong></td>
</tr>
</tbody>
</table>

7.4 As anticipated in previous months, difficulties in ophthalmology outpatients contributed significantly to the recent rise in the number of outpatients over 12 weeks. The rise in August was less than the previous month. The overall position is expected to stabilise and to begin to reduce again in the coming months.

7.5 Table 6 outlines list size and unavailability for outpatients over recent months. Discontinuities were introduced in July 2013. This is explained later in the paper. Table 7 shows the level of patient choice unavailability being applied to outpatient waits currently.
### Table 6 - Outpatient List Size and Unavailability

<table>
<thead>
<tr>
<th></th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
<th>Jul-12</th>
<th>Aug-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td>38480</td>
<td>39743</td>
<td>39026</td>
<td>41960</td>
<td>42095</td>
</tr>
<tr>
<td>Unavailable</td>
<td>770</td>
<td>847</td>
<td>858</td>
<td>913</td>
<td>858</td>
</tr>
<tr>
<td>Waiting List Size</td>
<td>39250</td>
<td>40590</td>
<td>39884</td>
<td>42873</td>
<td>42953</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
<td>2.0%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.1%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

### Table 7 – “Patient Choice” Unavailability in Outpatients

<table>
<thead>
<tr>
<th>Count of UHPI Number</th>
<th>Suspension Reaso Hospital Code</th>
<th>Patient Advised - requests specific consultant</th>
<th>Patient Advised - requests specific location</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SJH</td>
<td>CHA</td>
<td>LCTC</td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
<td>1</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Community Reproductive &amp; Sexual Health</td>
<td></td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Fertility and Rep Endocrine Centre</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopaedics</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Procedure</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>19</td>
<td>16</td>
<td>9</td>
</tr>
</tbody>
</table>

#### Ophthalmology Outpatients

**Figure 7 – Ophthalmology Waiting List and Activity**

7.6 Additional See and Treat activity has been put in place over recent weeks and going forward to support the reduction of waits. Board members will recall that the clinical priority of those patients waiting for return appointments – with their eyesight at risk due to conditions such as glaucoma and diabetes – is always the first clinical priority. Consequently this review activity is given precedence over those new
referrals covered by a standard but of lesser clinical priority and lower risk of blindness.

7.7 The graph above shows how the preference given how the appropriate prioritisation of return patients put the system out of balance and impacted on the waits for new outpatients. Between the last six months of 2012 and the first six months of 2013 there was been a 9% increase in the number of return attendances.

7.8 This rate has been reduced in recent weeks and in turn slowed the increase in the number of patients breaching 12 weeks. However the full impact of the additional activity will become clearer in the coming weeks as the development of an increased new and return patient capacity is implemented.

7.9 Additional activity will continue to be identified to reduce those breaching standards while ensuring those of clinical priority are seen in appropriate timescales. The Clinical Management Team is reassessing the capacity available within the service to identify what further steps are necessary – in particular reviewing the activity at a sub-specialty level where there are significant variances in the pressures on waiting times. Current clinic capacity has relied on routine over-booking historically and the service is developing a plan to reduce this practice over time.

7.10 E-triage of out-patient referrals has been introduced since the start of September. This approach reduces delays in the triage process and allows streaming of suitable patients to the independent sector more appropriately at an earlier stage. The service is also introducing pooled waiting lists across Lothian to allow better use of capacity between sites.

7.11 After a Lean event earlier in the year, an open access service for Field Testing for Glaucoma (the key measurement for the progression of the condition) has been introduced in August. This will reduce waits for this part of the patient pathway and the total number of outpatients waiting.

7.12 The underlying trend of increased demand in Ophthalmology apparent in Lothian is reflected nationally, as the specialty is susceptible to the impact of the increased age of the general population as well as the incidence of diabetes.
7.13 Waits in this specialty have increased as the service has moved out of balance in contrast to its situation earlier this year with an increase in referrals which coincided with the inclusion of specific Rheumatoid Arthritis and Osteoporosis indicators in the Quality and Outcomes Framework (QOF) 2013/14.

7.14 As a long-term condition, rheumatology is a service which experiences ongoing pressure across the UK and is one which is not generally suited to the use of see and treat solutions. Specific see and treat arrangements have been introduced and first patients sent for targeted patient pathways to ensure that all potential solutions have been considered.

7.15 In addition a business case is being prepared for the appointment of an additional Consultant Rheumatologist to increase core outpatient clinic capacity on an ongoing basis. It is anticipated that the appointment of this additional post would generate capacity in the region of 550 new outpatient appointments per year.

7.16 Furthermore the service is working to secure the appointment of 2 sessions of GP with specialist interest time to support the Osteoporosis service. The specialty will have ongoing difficulty holding its current waiting time position while these avenues are pursued and it is anticipated that the 12 week outpatient position will not be recovered until additional activity is in place.
7.17 Maintaining last year’s high levels of additional activity has been problematic. One consultant has been absent and those remaining have also been supporting both the provision of increased senior medical input into unscheduled care and the drive to reduce waits for diagnostic and surveillance endoscopy.

7.18 Furthermore the deployment of further see and treat activity, which addressed many of those waiting in excess of standards last year, has been more limited due to the casemix of the patients involved and the ongoing support of “treat” elements of those seen in this pathway.

7.19 This change in activity has been accompanied by an increase in referrals coinciding with the Detecting Cancer Early initiative. These referral patterns are being examined to inform possible alternatives to be seen as outpatients by Consultant staff.

7.20 The Management Team are pursuing a range of options currently, revising the recovery plan to address the current backlog and importantly to ensure a sustainable service going forward and discussions are underway with Finance to support this. These steps would further add to the extra clinics already in place and the additional 1.4 Consultants recruited.

7.21 Recruitment of additional consultants on a temporary basis is being actively pursued, although this has proved challenging previously, as well as seeking other options to increase medical staff capacity.
General Surgery Outpatients (Colorectal)

Figure 10 – Colorectal Waiting List and Activity

7.22 Overall outpatient waiting list size in colorectal surgery is shown above.

7.23 This improvement has occurred against the backdrop of increased referrals since March 2013 and coincides with the promotion of the Detect Cancer Early programme.

7.24 There are a number of actions identified to address the backlog and to develop the capacity required to ensure this can be maintained.

7.25 Investment from tranche 1 supported the appointment of an additional consultant colorectal surgeon. He commenced in post in June 2013, it is expected that he will deliver approximately 330 new outpatient appointments per year. A further consultant surgeon funded from tranche 2 money will commence in January 2014 and is expected to deliver a similar level of activity. In addition two clinical fellow posts have been funded and it is anticipated that they will be appointed to commence early in 2014. It is expected that these posts will increase outpatient capacity by further 400 new appointments per annum.

7.26 A new development within the service is the plan to include advanced nurse practitioners in the delivery of colorectal outpatient clinics. Discussions are at an early stage however this model is widely supported by the consultant group. A feasibility review is ongoing to determine the roles and responsibilities of these appointments to ensure maximum release of medical time.

7.27 In order to ensure the ability to deliver TTG compliance the service will continue to access See and Treat capacity with the Independent Providers, thus introducing capacity above that within NHS Lothian.

7.28 Alongside the See and Treat capacity a closely monitored number of additional internal WLI sessions will continue. This is a cost effective means of delivering
additional capacity which generates capacity for some of the more specific / complex referrals who can only be seen by NHS Lothian consultants.

**Urology Outpatients**

Figure 11 – Urology Waiting List and Activity

7.29 Waits in Urology outpatients have continued to demonstrate a reduction as a result of additional internal and external capacity. The appointment of an additional consultant in March 2013, referred to above, has helped contribute to this improving position despite the absence, highlighted earlier, of colleagues.

7.30 Overall the general urology queue is in balance although there are ongoing challenges with Joint Incontinence and Andrology subspecialty queues. See and treat pathways have been agreed with external providers to help address the significant challenge with Joint Incontinence referrals and this should continue to demonstrate improvements.

8 Diagnostics

8.1 Finalised figures for the diagnostic waiting time position at the end of August is not available at the time of writing.

8.2 The diagnostic endoscopy waiting times continues to remain within the 6 weeks target for the vast majority of patients. All bowel screening and cancer trackers are seen within 2 weeks of referral as a priority.
8.3 The exception to this downward diagnostic trend occurred in August due to the loss of list capacity as a result of annual leave. The expected long term trend is that demand will continue to meet capacity for diagnostics through continuing to utilise in house capacity including waiting list initiatives as additional internal and regional NHS capacity is established.

8.4 Two new funded lists have been introduced in August at the Royal Infirmary with an anticipated additional yield of 550 patients per year.

8.5 Further work is underway to identify additional operators to enable a further 5 funded lists to be opened. This will increase throughput by a further 1375 patients per year and would allow repatriation of a substantial proportion of activity.

8.6 Work is currently underway to explore the use of Advanced Nurse Practitioners as an alternative to Consultants to undertake lists and to improve the take up of NHS capacity elsewhere, particularly in NHS Borders.

8.7 Provisional information suggests that cystoscopy waits were increased over the summer. Further increases are expected this month in advance of additional capacity impacting.

9 Surveillance Endoscopy
9.1 The final figures for the end of August on surveillance are not available at the time of writing. The graph below, using provisional management information, shows the reduction in the number of both endoscopy and cystoscopy patients overdue their surveillance procedure.
9.2 As board members will note this continues to reduce.

9.3 A combination of internal waiting list initiatives and that externally has guaranteed slots for 250 patients per month, suggesting that the remaining backlog should be eliminated by the turn of the year.

9.4 Nurse Validation for Surveillance patients is also being introduced to ensure that patients undergo this procedure when clinically required.

9.5 The number of patients waiting longer than planned for their surveillance scope has continued to reduce.

10 Child and Adolescent Mental Health and Psychological Therapies

10.1 Performance for July is covered in the Performance Management paper elsewhere on the agenda. Updated figures and trend, including the August position in CAMHS, are outlined in this section.

10.2 Up to £700,000 has been allocated to increase capacity for a number of services and teams to ensure that patients who have waited in excess of 18 weeks and 26 weeks are assessed and enter into the appropriate treatment pathway.

10.3 The funding will support a number of short term posts and enable the earlier recruitment of substantive posts which have been identified through using DCAQ analysis and population data to predict an estimated capacity to meet predicted demand for services.

10.4 From March 2013, 90% of patients referred to CAMHS should be treated within 26 weeks of referral. This is to reduce to 18 weeks by December 2014, in line with the introduction of the psychological therapies standard.
Table 8 – Trend in CAMHS Performance

<table>
<thead>
<tr>
<th>Percentage seen within 26 weeks*</th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
<th>Jul-13</th>
<th>Aug-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage seen within 18 weeks</td>
<td>93%</td>
<td>85%</td>
<td>84%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>Total waiting at end of month</td>
<td>1252</td>
<td>1296</td>
<td>1351</td>
<td>1301</td>
<td>1243</td>
</tr>
<tr>
<td>Those waiting more than 26 weeks</td>
<td>65</td>
<td>85</td>
<td>99</td>
<td>101</td>
<td>117</td>
</tr>
<tr>
<td>Those waiting more than 18 weeks</td>
<td>218</td>
<td>204</td>
<td>203</td>
<td>255</td>
<td>257</td>
</tr>
</tbody>
</table>

Data for patients seen was adjusted for non-attendance in line with national guidance.

Table 9 – Trend in Psychological Therapies Performance

<table>
<thead>
<tr>
<th>Percentage seen within 18 weeks*</th>
<th>Apr-13</th>
<th>May-13</th>
<th>Jun-13</th>
<th>Jul-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trajectory for seen within 18 weeks</td>
<td>63%</td>
<td>49%</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>Total waiting at end of month</td>
<td>820</td>
<td>858</td>
<td>974</td>
<td>979</td>
</tr>
<tr>
<td>Those waiting more than 18 weeks</td>
<td>177</td>
<td>189</td>
<td>308</td>
<td>256</td>
</tr>
</tbody>
</table>

The July data for patients seen was adjusted for non-attendance in line with national guidance. No adjustments were applied to the data from April to June.

10.5 It should be noted that the reporting of the Psychological therapies HEAT data is being progressed incrementally. Data is reported from approximately 50% of services that deliver psychological therapies. Work is continuing to allow reporting from all services and ensure the accuracy and completeness of reported data. The monthly increase in total patients waiting more accurately reflects additional services reporting data rather than an overall increase of patients waiting within services.

10.6 The August figures for psychological therapies are in the process of being finalised.

Andrew Jackson  
Associate Director  
Strategic Planning  
20 September 2013 (Updates: 26th September 2013)  
andrew.c.jackson@nhslothian.scot.nhs.uk
### SUMMARY PAPER - MEDICAL WORKFORCE RISK ASSESSMENT

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>Roll out of the medical workforce risk assessment process is almost complete for all areas with the exception of Lothian Unscheduled Care Service. Assessments will be updated in January and June. The next board paper will look at other areas where significant levels of risk are impacting on capacity and patient flow.</th>
<th>3.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine(EM) – Findings from the revised service model at St John’s Hospital</td>
<td></td>
</tr>
<tr>
<td>Median of 20 presentations overall per night between 7th and 27th August</td>
<td></td>
</tr>
<tr>
<td>Median of 1 child presenting per night, on 5 occasions there were no presentations</td>
<td></td>
</tr>
<tr>
<td>Median of 2 patients per night was admitted to the ED Observation Ward.</td>
<td></td>
</tr>
<tr>
<td>Median of 10 patients per night was discharged directly.</td>
<td></td>
</tr>
<tr>
<td>7 transfers in total to other hospitals during period.</td>
<td></td>
</tr>
<tr>
<td>There have been no clinical concerns expressed by key parties. Recruitment of an EM Consultant is planned for 22.10.13, this additional post will provide robust weekend and evening presence at SJH from February 2014. Further recruitment of Clinical Development Fellows and Consultants will take place in 2014 to support the late evening weekend consultant presence</td>
<td>4.1</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td></td>
</tr>
<tr>
<td>The staffing situation at St John’s is currently stable. However, for the foreseeable future rotas at RIE remains dependent on a mix of internal locums, external agency locums and consultants covering middle grade slots. Support has recently been confirmed for two further new consultant posts and two new specialty doctor posts at RIE. These will be challenging to fill and may require international recruitment.</td>
<td>4.2</td>
</tr>
<tr>
<td>Paediatrics:</td>
<td></td>
</tr>
<tr>
<td>The Clinical Fellows with out of hours commitments at St John’s that had been anticipated to start in June will now start in October at the earliest. All of the rotas are more robust than they were earlier in the year but the middle grade rota at St John’s remains the most fragile. Four members of the nursing staff at RHSC have enrolled on the national Advanced Paediatric course, which commences in September. The Community Child Health Service is currently experiencing staffing shortages and recent recruitment efforts have been only partially successful.</td>
<td>4.3</td>
</tr>
</tbody>
</table>
MEDICAL WORKFORCE RISK ASSESSMENT

1 Purpose of the Report

The purpose of this report is to update the Board on the development and application of a medical workforce risk assessment process within NHS Lothian and highlight the key areas of risk identified to date.

This report will also highlight the actions currently underway to ameliorate risks to service sustainability within the specialties of Emergency Medicine, Paediatrics and Obstetrics & Gynaecology (O&G), which have been identified as specialties of high risk.

2 Recommendations

2.1 Note the updated medical risk assessment position.

2.2 Note the positive findings to date of the audit that has been undertaken to assess the effectiveness of the revised model for the Emergency Medicine Department at St John’s Hospital.

2.3 Support the short and medium term plans to enhance the resilience within the Emergency Medicine workforce.

2.4 Note the continuing difficulty in recruiting Consultants within O&G at the RIE and the on-going reliance on mix of internal locums, external agency locums and consultants to middle grade slots.

2.5 Note the delay in the first 2 Paediatric Clinical Fellows starting, the enrolment of 4 nurses on the NHS Scotland Advanced Nurse Practitioner course and successful recruitment to only one of two community child health staff grade positions.

2.6 Support NHS Lothian’s position on increasing medical training numbers nationally.

3 Discussion of Key Issues

3.1 Background

In June 2013 a detailed paper was prepared for the Board detailing the roll-out of a medical workforce risk assessment process across the South East Region. The aim of the process is to build upon previous work carried out within boards and apply a consistent risk assessment methodology across all SE Region boards and services. The June 2013 Medical Workforce Risk Assessment paper also provided detail on the process, the risks that were being assessed and emerging findings. The areas of highest risk were highlighted as Paediatrics, Obstetrics & Gynaecology (O&G) and Emergency Medicine.
The July 2013 Medical Workforce Risk Assessment paper provided detail around what the workforce planning processes are at a local, regional and national level. It also provided an update on the progress of plans within Paediatrics, O&G and Emergency Medicine.

This paper will provide a further update around the progress of these plans.

3.2 Medical Workforce Risk Assessment Process

The first iteration of the workforce risk assessment has been completed for all key areas, with the exception of Lothian Unscheduled Care Service (LUCS), which will be reviewed at the end of September.

This paper and papers to date have focussed on Emergency Medicine, Paediatrics and O&G as these are areas where there are key pressures on services currently. The medical workforce risk assessment process has however also identified significant workforce pressures within Anaesthetics, Geriatrics, Radiology and Ophthalmology. These relate to the recruitment and retention of both trained and training grade medical staff, with associated risks around capacity and financial expenditure. Further details will be provided on these risks and the plans that are in place to ameliorate them will be set out in the next Board paper.

3.21 Review Process

As part of the national workforce planning arrangements Boards are required to produce annual workforce plans mid year and a workforce planning section as part of the local delivery plan at the beginning of the financial year. Both of these require boards to detail where they are facing workforce challenges, providing the Scottish Government with an overview of challenges to inform national planning. It is therefore intended that the risk assessments will be reviewed in the months of January and June.

The review process is intended to be carried out by the relevant Clinical Director with support from Workforce Planning where necessary.

4 Progress in addressing key risks

4.1 Emergency Medicine

The July Medical Workforce Risk Assessment paper set out the following updated model of care for emergency medicine at Saint John’s Hospital (SJH).

Model of care from 23.00hrs on the 7th August 2013

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.

An on-going monitoring process has been reviewing the effectiveness of the model of care around the original 3 patient pathways: paediatric emergencies, cardiac arrests, and physiological criteria.

The summary findings for August are as follows:

**Current SJH ED staffing:**

- Additional 22 hrs / week of ED consultant shop floor presence across 7 day period.
- 2 x junior doctors on throughout overnight period with an ED consultant on call from home.
- Dedicated ENP presence overnight with additional Band 6 DCN presence and support.

**Summary of presentations between 2300-0800hrs from 7th to 27th of August:**

- There has been a median of 20 presentations overall per night.
- The majority (55%) have been trolley-type presentations.
- There has been a median of 1 child presenting per night, on 5 occasions there were no presentations.
- A median of 4 patients per night was admitted to a medical area.
- A median of 2 patients per night were admitted to the ED Observation Ward.
- Median of 10 patients per night were discharged directly.
- A total of 10 patients were transferred to LUCS during the monitoring period.
- 4 patients were transferred to general surgery, 1 to urology and 2 to cardiology.
- During the monitoring period only 1 patient required to be admitted to ITU.
Clinical experience by key parties:

- ED Clinical Development Fellows (CDF), FY2s and GP Specialty Trainees have reported no concerns.
- ED Enhanced Nurse Practitioners and Staff Nurses report no concerns.
- Medical team report no concerns, with a marked benefit from additional evening FY1 hours highlighted by Acute Medicine.
- ITU/Critical care have confirmed they have no concerns to report.
- The Scottish Ambulance Service (SAS) have reported no clinical concerns, and have no reported Datix incidents as at the end of August.
- Patient experience seems positive as measured by the Tell us Ten Things questionnaire.

Short-term resilience plan

The following actions are being taken in the short-term to provide increased resilience within the ED at SJH.

- Continuation of FY1 support for additional evening hours in the Medical Assessment Unit.
- Completion of CDF development plans and commencement of MSc programme and consolidation of the CDF ‘brand’
- Development of a CDF recruitment programme for the Academic Year 14-15.
- Planning for the commencement of winter 2013-14.
- Recruitment of an Emergency Medicine Consultant planned for 22.10.13. This additional consultant will provide robust weekend and evening presence at SJH from February 2014.

Medium-term ED resilience plan

In the medium term there is a continuing requirement to promote the specialty of Emergency Medicine locally and across the region building on the comparative attractiveness for trainees. The investments that are being made as part of the EM workforce plan should help make the specialty more attractive. There is also a need for the SEAT region to seek a national expansion in ACCS training numbers in 2014-15. It is also important that there is robust support and development for FY trainees and possibly reviewing allocation of trainees if necessary.

The commitment to a further cohort of CDFs for the 2014/15 academic year will support on-going sustainability of services whilst providing excellent development opportunities. The commitment to the appointment of a further 3 EM consultants in the 2014-15 financial year will provide support to the late evening weekend consultant presence (1800-0200hrs Fri-Sun 52/52). This will provide the recognised quality and patient safety benefits associated more senior decision-makers. Having a more robust consultant workforce also supports the ability to manage flow more reliably and deliver the 4 hour improvement trajectory set out in NHS Lothian’s Local Unscheduled Care Action Plan – achieving a mean performance of 95% for the twelve months from October 2013 to September 2014.
4.2 Obstetrics & Gynaecology

The South East Scotland O&G training programme experiences a high level of gaps due to trainees going Out of Programme (OOP) for research/experience, maternity leave and less than full time working. The numbers of gaps varies on a month by month basis. The service has been heavily dependant upon locums to sustain Out of Hours (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 having to cover resident middle grade OOH shifts is now required several times a month with a consequent impact on day time availability.

In 2012 NHS Lothian funded and appointed two new consultants (RIE) and two new specialty doctor posts (St John’s) followed by a further three consultant posts at RIE in 2013 (includes out of hours resident shifts in place of an experienced trainee). 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 posts have been filled. The national headcount of consultants has increased by 4.6% between March 2012 and March 2013.

As a result of this recruitment the staffing situation at St John’s is currently stable. However, 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.

Support has recently been confirmed for two further new consultant posts and two new specialty doctor posts at RIE. It is likely that further recruitment over two to three years will be necessary to ensure stable and sustainable out of hours cover by adequately experienced staff. 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 current Scottish Government target for the South East Scotland O&G Training Programme is to reduce from the current 46 posts to 42 posts. There is a strong possibility however that the Scottish Government (SG) will are either pause or abandon any further reductions in the face of stronger than anticipated demand and other workforce challenges. If this occurs there may however be an adjustment in the allocation of trainees.

4.3 Paediatrics

Following changes to the allocation of trainees out of hours paediatric middle grade trainees have been removed from out of hours work at St John’s and Borders General Hospital from August 2013.

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. These have been partially mitigated by recruitment of a combination of fixed term and substantive staff. These include an additional consultant and specialty doctor at St John’s in addition to two new consultants appointed in 2012, two
senior Clinical Fellows and two advanced neonatal nurse practitioners in neonatology at RIE, two junior Clinical Fellows shared between RHSC and RIE, a Clinical Fellow in Paediatric Intensive Care at RHSC and the consolidation into clinical practice of two advanced nurse practitioners in the paediatric intensive care unit at RHSC. An advanced nurse practitioner in paediatric and an advanced neonatal nurse practitioner are now established in the middle grade rota at St John’s for some time,

Posts for Clinical Fellows with out of hours commitments at St John’s have been offered to four doctors from Myanmar. It had been anticipated that two would start in June and two in December. The issues with GMC registration, demonstration of adequate English language skills and work permits have been complex and the earliest date we now expect anyone to start is October. They will need a three month induction period at St John’s, RHSC and RIE before undertaking out of hours shifts.

All of the rotas are more robust than they were earlier in the year but the middle grade rota at St John’s remains the most fragile. This rota relies heavily on existing NHS Lothian staff doing locum shifts in addition to their usual commitments to cover gaps.

The recent Tailored Workforce Support Team Report (TWST) report highlighted the expansion in the number of Advanced Paediatric and Neonatal Practitioners as an important means of developing a longer term solution to supporting the paediatric workforce. The importance of developing such roles across Scotland has been recognised by the Scottish Government through sponsoring the development of a collaborative Advanced Nurse Practitioner courses for paediatrics and neonatal commencing in September, with 20 places available nationally in paediatrics and 10 in neonatal in both 2013 and 2014. Four members of the nursing staff at RHSC have enrolled on the paediatric course, which commences in September. Both courses lead to an MSc degree qualification and take between two and three years to complete depending on whether study is full or part time. Whilst these nationally supported developments will be helpful in building workforce sustainability and resilience in the longer term, the length of time to complete training will mean that these roles will not support service sustainability in the short term.

The Community Child Health Service is facing staffing shortages now and in coming months mostly due to sickness, retirements and difficulties in recruiting. This service provides most of the medical input into child protection concerns in Lothian. This situation is particularly difficult in West Lothian. We have managed to recruit a consultant and a specialty doctor who have started work in September and have advertised for two further consultants. There were recent interviews for two specialty doctors to replace retirements, however only one appointment was made.

In recognition of the significant pressures associated with the very high level of out of programme and retirements within community child health in coming years across Scotland national a recommendation has been made to the SG to increase paediatrics training numbers nationally by 10 trainees per year. This remains subject to final approval by the SG.

4.4 National Planning of Training Numbers

NHS Lothian and the South East Region Medical Workforce Group has indicated to the Scottish Government that they would strongly support an increase in training numbers in some core training programmes i.e. Anaesthetics and a number of higher specialty training/run through programmes i.e. Paediatrics, Geriatrics and Acute
Medicine. These are areas where there are currently significant challenges in recruiting trained doctors and where there is significant expenditure on locum staff and other forms of supplementary workforce capacity. Whilst any increases in trainee numbers would require to be funded by services this would help reduce these supplementary staffing costs. However this will not provide a solution to problems currently being faced given the length of training programmes.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

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18 June 2013

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 purpose of this report is to invite the Board to consider and approve the draft NHS Lothian Children and Young People’s Strategy, prior to public consultation. 2.1
- This strategy is aligned with the NHS Lothian Clinical Framework and its development is specified within the corporate objectives, as agreed by the Board in July 2013 3.1
- The strategy is also directed by the United Nations Convention on the Rights of the Child (UNCRC) and the Scottish Government’s intention to introduce legislation from 2014 that would combine proposals to improve the delivery of children’s rights and services for children and young people. 3.1

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5 September 2013
1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to consider and approve the draft NHS Lothian Children and Young People’s Strategy, prior to public consultation.

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

2 Recommendations

2.1 Approve the draft Children and Young People’s Strategy to allow it to proceed to public consultation.

3 Discussion of Key Issues

3.1 This strategy is aligned with the NHS Lothian Clinical Framework and it’s development is specified within the corporate objectives, as agreed by the Board in July 2013. It is also directed by the United Nations Convention on the Rights of the Child (UNCRC) and the Scottish Government’s intention to introduce legislation from 2014 that would combine proposals to improve the delivery of children’s rights and services for children and young people.

3.2 In May 2013, JMT received a presentation on the proposed vision, policy context, principles and priorities that would be the foundation of the NHS Lothian Children and Young Peoples Strategy. As requested by JMT, the attached strategy (appendix 1) has been prepared for consultation. It is the result of engagement from staff across NHS Lothian that work directly with, or manage services for, children and young people (see section 7).

Overview of the Strategy

3.3 The vision for NHS Lothian is that every child should have the best start in life and grow up being healthy, confident and resilient. This vision will only be achieved by building on the capacities and assets of our staff working jointly with people living and working within local communities.

3.4 The following outcomes are proposed as the key drivers of the strategy:
• Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity
• Children with disabilities will have their additional needs met
• Children, young people and their families will be involved in decisions that affect their health
• NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services
• NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health and resilience in those more vulnerable to poor health
• The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services, and the development of services at St John’s Hospital
• NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population
• Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy

3.5 Over the past several years, NHS Lothian has worked to ensure that the national principles and indicators of *Getting it Right for Every Child* (GIRFEC) are at the heart of all services working directly with children, young people, their families and carers. *Improving the Health and Well-being of Lothian’s Children and Young People* builds on this foundation and takes account of the imminent Children and Young People (Scotland) Bill and opportunities brought through integration of children’s services.

3.6 We think that the best way to explain our strategy is through a ‘life stages’ approach. We can therefore describe this as:

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</tbody>
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3.7 Explaining our strategy in this way enables us to articulate the different approaches and interventions that children may need growing up to become healthy, confident and resilient adults.

3.8 Throughout October to December there is an invigorated and targeted focus on engagement with communities of interest and community planning groups.

3.9 In addition to these more traditional methods of engagement, many of the stakeholder groups we wish to consult with are confident users of social networking sites such as facebook and twitter.
3.10 Lothian Area Partnership Forum will continue to participate in all stages of the development of the strategy. Representatives from the partnership forum are members of the Early Years Framework Group.

3.11 It is anticipated that Lothian NHS Board will be asked to sign-off the final Children and Young People’s Strategy in March 2014.

4 **Key Risks**

4.1 There are no key risks identified with the recommendations outlined in this report.

5 **Risk Register**

5.1 There are no new risks noted from this programme for NHS Lothian’s risk register.

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

6.1 A Rapid Equality Impact Assessment was carried out on 21st August 2013. The assessment recognised that addressing inequalities in health is a specific focus and outcome for the strategy, particularly noting the positive impacts of children’s rights and rolling out Children’s Rights Impact Assessments.

6.2 The EIA acknowledged that a further draft would include a detailed demographics appendix and this would be the opportunity to include further details on the needs of children and young people with protected characteristics. It was agreed that the consultation process would specifically target people with protected characteristics to gain their views. This has been fed into the consultation plan. A further Equality Impact Assessment will be undertaken after the consultation has been completed and views fed into a later draft.

7 **Involving People**

7.1 Since May 2013, a series of meetings have been held and presentations made to ensure that staff across NHS Lothian representing different disciplines and services have had opportunities to engage with the development of the strategy. It has also been discussed with local authority colleagues to ensure consistency with our integrated children’s services plans. Presentations have been made to:

- Early Years Framework Group¹
- Children’s Clinical Management Team
- Community Child Health Executive Team
- Clinical Area Forum
- Edinburgh CH(C)P Sub Committee
- Midlothian CH(C)P Sub Committee
- East Lothian CH(C)P Sub Committee
- West Lothian CH(C)P Sub Committee

¹ with representation from Partnership Forum, Strategic Planning, CH(C)Ps, Public Health, Allied Health Professionals and Health Promotion Service
7.2 The strategy is a result of direct input from senior staff within Strategic Planning, Performance Reporting & Information, Public Health & Health Policy, Royal Sick Children’s Hospital Services, CH(C)Ps, Maternity Services, Health Promotion Services, Organisational Development, Finance and the RSCH Reprovision Team.

8 Resource Implications

8.1 This NHS Lothian Children and Young People’s Strategy is key to improving outcomes for children and reducing upward and future pressure on budgets for Looked After Children, Child and Adolescent Mental Health and Adult Health and Social Care / Criminal Justice Services

8.2 The strategy outlines baseline financial information regarding the investment NHS Lothian makes in Children’s Services in Lothian. It also highlights the increased investment from 2012 that is supporting the roll out of the 27-30 month review and implementation of health assessments for all looked after children (CEL 16).

8.3 The main resource implications aligned with implementing this strategy relates to the Children and Young People (Scotland) Bill and implementing the role of the Named Person. NHS Lothian has responded to the Financial Committee outlining our concerns of having to find up to £2.8 million to develop the necessary capacity within Midwifery and Health Visiting Services to implement the Bill.

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5 September 2013

List of Appendices

Appendix 1: Improving the Health and Well-being of Lothian’s Children and Young People
IMPROVING THE HEALTH AND WELL-BEING OF LOTHIAN’S CHILDREN AND YOUNG PEOPLE

The NHS Lothian Strategy for Children and Young People
2013 - 2020
CONTENTS

1. Introduction
2. Scope of Improving the Health and Well-being of Lothian’s Children and Young People
3. Understanding the health needs of children and young people in Lothian
4. Policy Context
5. Our Vision and Principles
6. Working in Partnership and Community Planning
7. Addressing health inequalities
8. Meeting the needs of Children and Young People
9. Reprovision of the Royal Hospital for Sick Children
10. Workforce Planning: Ensuring that we have a workforce that is fit to meet the demands of a growing population
11. Finance
12. Governance and performance improvement arrangements for overseeing implementation of this strategy

Appendices

1. Children and Young People – Contact With Services
2. Key Messages from Fair Society, Healthy Lives, Marmot Review
3. Draft Implementation Plan
1. Introduction

NHS Lothian believes that every child should have the best start in life and grow up being healthy, confident and resilient.

This strategy sets out a clear vision, principles and approach for how NHS Lothian will work with children and young people, their families, the public, the voluntary sector and the four local authorities across Lothian to improve the physical and emotional health and well-being of children and young people across Lothian.

Based on an understanding of our child population and what we know from children and young people accessing services, this strategy builds on the commitments NHS Lothian has already made in the four Integrated Children’s Services Plans for East Lothian, Edinburgh, Midlothian and West Lothian. It also builds on our existing assets, especially:

- Our Staff – who are highly motivated, passionate, knowledgeable and experienced
- Our services – that are life saving, safe, evidence based, efficient and fast to respond when we know children and young people need help
- Our partners – including children, young people, their families, the public, the voluntary sector and the four local authorities across Lothian, all who have a wealth of knowledge, skills and expertise
- Our values – such as respecting our diverse child and young population, their background, culture, environment, abilities and needs.

We know that we still have more to do. Getting it Right For Every Child (GIRFEC), the national policy which underpins this strategy and the new Children and Young People (Scotland) Bill which incorporates the principles of the United Nations Convention on the Rights of the Child (UNCRC), has helped evidence that to improve the life chances and well-being of all children and young people in Scotland, we must focus on keeping children Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible and Included (also known as the well-being indicators). We know we cannot do this alone and therefore rely on our strong working relationships with partners to ensure children’s needs and rights are met.

We need to continue responding to needs when they are presented. If we are to seriously improve the longer term health needs of not only children, but our future adult population, then we must get better at focusing on prevention and early interventions. That means beginning with reducing inequalities during pregnancy. The Early Years Change Fund, introduced by the Scottish Government in 2013, is also one mechanism for helping us consider how we shift the balance of emphasis, mindset and physical resource.

We must also have a trained, effective workforce that has the capacity to respond to the current needs of children and young people and be ready for emerging trends.
2. Scope of *Improving the Health and Well-being of Lothian’s Children and Young People*

The scope of this NHS Lothian strategy is far reaching. It has the opportunity to affect not only services for children and young people but all adult services that work with parents or carers. This strategy therefore aims to create a child centred ethos within NHS Lothian alongside identifying the specific services it will provide for children and young people.

This strategy does not mean to duplicate or rewrite existing Lothian strategies or frameworks that are already in existence. There are strong links in particular with the aims of the NHS Lothian Strategic Clinical Framework which prioritises prevention and reducing inequalities – the foundation of this strategy. It also compliments the Refreshed Maternity Framework, *A Sense of Belonging: A Joint Strategy for Improving the Mental health and Wellbeing of Lothian’s population*, the 2011 – 2016 Lothian Sexual Health Strategy and the (draft) Strategic Clinical Framework for Primary Care. *Improving the Health and Well-being of Lothian’s Children and Young People* brings together the key components of these strategies to help articulate NHS Lothian’s overall strategic approach to improving children and young people’s health.

This strategy will focus on achieving the following outcomes, aligned with the Rights of the United Nations Convention on the Rights of the Child (UNCRC):

- Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity (Article 24 UNCRC)

- Children with disabilities will have their additional needs met (Article 23 UNCRC)

- Children, young people and their families will be involved in decisions that affect their health (Article 12 UNCRC)

- NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services (Article 3 UNCRC)

- NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health and resilience in those more vulnerable to poor health (Article 24 UNCRC)

- The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services, and the development of services at St John’s Hospital (Articles 24 & 42 UNCRC)
NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population (Article 42 UNCRC)

Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy (Articles 43 -54 UNCRC)

Improving the Health and Well-being of Lothian’s Children and Young People will focus on NHS Lothian’s contribution to achieving these outcomes and will seek continued support from our partners to make progress towards outcomes that cannot be solely achieved by NHS Lothian.

We think that the best way to explain our strategy is through a ‘life stages’ approach, in line with NHS universal service provision. We can therefore describe this as:

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</tr>
<tr>
<td>1 month – 4 years (pre-school)</td>
<td>12 – 18 years (secondary)</td>
<td></td>
</tr>
</tbody>
</table>

Explaining our strategy in this way enables us to articulate the different approaches and interventions that children may need growing up to become healthy, confident and resilient adults.

As this approach ensures that the needs of children and young people are considered from conception through to adulthood, this strategy recommends that any new strategies or frameworks being developed by NHS Lothian take into account the life stages identified above. This will also ensure that issues relating to transition from children’s to adult services will be considered.
3. Understanding the health needs of children and young people in Lothian

**Outcome this section covers:**

NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services.

Information available locally and nationally has been used to build up a profile of the health and well-being of children and young people in Lothian. This section provides an overall picture/snapshot whilst an appendix (to be completed post consultation) will provide a more detailed profile of the children and young people’s population. This appendix will also provide a summary of national and local delivery targets for improving outcomes for children and young people in Lothian.

### 3.1 Current and Future Profile of Children and Young People in Lothian

**Current Population**

The remit of the strategy covers young people in transition as well as children of school age and below. Chart 1 shows the most recent numbers of children and young people aged 18 and under in Lothian compared to Scotland. There are a total of 172,130 young people and children aged 18 and under in Lothian, 20% of the total population for Lothian. City of Edinburgh has the fewest proportion of the total population aged 18 and under (18%) compared to 23% in West Lothian. The proportion of females in Lothian is same as the Scotland wide figure for those aged 18 and under (52%).

![Chart 1 Population Estimates by Age Group (18 and Under)](chart.png)
Projected Populations for 2017 and 2022

Chart 2 shows that by 2017 the population of Lothian children in the age group 5-11 will increase by 14% to 67,606. This is greater than the percentage increase in Scotland for the same age group (9%). The largest increase will be in City of Edinburgh (23%).

The ten year population projections paint a slightly different picture in Lothian particularly in the 12–18 age group. In contrast to the five year projection all CHPs (apart from Midlothian) and Lothian as a whole will see an increase in numbers. The largest increase will be in City of Edinburgh (12%). For Lothian as a whole the largest projected increase will be in the 5-11 age group, an increase of 18%.
3.2 Information about the Health and Well-Being of Children and Young People in Lothian

Key Points

- The percentage of babies with a healthy birth weight in Lothian was 90.4% in year ending March 2011, very similar to the Scottish Average (90.1%). This percentage has remained relatively stable over the last five years. In Scotland as a whole rates of healthy birth weight are lower in the most deprived areas, however the figures are less marked in Lothian according to latest figures. Birthweight that is not within normal ranges has a strong association with poor health outcomes in infancy, childhood and across the whole life course, including long term conditions such as diabetes and coronary heart disease.

- In Lothian the most common age for starting a family in the area of lowest deprivation is 30-34, which is 10 years later than the most common age in the area of highest deprivation.

- In Lothian in 2012 the overall percentage of women who reported smoking at the time of their first antenatal booking was 17.7% which is less than the Scottish average of 19.3%. It should be noted that there is known to be considerable under-reporting of smoking by pregnant women.

- Over 45% of pregnant women in Lothian are overweight or obese at the time of booking. Maternal weight out with the normal boundaries is associated with complications in pregnancy for both the mother and child including an increased likelihood of stillbirth and neonatal death. Data
from Lothian in 2011/12 confirms this increased risk with obese mothers approximately twice as likely to suffer a stillbirth or neonatal death.

- The prevalence of overall and exclusive breastfeeding at the 6-8 week review has remained static across both Scotland and Lothian over the last five years. There are a number of personal, social and cultural issues that are strongly associated with the likelihood of breastfeeding including maternal age, deprivation and smoking status. Scotland wide figures show that mothers in the least deprived areas are nearly three times as likely to exclusively breastfeed at 6-8 weeks compared with mothers in the most deprived areas.

- There are currently around 560 children aged 15 and under on the child protection register in Lothian. The rate per 1,000 is highest in Midlothian (7.5) and lowest in City of Edinburgh (3.1). The figure for Scotland is 3.0.

- There were 2,289 looked after children/young people in Lothian in 2012.

- There are currently 58 children in Lothian who have been identified as having exceptional healthcare needs (CEN). The best estimate of the overall prevalence of CEN currently available is around 30 per 100,000 in Scotland. The rate per 100,000 population for Lothian is very similar to the Scottish Average (34).

- There is no locally available information on the numbers of children and young people with physical and learning disabilities. Using nationally available prevalence data it is possible to get an estimate of numbers for Lothian. Assuming Lothian has around 16% of the Scottish population, it is likely there will be approximately 2,450 children and young people with disabilities of whom around 1,000 will have learning disabilities.

- Official UK Statistics estimate one in ten children between the ages of one and 15 has a mental health disorder. Many mental health problems start early in life. Half of those with lifetime mental health problems first experience symptoms by the age of 14, with three-quarters of those with lifetime mental health problems experiencing symptoms by their mid-20s.

- In the latest quarterly period where data is available 1,137 referrals were made to the Child and Adolescent Mental Health services. The referral rate per 1,000 people under 18 for Lothian was 7.0 slightly higher than the figure for Scotland (6.5).

- In Scotland the target of the national immunisation programme is for 95% of children to complete courses of the following childhood immunisations by 24 months of age: Diptheria, Pertussis, Tetanus, Polio and Hib. An additional national target of 95% uptake of one dose of the Measles, Mumps and Rubella (MMR) vaccine by five years of age (with a supplementary measure at 24 months) was introduced in 2006 to focus efforts on reducing the number of susceptible children entering primary
school. Latest data published shows that in Lothian 95% of children are immunised against MMR, the same as the Scottish Average. 97.7% of babies were immunised against Diptheria, Pertussis, Tetanus, Polio and Hib. The figure for Scotland is 97.5.

- The levels of Primary one children who are classed as being overweight or obese is very similar to the Scottish average: 22.4% in Lothian compared to 23.1% for Scotland. Data for 2011/12 show that Scotland wide the prevalence of healthy weight amongst children in Primary 1 increases with deprivation.

- Latest dental inspection figures found that 70.1% of P1 children in Lothian have no dental disease. This is similar to the Scottish figure (67%). Scotland wide figures show that there are clear inequalities in terms of dental disease looking at deprivation categories. There is a large difference in levels of P1 children without dental disease between those in most deprived group and the least deprived group (30.7%).

- The teenage pregnancy rate (16 and under) in Lothian has fallen over recent years and is similar to the Scottish Average (5.6 per 1000 in NHS Lothian, 5.7, Scotland average). Midlothian has the highest rate based on the latest three year rolling period.

- The age groups with the highest rates per population attending Accident and Emergency are for those aged four and under. In the year ending March 2013 29,394 children aged 4 and under attended Accident and Emergency. 17 per cent were admitted as inpatients.

- Almost one in five individuals in Lothian come from minority ethnic groups.
4. Policy Context

The Scottish Government’s ambition is that Scotland should be the best place in the world for children and young people to grow up. There are a number of national policies and local strategies that we link with to help achieve this ambition and ensure that children and young people who live in Lothian will have the best possible start in life and achieve the best outcomes.

The Refreshed Maternity Framework (2011) has been designed to address all care from conception, throughout pregnancy and during the postnatal phase. This document clearly outlines the strategic direction for maternity services in Scotland and NHS Lothian has an implementation plan for delivering on this Framework.

Similarly, the Neonatal Care in Scotland: A Quality Framework, (2013) outlines the approach required to deliver high quality care for neonates and their families across Scotland. The South East of Scotland and Tayside (SEAT) Managed Clinical Network for Neonatal Services, of which NHS Lothian is a key member, has an approved work plan that drives local delivery of this Framework.

Recognising the plethora of national policy related to children and young people, the Scottish Government published a summary of Scottish Government policy, titled Supporting Young People’s Health & Wellbeing in March 2013. This document brings together key policies from across a range of Scottish Government Directorates and helpfully provides a broad overview of the national context in which NHS Lothian operates.

This document also outlines the Scottish Government’s intention to introduce legislation from 2014 that would combine proposals to improve the delivery of children’s rights and services for children and young people. The legislation is wide-ranging in its focus, building on the foundations of Getting it Right for Every Child (GIRFEC) and has implications for NHS Lothian, particularly with the responsibilities outlined for the Named Person. We will therefore be working with our partner organisations to:

- Embed children’s rights in the design and delivery of local policies and services (as outlined within the UNCRC)
- Improve the way our services support children and families by ensuring every child and young person has a single point of contact through the role of the Named Person
- Ensure better permanence planning for looked-after children by extending support to young people leaving care for longer, i.e. up to the age of 25

In addition to the national context, NHS Lothian has several strategies and frameworks that aim to improve the health and wellbeing of children and young people and keep them safe from harm. In particular, these include:
• A Sense of Belonging - A joint strategy for improving the mental health and wellbeing of Lothian's population, 2011 to 2016
• Inter-agency Child Protection Procedures Edinburgh and the Lothians
• 2011 to 2016 Lothian Sexual Health and HIV Strategy
• NHS Lothian Clinical Framework
• Strategic Clinical Framework for Primary Care 2013 – 2020 (Draft)

This strategy does not set out to replicate nor supersede these documents. Instead, it should build on the existing direction of travel and complement the components of these strategies that apply to the health and well-being of children and young people.
5. Our vision and principles

NHS Lothian’s vision is that - Every child should have the best start in life and grow up being healthy, confident and resilient.

This vision will only be achieved by building on the capacities and assets of our staff working jointly with local people living and working within our communities. Achieving this vision requires collective action to:

- Focus on our strengths
- Identify ways that we make best use of our skills, knowledge and resources
- Enable local people to be part of the solution to the challenges we face
- Focus on our relationships with children, young people and their families and our partner organisations.

The following diagram, developed by an organisation called Brighter Future Together, outlines the many assets that can be found within local communities and helps us articulate who our partners are that we will be working with to achieve our vision.
Principles of Getting It Right For Every Child (GIRFEC)

Over the past several years, NHS Lothian has worked to ensure that the national principles and indicators of Getting it Right for Every Child (GIRFEC) are at the heart of all services working directly with children, young people, their families and carers. The following diagram, often described as the Well-being Wheel, demonstrates what NHS Lothian is committed to making a reality. We know that we cannot do this alone, which is why we are working with all our partners to implement it.
6. Working in Partnership and Community Planning

Outcomes this section covers:

NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health and resilience in those more vulnerable to poor health.

Partnership working is a “must do” for children and young people’s services for a range of practical and financial reasons:

- Taking a holistic approach to improving children and young people’s health and reducing health inequalities is complex, with a range of different agencies involved (including health care, children and families services, voluntary sector and youth services)
- Many children and young people are vulnerable or have limited ability to negotiate complex bureaucracies. They therefore need services that are well integrated at the point of contact, are easy to negotiate and are focused on their needs
- Partnership working can help minimise bureaucracy and duplication as well as maximise integration for service users and staff
- Resources are scarce, but the task is broad. It therefore makes sense for us to work together, strategically and operationally, to make best use of the knowledge, experience and skills we have that will make sure we achieve our collective vision for children and young people

Effective partnership working is essential for children, young people and their families, who can often experience fragmented services, a lack of continuity and conflicting information in situations where local agencies fail to collaborate effectively.

There are strong examples of good partnership working between NHS Lothian, City of Edinburgh Council and the voluntary sector, as recently evidenced in the Inspection and Scrutiny of Children’s Services in Edinburgh where the following examples were highlighted:

- A clear strategy for integrating children’s services, including strong involvement of the voluntary sector
- Strong partnership working and promotion of team working across services
- Building strong leadership

For partnership working to happen effectively across services, it should be demonstrated through leadership. NHS Lothian is actively engaged strategically and operationally within each of the four Community Planning Partnerships (CPPs) which demonstrate that leadership across Lothian. Each CPP has a focus on early years outlined in its Single Outcome Agreement, with a children
and young people’s sub group and Children’s Integrated Services Plan driving delivery and partnership working.

Within the Single Outcome Agreements, all partners across the four CPPs in Lothian have signed up to the high level outcome, ‘Every child has the best start in life and is ready to succeed’. Details of how this outcome will be achieved are outlined in each of the local plans and takes into account the needs of all children, while recognising the specific needs pertaining to local communities in that CPP area. This includes the crucial role that parents play in giving children the best start in life and the additional support some parents need with bringing up their children.

Ensuring that children and young people are protected from emotional and physical harm is a priority for NHS Lothian and our local authority partners. The commitment, approach and actions to be taken are clearly outlined in the Interagency Child Protection Procedures, Edinburgh and the Lothians and should be considered alongside this strategy. Keeping children safe from harm is also an integral component of the four Integrated Children’s Services Plans that NHS Lothian helped develop and is currently helping to implement.

NHS Lothian is also committed to driving the work of the Early Years Collaborative and is heavily involved in testing new approaches across the three work streams (conception to one year, one year to three years and three years to five years), using the Plan, Do, Study, Act methodology. With a principle of ‘think big, start small, scale fast’, early years staff have been encouraged to move quickly, using the ‘tests of change’ model of improvement, record the tests they are making and measure the progress that is being made. NHS Lothian staff will continue to work with our community planning partners in the statutory and voluntary sectors as members of the Early Years Collaborative and encourage a culture that supports innovation and using data to drive improvement.

There is also an opportunity to improve shared learning and good practice across Lothian. To this end, it is proposed that a new Lothian Children and Young People’s Programme Board be formed with representation from NHS Lothian, the four local authorities and the voluntary sector to share good practice. Further details of the remit of this group are discussed in section 11.
7. Addressing health inequalities

**Outcome this section covers:**

NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those more vulnerable to poor health.

Michael Marmot’s review of health inequalities (2010) provides the most comprehensive summary of the impact of health inequalities and approaches to reducing health inequalities.

Marmot notes that:
- people from different socioeconomic groups experience avoidable differences in health, well-being and length of life and that this is unfair and unacceptable
- these differences are strongly influenced by inequalities in experiences of daily life that are typically mediated through differences in education, occupation, income, gender, ethnicity and race
- these differences are also influenced by an overarching socio-political and cultural and social context.

Health inequalities can be observed in the distribution of many diseases and risk factors. Health inequalities have become more pronounced in the UK over the past thirty years. The difference in life expectancy at birth by socioeconomic status provides a stark and incontestable reminder of this fact. The differences by income are even further accentuated for disability free life expectancy. Similar gradients are observed for maternal smoking, breastfeeding, childhood obesity, childhood accidents and many other key risk factors and conditions.

Marmot’s report also summarises the current evidence and recommendations for tackling health inequalities in the United Kingdom. These recommendations, the culmination of decades of research, are consistent with earlier reports on health inequalities. However, what sets the Marmot’s report apart is the particular focus on maternal and child health (the early years), early intervention and parenting (see appendix for a more detailed list of key messages).

The Marmot report also notes that “focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage” referring to this as “proportionate universalism”. This has clear relevance to discussion on universalism versus targeting. The approach of offering a comprehensive programme of child health reviews and interventions (e.g. vaccination) for all children in Lothian is an example of a universal approach.
To address and reduce health inequalities requires three types of action:

- Actions to **mitigate** the health and social consequences of social inequalities.
- Actions to help individuals and communities **resist** the effects of inequality on health and wellbeing.
- Actions to **undo** the underlying inequalities in power and resources. Key areas are *employment, income and education*.

**Current NHS Lothian approach**

NHS Lothian has adopted a ‘whole system approach’ that recognises three strands to the role of health services in addressing health inequalities. The three strands of work are:

- Ensuring mainstream services are accessible to and appropriate for all groups in the population – using tools like impact assessment and equity audit
- Providing additional support and targeted services for disadvantaged groups whose needs cannot be fully met by mainstream services – for example the Homelessness and Health Team, Family Nurse Partnerships and Throughcare and Aftercare Nurses
- Working with partners to address underlying causes of health inequalities

These approaches will be integral to the delivery of the Children and Young People’s Strategy.
8. Meeting the health needs of children and young people in Lothian

Outcomes this section covers:

- NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those more vulnerable to poor health
- Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity
- Children with disabilities will have their additional needs met
- Children, young people and their families will be involved in decisions that affect their health

From the time that a woman finds out she is pregnant, through to birth, NHS Lothian has a maternity service across Lothian that supports the family to ensure that the child comes into the world as healthy as possible. Where extra support is required, we have a flagship neonatal unit and targeted initiatives such as PrePare (for pregnant women with a drug or alcohol problem) and Family Nurse Partnerships (for teenage mothers) that are held in high regard.

When a child is born through to age five, the first point of contact for support is through the Health Visiting Service with responsibility transferring to the School Nurse from the time a child starts school. Appendix 1 shows the contact that all children will have with NHS Lothian services and includes specialist services for those children that have additional support needs or are more vulnerable.

Addressing the needs of vulnerable children can only be achieved where services work together. The recent inspection of children’s services in Edinburgh evidenced that NHS Lothian has strengths in protecting children and keeping them safe, however, we know that we can always do better. Where we have to focus more of our energies is in relation to increased prevention activities, helping prevent situations where children are at risk and where they are in difficult situations, have the resilience to manage them. This agenda will therefore continue to remain a priority for NHS Lothian and our local authority and voluntary sector partners within the four Integrated Children’s Services Plans.

Appendix 3 outlines the beginning of an Implementation Plan with the actions NHS Lothian will focus on to achieve the outcomes above. The Implementation Plan will developed to include actions that are specific, measurable, attainable, realistic and time bound (SMART).
9. Reprovision of the Royal Hospital for Sick Children

Outcome this section covers:

The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services and the development of services at St John’s Hospital.

We are committed to maintaining Edinburgh’s reputation as a world-class facility for healthcare and research. Our project to re-provide services from the Royal Hospital for Sick Children (RHSC), Child and Adolescent Mental Health Service (CAMHS) and the Department of Clinical Neurosciences on the Little France site will help us to provide children and their families with facilities and services that ensure they receive the highest possible standards of care and provide a safe, spacious, light and comforting environment which promotes recovery and meets the needs of children, young people and their carers.

The benefits of having children’s, maternity and adult services on the same site are well documented. This new building will bring the pieces of the jigsaw together to create a new centre of excellence at Little France. Having paediatric care, specialist neonatal care, adult neurosciences and children’s and adult emergency departments all on one site will ensure that teams can share experience and expertise for the benefit of children and their families as well as adult patients.
The existing RHSC provides a comprehensive range of dedicated children’s services, caring for over 100,000 children, up to the age of 13, and to age 18 in certain cases, from across Lothian and beyond. Services include accident and emergency, acute medical and surgical care, specialist surgical and medical care, haematology and oncology, neurosciences, day care, and critical care. The busy outpatients department cares for more than 34,000 patients a year. A number of regional and national services are hosted by RHSC, including the Paediatric Intensive Care Unit and the national Scoliosis service.

The hospital has been based at its current site in the centre of Edinburgh for almost 120 years. A three floor extension was added in 1995 and the vacated wards created a new Paediatric Intensive Care unit. Based on current projections, the emergency department for children and young people will expect to see around 50,000 attendances a year by 2016. The hospital is also expected to admit 9,500 inpatients, treat 8,000 day cases and see 64,000 outpatients under 18 years of age.

Plans for this project have been developed over a number of years. Specific factors driving the need for change in children’s and young people’s services and clinical neurosciences are:

- the age and limitations of the current premises
- the need to deliver sustainable specialist services whilst meeting the challenge of relatively small numbers of patients and small numbers of clinical experts
- the national policy for Paediatric Intensive Care Units in Scotland, which have been commissioned under NHS National Services since 2007, sited in two hospitals for children and young people
- the need to provide care for young people up to 16 years of age, and up to 18 in some cases, in an age appropriate facility

Clinical benefits of integrating the services into one building, supporting the Board’s and national strategic ambitions include:

- the ability to deliver paediatric and adult neurosurgery in the same theatre suite, maximising the utilisation of specialist equipment (e.g. intra-operative MRI) and expert staff, with direct internal access to age-appropriate critical care wards
- mental health services on the same site as acute hospital services for children and young people, supporting their physical and psychological care
- joint-working and economies of scale in high-cost specialist clinical areas such as theatres and radiology
- the opportunity to improve emergency access to services by incorporating a helipad on the roof of the new build.

The Reprovision of the new facility brings about opportunities for redesign of services and work has already commenced in this area with a focus on patient pathways and models of care.

Extensive public consultation has taken place in the development of the proposals for this Project utilising existing stakeholder groups and in addition,
specific stakeholder groups have been set up to ensure that patients and partner organisations have an understanding and input into the Project.

The Project will co-locate services currently provided at the existing Royal Hospital for Sick Children based in Sciennes, Edinburgh and CAMHS based at the Royal Edinburgh Hospital, Morningside with the adult clinical neuroscience services currently provided out of the Western General Hospital on Crewe Road South, Edinburgh, on the existing RIE site adjacent to the RIE Hospital at Little France.

Linked to the RHSC reprovision, we will also continue to look for opportunities to develop specialist outpatient services and more day surgery/programmed investigation services at St John’s Hospital, to meet the needs of the population in West Lothian by providing these services more locally, wherever possible.
10. Workforce Planning: Ensuring that we have a workforce that is fit to meet the demands of a growing population

Outcomes this section covers:

NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population

The range and quality of healthcare services for children and young people will be improved the reprovision of the Royal Hospital for Sick Children, the integration of children’s services and the development of services at St John’s Hospital.

Workforce Planning: An Overview.

NHS Lothian is committed to working closely with staff, the NHS Lothian Partnership Forum and the population in aligning workforce capacity to meet the needs of children, young people and their families for today and tomorrow, across all NHS services.

In taking forward workforce planning across those services working with children and young people, NHS Lothian endorses the nationally sponsored 6 step workforce planning methodology. This offers a framework for services to adopt in developing workforce plans that will underpin future service delivery. The 6 steps are:

- **Step 1:** Defining the plan
- **Step 2:** Visioning the future/Mapping service change
- **Step 3:** Defining the required workforce
- **Step 4:** Understanding workforce availability
- **Step 5:** Developing an action plan
- **Step 6:** Implement, monitor and refresh.

Such a framework not only provides a practical framework for services to follow, it also allows for an element of consistency in the way services assess and plan for their future workforce.

Workforce planning should also be developed on an integrated basis that makes clear connections with service planning and financial planning arrangements, therefore ensuring the validity of any emerging workforce plans. Such plans should also be developed iteratively enabling challenges to be identified and addressed on an on-going basis rather than on an annual basis

Workforce Planning: Child and Maternal Health Services

NHS Lothian’s greatest asset is undoubtedly its workforce, operating across a wide range of settings in the delivery of a vast array of services, many of which
are provided on a 24 hour/7 days a week basis. NHS Lothian is therefore committed to ensuring that its workforce has the right skills and are in the right place to provide the high quality, safe, effective, person centred care that children, young people and their families deserve.

The development of The NHS Lothian Strategy for Children and Young People, 2013-2020 is therefore crucial to supporting the formulation of robust child and maternal health workforce plans that deliver for the short, medium and long term.

There are currently a number of significant challenges within child and maternal health services in Lothian. The following list sets out some of the key issues that need to be addressed. It also highlights where a robust and integrated workforce planning approach can ensure that we are able to provide a workforce that is fit for a leading 21st century public sector health provider.

These challenges, and NHS Lothian’s collective responses, will form part of a wider Child and Maternal Health Action Plan, an element of which will reflect the ongoing workforce planning activity across a range of specific service areas. This Action Plan, addressing issues outlined below, will be driven by a Workforce Planning subgroup of the Lothian Children and Young People’s Programme Board.

**Key Issues**

**Implications of the Children & Young People (Scotland) Bill for Midwives and Health Visitors**

NHS Lothian welcomes the Scottish Government’s move towards prevention and early intervention through the Named Person, as set out in the Children and Young People (Scotland) Bill. For NHS Lothian, this means that we have increased duties to promote well-being of children and be the first point of contact for providing support and responding to concerns.

The Scottish Government has estimated the additional resource implications of introducing the named person to routine Midwifery & Health Visiting Services and that this equates to over £16 million for Scotland.

Based on the number of live births (9,794) and numbers of 0-5 year old children (48,980) in the 2011 census, NHS Lothian estimates that this will place additional demand for workforce resource, particularly across Maternity and Health Visiting services.

While it is recognised that these changes are not likely to come into effect until 2016, there are two main challenges facing NHS Lothian, namely:

- Funding any additional capacity recognised within the Bill; and
- The feasibility of being able to develop and/or recruit to midwifery and health visiting roles in order to make a step change within our current workforce.
Such changes will require innovative planning across a range of key stakeholders in order to meet the requirements of the Bill. This may involve elements of service re-design, options for new ways of working as well as a review of skill mix across teams.

**Maternity Services**

The opening of the Lothian Birth Centre has been an unprecedented success within NHS Lothian, with over 1,500 midwife led births during 2012-13. However, this move of low risk births out of the main labour ward has highlighted more clearly the increasingly high percentage of complex cases going through the labour ward. There has also been a corresponding increase in length of stay within the postnatal wards, despite an increase of 10 postnatal beds within the SCRH with the opening of the birth centre. This in turn impacts on patients moving through services, leading to capacity and staffing pressures at SCRH and an increasing number of times that patients are diverted to St John’s Hospital at short notice.

The service has already developed an internal improvement action plan and has recently implemented the National Maternity Patient Safety Programme, which aims to reduce avoidable harm by 30% (including post partum haemorrhage), reduce stillbirth by 15%, address safety culture within the organisation and improve women's satisfaction with care by 2015. There is centrally funded midwifery time in Simpsons and St Johns to lead the programme of work that will achieve these aims.

There is a recognition that both workforce (medical and midwifery) and capacity needs to be reviewed now with some urgency, in order to ensure we have a safe and sustainable maternity service for women and babies. The Chief Midwife will lead this work with recommendations being identified within the first year of the strategy.

**Hospital Paediatric Workforce Pressures:**

We currently face significant challenge with regards to Paediatric and Neonatal Consultants. Gaps in middle grade registrar rotas caused by maternity leave, less than full time training and out of programme training currently affect all paediatric and neonatal rotas in Lothian (as well as Borders and Fife). This includes the neonatal intensive care unit at the Royal Infirmary Edinburgh (RIE), the paediatric intensive care unit at the Royal Hospital for Sick Children (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.

**Paediatric Workforce Planning: Short, Medium and Long Term**

Workforce solutions to the issues across Paediatric services in Lothian will need to be planned for the short, medium and long term. Currently a range of
measures have been implemented to build current capacity within Paediatric and Neonatology services across NHS Lothian.

In terms of planning over the medium term, NHS Lothian has reviewed the outcomes of the commissioned independent Tailored Workforce Support Team (TWST) Report, which was set up by the Scottish Government Health and Social Care Directorates, in conjunction with NHS Lothian, to look at the future sustainability of the service. A range of alternative models and workforce options to maintain the service in the medium to long term have been highlighted and are currently being considered in full.

Looking to the longer term it will be important that any workforce planning activity reflects the Scottish Government’s 20:20 vision as well as NHS Lothian’s Strategic Clinical Framework, and in accordance with NHS Lothian’s Vision and Values.

In taking forward this work it will be important to work closely with other NHS Boards given that NHS Lothian provides a number of services across the region.

Community Child Health

The Community Child Health Service provides a range of services including medical input into child protection issues in the Lothians. Currently the service is facing numerous workforce pressures following retirements and the loss of key personnel, knowledge and skills, with a shortage of suitably experienced applicants to fill some of these posts. This is a national challenge as well as a local one and it is essential that we undertake effective workforce planning, working with key stakeholders to ensure that these crucial services remain sustainable over the longer term and that we have a workforce fit for purpose.

Integration of Children’s Services

There are many opportunities brought by the integration of children’s services for improving the outcomes of children and their families. As we work through the practicalities of what this means for staff and the services we offer, NHS Lothian makes a firm commitment to working with staff to:

- fully involve them in decisions that affect them
- identify the opportunities integration brings
- ensure that any identified risks are mitigated
- Ensure that patient safety and quality of care will be sustained or enhanced and that there is no inequity across Lothian
- explore more opportunities for interagency training and development that results in improved joint working and in improved outcomes for the children and families staff work with.
Children and young people are crucial to the future well-being and prosperity of Scotland. Healthier adults in the future will reduce the demand placed on NHS services.

The Scottish Government in its report “The Financial Impact of Early Years Interventions in Scotland” has indicated that investing in early years services produces the potential for savings in the short, medium and long term.

Discussions within NHS Lothian during 2012 resulted in a proportion of the additional monies that are received from the Scottish Government to reflect population changes being utilised to support Early Years. Further discussions are required locally and with the Scottish Government to identify resources that are required to implement the requirements of NHS Lothian in implementing the Children’s Bill from 2014.

There will also be ongoing discussions with Primary Care to look at areas where the Quality and Outcomes Framework (QOF), can be utilised to improve the quality of services provided to children, young people and their families.

The financial baseline for this strategy will be 2012-13, recognising that the development of this strategy and NHS Lothian’s commitment to early years has begun a shift in resource, in line with the Early Years Change Fund.

**Table 1: NHS spend on healthcare services for children and young people (0-17 years) 2012/13.**

<table>
<thead>
<tr>
<th>Spend on Under 18s</th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Lothian Wide</th>
<th>Non-Lothian and other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>£12,564,899</td>
<td>£3,128,096</td>
<td>£2,318,175</td>
<td>£7,009,273</td>
<td>£0</td>
<td>£15,949,753</td>
<td>£40,970,197</td>
</tr>
<tr>
<td>Day Cases</td>
<td>£2,680,065</td>
<td>£643,881</td>
<td>£467,809</td>
<td>£1,342,948</td>
<td>£0</td>
<td>£1,892,494</td>
<td>£7,027,197</td>
</tr>
<tr>
<td>Outpatients</td>
<td>£8,808,712</td>
<td>£1,997,269</td>
<td>£1,838,613</td>
<td>£3,621,171</td>
<td>£0</td>
<td>£1,235,196</td>
<td>£17,500,961</td>
</tr>
<tr>
<td>Community</td>
<td>£9,571,093</td>
<td>£2,182,610</td>
<td>£1,866,719</td>
<td>£4,002,711</td>
<td>£13,797,364</td>
<td>£203,576</td>
<td>£31,624,074</td>
</tr>
<tr>
<td>Payments to Voluntary Organisations</td>
<td>£603,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td><strong>£33,624,770</strong></td>
<td><strong>£7,951,857</strong></td>
<td><strong>£6,491,316</strong></td>
<td><strong>£15,976,103</strong></td>
<td><strong>£14,400,364</strong></td>
<td><strong>£19,281,019</strong></td>
<td><strong>£97,725,429</strong></td>
</tr>
</tbody>
</table>

**Table 2: NHS Additional spend on healthcare services for children and young people 2013/14**

<table>
<thead>
<tr>
<th>Spend on Under 18s</th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Lothian Wide</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in population - Health Visitors</td>
<td>£135,500</td>
<td>£34,000</td>
<td>£34,000</td>
<td>£67,750</td>
<td>£271,250</td>
<td></td>
</tr>
<tr>
<td>Implement 27-30 month review – Health Visitors</td>
<td>£162,000</td>
<td>£40,500</td>
<td>40,500</td>
<td>£81,000</td>
<td>£324,000</td>
<td></td>
</tr>
<tr>
<td>Implement 27-30 month review – Speech &amp; Language Therapy</td>
<td>£22,000</td>
<td>£5,500</td>
<td>£5,500</td>
<td>£11,000</td>
<td>£44,000</td>
<td></td>
</tr>
<tr>
<td>Increase in population – school nurses</td>
<td>£42,000</td>
<td>£11,500</td>
<td>£11,500</td>
<td>£21,000</td>
<td>£86,000</td>
<td></td>
</tr>
<tr>
<td>Enteral Feeding for Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£86,000</td>
<td></td>
</tr>
<tr>
<td>Implement CEL 16 – review all looked after children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£595,907</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td><strong>£361,500</strong></td>
<td><strong>£91,500</strong></td>
<td><strong>£91,500</strong></td>
<td><strong>£180,570</strong></td>
<td><strong>£681,907</strong></td>
<td><strong>£1,407,157</strong></td>
</tr>
</tbody>
</table>
12. Governance and performance improvement arrangements for overseeing implementation of this strategy

**Outcome this section covers:**

Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy

Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy.

The implementation of this strategy will require improvements to the current process of measuring how children and young people’s healthcare services are performing. The production of good quality data and information will be necessary in order to ensure that we know that every child has the best start in life and is growing up healthy, confident and resilient.

While we are good at collating data, we need to ensure that we are collating the right data that evidences that we are achieving positive outcomes or not. We will therefore work across NHS Lothian to review the data we collate and ensure that it helps:

- practitioners understand more about the children they work with, either individually or at population level
- contribute to demonstrating progress towards the outcomes of this strategy and the Integrated Children's Services Plans agreed with partners.

To oversee implementation of this Strategy, the ‘NHS Lothian Children and Young people’s Strategy and Modernisation Group’ will be replaced by the Lothian Children and Young People’s Programme Board.

The remit of this group will be to:

- oversee implementation of this strategy, monitoring progress against identified indicators and outcomes
- identify and progress areas of work where there is a greater chance of improving children and young people’s outcomes by working across Lothian
- share learning across partners and geographical areas in order to improve the quality of service provision at a local and regional level
- clarify the contributions to be made by each agency towards the identified Lothian wide outcomes
- support the integration of children and young people’s services where appropriate in order to improve the pathways of care for children and young people
To ensure that the Lothian Children and Young People’s Programme Board addresses the broad spectrum of work associated with the strategy, the agenda will focus on the different life stages and oversee progress of the implementation plan.
Appendix 2

Key messages from Fair Society, Healthy Lives
Marmot Review
http://www.marmotreview.org/ - this could go as an appendix?

1. Is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.

2. There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health.

3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

6. Economic growth is not the most important measure of our country’s success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.

7. Reducing health inequalities will require action on six policy objectives:
   - Give every child the best start in life
   - Enable all children young people and adults to maximise their capabilities and have control over their lives
   - Create fair employment and good work for all
   - Ensure healthy standard of living for all
   - Create and develop healthy and sustainable places and communities
   - Strengthen the role and impact of ill health prevention

8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.

9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

Appendix 3 – Draft Implementation Plan

This section outlines the beginning of an Implementation Plan with the actions NHS Lothian will focus on to achieve the outcomes above. The Implementation Plan will be developed to include actions that are specific, measurable, attainable, realistic and time bound (SMART)

<table>
<thead>
<tr>
<th>Life Stage: Early Years (Conception to five years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome</strong></td>
</tr>
<tr>
<td>NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those most vulnerable to poor health</td>
</tr>
<tr>
<td>Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity</td>
</tr>
</tbody>
</table>
meet their developmental targets
We will improve access to healthcare and reduce unnecessary presentation at A&E
We will work with the Scottish Commissioner for Children and Young People’s Office to roll out Children’s Rights Impacts Assessments (CRIA) on any new policies or services that directly, or indirectly affect children and young people

<table>
<thead>
<tr>
<th>Children with disabilities will have their additional needs met</th>
<th>We will identify ways of improving support for those children whose health needs are not at the most complex end of the spectrum, but whose families require extra support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We will explore opportunities for improving pre birth and post birth psychological support for parents of children with exceptional healthcare needs</td>
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| Children, young people and their families will be involved in decisions that affect their health | We will improve the quality of our services through continuous engagement with children, young people and their parents |

<table>
<thead>
<tr>
<th>Life Stage: School age (5 – 18 years)</th>
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<tbody>
<tr>
<td><strong>Outcome</strong></td>
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<tr>
<td>NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those most vulnerable to poor health</td>
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<tr>
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</table>
| Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity | We will improve access to healthcare and reduce unnecessary presentation at A&E  
We will work with Scottish Commissioner for Children and Young People’s Office to roll out Children’s Rights Impacts Assessments (CRIA) on any new policies or services that directly, or indirectly effect children and young people.  
We will take forward the recommendations of the 'Development for age appropriate cancer services for 16-24 year olds with cancer in Scotland' report (2013) |
| Children with disabilities will have their additional needs met | We will work with children, young people and services to develop a set of core principles for managing the transition from children’s to adult services, that services will have to apply.  
We will ensure transition planning takes place early and monitor outcomes for all young people                                                                                                                                                                                                                                                                 |
| Children, young people and their families will be involved in decisions that affect their health | We will improve the quality of our services through continuous engagement with children, young people and their parents                                                                                                                                                                                                                                                                              |

We recognise that some improvements that need to be made are not specific to individual life stages and cut across all three. The following table highlights key actions we will take forward across all three life stages.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>What we plan to do</th>
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| Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity | We will implement the recommendations from the Scottish Government Children and Young People's Palliative Care Network  
We will work with our local authority partners to improve the quality and equity of packages of care for children with exceptional health care needs  
We will work to reduce do-not-attend (DNAs) rates and improve follow-up where children may be vulnerable  
We will reduce the average length of bed stay in hospital  
We will develop a child centred Portal which will enable NHS and local authority staff working with a child or young person to access appropriate information regarding their care  
Wherever possible, we will provide services closer to home in age appropriate, safe and fit for purpose accommodation  
We will provide better care for children and young people with long term conditions. |
### SUMMARY PAPER - SINGLE OUTCOME AGREEMENTS & LOCAL DELIVERY PLAN

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

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

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<tr>
<td>1.1</td>
<td>The purpose of this report is to invite the Board to receive the final Single Outcome Agreements within each Community Planning Partnership in Lothian, and to note the NHS Board Contribution to Community Planning Partnerships as part of the Local Delivery Plan process.</td>
</tr>
<tr>
<td>2.2</td>
<td>Agree that a six month update and progress report be brought back to the Board having also been discussed at each of the Health &amp; Social Care Partnerships of CH(C)P Sub-Committees.</td>
</tr>
<tr>
<td>2.3</td>
<td>Note that the publication of the SOAs is the last piece of the 2013/14 Local Delivery Plan process. That the SOA’s will be put on the NHS Lothian website alongside the Strategic Clinical Framework; the Local Delivery Plan and the Corporate Objectives.</td>
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12 September 2013  
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**Alex McMahon**  
Director of Strategic Planning  
12 September 2013  
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SINGLE OUTCOME AGREEMENTS & LOCAL DELIVERY PLAN

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to receive the final Single Outcome Agreements within each Community Planning Partnership in Lothian, and to note the NHS Board Contribution to Community Planning Partnerships as part of the Local Delivery Plan process.

2 Recommendations

2.1 Agree to sign off the final Single Outcome Agreements as agreed by local Community Planning Partnerships which NHS Lothian has inputted to through their development.

2.2 Agree that a six month update and progress report be brought back to the Board having also been discussed at each of the Health & Social Care Partnerships of CH(C)P Sub-Committees.

2.3 Note that the publication of the SOAs is the last piece of the 2013/14 Local Delivery Plan process. That the SOA’s will be put on the NHS Lothian website alongside the Strategic Clinical Framework; the Local Delivery Plan and the Corporate Objectives.

2.4 Note that due to the length of the combined SOA’s (several hundred pages) that where available, these have been made available via electronic link as attached.

2.5 Note that this is the first time that NHS Lothian as been asked to submit evidence of our contribution to Community Planning Partnerships as part of the Local Delivery Plan process.

2.6 Note that Mike Ash and David Small have been nominated to the East Lothian CPP Board and that within Edinburgh the Joint Director has been asked to join the Edinburgh Partnership Executive.

3 Discussion of Key Issues

3.1 At the Board meeting in April 2013, members noted good progress and considered draft targets and outcomes being considered within the Single Outcome Agreements (SOAs).

3.2 One comment made by Board members, particularly those that are members of the new Shadow Health and Social Care Partnerships was that there is a need for more direct input into the process. We would encourage this and would ask Members to note the updated position as reported above re East Lothian and Edinburgh.
3.3 We will continue to work with the Chairs of the Shadow Health and Social Care Partnerships to ensure delivery of the Single Outcome Agreements (SOAs).

<table>
<thead>
<tr>
<th>Community Planning Partnership - NHS Membership</th>
<th>East Lothian</th>
<th>Edinburgh</th>
<th>Midlothian</th>
<th>West Lothian</th>
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<tbody>
<tr>
<td>Mike Ash</td>
<td>Brian Houston</td>
<td>Eibhlin McHugh</td>
<td>Jim Forrest</td>
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<td>David Small</td>
<td>Tim Davison</td>
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<td>Alex McMahon</td>
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<td>Peter Gabbitas</td>
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3.4 All SOAs in Lothian set out clear and agreed priorities, rooted in the CPP’s understanding of place, for improving local outcomes. They have all been developed using the national guidance (which can be accessed at [http://www.scotland.gov.uk/Resource/0040/00409273.doc](http://www.scotland.gov.uk/Resource/0040/00409273.doc)) and focus on national outcomes, with particular priority given to:
- Economic recovery and growth;
- Employment;
- Early years;
- Safer and stronger communities and reducing offending;
- Health inequalities and physical activity; and
- Outcomes for older people.

3.5 Communication across NHS staff engaged in development of the four final SOAs has reinforced NHS Lothian’s priorities, e.g. aims of the Strategic Clinical Framework including prioritising prevention and reducing inequalities in health as well as continued partners work in relation to promoting mental health and wellbeing, tackling substance misuse and offending and re-offending and physical health, as well as investing in early years and the agenda around ‘Getting it Right for Every Child’. The integration of health and social care services will been instrumental in supporting delivery of the SOAs going forward.

3.6 As can be seen in the final SOAs (Appendices 1-4), there are common outcomes and indicators across Lothian to enable opportunities for benchmarking and providing continuity for recording data, especially for Lothian-wide services. This has mainly been achieved across the four CPPs; however, there is local variation due to this being a locally focused process.

3.7 Monitoring of SOAs will be undertaken through CPPs with each CPP receiving regular progress reports to ensure it is on track for delivery. The structural process for monitoring the SOA in each CPP is broadly similar, with thematic strategic partnerships (health, community safety, children & young people, economic development, etc.) taking responsibility for monitoring local indicators, which inform progress against the SOA. There is support for this provided by a CPP Working Group in each area, comprising officers from statutory partners, with overarching governance and accountability resting with the CPP Board.

3.8 In this year’s Local Delivery Plan, NHS Boards were asked to include a summary of the key tangible contributions that will be made during 2013/14 towards improved outcomes as outlined in section 3.4 above. While the LDP was initially signed off in March 2013, in May 2013, the Scottish Government wrote to NHS Boards requesting that they sign-off a section of the Local Delivery Plan that provided...
evidence of NHS Boards contribution to community planning and forward to the Scottish Government.

3.9 NHS Lothian's response to this request is attached in appendix 5 and provides examples of NHS Lothian’s contribution across the four CPPs to addressing the different priority areas.

3.10 As we develop the Strategic Plan and indeed the joint integration and strategic commissioning plans for each partnership through the Integration process, SOAs may well be key measures that can be used for measuring multi-agency contribution to the higher level outcomes that we would aim to deliver.

4. Key Risks

4.1 The main risk associated with the delivery of the outcomes within the SOAs is the partnership nature of the document. Therefore, there is a reliance on other community planning partners to deliver on targets which are out with the influence of NHS Lothian. This is mitigated through effective and timely performance monitoring reports to the relevant CPP Board.

5. Risk Register

5.1 There are no new risks noted from this programme for NHS Lothian’s corporate risk register.

6. Impact on Inequality, Including Health Inequalities

6.1 There is a strong focus in the SOAs to address inequalities through national and local outcomes which seek to improve health and social circumstances. This will be reflected in the final SOAs agreed by each CPP.

7. Involving People

7.1 The development of the Single Outcome Agreements across the CPP areas have included extensive involvement and engagement of people and communities. This has included stakeholder engagement events in addition to using the expertise of existing multi-agency groups currently in operation to drive forward local priorities.

8. Resource Implications

8.1 There are no direct resource implications associated with this report.

List of Appendices


Appendix 4: link to West Lothian SOA [http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers](http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers)
Appendix 5: NHS Lothian’s contribution to Community Planning

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9 September 2013
Improving partnerships during 2013/14
Contributing to better outcomes through collaborative gain

NHS Lothian, through CH(C)Ps supported by Strategic Planning and Public Health colleagues, continues to be actively involved in the SOA process across Community Planning Partnerships (CPPs). CH(C)Ps are actively engaged in leading the development and delivery of the health related outcomes within the SOAs, with clear performance processes in place.

Development of local SOAs has had significant involvement from NHS staff, particularly CH(C)P, Strategic Planning, Performance Reporting & Information and Public Health & Health Policy. This has involved participation in local consultation events and membership of and engagement with various themed groups. Communication across NHS staff engaged in development of the four SOAs has reinforced NHS Lothian’s Strategic Clinical Framework priorities, which include prioritising prevention and reducing inequalities in health.

Where possible, there has been willingness to identify common outcomes and indicators across Lothian to enable opportunities for benchmarking and provide continuity for recording data, especially for Lothian-wide services. This has mainly been achieved across the four CPPs, however, there is some local variation due to this being a locally focused process. Examples of high level outcomes being considered across the CPPs include:

- Our Children have the best start in life and are ready to succeed
- Older people are able to live independently in the community with an improved quality of life
- We live healthier, more active and independent lives
- Citizens experience improved health and wellbeing, with reduced inequalities in health.
- Older people are able to live independently in the community with an improved quality of life
- Safer and stronger communalities, and reducing reoffending

This submission outlines the contribution NHS Lothian makes to Community Planning and the 6 key themes that are core to Single Outcome Agreements. Examples of activity across Lothian in Community Planning Partnerships are provided.

Community Planning Partnership:

Summary of the key tangible contributions that the NHS Board will make during 2013/14 towards improved outcomes
**Priority: Early years and early intervention**

### NHS Board Contribution in 2013/14

**Early Years**
Getting it right for children and young people, families and carers, from the start, ensures that young children are healthy, happy and ready to succeed in life. Children's life chances depend significantly on the quality of experience they have in their first years; the secure and reliable attachments they have with parents and other adults important to them; the relationships they build with other children and within their families and communities; the quality of care they are given by parents and other carers; the richness of the learning opportunities they have; and the support and services which children, parents, families and carers can rely on.

**NHS Lothian, East Lothian Council, voluntary, third and private sectors** have done much in recent years in this area. A key development has been the Support from the Start test site which has been running in some areas of the country.

**Support from the Start** was established in East Lothian as a test site for the National Equally Well strategy in October 2008. It built on existing planning arrangements but sought to address inequalities in health more effectively and well being by doing some new things and doing some things differently. The development of a network of service and community champions, active community engagement and shared learning were integral to the successful development of the test site.

An evaluation undertaken by Queen Margaret University found that:

**Changes identified by parents and families include:**
- Parents identifying greater confidence and resilience in their children
- Improved routines and patterns in family life
- Improved transitions between services for children and their families.

**For parents their involvement in ‘Support from the Start’ groups led to:**
- Improved family relationships
- Improvements in mental health and wellbeing
- Reported increase in confidence.

**Early years practitioners have developed:**
- New ways of working and
- Increased ability to manage devolved budgets.

Learning from ‘Support from the Start’, as documented in the evaluation report, includes:
- Strategic leads need to endorse and be visible in the health inequalities agenda
- Community engagement and involvement in service design has been fundamental
- Support structures need to be in place to facilitate shared learning
- Giving permission and support to front line staff to progress action in a way that they believe will make a difference has resulted in improved early outcomes.

The approach taken forward in the second phase of Support from the Start and the
broader early years review process fits well with the findings and recommendations the report by Susan Deacon as national early years champion – ‘Joining the Dots’. It also accords well with principles set out by the Christie Commission on the future management of public services, with a particular focus on prevention and early intervention.

It will contribute significantly to the single outcome agreement (SOA) – ‘East Lothian’s children have best start in life and are ready to succeed’ by investing in and developing community resources for early child development.

There are a range of contributions currently made in the area of early years support, from midwifery, health visiting, primary care and other services. However specifically in relation to Support from the Start Mid & East Lothian Community Health Partnerships have agreed that the Public Health Practitioner post holders will continue to provide co-ordination to the local cluster/link up groups as part of their roles.

To support delivery of the national outcome, Our children have the best start in life and are ready to succeed, from April 2013 onwards, NHS Lothian is also reintroducing the 27 – 30 month health check for all children across East Lothian, Edinburgh, Midlothian and West Lothian. Recognising the impact this assessment will have on partner agencies, it has been agreed that specific indicators will be included in the new SOA, appreciating the developmental role within the first year. This is also being seen as a key contributor to evidencing progress made against the stretch aims of the Early Years Collaborative, which is now aligned with each Community Planning Partnership in Lothian. The indicators included in East Lothian, Edinburgh, Midlothian, West Lothian SOAs are as follows:

- To ensure that 85% of all children within the CPP area have reached all of the expected developmental milestones at the time of the 27-30 month child health review, by end 2016
- 100% of families are offered the 27-30 month review of children’s health and development.*

*An indicator for uptake of the 27-30 month review will be agreed for 2014/15 using baseline data gathered during 2013/14.

This work is fully integrated into the community planning process and feeds back directly through the relevant sub groups of the Children’s Partnerships in each CPP area. The achievement of the outcomes within Support from the Start and the 27-30 month assessment cannot be achieved without strong partnership working across other community planning partners such as education, voluntary organisations, private sector agencies and perhaps most crucially, local communities.

**Current and Planned Performance Levels**

There is already good evidence of continuous improvement associated with Support from the Start as demonstrated through the research into the first phase of the programme. Further evaluation work is underway in 2013/14 looking at resilience in parents supported by Support from the Start.

There has also been a series of information sessions to key stakeholders across
Lothian and all CPPs on the approach adopted within Support from the Start and this has continued as the programme develops. Key actions for Support from the Start in 2013/14 are to:

- Continue to support the development of area based Support from the Start champion groups within the East Lothian community planning framework.
- Continue to support the development of an East Lothian wide Support from the Start champions group within the East Lothian community planning framework.
- Work with the ELC early years team to improve access to information about early years resources in East Lothian for parents and professionals.
- Work with a range of services to develop and co-ordinate key early years practice/skills development programmes as follows:
  - Use the data from the Early Development Instrument survey carried out in 2012 as a basis for readiness to learn engagement events in each of the six school cluster areas.
  - Work with East Lothian Council and other partners to develop a play strategy for East Lothian.

Performance management is undertaken by the Support from the Start Project Board which links into the Getting it Right for Children and Young people Community Planning Theme group. This theme group is part of the wider Community Planning structures within East Lothian and reports on progress to the Community Planning Board of which NHS Lothian are represented.

Overall performance management is linked to the local outcomes and indicators within the East Lothian Integrated Children’s Services Plan, which is currently being updated in light of the new SOA. Draft indicators are as follows:

- % of children exclusively breast-fed at 6-8 weeks
- % of all East Lothian children aged 3-5 registered with a dentist (by postcode)
- % of children in P1 who are above the 95th centile of BMI (Body Mass Index)
- % of children assessed as ‘vulnerable’ in East Lothian communities in the five domains of early development (Physical Health and Wellbeing; Social Competence; Emotional Maturity; Language and Cognitive Skills; Communication Skills) as assessed by the Early Development Index

**Early Intervention**

Scots across all ages and socio-economic groups are drinking to harmful levels. The resultant health and social harms from problematic alcohol are evident in West Lothian and place a heavy burden on us all, including costs to health and social work services, crime, loss of productive capacity and wider social costs such as mortality and family breakdown. There were 1,146 hospital discharges for alcohol-related causes in West Lothian in 2010 and levels of hospitalisation for alcohol-related medical causes in West Lothian are the highest of the Lothians and similar to Scotland’s high average. Drinking is also a major contributory factor to crime rates in
Scotland, with 50% of prisoners reporting being drunk at the time of their offence (77% for young offenders) and 70% of assaults requiring treatment in A&E are thought to involve alcohol.

Within Lothian, alcohol consumption within the male population is above the Scottish average and 31.7% of men who drink are hazardous drinkers (i.e. they drink over 21 units/week, levels which may cause long-term health harm). Likewise the female population of Lothian has among the highest levels of alcohol consumption in Scotland; 23% of women drink at hazardous levels (over 14 units per week). More than a quarter of the adult population in Lothian are drinking at harmful levels and they are the main target of prevention and early intervention measures.

The West Lothian Tobacco Alcohol and Drug Partnership (TADP) is a multi-agency strategic and operational partnership tasked with identifying and co-ordinating local action and prioritising on tobacco, alcohol and drug use. Reducing the alcohol consumption of heavy but non-dependant drinkers is a key part of each ADP’s whole population strategy to reduce alcohol related harm.

Alcohol Brief Interventions (ABIs) are structured conversations between a professional and an individual about their drinking, which aim to motivate and empower them to change their behaviour. ABI’s have a significant impact on people who are drinking enough for it to be causing health, personal or social problems but are not (presently) so severely affected to need treatment. They are a highly effective and inexpensive way to encourage heavy (but non-dependent) drinkers to reduce their consumption. Opportunistically intervening with those who would never present to specialist services can have a dramatic and enduring effect on individuals, and the effect of a programme of these is potentially significant in reducing the total amount of alcohol consumed in the community.

There are two specific interconnected programmes relating to ABIS run by NHS Lothian as a strategic partners of the WLTADP.

One is the national initiative to deliver ABIs through the HEAT H4 three priority areas: primary care; maternity and A&E, which are funded through the Scottish Government allocation for alcohol misuse.

The second is the training of non-clinical workers, whose work brings them into contact with problematic drinkers, to implement ABIs. The training is delivered by staff working in the NHS Lothian Health Promotion service with training in West Lothian co-delivered by a third sector agency. This training is jointly delivered by an agency contracted by TADP (the West Lothian Drug and Alcohol Service) and by the NHS training team. This programme is led by the ADP officers, who are located in the council, and is provided to professionals from Housing, Social Work, Health Workers, Youth Workers, the voluntary sector, the Police and Fire and Rescue services. ABIs are also delivered to members of the community at local events, through various communities projects such as Community Action Blackburn. There is good evidence of the effectiveness of brief interventions in non-clinical settings.
NHS Lothian contributes to the delivery of ABIs at multiple levels: Strategically, they are involved in allocation of resources for and in the development and management of the training team, which has been a pivotal resource in all the local developments.

Operationally, they are central to the delivery of clinical ABIs through provision of funding, promotion of the programme and monitoring activity and impact. In the non-clinical programme, they provide much of the training resource and significant efforts in raising the profile of ABIs across a wide range of partnership agencies.

NHS Lothian jointly develops and delivers the training to the Council and its partners and raises the profile of ABIs across partnership agencies.

Current and Planned Performance Levels

In 2012/13 over 17,000 ABIS were delivered across Lothian against a Heat Standard of 9,938.

In 2013/14 a similar number are expected to be delivered. The infrastructure for training, quality assurance and reward mechanisms remain in place. NHS Lothian is working with partners within all three ADPs to agree which staff groups should be prioritised for training.

The focus for the delivery of ABIs in West Lothian will be proposed by NHS Lothian and agreed through the West Lothian TADP to ensure it fits with the local ADP strategic plan.

Priority: Safer and stronger communities, and offending

NHS Board Contribution in 2013/14

In Lothian, partners from across public and 3rd sector agencies have come together to create Re:D. Re:D is a collaborative venture which aims to improve outcomes and the lived experience of people with multiple and complex needs, many of whom will have problems with drugs, alcohol or mental health issues and will have offended, reoffended or be at risk of offending.

The ethos reflects the priorities and recommendations of the Christie Commission. Partners are challenged to consider – “If we were able to re-orientate the criminal justice system to focus on reducing reoffending behaviour by understanding the motivations for offending, which often stem from a complex mix of personal experience and circumstances, mental health conditions, drug and alcohol abuse and peer influence, would this begin to lessen the health inequalities experienced by a significant part of Scottish society?”

NHS Lothian, SACRO and City of Edinburgh Council are also working in partnership to pilot a holistic, women centred, integrated service for women who have offended that is less stigmatising, more cost effective than custodial sentences and more importantly engages women and addresses their multiple needs. Staff from the
partner agencies work together in a co-located multi-disciplinary team. The pilot service is based around a group-work model, although each woman is assigned a key worker to focus on their individual needs.

NHS Lothian:
- is the lead partner and chairs the strategic project board
- commits £60k per year to the pilot service including the following staff time: 0.2 wte Clinical Associate Applied Psychology and 0.1 wte Keep Well Nurse Case Manager
- NHS Lothian has also agreed through the Edinburgh ADP to fund a further £60K to Willow from the Scottish Government allocation for problematic substance use.
- provides accommodation for the programme delivery and hosts the multi-agency team
- works closely with partners to develop integrated policies to support quick and easy access to NHS services

NHS, CEC Criminal Justice Social Work and SACRO staff work as a co-located multi-disciplinary team bridging traditional organisational boundaries to provide a service to this excluded and vulnerable group of women. A range of additional partners, including Venture Trust, Edinburgh Community Food Initiative, Festival Theatre and Access to Industry, contribute to the overall programme.

Women attend Willow two days a week and participate in a group work programme. Each woman is also assigned a key worker for individual support and person centred goal planning. The programme includes:
- Connections – supporting desistence by promoting self-esteem, self identity and addressing offending behaviour
- Survive and Thrive – support to cope with the effects of trauma and abuse
- Reaching In – Reaching Out – building social capital and developing links with the local community
- Health Promotion including smoking cessation, physical activity, nutrition and sexual health
- Health Check and support to access primary and secondary health care services
- Support to access further education and employability services

In March 2013 the programme offers the following for women access Willow:

**Service (assessment)**
- Keep Well Health assessment
- Sexual health screen
- Mental health screen
- Gender sensitive addictions, mental health and BBV assessment at female only clinic (with Harm Reduction Team)

**Service (interventions)**
- Nursing clinic
- 1-1 key work support
- Treatment for addictions
- Trauma intervention
Offending behaviour intervention
Drug and alcohol group work
Outreach support
Mental health and wellbeing support
Confidence, self esteem and assertiveness
Healthy eating and nutrition education
BBV and sexual health education
Domestic abuse awareness and safety planning
1-1 psychological interventions (re. PTSD, depression, anxiety etc)
Dental health and hygiene input
Sleep hygiene input
Social capital and capacity development (networks and relationships)
Employability

Planned developments in 2013/14 are:
- Alcohol counselling
- Mentoring
- Peer support
- Volunteering
- SMART group
- Cognitive Behavioural Therapies (1-1)
- Person centered counselling

The partnership has overcome financial, structural, cultural and process challenges to deliver the service through one access point. Through pooled resources and working together women completing the programme have experienced transformational change that could not be achieved by any single agency input.

Current and Planned Performance Levels (R:eD)
Re:D comprises various work streams which include a focus on women, prolific male offenders, young people and employment. Each work strand or initiative will have a developed logic model detailing the inputs, activities and outputs which will contribute to the national 9 Offender Outcomes. Evaluation will also focus on “Distance Travelled” - a measurement term that refers to the progress that a person makes towards harder outcomes like employment or ceasing reoffending. This can include differences in feelings, attitudes, perceptions or skills over time, using self-reporting and observation methods.

Current and Planned Performance Levels (Willow)
- Edinburgh’s citizens experience improved health and wellbeing, with reduced inequalities in health
- Edinburgh’s communities are safer and have improved physical and social fabric
- We have tackled the significant inequalities in Scottish society
- We have improved the life chances for children, young people and families at risk
- We live our lives safe from crime, disorder and danger
- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others
NHS Lothian co-ordinate and convene a multi-agency project board to oversee the development and delivery of Willow. The following 5 outcome areas are measured pre and post programme and reported to the project board.

<table>
<thead>
<tr>
<th>Outcome Area</th>
<th>Outcome Measure</th>
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<tbody>
<tr>
<td>Mental Health &amp; Wellbeing</td>
<td>CORE and PTSD Checklist</td>
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In March 2013 Willow was working with 28 women in four groups and had 25 referrals for assessment.

The outcomes from Willow are reported through the Edinburgh Community Health Partnership, which has a strategic lead within the Edinburgh Partnership for overseeing the health outcomes. There is also emerging work through the Community Safety Partnership to ensure the contribution of the Willow Service is reflected in the wider reoffending agenda.

Priority: Health inequalities and physical activity

**NHS Board Contribution in 2013/14**

Health Inequalities
Each of the four Lothian Community Planning Partnerships has a Health Improvement Partnership within its structure, chaired or co-chaired by NHS Lothian public health or health promotion staff. These all manage a programme of health improvement activities with a strong focus on health inequalities, and also seek to work with other partnerships to influence wider determinants of health. These groups lead on delivering on relevant outcomes and indicators in the SOAs and are the central mechanism by which NHS Lothian and partners plan, deliver and monitor a range of health improvement activities in each area. Direct investment through the Health Improvement Fund is allocated on the basis of advice from these partnerships to ensure they meet locally identified needs and priorities.

In Edinburgh the relevant health improvement partnership, the Health Inequalities Standing Group, has developed a Health Inequalities Framework that identifies the role of partners across Community Planning Partnership. This group has invested in support for community health initiatives that work in more deprived areas of the city. NHS Lothian staff are also heavily involved in the Edinburgh Poverty and Inequalities Theme group, which is identifying interventions to address poverty and inequalities in Edinburgh.
Physical Activity:
Ageing Well projects in the four Community Planning Partnership (CPP) areas of Lothian aim to improve, maintain and promote the physical and mental health and wellbeing of older people and improve their quality of life through a programme of activities and services. These projects are part of the community planning structures in the four CPPs areas. Projects involve older people in volunteering to engage their peers in activities which benefits both volunteers and participants. Priority is given to tackling health inequalities.

Physical activity is a key focus for Ageing Well projects. An active lifestyle improves physical and mental health. The social nature of Ageing Well activities help to address isolation and loneliness which are known to be key risk factors for poor mental health in older people.

The Health Promotion Service provides funding to all four projects through Service Level Agreements. A consistent approach across Lothian has been developed whilst retaining the flexibility to address local needs. Evaluations of each project were completed and action plans were rapid impact assessed to ensure that work will focus on reducing inequalities in health and reach equalities groups among older people.

NHS Lothian also funds physical activity programmes through the Health Improvement Fund. In West Lothian this funding supports a worker and budget to develop and implement the ‘West Lothian On the Move’ strategy. In East Lothian the funding supports Active Choices East Lothian, which provides physical activity intervention for people with long term conditions. In Edinburgh several projects are funded which are all overseen by the Edinburgh Physical Activity and Health Alliance.

Current and Planned Performance Levels

The partnerships lead on the relevant outcomes in the single outcome agreements. The high level outcomes are as follows:

East Lothian: In East Lothian we live healthier, more active and independent
Edinburgh: Edinburgh’s citizens experience improved health and wellbeing, with reduced inequalities in health
Midlothian: Reduce Inequality in Health Outcomes
West Lothian: We live longer, healthier lives and have reduced health inequalities

Each health improvement partnerships has several topic specific subgroups charged with developing and delivering an action plan. The partnerships monitor progress against these plans.
Projects funded by the Health Improvement Fund are being evaluated during 2013/14. The partnerships are using these evaluations to advise on priority allocations for the next round of funding. Demonstrated outcomes from these projects in the past year include:

- 479 attendances at walking activities in Gorgie/Dalry, 566 in Wester Hailes, 87 in Pilton. These have targeted sedentary individuals who need support to take
part in walking activities but benefit from both the physical activity and the social support that the groups provide.

- Over 3,000 other physical activity attendances in Pilton, 1433 in Wester Hailes, over 500 in Gorgie/Dalry. These activities include aquafit, zumba, line dancing, chair based exercises for older people, and target sedentary individuals with low incomes who find it difficult to access other opportunities.

- Innovative use of social media to engage with, increase access to information and services and seek views of Deaf people. This project can demonstrate increased use of community cafes by Deaf people with opportunities to mix with and engage with local people and participate in local issues.

- Training in baby massage in all Midlothian Sure Start centres, with reported outcomes for clients including use of new skills at home, calming effect on babies and mothers, improved bonding, and improved sleeping.

- Parenting skills courses for vulnerable parents in Midlothian, which have increased parents’ confidence and skills. Parents have reported using new strategies and have demonstrated better skills to deal with challenging behaviour.

- Oral health programme in Midlothian Sure Start centres that resulted in 79.5% of families taking part being registered with a dentist.

- Provision of support to vulnerable, ‘hard to engage’ families in East Lothian that has resulted in parents becoming less isolated and being linked into drugs misuse and other services; in total clients have been supported to engage with 21 other agencies to meet their needs.

- Recorded improvements in healthy eating, child behaviour, sleep patterns and family engagement in vulnerable families in East Lothian.

- Vulnerable young people at risk of homelessness in Broomhouse are now accessing additional support on training/ employment and income maximisation.

- Service users of a range of initiatives in Edinburgh community health projects have reported improvements in physical and mental wellbeing, reduced social isolation and increased social networks.

- A small investment in a home safety programme in East Lothian has allowed provision of home safety equipment including 938 blind cleats, 65 information safety packs and face to face information provided to more than 100 families.

- 62% of relevant East Lothian staff, 35% of Midlothian staff and 74% of Edinburgh staff have received up-to-date breastfeeding training from the infant feeding advisers. This is important to ensure women receive evidence based advice and support and achieve baby friendly status.

- 57 premises in East Lothian and 30 in Midlothian accredited as ‘breastfeeding friendly’.

- Training for nursery staff in Edinburgh resulted in the proportion reporting positive attitudes towards breastfeeding increasing from 30.2% to 62.9%.

- Peer support programmes are now in place for breastfeeding women in each CHP area, using trained volunteer supporters.
Performance of the Ageing Well Programme is overseen by local Physical Activity Alliances which are supported through effective leadership of the NHS Lothian Senior Health Promotion Specialist and each have their own local Action Plans. Activity at local level contributes to achieving several outcomes for older people including:

- Older people live healthier, independent lives
- Older people experience better physical health
- Older people experience improved mental health and wellbeing

Benefits of our approach identified in Midlothian are as follows:

- Membership 356 older people but reaches approx 900 in a year
- Members engaged in the development of the ageing well services including the monitoring and evaluation
- Volunteers trained in food handling, walk leadership, first aid and health MOT health checks
- Volunteers lead and develop their own activities e.g ‘walk the line’ -204 people
- Members contribute to the development of ML older peoples strategy
- Activities chosen and evaluated by older people: Tai Chi, Yoga, Dance classes, Seated exercise, Pilates, New Age Kurling 50+ keep fit, Aquafit Singing group, Health walks
- Entered teams in Seniors Olympics from care homes – Increased physical activity, reduced social isolation and improved mental health and well being. Sustained changes following event where 100 took part.
- Changes include Feel fitter and healthier 68%, Increased social life – 51% and Happier – 43%

Priority: Economic recovery and growth

NHS Board Contribution in 2013/14

NHS Lothian is a main employer in and around Lothian. We are collaborating fully with East Lothian, Edinburgh Midlothian and West Lothian Community Planning partners in driving forward the economic recovery in the area as well as looking at innovative ways of working and supporting people through a range or developments and initiatives. Many of these may be through the work that we are and will do in developing our clinical services and in developing and redeveloping our ‘physical’ capital developments in the shape of new hospitals and community and primary care premises.

In developing the latest SOA for Midlothian, CPP partners have recognised the key future challenges being the national, and our locally based, response to the continuing economic downturn which was sparked by the 2007/8 financial crisis and subsequent global recession. This has given rise to, for example, severe cutbacks in public expenditure, the current and future challenges posed by public sector reform and the ongoing impact of welfare reform. Put together, these challenges are impacting, and will continue to impact, on our communities, businesses and local people living in Midlothian. In order to ensure local economies such as Midlothian can continue to take advantage of economic opportunities and address growing
problems, NHS Lothian and CPP partners recognise the need for greater partnership working and that joint solutions are more important than ever.

To address the challenges faced it is essential that partners work collaboratively and innovatively to grow Midlothian's economic potential and, in turn, support people into employment. The focus of our partnership work is geared to meeting these challenges and in supporting the effective delivery of our local economic outcomes. A key area of work in this regard is the development of an Economic Recovery Plan for Midlothian.

During 2013, NHS Lothian will therefore actively contribute to the development of the Midlothian Economic Recovery Plan (MERP) and implementation of actions contained in the MERP.

West Lothian’s rate of unemployment has increased by 0.4% to 4.5% in February. Through the community planning partnership and also through the West Lothian CHCP, NHS Lothian strives to ensure that all opportunities for employment and supporting people whilst unemployed are explored.

See additional NHS Lothian activity under the 'employment' section.

**Current and Planned Performance Levels**

Performance indicators to be developed, in line with the MERP

**Monitoring of West Lothian Economy**

**Priority: Older people**

**NHS Board Contribution in 2013/14**

2013/14 will be a key year for the four partnerships across Lothian for older people, in relation to the development establishment of Integrated Health & Social Care Partnerships, which will include services for older people.

The Board, through the Executive Leadership Group will lead and direct these developments from an NHS perspective, ensuring that key opportunities for improving quality and more effective and efficient service provision are maximised.

The Board Strategic Programme for Older People will be instrumental in the ongoing development of and implementation of Joint Commissioning Plans for older people, which are based on the robust foundations of the Joint Plans for Older People across the four partnerships, and the learning form the Change Fund Plans, with the focus on the following work streams:

- Preventative & Anticipatory care
- Proactive Care and Support at home
- Effective care at times of transition
- Hospital & Care Homes
- Enablers
NHS Board Information & Analysis support from will contribute to the ongoing development of projected capacity against future demand – feeding into the joint commissioning plan development.

The key indicators used to monitor performance across all four partnerships, are consistent with national measures, and will be reported through the appropriate governance structures within NHS Lothian are:

- reduce emergency admissions
- reduction in acute bed days rate
- reduction in delayed discharges
- improve quality of healthcare experience
- improve end of life care, improve mental well being
- improve support to meet care needs
- improve perceptions of care needs
- increase levels of support in intensity and numbers

**Partnership Examples:**

In terms of the wider policy agenda on shifting the balance of care, the **Midlothian Partnership** has successfully achieved and maintained its target for delayed discharges but continues to maintain it as a priority area.

The new delayed discharge standard came into effect on 1st April 2013 which is - the maximum wait for any patient to move to a community setting from being declared clinically ready for discharge is 4 weeks. Midlothian are on track to meeting this standard going forward. Resources have been transferred from care home settings into community based alternatives and this process will continue.

The role of unpaid/family Carers is a Local and National priory and Social Work works with partner agencies in the voluntary sector to ensure that their needs are identified and appropriate support and short breaks are available.

The Midlothian Partnership has been able to utilise the initial Change Fund resources to build on the successes of its transformation programme. This is perhaps best evidenced through the work streams that support capacity-building in the voluntary/independent sector, such as the extension of the re-ablement model. This continues the direction of travel and supports sustainability in future years. Such transformation has only been possible through strong partnerships and the Change Fund has accelerated the process by which the existing partnerships can jointly develop and manage commissioning strategies to ensure more effective and efficient services.

However, it is clear to all partners that if we are to realise our ambitions of providing seamless integrated care across primary, secondary, community and social care, then further work is required, supported by the Change Fund.

This approach is strengthened by the capacity to utilise lower-level partnerships within the community planning structure to allow more meaningful involvement from a greater number of voluntary and independent sector representatives.
Current and Planned Performance Levels

The Change Fund in Midlothian is a partnership approach with Midlothian Council, NHS Lothian and Midlothian CHP, Midlothian Voluntary Sector Providers, Midlothian Independent Sector Care Providers and VOCAL. A range of activities and interventions (detailed below) are being supported during 2012/13 to support the delivery of local and national outcomes.

- **Preventative & Anticipatory care**
  - Day treatment in local community hospital
  - 24-hour falls response service inc. SAS referral
  - Specialist input on respiratory conditions
  - Implementation of extra care housing mode. This will include the new development in Penicuik as part of the Phase 2 new build housing programme agreed by Council on 22/02/11
  - Day support – social isolation
  - Carers education
  - Short Breaks

- **Proactive Care and Support at home**
  - Increased skills to support people to die at home/ in care homes (linked to Complex Care Review)
  - Development of more capacity in care homes to manage ill health /end of life care.
  - Telecare/telehealth

- **Effective care at times of transition**
  - Assessment and step-down beds in Highbank
  - AHP time to enhance Community Rehab. capacity in relation to Intermediate Care
  - Working with social care sector on medication management
  - Local authority and independent CAH providers Reablement and Rehabilitation

- **Hospital & Care Homes**
  - Assessment and step-down beds in Highbank
  - Hospital in reach and needs assessment (L.T. replace SW service provided by City of Edinburgh)
  - Working with social care sector on medication management
  - Development of more capacity in care homes to manage ill health /end of life care.

- **Enablers**
  - Increased skills to support people to die at home/ in care homes (linked to Complex Care Review)
  - Development of more capacity in care homes to manage ill health /end of life care.
  - Quality assurance of independent sector

Local Indicators
- Enhance the Quality and Capacity of Services to Support People Safely in Their Own Homes
- Enhance Support Systems for Carers

National indicators
- We live longer, healthier lives
- We have tackled the significant inequalities in Scottish society
- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others
- Our public services are high quality, continually improving, efficient and responsive to local people’s needs.

Performance management information, against the agreed measures indicated above, will be used to determine trends and evaluate projections against population increases to determine demand on services, which will be enhanced, and reshaped to meet future needs.

The Change Fund allocation has a specific innovation element to it, allowing new ways of working and service delivery to be tried to achieve best results in the future.

The joint plan will be implemented using the Change Fund as a catalyst to achieve a shift in the balance of care to home or homely setting, whilst redesigning health and social care delivery and supports in order to meet future demands, across the whole system.

There is also performance monitoring on local indicators undertaken via the joint performance framework locally in Midlothian, which in turn will report on progress through the SOA into the Midlothian Community Planning Steering Committee.

The governance for the partnership is firmly rooted within Community Planning Partnership structures, acknowledging that the Change Fund ethos of equal partnership between sectors aligns with community planning’s vision of agencies and communities working together to plan and deliver better services, and will further develop as the integration of health and social care progresses.

EDINBURGH PARTNERSHIP

Through the Change Fund Partnership within Edinburgh, a robust evaluation process has been set up to monitor the performance and impact of the investments.

An Evaluation Framework has been developed for the Change Fund to ensure that programme is appropriately monitored and the impact on high level objectives is demonstrated as effectively as possible. The Evaluation Framework consists of the following elements:

- A logic model has been developed to demonstrate the linkages and contributions made by the range of work streams in delivering the high level outcomes of the programme.
• A range of high level system measures have been developed for each Lothian partnership and trends will be monitored as Change Fund plans are implemented further. A dashboard of key indicators has been created for regular reporting to the Change Fund Core Group.

• Local performance measures are being developed for each individual work stream to ensure that the outputs and outcomes achieved from the additional funding can be demonstrated.

• Contribution analysis is being developed with support from NHS Health Scotland and the Scottish Government Joint Improvement Team to support the evaluation of support for carers of people with dementia. It is hoped that the methodology can then be applied to other areas.

• Members of the Edinburgh partnership will be involved in ‘A Stitch in Time’, a Lothian wide project being led by the JIT to evaluate the impact of voluntary sector services to Reshaping Care for Older People.

Templates have been developed for the ongoing monitoring of financial and performance measures and work stream leads are supported to complete these.

Six-monthly evaluation meetings are held with the majority of the work streams within the programme. The evaluation of investments managed by the Voluntary sector partner, EVOC, are conducted on an annual basis. A full report is created on a six-monthly basis to reflect the progress made across these work streams. The most recent completed report is for the period to the end September 2012, with current work being done to compile reports to the period ending March 2013.

A small selection of some of the more sizeable investments made within the Edinburgh Change Fund Partnership are noted below:

Home Care Reablement enhancement: 2012/13 allocation: £1.145m

Additional Social Care Workers have been recruited to expand the capacity of the Re-ablement Service. Funding allows for 36 Whole Time Equivalents (WTE). The first additional worker came into post on 5 May 2011. Over 18 months, by the end of September 2012 a net increase of 19.5 WTE were in post. Most of this increase occurred at the beginning of the period. In April 2011 there were 185.6 FTE which had increased to 203.8 FTE in July 2011. The number of staff has remained relatively stable since then with 205.1 FTE in post in September 2012.

Money from the Change Fund was also used to continue the Re-ablement Service capacity developed as part of the Phased Implementation of New Model of Care for Orthopaedic and Stroke Rehabilitation Pathways.

Reablement is currently delivering 3,147 hours per week, but it is expected that when fully staffed the service should be able to deliver 4,400 hours per week.

Care at Home
2012/13 allocation: £1,000,000

The additional money made available through the Change Fund will be used to expand the services currently in place. At £14 per hour the £653,804 spend in 2011/12 is the equivalent of 898 hours per week.
During 2012/13 Care at Home provision for older people has increased from 27,101 hours in the first week of April 2012 to 30,235 hours in the last week of September, an increase of 11.6%. The projected volume of Care at Home delivered is expected to further increase by the end of March 2013 to 34,107 hours.

Overnight Service; 2012/13 allocation: £300,000

Money from the Change Fund is being used to expand the service. Prior to the additional funding three teams operated in the city. The extra funding allows the recruitment of staff for a further two teams to operate overnight. The fourth team commenced operation at the beginning of November 2011. The fifth team started work in February 2012.

The number of visits made by the service per night has increased from 65 visits in October 2011 to 99 in September 2012 (65%). The number of services users supported has also increased, but by a lower proportion (27%). This suggests that the number of people requiring more than one visit is increasing which would be expected as people with higher levels of need are supported in the community. The average cost per visit is £19.

**Priority: Employment**

**NHS Board Contribution in 2013/14**

NHS Lothian is the first Health Board in Scotland to have developed an outcome focused framework to support the planning, delivery and evaluation of its contribution to the Scottish Government’s Health Works strategy.

NHS Lothian acknowledges that Health Works outlines the NHS contribution to the ‘Scottish Offer’ as the commitment to include work outcomes as part of the patient recovery plan.

NHS Lothian took up the opportunity to pilot the national evidenced based outcomes framework and between September 2011 and May 2012 was supported by NHS Health Scotland to adapt the framework to a Lothian context. Those involved in the process included Public Health and Health Policy, Strategic Planning, Partnership, Human Resources, Health Promotion Service Healthy Working Lives, Allied Health Professionals, Occupational Health and Safety, The Works, Working Health Services Lothian and Community Health Partnerships/Community Health (Care) Partnerships. Key stakeholders including the Scottish Government and Jobcentre Plus were also involved.

NHS Lothian's vision for its framework is that it will contribute effectively to keeping people well and in work by:

- Protecting and promoting health in the workplace
- Supporting people with health conditions to stay in work
- Acting as an exemplar employer
- Encouraging the working age population to remain engaged with the world of work
Implementation of the framework is the responsibility of the NHS Lothian Health Works Strategic Group, chaired by the Director of Public Health and Health Policy. This group will retain an overview of NHS Lothian’s contribution to the health, work and wellbeing agenda nationally and locally, and also in relation to other strategies produced by NHS Lothian and community planning partners.

Developing the framework has highlighted the need for NHS Lothian to retain Working Health Services Lothian, a vocational rehabilitation service for small to medium enterprises (fewer than 250 employees). Funded since 2009 by the Scottish Government and the United Kingdom Department for Work and Pensions, the service (based at the Astley Ainslie Hospital) provides a multi-disciplinary and integrated case-management approach to vocational rehabilitation.

**Current and Planned Performance Levels**

To assess, monitor and review the performance of NHS Lothian in implementing the Health Works Outcome Focussed Framework, NHS Lothian has received funding from the Scottish Government to carry out this task during 2013-14. Through this process, measurable and realistic performance indicators for 2014-15 will be established. Where possible, performance will be measured and reported on at CPP level.
SUMMARY PAPER - STRATEGIC PLANNING COMMITTEE

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

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

- Agree that the Strategic Planning Group be established as a formal Committee of the Board chaired by the Board Chairman.  2.1
- Agree the attached Terms of Reference, including remit, membership and quorum of the Strategic Planning Committee.  2.2
- Agree that the first meeting of the Committee be held on Friday 18 October 2013.  2.3
- Agree the appointment of eight non-Executive Board members to the Committee.  2.4

Peter Reith
Secretariat Manager
12 September 2013
peter.reith@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
25 September 2013

Chairman

STRATEGIC PLANNING COMMITTEE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board establishes a Strategic Planning Committee.

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

2 Recommendations

2.1 Agree that the Strategic Planning Group be established as a formal Committee of the Board.

2.2 Agree the attached Terms of Reference, including remit, membership and quorum of the Strategic Planning Committee.

2.3 Agree that the first meeting of the Committee be held on Friday 18 October 2013.

2.4 Agree the appointment of the following non-Executive Board members to the Committee:

Kay Blair
Jeremy Brettell
John Iredale
Alex Joyce
Alison Meiklejohn
Alison Mitchell
George Walker
Robert Wilson

3 Discussion of Key Issues

3.1 During 2012 it was agreed that a number of Committees and operational groups would be merged in order to reduce the number of groups that Executive and Non Executive Board members were required to attend. These included the Board’s Service Redesign Committee, the Strategic Planning Group, Clinical Strategy Advisory Group as well as the Improving Care Investing in Change Board.

3.2 In merging these groups into the Strategic Planning Group it was agreed that this should be an operational group, supporting the development of the strategic plan/plans rather than a Committee of the Board. However in order to ensure that Non-Executives could be engaged in the process around developing our strategic agenda, it was agreed that a number of Non-Executive Board members be asked to join the Strategic Planning Group. Initially this included five Non-Executive Board members and then a sixth when the Chairman also joined the group. The current Non-Executive Board members on the
Group are: the Board Chairman, Robert Wilson, Alex Joyce, Alison Meiklejohn, Richard Williams, John Iredale and Robert Wilson.

3.3 Following the Board development session on 26 August and subsequent meetings of the Chairman, Chief Executive, Director of Strategic Planning, Performance Reporting and Information with a number of Non-Executive Board members it was agreed that there might be real value in the Strategic Planning Group becoming a formal Committee of the Board and be Chaired by the Board Chairman. In so doing this would provide fuller input and support from Non-Executive Board members in the key function of setting and influencing the strategic agenda of the organisation.

3.4 The paper sets out the remit and purpose of the proposed Committee as well as membership. It also states that at least three Non-Executive Board members need to be present to allow the Committee to be quorate.

4 Key Risks

4.1 The key risk is that the Board cannot effectively serve the population in future years. This can arise through failing to anticipate future health needs, or failing to recognise and respond to the strengths and weaknesses the Board has or the opportunities or threats that it faces. The proposals will facilitate the delivery of the Strategic Plan.

5 Risk Register

5.1 The proposals will contribute to the delivery of Corporate Objective 4 “To develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements”.

6 Impact on Inequality, Including Health Inequalities

6.1 Whilst a Rapid Impact Assessment has not been prepared for this terms of reference, strengthening the strategic planning processes and the engagement of Board members in them should generally assist the Board in addressing inequalities.

7 Involving People

7.1 This proposal has been discussed with the Chief Executive, Director of Strategic Planning, Performance Reporting and Information with a number of Non-Executive Board members.

8 Resource Implications

8.1 There are no resource implications arising from this proposal.

Peter Reith
Secretariat Manager
12 September 2013
peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Draft Terms of Reference
STRATEGIC PLANNING COMMITTEE

Remit

- Ensure that the Strategic Clinical Framework is driving all planning activity and the operational delivery of services and functions.
- Make effective use of intelligence from population health needs and epidemiological information, health and healthcare horizon scanning, demand and capacity analysis, and the performance information from the Board’s activities.
- Develop and recommend strategies to the Board for approval.
- Advise the Board on the appropriateness of clinical and supporting service strategies to achieve the high level vision and aims of the NHS Lothian Strategic Clinical Framework.
- Take an oversight role for the implementation of the Strategic Clinical Framework and identify the priority workstreams required to deliver safe, effective, person-centred care.
- Monitor the implementation of individual strategies and inform the Board of the extent of progress in comparison to the agreed implementation plans.
- Prepare a Committee response to requests for input to relevant external consultations, as well as internal consultations on specific Board plans e.g. financial plan, workforce plan, property and asset management plan. These responses should be from the perspective of implementing the Strategic Clinical Framework.
- Develop sustainable capacity plans to meet future demand.
- Ensure that the Board’s responsibilities for consultation and engagement within the planning processes are effectively discharged.

Membership

- Board Chairman (Chair)
- Employee Director
- Chair of the Area Clinical Forum
- University stakeholder member of the Board
- Six other non-executive Board Members
- Chief Executive
- Director of Strategic Planning, Performance Reporting & Information
- Director of Finance
- Medical Director
- Nurse Director
- Director of Public Health & Health Policy

All Board members shall have the right of attendance and have access to papers.
The following officers shall be routinely invited to attend all meetings:

- Director of Human Resources & Organisational Development
- Director of Communications & Public Affairs
- Joint Director of Health & Social Care - East Lothian
- Joint Director of Health & Social Care - City of Edinburgh
- Joint Director of Health & Social Care - Midlothian
- Joint Director of West Lothian Community Health & Care Partnership
- Associate Director (Strategic Planning)
- Director, Capital Planning

The Committee may invite additional individuals to attend to present on particular issues relevant to the Committee’s role.

**Frequency of Meetings**

Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. In any event, meetings shall normally be held monthly.

**Quorum**

No business shall be transacted at a meeting of the Committee unless at least three non-Executive Board members are present. Any Non-Executive Board Member may deputise for a non-Executive member of the Committee at any meetings.

**Reporting Arrangements**

The Committee will report to the Board by means of submission of minutes to the next available Board meeting, along with a summary of the key issues discussed.

The Committee will also produce an annual report to the Board on its activities in order to review its own effectiveness, and to contribute to the overall review of the effectiveness of the Board’s system of corporate governance.
SUMMARY PAPER – AUDIT SCOTLAND ANNUAL REPORT ON THE 2012/13 AUDIT

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

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

| • Audit Scotland’s annual report on Lothian NHS Board is published in the public domain alongside those of 200 other public organisations they audit | 3.1 |
| • The Annual Report on the 2012/13 audit incorporates aspects of the audit of the financial statements for 2012/13 already considered by Audit & Risk Committee in June 2013 in the form of the ISA 260 report. | 3.2 |
| • The Audit Scotland Report also comments on Governance and Accountability matters, Best Value, financial planning and identifies key risks with proposed management actions. | 3.5 – 3.5 |
| • The Annual Report is used to compile an overview of the NHS in Scotland which is also and separately published annually, usually in the last quarter of the calendar year, and broadly coinciding with the publication in public domain of the NHS Board Annual Accounts. | 3.1 |
| • The Audit and Risk Committee’s timetable has not permitted it to examine the contents of the Annual Report. Board officers have confirmed the consistency of the Financial Statements’ audit findings with the ISA 260 report and have reviewed the other contents of the report for accuracy and consistency. | 7.1 |
| • The Board will wish to consider the adequacy of the management responses to identified risks in appendix B of the report. | 3.4 |

Susan Goldsmith
Director of Finance
17 September 2013
Susan.goldsmith@nhslothian.scot.nhs.uk
AUDIT SCOTLAND: ANNUAL REPORT ON THE 2012/13 AUDIT

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the publication and contents of the Audit Scotland Annual Report on the 2012/13 audit of NHS Lothian. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 It is recommended that the Board note the management team responses to the high level risks identified in the report and,

2.2 note the context in how the report is embedded in the cycle of governance and accountability for public funds for NHS Lothian and NHS Scotland.

3 Discussion of Key Issues

3.1 The Audit Scotland Annual Report on the 2012/13 audit of NHS Lothian (The report), was issued by Audit Scotland at end July 2013. After consideration by the Board the report will be published on the Audit Scotland website and the information in the report will be used for the Auditor General’s annual overview of the NHS in Scotland. The annual overview report is published and presented to the Public Audit Committee of the Scottish Parliament around the end of the calendar year.

3.2 The report is issued separately and subsequent to the Report to those charged with governance on the 2012/13 audit (ISA 260) which was presented and reviewed by Audit & Risk Committee on 24th June 2013 as part of the audit and approval of the 2012/13 financial statements of NHS Lothian. The financial statements are expected to be laid before Parliament towards the end of September and the publication of the report is expected to be aligned with that, after consideration by the Board.

3.3 Whilst the content of the report incorporates the points contained within the ISA 260 the content is extended to cover wider issues of corporate governance, risk management, financial planning and partnership working. The issues identified here have been reviewed by officers for consistency with information held locally.

3.4 In addition, the report’s content is enhanced by the identification of high level risks identified during the audit. These risks, along with the planned management actions identified by officers, are included in appendix B to the report. Audit Scotland does not expect all the high level risks identified to be eliminated or even minimised. They
do expect the Board to understand these risks and the arrangements put in place to manage these.

3.5 The report includes specific additional financial comments (paragraphs 23 and 24) on the actuarial valuation of the NHS Scotland pension scheme underpinning the Board’s 2012/13 annual accounts disclosure in Note 24, and the impending adoption of IAS 27 which will potentially bring the assets and liabilities of the Edinburgh & Lothian NHS Foundation into a consolidated balance sheet for the Board in 2013/14.

4 Key Risks

4.1 The risks identified in the report are high level risks whose mitigation is part of the overall process of risk management in NHS Lothian.

5 Risk Register

5.1 The NHS Lothian and Department risk registers have more detailed and specific risks attached to financial performance, savings and performance target delivery and workforce management.

6 Impact on Inequality, Including Health Inequalities

6.1 There is no impact on inequalities arising from recommendations covering this report. The report itself highlights on pages 21 and 22 the Board’s progress on its general duty to encourage the mainstreaming of equality into its core work.

7 Involving People

7.1 The report was initially presented to officers in draft by Audit Scotland on 12th July 2013. Lead directors identified for the high level risks have provided the input to the management actions identified in respect of these risks. The report is addressed to the Board and the Auditor General for Scotland. However, it has not been possible to incorporate consideration or discussion of the report into the agenda and work plan of the Audit & Risk Committee.

8 Resource Implications

8.1 There are no significant resource implications arising from the report which deals specifically with the reporting and management of resource use and general corporate governance.

Susan Goldsmith
Director of Finance
16 September 2013
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List of Appendices

Appendix 1: Copy of Audit Scotland Report on the 2012/13 audit
Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.
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**Key Messages**

**2012/13 Key Facts**

The Scottish public sector is experiencing significant financial challenges in providing expected levels of service within the agreed financial framework. In 2012/13 we assessed the key strategic and financial risks being faced by Lothian Health Board. We audited the financial statements and we also reviewed the use of resources and aspects of performance management and governance. This report sets out our findings. The key financial messages are summarised in the exhibit below:

![Financial Statements Diagram]

**Financial Statements**

We have given an unqualified audit report on the financial statements of Lothian Health Board for 2012/13. We also concluded that in all material respects, the expenditure and income shown in the financial statements were incurred or applied in accordance with applicable enactments and relevant guidance issued by Scottish Ministers.

**Financial position and use of resources**

The board achieved all of its financial targets in 2012/13 and returned a saving against its total Revenue Resource Limit of £0.647 million as at 31 March 2013. Total efficiency savings of £37.500 million have been delivered in line with planned efficiencies for 2012/13. However £9.600 million of these savings were on a non-recurring basis. As a result, this has increased the recurring savings targets included in the board's 2013/14 financial plans to £24.7 million. It is important that the board achieves these targets as carrying forward unachieved recurrent
savings is unsustainable in the longer term although the level of carry forward is relatively stable and is reduced from 2011/12.

The board received £10 million brokerage from the Scottish Government Health and Social Care Directorates (SGHSCD) in 2012/13 to help address the waiting times backlog. The board has now repaid £2 million ahead of schedule to the Scottish Government leaving a remaining balance of £8 million. It anticipates repaying this outstanding balance by 2015/16 financed from efficiency savings.

The total capital budget was reduced from £53.7 million in 2011/12 to £34.3 million in 2012/13 as a consequence of a reduction in core capital allocations. The capital budget was higher in 2011/12 to accommodate a substantial phase of funding for the new Royal Victoria Hospital Building opened in 2012/13.

Governance and accountability

In 2012/13, the board had sound governance arrangements which included a number of standing committees overseeing key aspects of governance. These included Audit and Risk, Staff Governance, Healthcare Governance and Finance & Resources Committees. The board also had an effective internal audit function and sound anti-fraud arrangements. NHS Lothian continues to address the management culture issues identified at the time of its waiting lists investigation, with senior staff being more open about problems and operating within a more integrated and cohesive management team. The Chief Executive is also encouraging operational managers to be more open in the management of risks whilst pursuing operational performance targets.

Performance and best value

The board has a framework in place for monitoring and reporting performance. The board monitors performance through a suite of reports that are presented at monthly meetings.

In 2012/13 the board has met or exceeded a number of performance targets set by the Scottish Government. However the board is still addressing its waiting times problems, initially highlighted in 2011/12, and has not achieved its performance targets in this area. In particular, the board did not achieve its 4 hour Accident and Emergency waiting time target and there were also some cases where the statutory 12 week Treatment Time guarantee was breached. The board acknowledges that this will be a longer term challenge and aims to return to compliance on waiting times assisted by the brokerage support from SGHSCD noted above.

Audit Scotland’s report on the management of patients on NHS waiting lists found good practice at NHS Lothian in the use of TrakCare’s enhanced performance reporting to monitor patients on waiting lists and the development of the forensic dashboard tool. A local review of waiting times carried out by internal audit identified some areas for improvement. The board provided written assurance to the Scottish Government that improvement actions identified by internal audit had either been implemented or were in progress.
Outlook

The position for all NHS Boards going forward is becoming even more challenging than previous years with limited increases in funding, increasing cost pressures and challenging savings targets. To achieve continuing financial balance the board has to deliver £24.7 million of recurring cost savings in 2013/14. This will make maintaining or improving on the performance targets set by the Scottish Government even more challenging.

In this context, the board faces a number of performance challenges not least the achievement of access targets, which will take some further time to resolve. The board has considerably improved overall waiting time performance over the past year but challenges still remain as the recent good progress on reducing waiting times has stalled to some degree and indeed waiting times are likely to rise in the short term. Due to capacity and specialist workforce constraints in particular services (Orthopaedics, Ophthalmology and Urology) delivery of the waiting times and the new 12 week Treatment Time Guarantee, which is now a legal requirement (from 1 October 2012), requires significant resources to achieve and sustain. Managers are fully aware of the legislative nature of this guarantee.

NHS Lothian is also facing issues in relation to the management of unscheduled care where there are challenges in provision of sufficient workforce and facilities capacity to meet demand. In this context, demographic and population changes make it particularly difficult for the board to meet its demand targets. For example, Lothian's population is growing by 1% per year, broadly resulting in the need for one new GP practice per year and as the population becomes older there are more chronic conditions that need to be managed in the primary care sector. These are areas on which the board will be focussing as it develops its future service strategy.

The impact of the Public Bodies (Joint Working) Bill currently being reviewed through Parliament is likely to stretch the capacity of management in the short term, in locally meeting the organisational, governance and financial implications of the legislation around the integration of health and social care services.
Introduction

1. This report is the summary of our findings arising from the 2012/13 audit of Lothian Health Board. The purpose of the annual audit report is to set out concisely the scope, nature and extent of the audit, and to summarise the auditor’s opinions (i.e. on the financial statements) and conclusions and any significant issues arising. The report is divided into sections which reflect the extent of our public sector audit model.

2. A number of reports have been issued in the course of the year in which we make recommendations for improvements (Appendix A). We do not repeat all of the findings in this report, but instead we focus on the financial statements and any significant findings from our wider review of Lothian Health Board.

3. Appendix B is an action plan setting out the high level risks we have identified from the audit. Officers have considered the issues and agreed to take the specific steps in the column headed "planned management action". We do not expect all risks to be eliminated or even minimised. What we expect is that Lothian Health Board understands its risks and has arrangements in place to manage these risks. The Board and Accountable Officer should ensure that they are satisfied with the proposed management action and have a mechanism in place to assess progress.

4. This report is addressed to the board and the Auditor General for Scotland and should form a key part of discussions with the Audit & Risk Committee, either prior to or as soon as possible after the formal completion of the audit of the financial statements. Reports should be made available to stakeholders and the public, as audit is an essential element of accountability and the process of public reporting.

5. This report will be published on our website after consideration by the board. The information in this report may be used for the Auditor General's annual overview of the NHS in Scotland's financial performance later this year. The overview report is published and presented to the Public Audit Committee of the Scottish Parliament.

6. The management of the board is responsible for preparing financial statements that show a true and fair view and for implementing appropriate internal control systems. Weaknesses or risks identified by auditors are only those which have come to our attention during our normal audit work, and may not be all that exist. Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.
Financial statements

7. Audited bodies’ financial statements are an essential part of accounting for their stewardship of the resources made available to them and their performance in the use of those resources.

8. Auditors are required to audit financial statements in accordance with the timescales set by Audit Scotland, which may be shorter than statutory requirements, and give an opinion on:
   - whether they give a true and fair view of the financial position of audited bodies and their expenditure and income
   - whether they have been properly prepared in accordance with relevant legislation, the applicable accounting framework and other reporting requirements
   - the regularity of the expenditure and income.

9. Auditors review and report on, as appropriate, other information published with the financial statements, including the Governance Report, governance statement and the remuneration report. This section summarises the results of our audit of the financial statements.

Audit opinion

10. We have given an unqualified opinion in that the financial statements of Lothian Health Board for 2012/13 give a true and fair view of the state of the body's affairs and of its net operating cost for the year.

11. Lothian Health Board is required to follow the 2012/13 Government Financial Reporting Manual (the FReM) and we confirm that financial statements have been properly prepared in accordance with the FReM.

12. We have also reviewed the board's governance statement and concluded that it complies with Scottish Government guidance.

Regularity

13. The Public Finance and Accountability (Scotland) Act 2000 imposes a responsibility on auditors that requires us to certify that, in all material respects, the expenditure and income shown in the accounts were incurred or applied in accordance with applicable enactments and guidance issued by Scottish Ministers. We have addressed this requirement through a range of procedures, including written assurances from the Accountable Officer as to his view on adherence to enactments and guidance. No significant issues were identified for disclosure.

Accounting issues

14. The unaudited accounts were provided to us on 6 May 2013 supported by a comprehensive working papers package. The good standard of supporting papers and the timely responses from finance staff allowed us to conclude our audit within the agreed timetable and provide our
proposed opinion to the Audit and Risk Committee on 24 June 2013 as outlined in our Annual Audit Plan.

15. A small number of errors were identified during the audit, where if adjustments were made these would have a net effect of increasing the revenue surplus by £0.929 million. The net impact on the balance sheet would be to increase net assets by £0.899 million.

16. As required by auditing standards we reported to the Audit & Risk Committee on 24 June 2013 the main issues arising from our audit of the financial statements. The main points were:

Corporate Governance Report

17. The board’s new Corporate Governance Report format included in the draft financial statements effectively combined three statements - 'The Directors Report, the Operating and Financial Review and the Governance Statement'. Although the draft new format report read well, the relevant guidance still requires a specified form, and the auditor’s report format requires us to report specifically on the specified narrative elements of the financial statements and the Corporate Governance Report. A subsequent version of the accounts addressed this issue by reformatting the integrated report into a separate Governance Report and Governance Statement.

FHS Accrual

18. Actual data on expenditure on GP Prescribing costs are produced approximately two months in arrears. This means that an accrual to estimate the last two months of the financial year’s prescribing costs must be made in order to close the accounts in time for the audit to commence in May. The accrual based on the March estimated chemists’ declared volume was different from the final actual position by £0.929 million, after including pricing changes applied to the declared volumes. Therefore the accrual is misstated by that amount. Though significant, the prescribing estimate was not amended on grounds of materiality and was recorded in the ISA 260 report as an unadjusted difference in the accounts.

Asset Lives

19. As a consequence of the implementation of the Non-current Asset Accounting System (Real Asset Management), a specific category of equipment depreciation relating to specialist medical equipment and related analytical equipment has now been incorporated into the notes to the accounts. This now reflects the appropriate spread of rates dependent on the nature of the equipment from items such as probes (3 years) to Linear Accelerators (15 years), and we concur with this approach.

Equal Pay Claims

20. The National Health Service in Scotland has received in excess of 9,000 equal pay claims and currently there remained 1,487 grievances registered against Lothian Health Board. These have been referred for the attention of the NHS Scotland Central Legal Office (CLO) to co-ordinate the legal response to this issue.
21. The SGHSCD, the CLO and Audit Scotland met in March 2013 to review the accounting treatment and disclosure requirements for the 2012-13 accounts. The CLO continues to advise that it is not possible to provide any financial quantification of Equal Pay Claims at this stage because of the lack of information available. Given the CLO’s advice, the SGHSCD have notified NHS boards that the appropriate accounting treatment is to disclose the claims as a contingent liability although with an expanded disclosure recognising the developments over the last couple of years. This is provided in note 19 to the board’s accounts.

22. As with other boards, Lothian Health Board has not been able to quantify the extent of its liability for Equal Pay claims and has disclosed a contingent liability. There is a residual risk that as these claims progress they could have an impact on the board’s financial position.

Risk Area 1

Pension costs

23. Following national guidance from the Scottish Government, Note 24 of the accounts: Pension Costs reflects a Scotland-wide net liability of £370 million for the NHS Superannuation Scheme arising from the most recent actuarial valuation for the year 31 March 2004. A more recent actuarial valuation was carried out at 31 March 2008, but the publication of this valuation has been placed on hold by HM Treasury pending the outcome of public sector pension reforms. Contributions by employees have been steadily increased since 2008 valuation. However, given that periodic actuarial valuations are critical to determining the adequacy of employer and employee contributions to the Scheme, publication of the latest actuarial valuation will bring clarity as to the adequacy of current contributions to meet the future costs.

Outlook

Endowments

24. As a result of an agreed derogation from the FReM NHS Scotland boards were not required to consolidate endowment funds within their 2012/13 financial statements in terms of IAS 27 (Consolidated and Separate Financial Statements). IAS 27 has now been superseded by IFRS 10 for 2013/14. The Treasury and Scottish Government have delayed the consolidation of NHS Endowment Funds until financial year 2013/14. The consolidation process will be reviewed as part of our audit of the 2013/14 financial statements.
Financial position

25. Audited bodies are responsible for conducting their affairs and for putting in place proper arrangements to ensure that their financial position is soundly based.

26. Auditors consider whether audited bodies have established adequate arrangements and examine:
   - financial performance in the period under audit
   - compliance with any statutory financial requirements and financial targets
   - ability to meet known or contingent, statutory and other financial obligations
   - responses to developments which may have an impact on the financial position
   - financial plans for future periods.

27. These are key areas in the current economic circumstances. This section summarises the financial position and outlook for the organisation.

The board’s financial position as at 31 March 2013

28. Lothian Health Board is required to work within the resource limits and cash requirement set by the SGHSCD. In 2012/13, the SGHSCD required NHS boards to differentiate between core and non-core expenditure for both revenue and capital. The board achieved all its financial targets in 2012/13 as outlined in the table below:

<table>
<thead>
<tr>
<th>Financial Target</th>
<th>Target</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue Resource</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core</td>
<td>1,193,832</td>
<td>1,193,185</td>
<td>647</td>
</tr>
<tr>
<td>Non Core</td>
<td>111,205</td>
<td>111,205</td>
<td>0</td>
</tr>
<tr>
<td><strong>Capital resource</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core</td>
<td>34,321</td>
<td>34,321</td>
<td>0</td>
</tr>
<tr>
<td>Non Core</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cash position</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash requirement</td>
<td>1,315,000</td>
<td>1,314,287</td>
<td>713</td>
</tr>
</tbody>
</table>

29. The board has achieved a cumulative surplus of £0.647 million. The board had budgeted to break-even against its Revenue Resource Limit in 2012/13. Despite the small surplus, in 2012/13 the board recorded an underlying recurring deficit of £9.6 million, which represented the excess of recurring expenditure commitments, over recurring funding and savings, carried forward into 2013/14, which was met by a non-recurring surplus. The challenge for 2013/14
will be to ensure that recurring expenditure is met through recurring funding as projected within the financial plan.

30. Historically, boards have relied upon a measure of non-recurring funding to achieve financial targets. However, due to the one-off nature of this type of funding, the tighter financial settlement compared to the past and reduced flexibility within expenditure budgets, there is less scope for reliance on non-recurring income to achieve financial balance as NHS boards seek to rationalise their cost base.

Risk Area 2

31. The board received £10 million brokerage from the SGHSCD in 2012/13 to address its Waiting Times backlog. The board has now repaid £2 million of this brokerage ahead of schedule to the Scottish Government leaving a remaining balance of £8 million. It anticipates repaying this outstanding balance by 2015/16 financed through further efficiency savings.

Capital Resource Limit

32. The board broke even against its total Capital Resource Limit (CRL) in 2012/13 with total capital expenditure of £34.321 million. The total capital allocation consisted wholly of core capital funding. The CRL limit was also adjusted in January in relation to a capital to revenue transfer of £1.500 million to assist the board address risks in relation to estate condition and backlog maintenance.

33. The core capital allocation was reduced from £53.742 million in 2011/12 to £34.321 million due to the completion of major build projects such as the Royal Victoria Building. In future years, the core capital allocation will increase to accommodate enabling expenditure for the new Royal Hospital for Sick Children and the Department for Clinical Neurosciences project.

34. Major items of capital expenditure in 2012/13 were £13.300 million on Medical Equipment, £4.300 million incurred on the new Wester Hailes Health Centre and £2.900 million on the Royal Victoria Building.

Financial planning to support priority setting and cost reductions

35. The board's Local Delivery Plan (LDP) for 2013/14 aligns the board's strategic priorities with its financial plan, workforce plan, operational target trajectories and risk management plan. The board's financial planning arrangements include regular monitoring, reporting and updating of information to ensure that the board has a key focus on inherent uncertainties and risks that will impact on cost pressures that the board will be required to manage. It is therefore important that the board continues to closely monitor costs in order to be able to take appropriate action to manage cost pressures. The board is undertaking work during 2013/14 to align its financial, asset management and workforce strategies to the clinical framework approved in February 2013.
Workforce Planning

36. The board is committed to ensuring that workforce planning contributes to efficiency savings, as improving efficiency and effectiveness within the workforce can generate savings for reinvestment. The board is investing a greater level of resource to resolve its waiting times backlog than first estimated. This has led to an increase in clinical resource within acute services to meet the additional demand, specifically for waiting times and also within unscheduled care. The average HCH Whole Time Equivalent Staff increased by 198.5 over 2012/13 (a 1% increase).

37. The board remains committed to ensuring maximum workforce efficiencies through the promotion of its attendance at work agenda and the overall target of 4% sickness absence rate. The board's sickness absence rate at 4.29%, though slightly higher than the target, is consistently the lowest of all Teaching Boards in NHS Scotland. The board is also on track to achieve the reduction in senior management target of 25% by 2013/14. This latter target is a particular challenge for the board in terms of reduced management capacity as it seeks to address the 12 week waiting time guarantee and reduce waiting time backlogs whilst also restructuring its acute and community health partnership management arrangements. The board is focussed on medical workforce risks and how it will respond to operational risks to services around recruitment and retention of specialist medical staff in areas such as emergency medicine and paediatrics.

Risk Area 3

Outlook

Financial sustainability and the 2013/14 budget

38. Uplifts in financial settlements have been reducing in recent years as outlined below:

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>General Uplift</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>3.15%</td>
</tr>
<tr>
<td>2010/11</td>
<td>2.15%</td>
</tr>
<tr>
<td>2011/12</td>
<td>1.1%</td>
</tr>
<tr>
<td>2012/13</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

39. Looking forward, the indications are that funding uplifts are likely to be around 2.8% in 2013/14 and 2.6% in 2014/15. Given the current economic conditions and the impact of national spending priorities, there is a risk that these pressures will have a significant impact on long term financial planning and the control of pay and non-pay costs.
40. The cost challenges facing the board are significant and in some cases there is an element of uncertainty about further potential increases in costs. In 2012/13 the board’s cost savings plan was pivotal to the board achieving financial balance. The plan set a recurrent cost savings target of £37.5 million which was achieved, with £27.9 million achieved on a recurrent basis and the remaining £9.6 million achieved on a non-recurrent basis. The board’s ability to achieve financial balance is again largely dependent on its success in development and ongoing management of a comprehensive cost savings plan which covers pan-Lothian work-streams as well as local departmental initiatives.

41. To break even in 2013/14, the board plans to achieve £24.7 million of recurring cost savings which is the equivalent to 2% of the board’s baseline revenue allocation. The challenge for 2013/14 will be to ensure that recurring expenditure is met through recurring funding as projected within the financial plan. In 2011/12, the board carried forward £10.5 million of non-recurrent savings so this position has improved in 2012/13 albeit slowly. However, this is not a sustainable position in the longer term. This represents a major challenge to the board and expenditure during the year will require to be closely monitored to identify and address any emerging budget pressures or projected overspends through its quarterly review and financial planning processes.

42. The board continues to face significant cost pressures relating to capacity and service developments, the rate of growth in anticipated prescribing costs and volume, along with anticipated increases in workforce costs and supplies during 2013/14. There are provisions in the 2013/14 Financial Plan to cover such issues as service developments (£3.2 million) and increased prescribing costs across both secondary and primary care (£10.5 million).

43. All additional expenditure will require to be met from the board’s existing funding resource, NHS Scotland Resource Allocation Committee (NRAC) uplifts and efficiency savings. It is worth noting that Lothian Health Board’s NRAC allocation remains significantly below parity which impedes the speed of its response in addressing capacity issues. Any significant fluctuations in these costs will present a major challenge to Lothian Health Board achieving financial balance for the coming year. The cost savings are to be achieved through a number of means, including work stream plans, strict vacancy management and a continued focus on prescribing costs.

44. As in previous years, the recurrent delivery of the Local Reinvestment Plan will remain a significant challenge for the board during 2013/14 and beyond. The level of flexibility within expenditure budgets is considerably reduced by the release of cost savings in previous years. Failure to achieve planned cost savings will impact on the board’s ability to achieve a break even position.

Risk Area 2
Governance and accountability

45. The three fundamental principles of corporate governance – openness, integrity and accountability – apply to all audited bodies, whether their members are elected or appointed, or whether they comprise groups of people or an individual accountable officer.

46. Through its chief executive or accountable officer, each body is responsible for establishing arrangements for ensuring the proper conduct of its affairs including the legality of activities, corporate and clinical governance, the probity of transactions, and for monitoring the adequacy and effectiveness of these arrangements. Audited bodies usually involve those charged with governance (including audit committees or similar groups) in monitoring these arrangements.

47. Consistent with the wider scope of public audit, auditors have a responsibility to review and report on audited bodies’ corporate governance arrangements as they relate to:
   - corporate governance and systems of internal control
   - the prevention and detection of fraud and irregularity
   - standards of conduct and arrangements for the prevention and detection of corruption.

48. In this part of the report we comment on key areas of governance.

Corporate governance

Management Culture

49. The previously documented problems with NHS Lothian's management culture have shown signs of improvement at the senior management level, which is now more open about problems and is working more closely as a management team. The board recognises that a lot of hard work is still needed to move away from a target focused environment based on a risk adverse culture. The Chief Executive and senior management are encouraging operational managers to take on and manage risks rather than focus solely on targets.

50. NHS Lothian has improved risk management through clearer alignment of the risk register with corporate objectives. The previous Audit and Operational Audit Sub-Committee have been replaced by the Audit & Risk Committee to improve the focus on the board's systems of risk management and that risk management approach appears to be working effectively. The Chief Executive has also set up a Risk Management Steering Group which meets monthly to quality assure and score current and emergent corporate risks. The board's agenda is also been restructured to reflect the risks that NHS Lothian has been identified as facing.
Processes and committees

51. In 2012/13, revised governance arrangements and changes to the management structure were implemented following the reviews of management culture and the adequacy of information coming to the board which had been prompted by the waiting list issues which emerged at the board in 2011/12. The aim was to look at streamlining the board committee structure to ensure appropriately triangulated and independently produced defensible information is reported to the board. The review identified a more efficient and effective committee structure, with revised remits to assist the board in discharging its overall governance responsibilities.

52. This work also included a review of all Governance Committees terms of reference as part of Lothian Health Board's action plan to address the organisational culture and the issues raised by the Review of Information Received report (April 2012). This is a four stage process with:

- a review of the board's overall assurance map in relation to the committees responsibilities
- a review of the terms of reference and a schedule of legal responsibilities
- approval of the terms of reference followed by development of a statement of assurance needs
- Identification by each committee of what information it requires to service its assurance needs and its wider remit, so as to be satisfied that it has reliable information sources and an adequate source of reporting.

53. The executive board members meet monthly with senior managers as a Joint Management Team (JMT). The full NHS Board meets on a monthly basis, for ten months of the year, with no meetings held in August or December. Oversight of performance is a key function of the board, but individual committees undertake performance review appropriate to their areas of responsibility, where previously this task was undertaken by one committee. The following paragraphs provide a brief comment on the main standing committees and changes:

- **Audit & Risk Committee** - The committee assists the board to deliver its responsibilities for the conduct of its business, including the stewardship of funds under its control. It also helps provide assurance to the board that an effective system of internal control has been in place throughout the year and risk management arrangements are working effectively to support the governance statement

- **Healthcare Governance Committee** - It supports the board in delivering its statutory responsibility for the provision of quality healthcare. In particular, the committee seeks to give assurance to the board that appropriate systems are in place, which ensure that clinical governance and clinical risk management arrangements are working effectively to safeguard and improve the quality of clinical care

- **Staff Governance Committee** - Its role is to provide assurance to the board that Lothian Health Board meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard. To support and maintain a culture within Lothian Health Board where the delivery of the
highest possible standard of staff management is understood to be the responsibility of everyone working within the system and is built on partnership and collaboration

- **Finance and Resources Committee** - Financial performance management remains the responsibility of the JMT and ultimately the board. The Finance and Resources Committee remit was revised to focus on financial strategy and planning, property and asset management strategy and Strategic and Capital Projects in order to strengthen governance and scrutiny arrangements in relation to key financial issues/risks.

### Patient safety and clinical governance

54. Overall, clinical governance is within the remit of the Healthcare Governance Committee. The Committee provides assurance to the board that the principles and standards of clinical governance are applied to health improvement and protection across Lothian Health Board. Patient safety is at the heart of clinical governance and risk management.

55. The Healthcare Environment Inspectorate (HEI) has a key role in helping NHS boards reduce the risk of Hospital Associated Infection (HAI) in acute hospitals through assessment, inspection and reporting of boards’ performance against HAI standards. The HEI carries out both announced and unannounced visits to hospitals over a three year cycle. In the last 12 months the HEI undertook an unannounced visit to the Royal Hospital for Sick Children in July 2012 and the Western General Hospital in February 2013. In both cases, HEI have highlighted scope for improvement and action plans have been implemented.

### Partnership Working

56. Partnership working is actively being promoted by the Scottish Government as a means of making service delivery more efficient and cost effective. The board has three well established Community Health Partnerships (CHPs) and one Community Health and Care Partnership - West Lothian. Lothian Health Board and West Lothian Council joined forces in 2005 to bring together community based health and social care services closer together wherever possible and working in partnership to deliver more accessible, integrated and high quality services which are jointly planned and community-focused.

57. The Scottish Government is moving forward on the integration of Adult Health and Social Care services across Local Authorities and NHS Boards. In keeping with this initiative Lothian Health Board has reviewed its CH(C)P structures in partnership with the local authorities within its area and has created four Health and Social Care Partnership Shadow Boards. In recognition of the scale of anticipated change these boards are focused on establishment of robust governance arrangements and the broader partnership arrangements between health and local authorities and maximising collaborative approaches both within health, across primary and secondary care and across sectors.
58. The main focus of these new arrangements is to drive forward the health and social care integration agenda consistent with Scottish Government Policy and to lead the development of new models of care to deliver improved outcomes and more efficient and effective services for the people of the Lothians. Lothian Health Board along with local councils is also considering what tangible steps can be taken to locate the Health and Social Care Partnership Board firmly within the Community Planning context. This is a very challenging agenda for public sector organisations given that plans are currently being formulated in relation to draft legislative proposals (Public Bodies (Joint Working) Bill) that are subject to service consultation, and against which corporate and financial governance frameworks have yet to be agreed.

Internal control

59. While auditors concentrate on significant systems and key controls in support of the opinion on the financial statements, their wider responsibilities require them to consider the financial systems and controls of audited bodies as a whole. The extent of this work is informed by their assessment of risk and the activities of internal audit. Key controls within systems should operate effectively and efficiently to accurately record financial transactions and prevent and detect fraud or error. This supports a robust internal control environment and the effective production of financial statements.

60. In their annual report for 2012/13 Lothian Health Board Internal Audit work provided their opinion that, based on the internal audit work undertaken during the year, that generally adequate and effective internal controls have been operating throughout the year. During the year no reports were issued with a ‘fully satisfactory’ or ‘unsatisfactory’ rating, although 6 audit reports (33%) were concluded as requiring improvement. Internal Audit work also supports the conclusion that the Governance Framework is sufficient for the Chief Executive to discharge his responsibilities as Accountable Officer.

61. As part of our audit we reviewed the high level controls in a number of Lothian Health Board systems that impact on the financial statements. This audit work covered a number of areas including general ledger, payroll, cash and cash equivalents, trade payables, trade receivables, family health services, capital accounting and inventories. We also reviewed employee severance schemes, the acceptance of gifts and hospitality and the register of interests. Our overall conclusion was that Lothian Health Board had adequate systems of internal control in place in 2012/13. We identified some areas where controls could be strengthened and agreed an action plan of improvements with management. This will be followed-up at a future date to confirm that improvements have been made.

Internal Audit

62. A key element of our work on internal controls is the extent of reliance that we can place on the work of internal audit in terms of International Standard on Auditing 610 (Considering the work of Internal Audit). The review of internal audit was carried out in December 2012 and concluded that the internal audit service operates in accordance with Government Internal Audit Standards and has sound documentation standards and reporting procedures in place.
63. We also placed formal reliance on the work of internal audit, for the purposes of our financial statements audit, in a number of areas including Primary Care Contractors - Payments and Contracts, Bank and Cash and Accounts Receivable. This not only avoided duplication of effort but also enabled us to focus on other areas of risk.

Governance Statement

64. The governance statement, provided by the board's Accountable Officer in the board's annual report and accounts, reflects the main findings from both internal and external audit work, and highlights the process by which the accountable officer obtains assurances over the adequacy and effectiveness of the system of internal control. Additionally, the governance statement includes the requirement for an overt assurance that arrangements have been made to ensure best value.

65. Overall it was concluded by the Chief Executive and Accountable Officer that no significant control weaknesses or issues have arisen, with the exception of waiting times and related issues of management culture. The Accountable Officer reports that substantial progress has been made towards meeting Waiting Times Standards and the Times to Treatment Guarantees set out in The Patient Rights Act 2011 and it is expected that this progress will continue. In addition, the Accountable Officer records that a repayment profile for the outstanding £8 million of Brokerage received from the Scottish Government is included in the LDP for 2013/14. Otherwise the statement reports that no significant failures have arisen in the expected standards for good governance, risk management and control, and that appropriate arrangements for Best Value are in place. Our audit has confirmed that we concur with this assessment.

ICT eHealth Services Follow-up

66. As part of our 2012/13 audit we carried out an ICT - eHealth Services Follow-Up at Lothian Health Board. We carried out a follow-up of three reviews that had been carried out in the past few years. Our audit considered the actions implemented to address risks identified in the following reports:

- Computer Services Review, letter issued 31 May 2012
- eHealth Service Delivery Review, report issued 30 September 2011

67. Overall good progress has been made in addressing the risks raised during our previous reviews. We found that from the 21 risk areas identified; only 3 risks have not been fully addressed yet and these are in progress. All other actions have either been fully implemented, have been superseded by technological developments, and further action is not required.
Prevention and detection of fraud and irregularities

68. Audited bodies are responsible for establishing arrangements to prevent and detect fraud and other irregularity. Auditors review and report on these arrangements.

69. Lothian Health Board has a range of measures in place to prevent and detect fraud, including Standing Financial Instructions, a Code of Conduct for board members and a number of other policies that are available to staff via the intranet including 'Freedom of Speech Policy' - (whistleblowing). The board has also entered into a formal partnership agreement with NHS Scotland Counter Fraud Services (CFS) and a Fraud Liaison Officer is in place to ensure reports are circulated to appropriate managers and to the Audit and Risk Committee.

70. Lothian Health Board has had a Counter Fraud Action Group in place for four years (which CFS are members of) and the board is active in making fraud referrals, which is a direct result of the awareness work that has been done. The board has a counter fraud action plan which summarises the arrangements that are in place.

71. The board’s internal audit function has a formal programme of work, which, although not designed to detect fraud, does provide assurance on the operation of the control systems which are designed to prevent fraud. In addition, the board has agreed a formal protocol covering a programme of payment verification checks within the Practitioner Services division of NHS National Services Scotland. The Audit & Risk Committee were assured that the board has adequate systems for people to raise issues relating to irregularities.

72. We concluded that the board's arrangements were adequate in relation to the prevention and detection of fraud and irregularities, although it should be noted that no system can eliminate the risk of fraud entirely.

NFI in Scotland

73. Lothian Health Board participates in the National Fraud Initiative (NFI). The NFI uses computerised techniques to compare information about individuals held by different public bodies, and on different financial systems, to identify circumstances (matches) that might suggest the existence of fraud or error.

74. NFI allows public bodies to investigate these matches and, if fraud or error, has taken place, to stop payments and attempt to recover the amounts involved. It also allows auditors to assess the arrangements that the bodies have put in place to prevent and detect fraud, including how they approach the NFI exercise itself.

75. The most recent data matching exercise collected data from participants in October 2012 with matches identified for follow-up in February 2013. The investigation so far has identified matches in both the creditors and payroll systems. All of the recommended matches are currently being investigated and to date, no instances of fraud have been identified.

76. The Audit and Risk Committee receives regular reports on anti-fraud activities including NFI updates. Overall, we concluded that the board has satisfactory arrangements in place for investigating and reporting data matches identified by the NFI.
Standards of conduct and arrangements for the prevention and detection of corruption

77. Audited bodies are responsible for ensuring that their affairs are managed in accordance with proper standards of conduct and have proper arrangements in place for implementing and monitoring compliance with standards and codes of conduct, standing orders and financial instructions. Auditors consider whether bodies have adequate arrangements in place.

78. The board has a Code of Conduct for Board Members that is in compliance with the Ethical Standards in Public Life etc. (Scotland) Act 2000. This includes a register of interests. Lothian Health Board's anti-fraud and corruption message is disseminated to staff through intranet, connections magazine and the procedure on business conduct (applying the principles of good business). Lothian Health Board's Standing Financial Instructions (“SFIs”) sets out high level principles on good business conduct expected of employees. This is supplemented with the procedures and guidance on applying the principles of good business conduct.

79. We have concluded that the arrangements for the prevention and detection of corruption in Lothian Health Board are satisfactory, and we are not aware of any specific issues that we need to identify in this report.

Equality Act 2010

80. In April 2011, the Equality Act 2010 introduced a new public sector ‘General Duty’ which encourages equality to be mainstreamed into public bodies’ core work so that it is not a marginal activity but part of everyday business. Lead responsibility for mainstreaming equality and diversity rests with Lothian Health Board's Director of Human Resources & Organisational Development supported by the Head of Equality and Diversity.

81. The board’s 'Mainstreaming Equality in Lothian Health Board - Report 2013' reports progress towards mainstreaming equality. The report sets out the context for equality legislation and Lothian Health Board. It cites potential benefits of mainstreaming and recognises what Lothian Health Board is doing to integrate equality into its core functions. This is being achieved in a number of ways, including:
   - Equality and Rights Action Plan 2013-17
   - Through the Equality and Diversity Team, EQIA Steering Group, Equality Leads and relevant Executive Directors and senior management
   - Targeted training programmes to meet identified needs from Equality Rights Action Plan 2013-17
   - The setting of objectives for relevant managers as part of their performance management arrangements
   - Establishment of baseline and robust data to measure achievement of equality outcomes
   - Communication of equality issues through the intranet, internet and staff newsletter
   - The achievement of equality outcomes for monitoring by the board.
82. In terms of the Equality legislation, the board is required to publish information about its Equality outcomes, the actions taken by the board and the progress made to achieve them. This is to allow the public to assess the organisation's performance on equality. Consequently, the board must publish a report on the progress made no later than 30 April 2015.

**Outlook**

**Partnership Working**

83. Between 2011/12 and 2014/15 the Scottish Government’s spending will fall by 5.5% (£1.5 billion) allowing for inflation. Reductions of this scale are a significant challenge for the Scottish Public Sector. The Christie Commission report on the future of public services (June 2011) highlighted the need for a new, more radical, collaborative culture throughout Scotland’s public services with a much stronger emphasis on tackling deep-rooted and persistent social problems in communities.

84. The Scottish Government is developing its approach to the integration of Adult Health and Social Care, with publication of the Public Bodies (Joint Working) (Scotland) Bill in May 2013, which will have organisational and operational impacts for all NHS boards. There is also now a renewed focus on partnership working focused on community planning. Audit Scotland’s recent report on Improving community planning in Scotland (March 2013) highlighted that community planning has had little influence over mainstream public sector budgets and other resources used to date. The Scottish Government has re-emphasised the central role that community planning should play in driving the reform of public services. Indeed, the ‘Statement of Ambition’ published by the Scottish Government and the Convention of Scottish Local Authorities sets out high expectations of community planning and puts the community planning process at the core of public service reform by providing the foundation for effective partnership working, within which wider reform initiatives will happen.

85. The increasing importance of partnership working within a community planning framework is still evolving and we will monitor progress in this area.
86. Accountable officers have a specific responsibility to ensure that arrangements have been made to secure Best Value.

87. The Auditor General may require that auditors consider whether accountable officers have put in place appropriate arrangements to satisfy their corresponding duty of Best Value. Where no requirements are specified for auditors in a period they may, in conjunction with their audited bodies, agree to undertake local work in this area.

88. As part of their statutory responsibilities, the Auditor General and the Accounts Commission may procure, through Audit Scotland, examinations of the use of resources by audited bodies and publish reports or guidance. Auditors may be requested from time to time to participate in:
   - a performance audit which may result in the publication of a national report
   - an examination of the implications of a particular topic or performance audit for an audited body at local level
   - a review of a body’s response to national recommendations.

89. Auditors may also consider the use of resources in services or functions, where the need for this is identified through local audit risk assessments. Audit Scotland has prepared a series of Best Value toolkits to facilitate its reviews in these areas.

90. During the course of their audit appointment auditors should also consider and report on progress made by audited bodies in implementing the recommendations arising from reviews in earlier years.

91. This section includes a commentary on the Best Value / performance management arrangements within Lothian Health Board. We also note any headline performance outcomes / measures used by Lothian Health Board and any comment on any relevant national reports and the board's response to these.

Management arrangements

Best Value

92. In March 2011, the Scottish Government issued new guidance for accountable officers on Best Value in Public Services. It required public bodies to take a systematic approach to self-evaluation and continuous improvement. Furthermore, the guidance identifies the seven themes which an organisation needs to focus on in order to deliver the duty of Best Value. It also notes that implementation should be appropriate and proportionate to the priorities, operating environment, scale and nature of the body's business.
93. The five themes and two cross-cutting themes (some of which we have commented on earlier in this report) are:

- Vision and Leadership
- Sustainability (cross-cutting)
- Effective Partnership
- Equality (cross-cutting)
- Governance & Accountability
- Performance management
- Use of resources

94. Lothian Health Board is committed to the principles of Best Value and continuous improvement, and produces an annual Best Value Assurance Statement. The Corporate Governance Manager presented this statement to the Audit and Risk Committee at their meeting on 24 June 2013. We will continue to monitor developments in this area.

Service Redesign

95. During 2012/13 oversight of service redesign became the responsibility of the newly established Strategic Planning Group (replacing the former Service Redesign Committee and Improving Care Investing in Change Executive Group). This group makes regular reports to the board and, in February 2013, published the Lothian Health Board Strategic Clinical Framework 2012-2020. Challenges facing Lothian Health Board in future years include:

- An increasing population with the greatest increase in the over 75 age group
- Socioeconomic health differences and lifestyle-based health problems
- Increased incidence of cancer, dementia and obesity
- Changes in the skills mix of the board workforce
- Stagnant real terms growth in health spending.

96. The Framework includes key principles for health and healthcare planning and sets out six aims and associated actions as follows:

- Prioritise prevention, reduce inequalities and promote longer healthier lives for all
- Establish robust systems to deliver the best model of integrated care across primary, secondary and social care
• Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
• Design healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
• Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
• Use resources efficiently and effectively.

97. Delivery of the actions within the framework will be through new models of care, some delivered jointly with local authority partners such as integrated health and social care. The immediate priorities outlined in the strategy are:
• integrated care pathways for frail and elderly patients with complex needs
• consistency of care for older people with complex needs accessing high volume elective surgery
• improved condition-specific pathways associated with long term conditions.

Performance management

98. A key component of the board's performance management and reporting framework is the monthly performance reporting to the board. Performance reports are presented at each meeting of the board and provide assurance of the overall performance of Lothian Health Board. Performance reports to the board focus on key aspects of performance - financial position, HEAT targets, waiting times and unscheduled care. Reports include narrative explaining trends in performance as well as actions being taken to improve performance.

99. The failures in reporting of the board's performance on waiting times had raised questions and wider concerns about the accuracy of reporting of performance information. Consequently a review of information received by the board was commissioned and the results and recommendations were presented in April 2012. The report was also provided to the Scottish Government. The report recommended that:
• the board's committee structure should be reviewed to ensure statutory responsibilities are met
• statutory information assurance requirements are agreed for the board and its committees
• the content and supply of information to the board and its committees is defined
• all information is validated and provided from a single source.

100. At the request of the Audit and Risk Committee, progress against recommendations was reviewed by Internal Audit. In March 2013 Internal Audit concluded that overall progress was satisfactory and actions resulting from the review have either been completed or are being progressed within the Management Culture Work Programme. We will continue to monitor these developments.
Scotland’s Public Finances – Addressing the challenges

101. In the current year, we carried out a focussed follow-up audit on Scotland's public finances: addressing the challenges report originally published in August 2011. Follow-up audits are also being carried out in all health boards and councils in Scotland. In addition, follow-up audits are being carried out at 20 central government bodies, including the Scottish Government, Scottish Enterprise and Scottish Water.

102. The original report set out a number of key issues and risks expected to be faced by the public sector in the period 2010/11 to 2014/15. The main aim of the follow-up audit is to look at what action has been taken since the publication of the original report in August 2011 and what difference this has made. In particular, auditors were asked to consider two key questions:

- Does the health board have sustainable financial plans which reflect a strategic approach to cost reduction?
- Do senior officials and non-executives demonstrate ownership of financial plans and are they subject to scrutiny before approval?

103. A key consideration in the Audit Scotland report was the extent to which workforce reductions were being used to deliver financial savings. This was not covered by the follow-up audit because of a separate study being carried out by Audit Scotland on changes to the Scottish public sector workforce which will look in detail at workforce planning.

104. The fieldwork on this study is nearing completion and we will report our findings to a future meeting of the Audit & Risk Committee.

Overview of performance targets in 2012/13

105. The board receives regular board executive performance reports from the Chief Executive on progress towards achieving the key performance targets set by the Scottish Government (HEAT targets and standards) and local targets.

106. The board has achieved good performance by either meeting or exceeding its targets in a number of areas. These include for example, patients referred urgently for cancer treatment, rate of clostridium difficile infections; smoking cessation and client referrals for drug and alcohol treatment.

107. Some targets were not fully achieved including the 4 Hour Accident and Emergency waiting time target, the Child and Adolescent Mental Health Service 26 week referral to treatment target, access to the Stroke Unit, incidence of MRSA/MSSA infections, delayed discharges, suicide reduction, and GP access. Maintaining and sustaining access targets is resource intensive and costly. This increases the pressure on the board at a time when it is requires to achieve significant savings on a recurrent basis.

108. The board established an Unscheduled Care Group during 2012/13 led by the Nurse Director and the Edinburgh CHP Director of Health and Social Care. One of the aims of the group is to help improve performance and achieve the 4 hour target. The board has also increased investment in staffing and opened additional acute beds as part of its strategy to address
unscheduled care demands. However, performance against the 4 hour target declined during the year and achievement still presents a significant challenge to the board.

**Risk Area 4**

109. The extent of the backlog of patients awaiting treatment at Lothian Health Board was only fully realised after failings in waiting time performance reporting were addressed. A significant number of patients, many with complex needs, are still awaiting treatment which will continue to present a challenge to the board.

110. The Patients Rights (Scotland) Act 2012 introduced a statutory 12 week treatment time guarantee for eligible patients. This became effective from 1 October 2012. The board did not achieve this target in a number of cases despite making additional capacity available. As with performance generally, there remains the challenge to balance achievement of performance targets (particularly access targets) against reducing funding levels and other competing service priorities. The board has received an additional £10m Brokerage from SGHSCD to address the waiting times backlog. However, it remains to be seen whether this will be sufficient to enable Lothian Health Board to achieve its treatment time targets.

**Risk Area 5**

National performance reports

111. Audit Scotland carries out a national performance audit programme on behalf of the Accounts Commission and the Auditor General for Scotland. The findings and key messages of these studies are published in national reports.

112. The board has a formal process to ensure that the findings of national reports relevant to the board are considered in detail to identify their potential impact and the board’s progress in addressing recommendations locally. These reports are discussed at the Audit and Risk Committee and where improvements are identified actions are agreed locally and progress monitored. Reports in the last year that may be of relevance to the board include, two of which are detailed further in the following paragraphs:

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### Table 2: A selection of National performance reports 2012/13

<table>
<thead>
<tr>
<th>Management of patients on NHS waiting lists (February 2013)</th>
<th>Health inequalities in Scotland (December 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing in general practice in Scotland (January 2013)</td>
<td>NHS Financial Performance 2011/12 (October 2012)</td>
</tr>
</tbody>
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www.audit-scotland.gov.uk

Management of patients on NHS waiting lists

113. Audit Scotland carried out a review of waiting times across the health service in Scotland following Lothian Health Board’s reported misuse of patient unavailability codes. The review
recognised the need for independent assurance on the management of waiting times to restore public confidence in the system.

114. In addition, NHS boards' internal auditors were requested by the SGHSCD to carry out a review of waiting times as part of their 2012/13 internal audit plans and to report their findings by 17 December 2012. Shortly after this date, the Cabinet Secretary for Health and Well Being reported to the parliament the findings from internal audits carried out across the NHS in Scotland. The main findings were:

- there is no evidence of wide scale manipulation of waiting times across the National Health Service in Scotland
- overall, the waiting times published by boards are reliable and accurate
- the principal shortcomings relate mostly to the capability to record on some information technology systems, the consistent interpretation of guidance, and staff training
- there are specific, localised issues in board areas that need to be addressed.

115. The Cabinet Secretary also made clear that he expected NHS boards to have implemented all locally identified recommendations for improvement by March 2013.

116. The internal auditors for Lothian Health Board had reported their findings to the Audit and Risk Committee held on 15 November 2012. They concluded that although various workstreams have improved how waiting lists are managed over the past year some areas for improvement were identified including the following:

- Non-centralised management of waiting lists and inconsistent practices
- Insufficient staff training in the use of the Standard Operating Procedures which does not fully reflect national guidance
- Periods of unavailability were applied which do not reflect national guidance
- Many users who do not require access can input or amend waiting list information on TrakCare
- The framework for reporting is complex and some information could be made clearer in board reports.

117. Management agreed an action plan of improvements which were subsequently reviewed in more detail by the Audit & Risk Committee in February 2013 to confirm progress in implementation as requested by the Cabinet Secretary. These enabled the Medical Director to provide a letter of assurance to the SGHSCD that local improvements had been implemented or were in progress. The SGHSCD have requested that all boards undertake a follow-up audit on the management of waiting times to ensure that planned improvements have been made and are working effectively. We will monitor the position at a future date.

118. Audit Scotland’s national report on the Management of patients on NHS waiting lists published in February 2013 highlighted similar issues to those outlined above:

- The systems used to manage waiting lists have inadequate controls and audit trails, and the information recorded in patient records is limited
• Most patients’ records that were examined did not include enough information to verify that unavailability codes had been applied properly

• Audit Scotland identified a small number of instances in which unavailability codes were used inappropriately. The limitations of waiting list management systems and the lack of evidence in patient records mean that it is not possible to determine whether these instances were due to human error, inconsistent interpretation of the guidance, or deliberate manipulation of waiting lists

• There was not enough scrutiny of the increasing number of patients recorded as unavailable.

119. The national report also highlighted good practice at Lothian Health Board, in particular, the use of TrakCare’s enhanced performance reporting to monitor patients on waiting lists and the development of the forensic dashboard tool. The report also notes the considerable investment made at Lothian Health Board to treat the backlog of patients waiting longer than target times for treatment.

NHS Financial Performance 2011/12

120. The report provides an overview of the financial performance of the NHS in Scotland during financial year 2011/12. It also highlights the financial sustainability, challenges and cost pressures facing the NHS.

121. The report notes that after several years of growth in public finances following devolution, public sector budgets are now falling. This reinforces the need for sound financial management and clear financial reporting, underpinned by good information and strong governance and accountability.

122. In 2011/12, spending on health accounted for about a third of the total Scottish budget and amounted to around £11.7 billion. Although the overall health budget has continued to increase in cash terms, it has been decreasing in real terms since 2009/10 and is projected to decrease further in real terms for the next three years.

123. The Scottish Government allocates over 90 per cent of the total health budget to 23 NHS boards, with the remainder retained by the Scottish Government to spend on other areas of its Health and Wellbeing Portfolio. While the overall health budget is decreasing in real terms, the Scottish Government has protected the total amount allocated to territorial boards and this will increase slightly in real terms (1.3 per cent) over the next three years. However, budgets for special boards will fall by 5.6 per cent in real terms.

124. The national report noted that the NHS in Scotland continued to manage its finances within total budget. However, this does not reflect the pressures faced by boards and a number of them had to rely on non-recurring savings to achieve balance. Moreover, some other boards needed extra help from the Scottish Government to break-even in 2011/12.

125. Boards are increasingly reliant on achieving savings to meet their financial targets yet across the NHS 20% of savings plans are considered high risk although some boards are indicating that they will have to achieve savings in excess of this level.
126. The national report highlighted that the board categorised two thirds of their savings plans as high risk and that more than ten per cent of required savings were unidentified raising concerns about the achievability of these plans. Furthermore, the national report noted that the board remained below its National Resource Allocation Committee formula allocation.

Outlook

Performance

127. Over recent years the board has invested substantial resources, particularly in relation to waiting times and unscheduled care, to achieve challenging performance targets set by the Scottish Government. The significant financial challenges that will be faced in 2013/14 and beyond make maintaining or improving performance even more difficult.

128. We will continue to monitor developments locally on waiting times issues. Also, the Auditor General has been asked by the Public Audit Committee of the Scottish Parliament to provide an update on Audit Scotland's Management of patients on NHS waiting lists report later this year. The audit work will focus on progress made by the NHS in establishing clear information audit trails and on the management and monitoring of waiting lists. The fieldwork for the report will be carried out at NHS boards in September and October of 2013 with a report to the Public Audit Committee by the end of December 2013.
Appendix A: audit reports

External audit reports and audit opinions issued for 2012/13

<table>
<thead>
<tr>
<th>Title of report or opinion</th>
<th>Date of issue</th>
<th>Date presented to Audit Committee</th>
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</thead>
<tbody>
<tr>
<td>Internal Audit Reliance Letter</td>
<td>21 December 2012</td>
<td>4 February 2013</td>
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<tr>
<td>Annual Audit Plan</td>
<td>15 January 2013</td>
<td>4 February 2013</td>
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<tr>
<td>Internal Controls Management Letter</td>
<td>7 March 2013</td>
<td>2 April 2013</td>
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<tr>
<td>Scotland’s Public Finances: Addressing the Challenges – Follow-up audit</td>
<td>tbc</td>
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<td>Best Value use of Resources - Sustainability</td>
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<td>tbc</td>
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<tr>
<td>ICT eHealth Services Follow up</td>
<td>14 June 2013</td>
<td>24 June 2013</td>
</tr>
<tr>
<td>Report to Audit Committee in terms of ISA 260</td>
<td>17 June 2013</td>
<td>24 June 2013</td>
</tr>
<tr>
<td>Independent auditor’s report on the financial statements</td>
<td>17 June 2013</td>
<td>24 June 2013</td>
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<tr>
<td>Annual Report on the 2012/13 Audit</td>
<td>31 July 2013</td>
<td>30 September 2013</td>
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## Appendix B: action plan

### Key Risk Areas and Planned Management Action

<table>
<thead>
<tr>
<th>Action Point</th>
<th>Refer Para No</th>
<th>Risk Identified</th>
<th>Planned Management Action</th>
<th>Responsible Officer</th>
<th>Target Date</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>22</td>
<td><strong>Equal Pay</strong></td>
<td>The NHS Scotland Central Legal Office and Equal Pay Unit are continuing to monitor the progress of all equal pay claims in NHS Scotland as well as developments relating to NHS equal pay claims elsewhere that may further inform the position. The period over which back pay for any established breach would have to be calculated is the period between dissolution of their employing Trust and 30 September 2004. For NHS Lothian this means that the period of the claim is limited to 9 months. The limited scope of these claims was upheld by the Employment Appeal Tribunal in the test case of Foley and Ors v Greater Glasgow Health Board (August 2012). Pay comparators have still not been identified, with the exception of a small number of cases. Work is still ongoing by both claimants and respondents in this regard. Until comparators are identified it is not possible to identify the term which is said to breach the equality clause. Central Legal Office therefore continues to advise that it is not possible to provide any financial quantification at this stage.</td>
<td>Director of Human Resources and Organisational Development</td>
<td>Through 2013/14 to March 2014.</td>
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</table>
because of the lack of information available. On the basis of their view the appropriate accounting treatment is to disclose the claims as a contingent liability that is not possible to quantify.

We are unable to do the work as the situation legally is sufficiently uncertain, therefore we are not in a position to make realistic assessments - This is the position negotiated by the Scottish Government in respect of all NHS Boards in Scotland.

The Director of Human Resources & Organisational Development will continue to monitor the position on a regular basis and advise the board as appropriate.

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<tr>
<th>Action Point</th>
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<td>2</td>
<td>30 &amp; 44</td>
<td>2013/14 Savings Target</td>
<td>The board's formal quarterly and mid-year financial forecasting review process and that supporting the development of the annual financial plan are key elements of the risk management approach to this challenge. The board has established an Efficiency and Productivity group which reviews savings proposals and progress with agreed savings schemes and workstreams; enhanced by local departmental plans. This is supported with programme managers recruited during 2013. It is the board’s intention, led by the Director of Finance to more</td>
<td>Director of Finance</td>
<td>Through 2013/14 up to March 2014.</td>
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<tr>
<td>Action Point</td>
<td>Refer Para No</td>
<td>Risk Identified</td>
<td>Planned Management Action</td>
<td>Responsible Officer</td>
<td>Target Date</td>
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<td>3</td>
<td>37</td>
<td>Workforce Planning</td>
<td>closely align the Financial Plan with the emergent Clinical Framework agreed by the board in February 2013. Progress and recommended actions are reported regularly to the Joint Management Team and the Finance and Resource Committee of the board.</td>
<td>Director of Human Resources and Organisational Development/Medical Director</td>
<td>Through 2013/14 up to March 2014.</td>
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<td>supplementary cost saving schemes. The longer term financial plan remains at risk of not being affordable due to the wide range of financial challenges and pressures being faced by the board, or that savings targets may not be achieved.</td>
<td>Key workforce metrics (including absence) are reported regularly to the Area Partnership Forum, and to the board. The Human Resources and Organisational Development Strategy was updated and reported to the board in November 2012 and is refreshed annually. Specific actions on variance on trajectory towards targets are agreed at such meetings and implemented in partnership with staff representatives. In addition to areas relating to absence, the board’s Risk Register Review identified medical workforce recruitment and retention issues, with particular impact on areas relating to regional provided and paediatric services, and measures to mitigate such risks have been subject of regular reporting by the Medical Director to the board. The board continues to monitor these risks.</td>
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</tbody>
</table>

3 Workforce Planning

The board is facing major challenges in achieving and maintaining the sickness absence target of 4%, as well as through the reduction in senior management target of 25% by 2013/14. There is a risk that workforce and management capacity issues may impact on the board’s ability to achieve its financial and non-financial performance targets.
<table>
<thead>
<tr>
<th>Action Point</th>
<th>Refer Para No</th>
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<th>Target Date</th>
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</thead>
<tbody>
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<td></td>
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<td>and appropriate actions are shared between the Medical Director and the Director of Human Resources and Organisational Development.</td>
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<td>4</td>
<td>108</td>
<td>Performance targets - unscheduled care</td>
<td>Despite considerable activity the board has not sustained improvement in its performance in unscheduled care. Failure to meet this target continues to present a risk to the board.</td>
<td>Director of Nursing</td>
<td>Sept 2014 through to March 2014.</td>
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<td>NHS Lothian is committed to improving its performance and in May 2013 achieved 94.9% against the 95% target. Performance against the 4 hour Emergency Care target has been challenging within NHS Lothian for some time. In response to that need, during 2012/13 under the leadership of its Unscheduled Care Group (UCG), NHS Lothian and its social care partners have been developing and implementing plans which largely mirror the recent publication of the national Unscheduled Care Action Plan with the goal of improving performance for patients. NHS Lothian is required to show within the Local Unscheduled Care Plan (LUCAP) that the necessary actions, supported by quarterly and annual trajectories, are in place to reach a minimum of 95% performance by September 2014 and to move to 98% as rapidly beyond this. The LUCAP was approved by the board in June 2013.</td>
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<td>5</td>
<td>110</td>
<td>Performance targets - waiting times</td>
<td>The board have been regularly sighted on issues in relation to delivering waiting times targets on a sustainable basis. Substantial progress was made during 2012/13 with support from the Scottish Government through financial brokerage as is reported in the annual accounts for 2012/13. The board continues to address issues of capacity through expansion of internal facilities and reduction in reliance on private providers over the next 12-18 months and the investment required has been reported and agreed by the board. Independent of capacity constraints (which impact particular specialities such as orthopaedics and ophthalmology), there are workforce issues in relating to the required complex procedures in specialities such as urology which impact on the ability to deliver Treatment Time Guarantees. The board anticipates continued progress towards delivering sustainable target performance over the next two years.</td>
<td>Medical Director/ Director of Finance</td>
<td>Throughout 2013/14 and 2014/15.</td>
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