NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 27 FEBRUARY 2013
TIME: 1:30 P.M. - 4:00 P.M.
VENUE: BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG

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

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

For further information please contact Peter Reith, ☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
5. Governance (2:00pm - 2:40pm)

5.1. Quality Report  DF *
5.2. Healthcare Associated Infection Update  AKM *
5.3. Progress Report on the Establishment of East Lothian Health & Social Care Partnership  DAS *

6. Performance Management (2:40pm - 3:25pm)

6.1. Waiting Times Progress and Performance  DF *
6.2. Unscheduled Care Update - February 2013  MH *
6.3. Performance Management  AMcM *
6.4. Financial Position to 31 January 2013  SG *

7. Policy & Strategy (3:25pm - 3:45pm)

7.1. NHS Lothian Strategic Clinical Framework 2012-2020  AMcM *
7.2. Corporate Objectives  AMcM *

8. Other Items (3.45pm - 4:00pm)

8.1. Legionella Outbreak Report  AKM v
8.2. NHS Lothian Patients’ Funds - Annual Accounts 2011/12  SG *
8.3. Communications Received  TD *

9. Date, Time and Venue of Next Meeting: Wednesday 27 March 2013 at 9:30 a.m., in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

10. Resolution to take items in closed session

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

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

In Attendance: Ms J Bennett (Corporate Governance Manager for Item 126); Mr J Forrest (Director, West Lothian Community Health and Care Partnership); Mr P Gabbitas (Director, Health & Social Care, City of Edinburgh Council); Mr A Jackson (Associate Director of Planning for Item 135); Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information); Mr D A Small (General Manager, East and Mid Lothian Community Health Partnership); Ms F Stafford Charge Nurse (Shadowing Mrs M Hornett); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications and Public Affairs).

Apologies for absence were received from Mr G Walker.

Declaration of Financial and Non-Financial Interest

The Chair reminded members they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Ms K Blair declared an interest as a Non Executive Board Member of NHS 24 which might impact on a number of agenda items.

119. Welcome and Introduction

119.1 The Chairman welcomed members of the public and the press to the meeting. He also welcomed Ms Bennett, Ms Stafford and Mr Jackson to the meeting.
120. Minutes of the Previous Meeting held on 28 November 2012

120.1 The Minutes were approved as a correct record subject to the following amendment; minute 114.1 Ms K Blair was appointed as a member of the Shadow Edinburgh Health and Social Care Partnership Board and not Vice Chair as recorded in the minutes.

121. Matters Arising

121.1 Royal Hospital for Sick Children – The Board noted an Open Day for interested parties in the Royal Hospital for Sick Children / DCN Reprovisioning Tender had been held with expressions of interest now having been received which were in the process of being evaluated.

121.2 Paediatric Staffing – The Board received an update on the recruitment campaign noting that 11 enquiries has been received resulting in 5 applications, 3 for Consultant posts (2 from Paediatrics and 1 for Neonatology) there has been 5 applications for the Paediatric Fellowship posts and 2 applications for the Neonatal Fellowship post and 1 application for a Specialty Doctor post. The applications had been received from throughout the world. Applications would be processed over the next few months. In addition a letter had been issued to all General Practitioners in Lothian to determine if there was support from General Practitioners to help the Paediatric situation at St John’s in a similar fashion to emergency medicine. The Board noted as yet there had been little response to the letter.

121.2.1 The Board noted that the Medical Director and Director of Human Resources and Organisational Development had met with consultants at St John’s, the Royal Hospital for Sick Children and the Consultant Neonatologist at Simpsons Memorial Maternity Pavilion in order to understand their specific concerns regarding staffing issues which were not solely confined to Paediatrics at St John’s. It was noted in November there had been 13 Paediatric vacancy posts in training grades and another 4 vacancies would appear in the next few months. This would therefore remain an ongoing problem.

121.2.2 The Medical Director advised his main area of concern was for the Neonatal Unit at the Simpsons Memorial Maternity Pavilion and the Paediatric Intensive Care Unit at the Royal Hospital for Sick Children rather than St John’s.

121.2.3 The Medical Director in response to Councillor Toner advised the implications of not being able to recruit needed to be considered including whether services could be sustained using a mixed economy model and this would need to be included as part of any Public Information Campaign. He stressed however that the firm intention was to maintain services.

121.2.4 The Chief Executive reiterated comments made at previous meetings where he had stated that no stone had been left unturned in the effort to provide sustainable Paediatrics Services across sites. The position in the South East of Scotland however remained fragile particularly in respect of maternity leave and staff turnover. The Chief Executive commented whilst good progress had been made it would not take much to destabilise the position.
121.2.5 The Medical Director commented given his earlier views about the Simpson Memorial Maternity Pavilion there might be a need to use some of the resource at St John’s Hospital to support the Simpson Memorial Maternity Pavilion position. He stressed this would not impact on the Paediatric position at St John’s.

121.2.6 Mr Johnston welcomed the report and shared the Chief Executives view that no stone had been left unturned to sustain services across Lothian and St John’s. The Medical Director advised that the rotas for February / March were sustainable for all sites with work in progress to produce viable rotas thereafter. The benefits of the recruitment exercise were expected to become evident over the course of the next few months although it was important to factor in timescales for the recruitment of foreign Doctors. The Medical Director stressed that all appointments would be made to normal competency standards and that the key drivers for appointment were around patient safety and not cost. It was noted that Medical Workforce remained a high profile issue on the Corporate Risk Register.

121.2.7 Professor Iredale advised that Paediatrics was a microcosm for future Medical Workforce Challenges with there being in general an increase in female participation in the profession resulting in a need to flex to make changes in other specialties and learn lessons from the Paediatric situation. The Director of Human Resources and Organisational Development reported that the Dean was aware of the issues and had accompanied himself and the Medical Director to meetings with Consultants.

121.2.8 The Chief Executive reported the original projection had been for a reduction in trainee numbers and that the rate of reduction had been paused in order to allow further reflection on the trainee numbers. The move to less than full time working and the increase in Maternity Leave would impact on future Workforce Planning and would need to be taken account off.

121.2.9 The Board received and welcomed the positive report.

121.3. Pension Auto Enrolment – The Director of Human Resources and Organisational Development commented that at the previous Board Meeting he had reported on the possibilities of being able to defer the Auto Enrolment arrangements until February 2017. He commented however since then the Scottish Government Health Department had agreed that Boards would only be able to defer Auto Enrolment arrangements until 2017 if they had received the agreement of local Trade Unions. He advised that Unison had made it clear that they would not entertain such a deferment. The Lothian Partnership Forum Meeting had agreed a short deferment to April 2014 in order to allow the logistics of the process to be worked through and communications to be issued to staff.

121.3.1 The Board noted therefore that there was a requirement to move to Auto Enrolment by 1 April 2013 and that the Director of Human Resources and Organisational Development and his team would work out the logistics of moving to this position. It was noted that the worse case cost scenario was £8m although it was unlikely that there would be a 100% uptake and that for budgetary purposes an estimate of 50% uptake had been allowed for resulting in provision of £4m. It was noted that the highest earning staff would probably withdraw from the scheme and that part time staff on the lowest grades who were not already in the scheme might also opt not to
join because their personal economic circumstances would not allow them to make that choice.

121.3.2 The Employee Director echoed the views of The Director of Human Resources and Organisational Development commenting that the vast majority of staff not already in the pension scheme did so through choice and he felt that more than 50% would withdraw. He advised that the scheme was bureaucratic and there was a danger the lowest paid staff would suffer hardship if they could not receive pension refunds quickly after opting out of the scheme. He welcomed the suggestion made by Professor McCallum that the Staff Welfare Scheme be engaged to work through these and wider issues in order to ensure that the lowest paid staff were adequately supported through the process.

121.3.3 Ms Blair commented she was an advocate of the principles of Auto Enrolment and felt it was important people planned for their retirement. She recognised the complexities for some people and commented guidance and communications to individuals would be essential. The Director of Human Resources and Organisational Development advised that arrangements for communications were covered by legislation and had been advised by the Scottish Government Health Directorate. The Board noted that staff would be automatically Auto Enrolled every 3 years.

121.3.4 Professor McCallum commented that as well as the Staff Welfare Scheme that there were a number of locally based advisory services located in areas where there was a concentration of lower paid staff who also be able to provide assistance in this key area.

121.3.5 The Director of Human Resources and Organisational Development and Employee Director undertook to keep the Board appraised of progress.

122. Board Committee Minutes

122.1 Audit & Risk Committee – Minutes of the meeting held on 15 November 2012 – The Board adopted the minutes. Mr Brettell advised his main concern was in respect of the number of Internal Audit Management actions that were still outstanding and that a review of these were underway. The Director of Finance commented that she was working with the Chief Internal Auditor on this issue and that an update report would be brought to the February Audit and Risk Committee. She commented however that she did not think any of the outstanding actions represented anything of significant materiality although she recognised this was not a reason why actions should not be pursued.

122.1.1 Mr Brettell commented in respect of Backlog Maintenance that the Committee’s focus was to get visibility on the risk of delays rather than focusing on the finances of completing the maintenance programmes. He advised the visibility of the Corporate Risk Register would be discussed later on the agenda.

122.1.2 The Chief Executive advised he was keen to discuss with the Audit & Risk Committee the number and materiality of the outstanding actions particularly given current staff workloads.
122.1.3 The Director of Finance advised new arrangements would mean that the Chief Internal Auditor would be responsible for following up on Audit recommendations and as part of this process consideration would be given to materiality and control issues. Mr Brettell reminded the Board it was not the Audit and Risk Committee’s role to determine what was an appropriate level of action but to receive assurance that these actions where in fact being followed through.

122.2 The Finance and Resources Committee – minutes of the meeting held on 12 December 2012 – The Board adopted the minutes and noted that the outcome of ongoing discussions around the terms of reference would be brought to a future meeting.

122.3 Healthcare Governance – minutes of the meeting held on 4 December 2012 the Board adopted the minutes. It was noted there had been discussion around the Liverpool Care Pathway which had been important given National Media attention that had caused concern to patients and carers. At the meeting the need to communicate had been discussed and it was noted that NHS Lothian would follow the Scottish Government Health Directorate timescale in that regard.

122.4 East Lothian Community Health Partnership Subcommittee – minutes of the meetings held on 6 September and 1 November 2012 - The Board adopted the minutes. It was agreed given the timing of meetings that it would be appropriate in future to bring draft Community Health Partnership Minutes to the Board if they had been cleared by the Chair.

122.5 Edinburgh Community Health Partnership Subcommittee – minutes of the meetings held on 3 October and 5 December 2012 – the Board adopted the minutes. It was noted that the focus of the committee was to ensure scrutiny around Governance including financial aspects; ensuring more robust quality and reporting as well as the Committee familiarising itself with the services delivered through the CHP. Another key aspect of focus was the preparation for the transition to the Health and Social Care Partnerships.

122.6 Midlothian Community Health Partnership Subcommittee – minutes of the meeting held on 27 September 2012 – The Board adopted the minutes. Mr Ash advised there had been subsequent meetings and the minutes of these would be brought forward to the next Board meeting.

123. Chairman’s Report

123.1 The Board noted the Chairman’s report and in particular that work was in progress with National Services Scotland to ensure National contracting arrangements allowed for the local Procurement of food to support the Food for Life pilot project at St John’s Hospital which would run for a 2 year period. It was noted that the Governance of these arrangements was being taken forward through Health Promoting Health Service. The Board noted the Chair has also attended a reception to mark 20 years of the Sick Kids Friends Foundation. He advised the Foundation would be working closely with NHS Lothian on the Reprovided Hospital.
124. Quality Report

124.1 The Medical Director advised that the report was in 2 parts the first covering routine dashboard reporting and the second providing a narrative where trends were moving in the wrong direction as agreed at the previous Board Meeting. Particular attention was drawn to readmission rates, compliance with significant adverse events and falls. In addition the Medical Director drew the Boards attention to the particular challenges in respect of achieving a 20% reduction in hospital standard mortality rates by 2015.

124.2 The Board noted that the Healthcare Governance Committee was particularly focussed on Stroke Indicators and the need to improve some of the results. One of the key result areas for 2013 would be medicines reconciliation which was a very complex piece of work looking at structured ward rounds, the role of the immediate discharge summary and its relationship between Primary and Secondary Care and IT.

124.3 The Medical Director advised that the Francis Report on the Mid Staffordshire Incident would be issuing soon and would represent an important agenda item for the Board given its focus on Patient Safety and Quality.

124.4 The Medical Director provided the Board with an update in respect of Cancer Performance including work around the Detect Cancer Early Programmes.

124.5 Mrs McDowell questioned how it was possible to reconcile from the report that falls prevention compliance was maintained when the actual number of falls recorded had increased. The Medical Director reminded the Board that the report represented a monthly summary and that the graph in the background provided a longer term view although it was correct to stress that the emphasis on falls was important. The Nurse Director advised that over the time period of the report there had been an increase in frail and complex patients within the system and therefore the risk of injury from a fall was increased. She advised that falls was one of NHS Lothian’s most frequent incidents and further work was being undertaken to mitigate this position.

124.6 The Chief Executive commented in respect of the trend line that falls with harm were reducing although it was important to recognise the spike in the previous month. He suggested that this was part of the value of this type of report being brought to the Board and commented that it might suggest whilst falls in general were falling that those patients that did fall were suffering more harm and this was an area that required to be watched closely as the expectation would be that both the total number of falls and the number of falls with harm would reduce.

124.7 The Medical Director in response to a question from Mr Wilson advised that he would hope to have more definitive data available on readmissions for reporting to the next Board Meeting although this would be dependant on on-going work with Information Services Division to get to the bottom of the reasons for the increase in readmissions. Dr Williams advised he was undertaking work with GP colleagues looking at patients who had been readmitted within 7 days and the causes for readmission and this would provide some additional factual data.
124.8 Mr Ash welcomed the exception report which he felt was important. He commented in terms of the question posed by the Medical Director about the type of indicators that the Board should consider that he felt there would be merit in the Health Care Governance Committee advising on a small number of high level indicators to be considered on a 6 monthly basis by the Board that might have correlations with other parts of the service that might not be immediately evident from high level debate at formal Board meetings. Dr Bryce agreed this would be an appropriate workstream for the Committee advising that it was currently undertaking a snap shot of the number of complaints received and looking at the themes of these complaints which were equally as important as the number received. Mrs Meiklejohn commented that the Area Clinical Forum could support and undertake some of the necessary analysis advising that she was also a member of the Healthcare Governance Committee and in that regard there were obvious linkages.

124.9 The Board noted the Quality Report

125. Healthcare Associated Infection Update

125.1 Professor McCallum provided her regular update on Healthcare and Associated Infection to the Board advising that she had concerns that the staphylococcus aureus bacteraemia target would not be met at March 2013 because of activity over the previous few months. She advised that as at December the position was reporting as 189 cases against a year end target of 213. She advised that each individual infection was looked at separately and that a process of improvements was underway. The Board were advised that there were no clear reasons for the increase in cases other than the frailty and number of patients going through the system aligned to the increased number of Waiting Times patients. Professor McCallum advised that in some areas work was underway to improve the healthcare environment through planned programmes of work. She commented that a difficulty was the significant number of people who presented into hospital with infection and that work was underway to look at the reasons behind this in order to help to mitigate overall positions.

125.2 The Board noted that hand hygiene compliance was high across all professional groups and that this had undoubtedly been a factor in the fact that very few NHS Lothian staff had contracted Norovirus. Mr Brettell noted the reduction in recorded hand hygiene achieved at the Royal Infirmary and asked if this was a concern. Professor McCallum advised that this was not a statistically significant variance, however the Chairman noted that it was right to query the information and asked that attention is focussed on the recent reduction. There had also been an improvement in the rapid use of isolation facilities as well as improvements in the use of Antibiotics over recent years. Professor McCallum commented that work was underway with Health Protection Scotland in order to identify any issues that might have been missed in terms of what the system should be doing around good practice. She noted in respect of clostridium difficile that the system was on target and commented the key issue was not about chasing targets but about improving care for patients and reducing avoidable harm.
125.3 Dr Bryce questioned whether work had been undertaken looking at workforce issues particularly in respect of the transitional workforce and agency staff and whether this has been an issue in respect of the increased incidences of infection. Professor McCallum commented that this had been an issue in the past but did not appear to be an obvious reason from the wards affected as these were not areas susceptible to key risks in terms of the transitional workforce.

125.4 Professor McCallum commented in respect of the hand hygiene compliance at the Royal Infirmary of Edinburgh that this was within confidence intervals and did not represent a significant change from previous reports. Dr Williams commented that it was important to recognise that the position represented a substantial improvement over performance in previous years and that the issue might simply be down to a seasonal blip.

125.5 The Board noted the progress being made in respect of managing Healthcare Associated Infection within Lothian.

126. Establishment of the Shadow Board of Midlothian Health and Social Care Partnership

126.1 Mr Small provided an overview of arrangements for the Shadow Board of the Mid Lothian Health and Social Care Partnership. It was noted that this was in response to the Scottish Government proposals for the integration of Health and Social Services.

126.2 The Board noted the proposals might be subject to change following the publication of legislation. It was proposed that the Shadow Partnership Board would consist of 8 voting members – 4 from the Council and 4 from NHS Lothian. The current Community Health Partnership would remain and work in parallel until the Shadow Board had undertaken the appropriate transfers of responsibilities. The position in respect of the Professional Advisory Committee and professional engagement was discussed in detail.

126.3 The Employee Director welcomed the inclusion of a Partnership member amongst the voting members of the Shadow Board and advised he would submit a name to Mr Small.

126.4 The Board noted similar proposals for East Lothian were expected in March. Councillor Grant reported that East Lothian Council would discuss proposals at the full council meeting on 25 April.

126.5 The Chief Executive advised his impression was that NHS Lothian was positively positioned in this process. It noted that NHS Lothian through Mr Gabbitas and Mr Forrest had been invited to participate in a ministerial group along with NHS Highland to share experiences. The West Lothian and Edinburgh model had been well received.

126.6 Dr Williams stressed that GP engagement was crucial to the success of the new arrangements. He felt in Edinburgh that GP’s had a voice although this engagement
did not appear to be as clear in the Midlothian proposal. Mr Small stressed GP forums were currently a key way of engagement and would probably be retained. In any event he would anticipate strong links with GP’s and the professional forum. Mr Small undertook to keep Dr Williams and Mrs Meiklejohn fully engaged.

126.7 The Nurse Director asked that as the Director for Nursing and Allied Health Professionals that she be specifically included in any discussions about arrangements for Professional Engagement and Professional Accountability and Clinical Governance.

126.8 The Board agreed to the proposed arrangements for the Shadow Board Remit, membership and Governance as outlined in the circulated report.

127. **Corporate Risk Register**

127.1 The Chairman welcomed Ms Bennett to the meeting commenting it was important that an effective Board was reminded of its top risks and the fact it was carrying these risks. He advised the ultimate end point would be that the Board should focus on addressing risk as its main area of business.

127.2 The Medical Director advised he and Executive colleagues were looking at developing a different approach to risk and that a Risk Management Steering Group had recently been established chaired by the Chief Executive to identify, assess, monitor and respond to risk. He reported that the circulated paper developed the risk architecture as well as outlining the key functions of the Risk Management Steering Group.

127.3 Mr Brettell reported that the Audit & Risk Committee would review and log risk as well as seeking assurance on progress towards mitigating these. It was anticipated this would be supported by an occasional deep dive process.

127.4 Ms Bennett advised work had been ongoing over the previous two years to develop an improvement framework to ensure there was a clear escalation process from individual services to the Board. The Risk Management Steering Group would review risk and ensure granularity of information and processes were in place to mitigate these risks. In addition an adequacy of control process was in place. The Board noted in some instances risk was not in its own control and there was a need to recognise this in terms of mitigating and controlling risk.

127.5 Ms Blair whilst welcoming the report questioned whether a more strategic less passive approach could be adopted possibly through an annual workshop where the Board could consider, identify and prioritise risk. Mr Brettell reported that at every meeting of the Audit & Risk Committee a risk update was produced and reported to the Board through the minutes of the Committee. Mr Brettell commented as risk was the responsibility of the Board he agreed with the benefit of at least the Annual Workshop.

127.6 The Chief Executive felt there were three strands to risk with these being organisational priority, the key corporate risks and how risk was constituted into Board and Joint Management Team agendas. The Risk Management Steering
Group assessed risk each month to determine whether there had been a change in risk or whether new issues were on the horizon.

127.7 The Chief Executive advised the risk Management Steering Group had discussed earlier in the week whether risk themes should feature in the top 10 in their own right or as strands within other themes. He pointed out although patient safety as a theme did not appear as a top 10 risk this however was an integral part of Waiting Times, Public and Child Protection as well as Unscheduled Care and other aspects of NHS Lothian business. He commented the process would evolve over the next few months and suggested that the Corporate Risk Register should be brought to the Board at least annually. Mr Brettell felt on terms of visibility the Risk Report should be considered twice per annum to ensure the Board was comfortable about the risk it was carrying.

127.8 Mr Ash felt that the Audit & Risk Committee should look at the process of managing risk and how it reported that to the Board in order to ensure there was no duplication of effort. He agreed that the engagement of Board Members in working through and identifying risk was extremely valuable. However he felt unless risk changed he would be happy to leave the detail to the Audit & Risk Committee with the Board focussing on strategic level risks through the workshop process.

127.9 Mr Wilson welcomed the progress being made and felt the Risk Register should come to the Board at least twice per annum if not quarterly as this was a fundamentally important aspect of how the Board functioned. He felt future reports should be granular enough to allow the Board to understand what exactly the risks were. Future papers should contain more detail around mitigating actions and dates for completion to ensure thorough scrutiny. The Chair concurred agreeing there was a need to seek evidence of the mitigations of risk.

127.10 Dr Bryce felt there was a need to consider what the Board was doing in terms of communications with the public to assure them risk was being addressed. She felt there was a need for the Health Intelligence Unit to undertake Horizon Scanning as the Risk Register should be dynamic and able to identify significant issues coming forward that would represent a risk to the organisation. Professor McCallum commented as the process matured it would be possible to look more at policy risk as well as immediate material risk to patients on the ground.

127.11 The Board noted the progress with the Risk Register and the further work in progress to make this more robust. Ms Bennett in conjunction with the Chief Executive and Mr Brettell would refine the next stages.

128 Improving Care for Older (Vulnerable) People in Acute Hospitals – Healthcare Improvement Scotland Inspection – January 2013 Update

128.1 The Nurse Director advised given the serious nature of concerns following an inspection in August 2002 she felt it important to keep the Board updated on progress. The Board noted a response had been submitted as required to Health Improvement Scotland (HIS).
128.2 The Board noted that HIS had paused their inspection process to review the methodology with the outcome awaited. It was noted HIS were also working to ensure strong links with other scrutiny agency requirements. The Nurse Director reported that through the Scottish Government Health Directorate a Person Centred Care process was being established and older people would be key to this. The new arrangements would be more formal and would operate along similar lines to the Scottish Patient Safety Programme.

128.3 The Board noted that the paper detailed a range of actions underway in respect of education and support to staff. The Nurse Director advised steady progress was being made although the reality of the pressures on the service meant there was still significant operational work needed to secure consistency of care. It was noted that the ability to improve care to patients was linked to addressing the Unscheduled Care position.

128.4 The Board received the updated report.

129. **Waiting Time Progress and Performance**

129.1 Mr Jackson was welcomed to the meeting.

129.2 The Medical Director advised that in addition to the routine report a summary paper had been circulated detailing the main issues that the Board needed to be aware of. He commented if the Board approved the new approach then only the summary paper would be issued in future with the detailed background paper available to Board members on request. The Board endorsed this approach.

129.3 The Board noted that progress continued around In Patients / Day Cases with there being less than 500 patients waiting more than 12 weeks. It was reported 44 patients had breached the treatment time guarantee of which 26 had subsequently been treated with a further 14 having been given dates for treatment leaving 4 patients yet to be offered treatment dates. The Medical Director advised by the end of March 2013 the waiting times figure would be down to between 200 and 300 largely comprising of Complex Neurology and Plastic Surgery cases. It was anticipated by the end of June the waiting times position would be mitigated.

129.4 The Board noted in respect of outpatients that at the end of December there had been 2868 patients waiting more than 12 weeks with work in progress to quicken the trajectory of patients being treated.

129.5 The Medical Director commented in respect of Endoscopy that there had been some slippage on both diagnostic and surveillance progress although overall the position was still on trajectory.

129.6 The Medical Director advised that the summary paper highlighted the TRAK updates that had been applied to address the new guidance and advised that until that process had been completed there would be some inconsistency in reporting. The Medical Director advised that issues raised in an Internal Audit Report would be discussed later on in the agenda.
129.7 Mr Brettell commented that there had been significant media debate about patients who could be included and excluded and as a Board Member he was not clear about how these applied and indeed until the media reporting he had been unaware of exclusions. The Chief Executive commented that the intention was to run a separate Board seminar lasting around two hours to allow Board member to drill down into the detail around waiting times issues.

129.8 Mr Brettell commented that he felt that the condensed paper was an excellent way forward and commented however that Board Members needed the level of detail being proposed through the seminar. He felt staff were in a potentially difficult position in terms of their ability to explain the waiting times process to patients given the complexity of the process. The Director of Communications and Public Affairs advised that individual Boards were tasked with providing specific direct patient communications as part of the terms of the new Waiting Times Guidance. The Chief Executive commented that the key aspect of the Internal Audit Report on Waiting Times was to address training and he advised that a more extensive programme of training would be put in place in future on a recurring basis which would mean that better trained staff would be able to inform and educate patients more clearly than might currently be the position.

129.9 Councillor Toner sought an update on steps to increase NHS Lothian’s own capacity to allow less reliance on the private sector. The Medical Director commented NHS Lothian continued to recruit into key areas with the second wave of recruitment now underway. Although it was anticipated that it might take up to two years to build up the capacity required the reliance on the Private Sector would slowly reduce.

129.10 Mrs Allan commented that she had found the summary report helpful and commented that in future iterations it would be helpful to know the proportion of breaches in relation to the totality to the waiting list.

129.11 The Board agreed the recommendations contained in the circulated report.

130 Performance Management

130.1 The Director of Strategic Planning, Performance Reporting and Information provided an update to the Board on the most recently available NHS Lothian Performance data as reported through local and national systems. He advised that he had tried to reduce the size of the paper and had withdrawn the waiting times information as this was reported elsewhere on the agenda. He commented that Unscheduled Care metrics had been included in the paper and these would be addressed by the Nurse Director.

130.2 The Board noted the specific focus on 31 and 62 cancer waits; stroke; palliative care; emergency beds days for over 75’s and unscheduled care and the actions being taken to either sustain or improve performance.

130.3 The Nurse Director commented that unscheduled care performance in December had been poor and continued into January. She commented that from December 2011 until December 2012 there has been an increase in attendance in all sites most
marked of which was at St John’s. In terms of patients attending hospital clinical
teams were reporting an increase in complexity and morbidity as well as a shift in the
age profile of patients. In addition there has been a seasonal increase in respiratory
conditions which had continued over the previous 6 to 7 weeks. The Nurse Director
also advised there has been an increase in unscheduled care inpatients admissions
and this had partly impacted on unscheduled performance. She advised a lot of
patients who where admitted were only admitted for short periods and that a new
model was being introduced at the Royal Infirmary of Edinburgh to help to discharge
people to home rather than having to admit them to hospital.

130.4 The Board noted that over the winter period there had been an average of 10 beds
per day closed because of Norovirus. The delayed discharge position had shown
significant improvement in terms of the speed of discharging patients with home care
packages. In addition an emergency meeting had been held with consultants to
address hospital flow issues with a Short Term Working Group having been
developed and an action plan put in place.

130.5 The Board noted that a “day of care audit” had been undertaken and had looked at
700 patients in the Royal Infirmary of Edinburgh to determine whether people were in
the correct place for the treatment they required. She advised that the data analysis
would be available the following week.

130.6 The Nurse Director concluded December had been a challenging month and that
staff had worked hard in difficult circumstances with additional staff and beds having
been added into the system. It was noted that even with this additional resource the
position remained challenging.

130.7 Professor McCallum provided an update on the position in respect of Smoking
Cessation; Child Healthy Weight and Fluoride Varnishing advising that good
progress continued to be made. She undertook to share with Councillor Toner data
from the Child Healthy Weight exercise as the West Lothian CHP were undertaking
work in that area. Professor McCallum would address these issues offline with
Councillor Toner.

130.8 The Board noted the update and progress being make in respect of performance
issues.

131. Financial Position to 31 December 2012

131.1 The Director of Finance advised that the financial position remained stable with an
underspend being reported to the end of December.

131.2 The Board noted that the key financial risk was around the Capital Programme.
Progress continued on the Backlog Maintenance Programme with a specific focus on
logistical issues. The Director of Finance advised construction activity would
become evident on the Royal Infirmary of Edinburgh site following the conclusion of
the Enabling Works process.
131.3 The Chair questioned whether the slippage being carried forward of £12.2m was a concern for the forthcoming financial year. The Director of Finance commented that this was the highest carry forward in recent years probably as a result of managers being focussed on addressing capacity and unscheduled care aspects of the business. She commented there was now a need to focus on looking at efficiency and that her finance colleagues had tried to support managers in this area. She advised that off the carry forward figure in excess of £6m had already been identified and reminded the Board that the NRAC position although improving made the challenge for efficiency harder although she recognised there was need to secure productivity improvement and this was an area that was being focussed on as well as the cash position. The Board noted that each Executive Director was heavily involved in developing Local Reinvestment Plan work-streams.

131.4 Ms Blair commented on she would be keen to receive details of key performance indicators around productivity and the need for these to link in to productivity measures. The Director of Finance advised that she did not believe that the carry forward position was a high risk for the Board and was reassured that more than 50% of the carry forward had already been identified. It was noted that it has been agreed that a different approach to efficiencies would be adopted in the forthcoming financial year which would also help to mitigate the position.

131.5 The Board noted the positive financial position and the fact that the Director of Finance was predicting a break even financial position at the year end.

132. **Royal Infirmary of Edinburgh Campus Redevelopment**

132.1 The Director of Finance advised the purpose of the report was to advise the Board of the extent of works on the Royal Infirmary of Edinburgh site over the next 4 – 5 years. She advised this represented a risk that needed to be proactively managed. In order to support the management of risk a Little France Working Group had been established to ensure coordination of activities and appropriate communication links into the NHS, University and Consort. This group would report to the Royal Infirmary of Edinburgh Health and Safety Group and would oversee and agree actions arising from this area of work.

132.2 The Board noted since the paper had been written there had been a meeting with Consort where it had usefully been agreed to separate additional works from the operational aspects of running the site. Consort had appointed a Variations Manager and NHS Lothian would make a similar appointment.

132.3 The Director of Finance in response to Mr Wilson advised NHS Lothian would be responsible for managing cost over runs arising from the Enabling and Clinical Enabling works. She commented however over runs were minimised by investing heavily in preparatory work around design costs. In that regard she felt there was a good understanding of budget risk and its assessment.

132.4 The Chief Executive felt the work on the Royal Infirmary of Edinburgh Campus Site should feature as a separate item on the Risk Register. He felt this was a manageable risk and that lessons could be learned from major capital projects undertaken elsewhere in Scotland.
132.5 Professor Iredale welcomed the establishment of the Little France Campus Working Group and Consort’s appointment of a Variation Manager and NHS Lothian’s intention to follow that approach and hoped this would facilitate the improved speed of projects in general.

132.6 The Board noted the information report.

133. **NHS Waiting Times Arrangements – Internal Audit Report**

133.1 The Medical Director commented aspects of waiting times had been discussed earlier in the meeting. He advised the key issue from the Internal Audit report had been to introduce a single management structure for waiting times and the process would be finalised by May 2015.

133.2 The Board noted another key recommendation had been around staff training. The Medical Director advised whilst the Single Waiting Times Team were being recruited focussed training would be delivered in February to dermatology and orthopaedics. Paediatrics and head and neck services would be the next part of the roll out procedure. The Medical Director advised different levels of training would be delivered to meet the requirements of the different staff groups involved.

133.3 Mr Brettell advised the Audit & Risk Committee had initially dwelled on the fact that the action in the initial report had not been explicit enough and for that reason a second report had been requested. He felt that the current position reflected a significant improvement against the previous position.

133.4 The Vice Chair commented she welcomed a single management structure although she had concerns about the need for clarity around issues around clock stops and patients being suspended from the waiting list. The Medical Director advised these issues would be addressed in the Board Development Session.

133.5 Mr Wilson noted that all of the actions were scheduled to be completed by December and January and he was unclear whether Executive colleagues had completed the process or if most of it had yet to be concluded. The Medical Director advised the action was for processes to be put in place to address the recommendations by the end of the year and this had been done with the exception of the restriction on TRAK where action had been completed. The Medical Director commented therefore that four of the actions were ready to be progressed with one already completed. This was in line with the Audit reports recommendations.

133.6 The Board noted the actions taken to address the recommendation in the Internal Audit Report.

134. **Date and Time of Next Meeting**
134.1 The next meeting of the Lothian NHS Board would be held at **1.30pm** on Wednesday 27 February 2013 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

135. **Invoking Standing Order 15.2**

135.1 The Chair sought permission to invoke Standing Order 15.2 to allow a meeting of NHS Lothian to be held in private. The Board agreed to invoke Standing Order 15.2.
PAEDIATRIC STAFFING

1 Purpose of the Report

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

2 Recommendations

The Board is recommended to:

2.1 Note the actions that have been taken since the Board meeting in November 2012 to manage these issues.

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

3 Discussion of Key Issues

3.1 The key issues were presented to the Board on 28 November 2012. Since then the SEAT Boards have undertaken a world wide recruitment campaign to attract consultant paediatricians, consultant neonatologists, specialty doctors in paediatrics, clinical fellows in paediatrics, neonatal clinical fellows, advanced neonatal nurse practitioners and advanced paediatric nurse practitioners to the paediatric and neonatal units in the region. This campaign is being coordinated by Havas, a leading recruitment agency with experience of recruiting to hard to fill medical posts.

3.2 The campaign comprises a series of measures:

Research to identify overseas talent
Targeting of passive jobseekers
A Google Ad words and Display Network Campaign
A Linkedin campaign
Production of a microsite on the internet to showcase the posts in Borders, Fife and Lothian
Engagement of a medical recruitment search / headhunting agency
Advertisements in paper and electronic versions of a number of leading paediatric and neonatal journals and the Sunday Times.

3.3 The initial closing date for applications was 31 January 2013. The applications received are:

Consultant paediatricians - two applications and one note of interest; interview planned for 20 March 2013.
Consultant neonatologist – no applications; post to be readvertised.
Specialty doctors - three applicants; plan to interview 22nd February 2013.
Paediatric Fellows - four applicants from Myanmar; plan to interview (by telephone or Skype) 22nd February 2013.
Prenatal Fellow - one applicant, plan to interview 18 February 2013.
Advanced Neonatal Nurse Practitioners- two notes of interest.
Advanced Paediatric Nurse Practitioners - one application.

3.4 During December, January and February the Medical Director and Director of Human Resources and Organisational Development have had several meetings with medical and nursing staff at St John’s, the Royal Infirmary and the Royal Hospital for Sick Children to better understand the fine detail of the staffing challenges facing paediatric and neonatal services in Lothian and more widely and to discuss potential measures to mitigate these.

3.5 The Director of Human Resources and Organisational Development has written to local General Practitioners to assess the number of General Practitioners who have the necessary competencies to work at middle grade trainee level in paediatrics and neonatology and to assess the level of interest among those people in undertaking shifts in hours and out of hours particularly at St John’s to help sustain paediatric and neonatal services there. So far no General Practitioners with necessary skills to work in the middle grade rota out of hours have been identified.

3.6 Scottish Government have committed to introduce a training programme within Scotland for advanced neonatal and paediatric nurse practitioners.

3.7 Each of the units has been working to produce workable rotas for the period from February onwards using a combination of the allocated middle grade trainees, locums and consultants acting down in to resident registrar shifts (with the consequent impact on clinical activity the day before and the day after the out of hours shift). The current situation is
RIE Neonatal Unit – rota is reasonable until April 2013. Options for managing the gaps are being considered.
St. John’s - February/March rota is covered. Work on April underway.
RHSC: Rotas are reasonable until April 2013. Problems are anticipated from May.

3.8 The Scottish Government Health Department and NHS Lothian have commissioned and external Workforce Support Team to review measures taken so far, review the work underway and support the local management team in managing the staffing challenges The Support comprises the Head of Planning for the West of Scotland Regional Planning Group, the Associate Medical Director for Women and Children’s Services from NHS Greater Glasgow and Clyde, the Medical Director of NHS London with support from SGHD.

3.9 The planning group chaired by the Director of Operations for Women, Children and Neurosciences NHS Lothian, Mrs Fiona Mitchell, which managed the similar situation in the spring and summer of 2012 has been reconvened. This group comprises staff from the three sites in Lothian along with the Regional Workforce Adviser and will meet fortnightly to monitor the staffing situation on each site in real time and to consider contingency plans.
Planning for a public information campaign on the risks to paediatric and neonatal services in each Board area and the potential need to redesign these is underway.

4 **Key Risks**

The key risks are

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

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

4.3 Short notice inability to staff St John’s paediatric unit and the clinical risk presented by an unplanned change in the service provided on that site.

4.4 Inability to recruit adequate staff to sustain the paediatric inpatient unit at St John’s.

5 **Risk Register**

5.1 The risk associated with the paediatric and neonatal workforce is on the Board risk register which will be updated to reflect the risk associated with the position from February.

6 **Impact on Health Inequalities**

6.1 An equality and impact assessment has not been undertaken. An assessment will be required if proposals for planned service change on any site are put forward.

7 **Involving People**

7.1 Planning for a public information campaign on the risks to paediatric and neonatal services in each Board area and the potential need to redesign these is underway.

8 **Resource Implications**

8.1 The additional short term costs of sustaining paediatric and neonatal services at St John’s are unlikely to be less than the £65K per month seen during the spring and summer of 2012.

8.2 Locum usage at RHSC and RIE is likely to be required to help cover gaps at those sites with further additional cost pressures.

8.3 The costs of the recruitment campaign are being partly underwritten by the Scottish Government.

8.4 Scottish Government has committed £600K of non-recurring funding over two years to the additional costs of staffing the units within Lothian.

8.5 Recurring funding will have to be made available for substantive posts filled as a result of the current recruitment campaign.
8.6 A financial plan will need to be developed to fund an increase in trained staff in the NHS Lothian paediatric and neonatal services.

David Farquharson
Medical Director
19 February 2013
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Minutes of the Meeting of the Staff Governance Committee held at 9.30am on Wednesday, 31 October 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs J McDowell (in the Chair); Mr A Boyter; Dr D Farquharson; Councillor D Grant; Mr S McLaughlan; Ms A Meiklejohn; Mrs A Mitchell; Mr G Warner and Mr R Wilson.

In Attendance: Dr C Kalman; Mrs R Kelly; Professor A McMahon (for item 26) and Mr P Reith.

Apologies for absence were received from Mr A Joyce, Mrs M Hornett, Mr S Wilson and Dr C J Winstanley.

Declaration of Financial and Non-Financial Interest

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

24. Minutes of the Previous Meeting

24.1 The Minutes of the previous meeting of the Staff Governance Committee held on 29 August 2012 were approved as a correct record, subject to the inclusion of Mr S McLaughlan amongst those present, rather than those in attendance.

25. Matters Arising

25.1 eESS Human Resources Update – Mrs Kelly informed the Committee that, following a risk assessment, it had been decided that rather than being one of the first Boards to move to the eESS Human Resources system, NHS Lothian should not move until March 2014. The new system was presently less functional than the Empower system currently in use in Lothian and following discussions with the National Project Board, it had been agreed that Lothian would wait to implement the new system until March 2014. NHS Lothian was still involved in the development of the system and the Head of the Human Resources Systems was working two days a week on the new national system.

25.1.1 The Chair thanked Mrs Kelly for the update and commented that this was very positive news.
25.2 Assessing the Equality Impact of Workforce Policies – the Committee noted that a number of the workforce policies had now been impact assessed, although some minor ones were still awaiting assessment. These were being undertaken and the impact assessment of all HR policies would be completed in the near future.

26. Health and Social Care Integration

26.1 The Chair welcomed Professor McMahon the meeting.

26.2 Professor McMahon introduced a previously circulated reported describing NHS Lothian’s strategic approach to the integration of health and social care in primary and secondary care.

26.3 Professor McMahon explained that this report had been considered at the Private Board meeting held the previous week and that the Board’s response to the Scottish Government had been submitted. It was noted that Edinburgh and West Lothian were moving forward with the creation of health and social care partnerships and East and Midlothian were looking at similar arrangements. The first of a number of information sessions with staff would be held that afternoon and work was underway to examine the types of services to be run by the health and social care partnerships.

26.4 Mr Boyter explained that the paper was coming to the Staff Governance Committee because of the very significant implications for staff arising from the implementation of health and social care partnerships. There was a possibility that health and social care partnerships might become employing authorities in their own right and the Scottish Government was currently looking at the human resources implications of such a move.

26.5 The Chair commented that the paper itself did not draw out the implications for staff and Mr Boyter advised that he was writing a paper for a Scottish Government short life working group on this and would produce a similar paper setting out the implications for staff for the January meeting of the Committee. It was agreed that the paper should explore the likelihood of unintended consequences and provide details of the consultation with staff to be undertaken.

26.6 Dr Kalman commented that there were significant health and safety issues involved in the integration of health and social care in primary and secondary care.

26.7 The Committee agreed to note the current position with the integration of the health and social care agenda.

27. Review of Management Culture

27.1 Mr Boyter gave the Committee an update on the current position of the Review of Management Culture and explained that arising from the waiting times report,
issues around management culture throughout the organisation had been identified and the Board Chair had convened a group reporting to the Cabinet Secretary to review management culture in NHS Lothian.

27.2 The Committee noted that this Group was partnership-based with Trades Union members and Lynne Khindria was acting as programme manager. An appropriate management response was being identified as was an action plan. A full written report would be going to the November Board.

27.3 Mr Boyter advised that the Scottish Government 20:20 Workforce Vision laid out the Government position of how healthcare would be provided in the future. Looking at the 20:20 workforce, there were three parts, capacity, leadership and governance, engagement and values. This last strand was being led by Mr Boyter and would be launched at the national NHS Conference. NHS Lothian’s local work would influence the national strategy.

27.4 Mr Boyter commented that this work was currently taking one day a week of his time and full-time civil service support was being provided, together with support from a public relations agency.

27.5 Mr Wilson commented that dealing with this issue should revert to the normal governance mechanisms as soon as possible.

27.6 Mr Boyter advised that a one-day conference was being considered. The changing of the organisation’s attitudes and behaviour was a major task and it was easier to change behaviour than it was to change attitudes.

27.7 Some concern was expressed that all of the people involved in the Management Culture Review Group had been with NHS Lothian at the time of the events concerned. Ms Meiklejohn advised the Committee that regular briefings were being given to staff, and Councillor Grant expressed the view that so long as there was transparency in the process, he did not see any problems with the membership of the review group.

27.8 The Committee agreed to note the update on the position.

28. Staff Governance Action Plan 2012/13

28.1 Mrs Kelly introduced the previously circulated Staff Governance action plan for 2012/13 explaining to the Committee that the plan was in a format set by the Scottish Government. The Board had been asked to submit a draft in advance of the annual review.

28.2 Mr Boyter advised that an update paper on the Human Resources and Organisational Development Strategy would be going to the November Board.

28.3 The Chair asked about the staffing implications arising from the integration of health and social care and Mrs Kelly advised that this could be included in the action plan as an additional item. Mrs Kelly advised that there would be
progress reports to the Staff Governance Committee meetings with a final report in April 2013.

28.4 The Committee approved the Staff Governance action plan for 2012/13, subject to the inclusion of an additional item on the implications of the integration of health and social care. As identified above, Mr Boyter undertook to bring back a report on the staff implications to the next meeting of the Committee. AB


29.1 Dr Kalman introduced the previously circulated annual Health and Safety report for 2011/12 and outlined the process of the report’s production.

29.2 The Committee noted that the Health and Safety Executive investigation into the fatality at the Western General Hospital was still ongoing and the Health and Safety Committee had reviewed this on a regular basis. Dr Kalman highlighted that there were a number of areas where work had been carried out to improve the situation and discussions were be held with the Health and Safety Executive. He was hopeful that the actions being taken would address the situation.

29.3 Mr Warner suggested that the Central Legal Office should be seeking an early decision from the Procurator Fiscal and Mr Boyter undertook to raise this with the Central Legal Office. AB

29.4 The Committee noted the position in respect of the Health and Safety Executive and that further update reports would be received.

29.5 It was agreed to approve the 2011/12 Annual Health and Safety report for NHS Lothian and to signify such approval to the Board.

30. Protection of Vulnerable Groups Update

30.1 Mrs Kelly advised the Committee that it had been hoped to bring a paper to the meeting but discussions with the staff side were still ongoing. The new “Protection of Vulnerable Groups” check on individual staff members was significantly more expensive than the previous full disclosure and the issue under discussion was whether some of this cost should be met by the employee.

30.2 The Committee noted that the Cabinet Secretary had determined that new staff in Bands 1-4 would have the fee of £59 per individual paid by the Board and that staff in Bands 5 and above should pay this fee on their recruitment in the same way as was the case already with other professional registrations.

30.3 Discussions about payment in relation to existing staff were still ongoing as all such relevant staff required to have their protection of vulnerable groups check carried out by March of 2015.
30.4 Mr Boyter emphasised that there were two important issues, mainly the trajectory to March 2015 to ensure that the necessary staff could be processed in order to allow services to be maintained and how to handle instances where previously unknown criminal convictions were unearthed.

30.5 Mt Boyter indicated that it was thought 1% of checks might throw up problems and it was hoped that there would be relatively few offences on which a decision required to be taken. It was noted that the courts already notified Health Boards about staff in registered occupations who were convicted of a criminal offence.

30.6 The Committee agreed to note the position and Mrs Kelly advised that she would provide an update to the January meeting.

31. **Auto-Enrolment for Pensions**

31.1 Mrs Kelly advised that the auto-enrolment of staff for pensions was being discussed at a national level to ensure that any changes were brought in on a common date. Management had some concerns over the possibility of increased employer contributions. Mrs Kelly agreed to bring a further update to the next meeting.

32. **Health and Safety Committee**

32.1 The Committee received for information the previously circulated Minutes of the Health and Safety Committee meeting held on 31 July 2012.

33. **Date of Next Meeting**

33.1 It was noted that the next meeting of the Committee would be held on Wednesday, 30 January 2013.
1.0 Apologies and Welcome

Apologies were noted as above.

Welcome and introductions were made by Mike Ash, Chairman for East Lothian & Midlothian CHPs.
2.0 **Minutes of the Previous Meeting held 27th September 2012**
The minutes were agreed as being a true and accurate record of the meeting.

3.0 **Matters Arising / Action Plan**
The Action Log was updated.

4.0 **Items for Decision**
No items for decision

5.0 **Items for Discussion**

5.1 **Integration of Health & Social Care**
DAS updated the Committee regarding the submitted consultation responses to the Scottish Government for both Midlothian and East Lothian. The Scottish Government has not yet responded to the consultation and there is not yet a date for the legislation to be put out in draft form.

In principle the Council and NHS Lothian have agreed that shadow arrangements should be in place by April 2013. Officers are working closely together on the detail but all proposals are subject to change by legislation.

The CHP Sub Committee may be disbanded in April 2014 pending receipt of legislation.

EMc indicated that there is a real understanding and clear focus from Social Care colleagues that we need to improve and continue to deliver our services. It is also clear that where services currently work across both areas that this will continue.

MAsh advised that this Committee gave an opportunity for questions or queries to be asked and recorded as and when issues arose until there is greater clarity.

JG asked about the Carer representation within the Shadow arrangements and whether there is a seat for carers. **ACTION**

DAS advised that the CHP Sub Committee will probably continue in its current format until 2014. Community Planning will also have to be embedded within the new structure too.

TW advised that until final guidance from Scottish Government is received there is not clarity about representation on the Shadow Boards. There has been discussions locally regarding carer and voluntary sector representation.

Mandy McKinnon emphasized the importance of maintaining communication/representation within the new shadow board on Health Improvement and Children’s Services.
MAsh advised that Children’s Services won’t currently be part of the Scottish Government Legislation.

TW advised that the main focus of the proposed Adult Health & Social Care Integration is on Older People and Adults and the learning gained on this integration process before Children’s services are involved.

TW also emphasized the importance of Community Planning as it covers transport, housing etc within the local areas and the new Shadow Board needs to be linked in with the Community Planning Board already in existence.

SE indicated that she supports the points about carer involvement, disappointment that a public representative is not mentioned at all. Sue asked if the paper will be ready for the 3rd week in January 2013. DAS and EMc both indicated that they hoped it would be. DAS advised that the new Shadow boards will probably be run in tandem with the existing committees.

TW reported that HR, EMc and TW met with the Midlothian GP reps group to discuss the integration agenda and the shadow board being put in place.

### 6.0 Performance Reports

#### 6.0 General Manager’s Report

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

**Delayed Discharges**

Continued excellent performance was noted.

**Premises**

**Malta House**

As reported at previous meetings, the Church of Scotland intends to sell Malta House. Discussions with the church have reached the conclusion that it will not be possible to secure the building for NHS Lothian.

A suitable alternative location has been found. Work is underway to cost the alterations to the building and a business case is being prepared.

**Homeopathy Review**

Public meetings have now been held in all CHP areas in Lothian. Following the last meeting in Edinburgh it has been agreed to extend the deadline for submission to 10th December to enable the maximum number of people to participate. The extension of the deadline has been communicated widely. The lead responsibility for the review will be taken on by the Director of Strategic Planning in NHS Lothian from 1st December 2012. It is anticipated that a report will be available in spring 2013.
Decisions

The report was noted

6.2 Staff Governance Report

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

DAS reported that sickness absence remains higher than expected.

Decisions

The report was noted.

6.3 Finance Report

The Sub Committee considered a finance report on month 6 which had been circulated in advance of the meeting. An updated report for month 7 was tabled at the meeting.

Over all, the finance team are forecasting breakeven at year end. Genuine Volume growth is in line with the rest of Scotland within Prescribing. A new Audit Scotland report “GP efficient prescribing” is due for release. This will show Lothian as among the most cost effective prescribers in Scotland.

Medicines Waste was raised at the last meeting. There is a Lothian wide group run by the Pharmacy Department within Primary Care which meets once a quarter. SE advised the Public Partnership Forum are aware of the existence of this group and have a representative on it.

Decisions

The reports were noted.

6.4 Clinical Director Report

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

HR included a report on the Midlothian Prescribing Budget July 2012.

Midlothian has the highest under spend within Lothian and has dropped to the second lowest spend per capita. Previously Midlothian had the highest costs and this reflects the hard work done by the primary care pharmacists and the GPs.

HR drew the Committee's attention to the “Primary Care Impact Report 2012”. It shows that 90% of healthcare activity is in primary care and the
impact GPs have had on ill health in the community.

TW requested a Midlothian breakdown. HR advised he would speak to the author.

Decisions
The reports were noted.

6.5 Chief Nurse Report

The Sub Committee considered a report which had been circulated in advance of the meeting. Annmarie Burgess Clinical Nurse Manager attended on behalf of Alison Macdonald, Chief Nurse.

The report highlighted key points in relation to:- Child Protection, Adult Protection, Recruiting relevant qualified staff, Ageing work force, Priorities around certain specification working with Child Protection, Adult protection and health visiting, Community Nursing (District Nursing, Health Visiting & School Nursing), Adult and Older People’s Services (Hospitals), HAI for Midlothian, For Information

The report shows that Hand hygiene audits remain compliant and above target at 95%.

Decisions
The report was noted.

6.6 AHP Manager Report

The Sub Committee considered a report which had been circulated in advance of the meeting. DAS updated the Committee on behalf of Robert Packham, AHP Manager.

Decisions
The report was noted.

6.7 Hosted Services
The Sub Committee considered reports which had been circulated in advance of the meeting.

6.7.1 – Learning Disability Services

Alistair Littlejohn talked to the paper on behalf of Sally Westwick.

There is now a downward trend in sickness/absence. Some of the sickness was attributed to staff injuries received by staff within the Greenbank Centre.

MAsh asked what action is being taken to reduce referrals levels.
AL advised that referrals reflect the level of need. Staff time can be taken up assessing patients to see if they qualify for Specialist care.

6.7.2 Substance Misuse Update

Ian Burns talked to the paper on behalf of Sally Westwick

The service has met the trajectory for initiation of treatment within three weeks.

Finance - It was noted that a significant number of posts are currently funded on a short term funding basis and this poses planning difficulties for the service.

The Datix Reporting system is being looked at and updated to differentiate between different categories of patient deaths. MAsh noted his interest around the Datix reporting.

TW indicated that the improvement in performance and waiting times from 30% to 90% is excellent. IB recommended the use of a Kaizen review for other areas in order to reduce waste.

LH expressed concern around the uncertainty about long term funding. There is to be a meeting with Scottish Government to discuss future funding and the changes around Drug partnerships.

6.7.3 Health Promotion HEAT Targets Update

Steven Wray attended to deliver the paper.

The report highlighted key points in relation to:- Coronary Heart Disease, Child Healthy Weight, Alcohol & Health, Mental Health, Smoking, Early Years (breastfeeding), Keep Well Health Checks, Child Dental Health

SWray highlighted that suicide rates within Midlothian have reduced although the target of 20% reduction was not yet met. It was noted that the numbers are small and that percentage changes may not be statistically significant.

SWray – advised that there are complex issues around women choosing not to breastfeed. Those in poorer areas tend not to breastfeed. Midlothian Council are trying to ensure that all their premises will be Breastfeeding friendly to assist with encouraging more mothers from the area to take up breastfeeding. In addition Midlothian was at 25.05% against the breastfeeding target of 35.15%.

SE asked about the child weight issue. SWray advised there is an improving picture across Midlothian but with inequalities across different areas of Midlothian.

Decisions

The reports were noted.
6.8 Primary Care Contractors Organisation

The Sub Committee considered reports which had been circulated in advance of the meeting for noting.

GMS update
LH updated the Committee on this report. Full details will be provided to the Committee out with this meeting.

The new GMS Contract will have Qof improvements to give clear patient benefits, with continuing Polypharmacy, prescribing and medicines management. With a focus on increased patient safety.

Decisions

The reports were noted.

7.0 Carers Forum

JG provided the Committee with a verbal update and apologised that there were not minutes issued for today’s meeting. These will be sent to the Sub Committee.

JG reported on the GP Survey to discuss how GPs can help Carers within their practice areas.

JG Gave a brief update on Carers Strategies monies funding one to one direct support to all carers.

MAsh advised he would be happy to hear about any events being run within Midlothian.

ACTION: Welfare Reform Report. Graham Kilpatrick project lead, welfare and reform Committee, to be invited to present a summary around benefits changes. TW/WM to liaise. Mandy advised that Graham has been working with Kate Burton, NHS Lothian.

Decisions

The verbal updated noted.

8.0 Public Partnership Forum

SE gave a verbal update on behalf of the Public Partnership Forum.

Patient transport is a high priority for the PPF and members. This has been highlighted within Community Planning at Newtongrange Neighbourhood planning Committee.

AMB reported that there is a clinic in Newtongrange. Children’s services are currently being run from this building.

SE to liaise with AMB and report back at the next meeting. ACTION

SE also highlighted capacity following housing increase and access to GP surgeries. HR advised that GP Surgeries within Midlothian still have open
lists (none of them are closed). The Community Health Partnership is engaging practices with potential population lists and how it will affect Practices.

Catherine Johnstone is aware of issues around access and waiting times and has met to discuss these with patient groups. Specific problems within one area were highlighted.

SE reported that her period as Chair on this group has expired. By end of March 2013 the new chair will be known.

Decisions

9.0 Community Health Partnership Committee Appointments

No items for discussion.

10.0 AOCB

There were no items.

51. Date and Time of Next Meeting

Thursday 31st January 2013 at 14:00 in the Council Chambers, Midlothian House, Buccleuch Street, Dalkeith
1.0 Apologies and Welcome

Apologies were noted as above.

Welcome and introductions were made by the Chairman for East Lothian & Midlothian CHPs.
Declaration of Interest
None were noted at this meeting.

1.1 Welfare Reform Update Presentation
Kate Burton (KB) and Nicole Bethune (NB) gave a presentation on the above.

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

EMc advised the Committee that there is currently a review within Midlothian Council of under occupancy for those tenants who will no longer receive their full housing benefit. The Welfare changes will impact greatly on the population within Midlothian. The Message to health care staff is to support people to take action now.

Administration of the welfare fund is being taken over by Midlothian Council rather than being distributed by the Department of Work & Pensions (DWP). There are very strict criteria. A review is being carried out to identify those families who are not managing currently.

HR advised that this will have an impact on all Midlothian GPs workloads. Kate is attending the Midlothian GP Forum to give the presentation.

EMc advised that GPs help to support people who are capable of getting back into employment to do so is very much appreciated.

2.0 Minutes of the Previous Meeting held 6th December 2012
The minutes were agreed as being a true and accurate record of the meeting.

3.0 Matters Arising / Action Plan
The Action Log was updated.

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 report which had been circulated in advance of the meeting on 22nd January 2013. No comments were received from the Committee.

DAS and EMc provided an update and advised on developing arrangements for the Shadow Board Management and Sub Committee.

Project team dates are scheduled in diaries in terms to oversee this process. A meeting has been set up for consultation with Patient
representatives, service users and carers along with Voluntary Sector colleagues.

Consideration is being given to professional engagement in the Shadow Board.

The Ministerial Statement is still awaited. A Summary of the Consultation has now been published.

SE asked about the voting members on the Shadow Board and who these will be. EMc confirmed that these would be 4 Councillors and four NHS Board nominees. There will be discussion on other involvement together at a meeting to which SE has been.

DAS advised that NHS Lothian is holding an event on 14th February to discuss the different elements of hosted services being provided in local areas.

JG asked about the outcomes of integration and the impact on people. It was suggested that a survey is carried out around care assessment, planning and review.

5.2 Joint Physical & Complex Disability Strategy Action Plan 2012-15
The Sub-Committee considered a report which had been circulated in advance of the meeting.

EMc advised that Midlothian recommends support and commitment for this strategy by the Committee. The finalised version of the strategy and ownership of the document is within the Community Planning Partnership.

Decisions
The Committee supported the document.

5.3 Carers Strategies Monies “Right Support for All Carers”
JG verbally updated the Committee on the above. The Welfare Rights Team and Citizen’s Advice Bureau (CAB) are to provide dedicated support for carers to access the right advice and support.

Decisions
The verbal update was noted.

5.4 GMS contract Update
DAS gave a verbal update on the above and advised that there was a highlighted version within the GM report.

The Scottish Government and the Scottish General Practitioners Committee have agreed to a new contract which differs from the contract for the rest of the UK. The Scottish contract will see new clinical thresholds in the Quality and Outcomes Framework (QOF), the extension of the Patient Safety Programme in Primary Care, the introduction of a new “Public Health Domain” in the QOF, the transfer of some QOF funds to core practice funding to increase financial stability for practices and a programme to improve the care of patients at high risk of emergency admission. Full details of these changes are awaited.
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, Malta House which is now called “Woodlands”, Homeopathy Review and “More Scottish” General Medical Services Contract.

Midlothian performance on the validated census in December was 6 with no patients in short stay beds and no patients over 6 weeks in post acute beds. In addition no patients were delayed over 4 weeks (the new national standard for April 2013). This represents continued excellent performance.

The Homeopathy consultation closed on 10th December 2012. Large numbers of written and online responses have been received and these are being analysed. It is planned to hold a stakeholders meeting on 21st February 2013.

There are also Capital Project’s being developed for Newbyres and Loanhead to extend their facilities.

Decisions

The report was noted.

6.2 Staff Governance Report

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

There is continued good performance with a turnover in the month at 0.95% and sickness absence at 4.16%.

Decisions

The report was noted.

6.3 Finance Report

The Sub Committee considered a report which had been circulated in advance of the meeting. Mike Porteous (MP) attended the meeting on behalf of Lynne Hollis (LH).

MP advised that the underspend reported within Core Services continues to be driven by the level of vacancies, particularly in Allied Health Professionals (AHPs) and Mental Health Services. The Hosted Services overspend is reducing month on month as the level of Nurse Bank usage is being managed down. Overall the CHP is on track to deliver its year end break even position.
Prescribing data is available from April to October 2012 with volume estimates for November. The current position builds on actual expenditure data received to the end of October (7 months known data), estimated volumes/items for November (from ISD) and a forecast position for December.

The CHP has identified two LRP schemes which are not delivering their planned savings. A substitute scheme has been identified and will be actioned over the remaining months to ensure the in year target is met. Work is ongoing to address the small recurring gap and identify schemes for the coming year.

Decisions

The reports were noted.

6.4 Clinical Director Report

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

6.4.1 Prescribing Action Plan 2012/13
A document had been previously circulated to the Committee covering prescribing efficiencies and indicators.

MA suggested all members review the executive summary within the document.

6.4.2 Protecting Vulnerable Groups (PVG)
All GPs have to be on the performers list and in order to be on this list the GPs have to follow this process.

Decisions

The reports were noted.

6.5 Chief Nurse Report

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

AMac highlighted the following areas: - Public Protection figures are for Child Protection.

A new Team Manager has been appointed for the Midlothian District Nursing team.

SE stated that she was encouraged about the work going on at the Midlothian Community Hospital and asked how are the questionnaires for monitoring quality and improvement targets being fed back.

AMac advised that peer review papers will become available in due course.
EMc praised the work within the Midlothian Community Hospital around palliative care and advised that a review is being carried out in Care Homes throughout Midlothian to have a similar service. The Fraility Programme will extend the expertise of Palliative Care ward staff.

Decisions

The report was noted.

6.6 AHP Manager Report

The Sub Committee considered a report which had been circulated in advance of the meeting. DAS updated the Committee on behalf of Robert Packham, (RP) AHP Manager.

Key Issues raised in the report were staffing, Arts Therapies, Governance of Therapy Services, Performance Data, Seven Day Working.

Decisions

The report was noted.

6.7 Hosted Services

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

6.7.1 – Learning Disability Services

Alistair Littlejohn (AL) updated the Committee on behalf of the Learning Disability Service.

AL advised that the NHS Lothian Learning Disability (LD) Service was delighted to receive a visit from the Chief Executive on 11 December 2012.

The LD management team will be relocating to the New Centre called Woodlands House at the Astley Ainslie Hospital.

Since our last report there have been no further RIDDOR reportable injuries sustained whilst treating the very complex patient referred to previously. There was a presentation to the NHS Lothian’s Health and Safety Committee in November highlighting the complexities of the learning disabilities patient group and the very difficult behaviours that staff frequently have to manage.

Reprovision of the existing LD services within the Royal Edinburgh Hospital Programme is being pursued as part of the Master planning for the site.

6.7.2 Substance Misuse Update

Ian Burns (IB) updated the Committee on behalf of the Substance Misuse Service.
IB advised that Waiting Times figures presented are very promising to achieve the 3 week target for 31st March 2013.

Alcohol and Drug Partnership (ADPs) have confirmed that all posts due to end on 31 March 2013 will be extended for one year. This will support delivery of the target and an Action Plan has been drawn up.

MA stated that it was good to hear that waiting time targets were going to be met.

HR mentioned the Open Access gateway or Recovery Hubs introduced last year are an excellent way of getting patients in to treatment and has been a great benefit for GPs.

EMc advised that she chairs the local ADP meeting in Midlothian. EMc said the work across both East and Mid; working together with voluntary sectors has managed to make this successful. All monies are focused on access to treatment and people are supported throughout the length of their recovery (which can be up to five years).

6.7.3 Joint Health Improvement Partnership
Mandy MacKinnon (MMac) updated the Committee verbally. The main item highlighted was the new initiative for Support for Breastfeeding in the community.

Decisions
The reports were noted.

6.8 Primary Care Contractors Organisation
The Sub Committee considered a report which had been circulated in advance of the meeting for noting.

6.8.1 PCFG Notes 13.12.12
The paper highlights the range of work going on throughout NHS Lothian.

Decisions
The report was noted.

7.0 Carers Forum
Julie Gardner (JG) gave a verbal update to the Committee.

JG advised that no Carers Forum meeting has been held since December. The next meeting will be held next month.

There is a National event on 12th March on “Reshaping Care” and Midlothian Carers have asked to present at this event. Presentation will be to highlight an overarching personal outcomes framework for Midlothian.

Vocal have been working from Grannies Park for a number of years, however they are currently in negotiation for new premises within the
Harden Green Industrial Estate.

MA advised that he would like to meet with the Carers Forum.

Decisions

The verbal updated was noted.

8.0 Public Partnership Forum

Sue Edmond gave a verbal update to the Committee.

MAsh will attend the Midlothian Public Partnership Forum on 22nd March 2013.

The Physical Disability Strategy was presented at the last Public Partnership Forum meeting.

Transport is now a high priority item on the agenda along with ambulance services and communication with the public.

The Public Partnership Forum are looking at the Public participation standards and the different groups that the PPF currently sit on and how they are kept involved with strategies, changes in services prior to them being made public.

SE raised the issue of standardisation of Sub-committee papers to ensure inclusion of the section on “involving people”.

DAS agreed that if there is inconsistency then it does need to be rectified.

EMc said it was important and helpful point. MELDAP agreed a framework for involving public within the service and linking in with PPF members.

MA requested minutes or a written report received from the Public Partnership Forum for future meetings.

Decisions

The verbal update was noted.

9.0 Community Health Partnership Committee Appointments

No items for discussion.

10.0 AOCB

10.1 Midlothian News

MA asked about the appropriateness of including information about the Community Health Partnership in the Midlothian News. It was agreed that this would be a good idea and EMc agreed to follow this up.

10.2 MINUTES

MA asked the Committee for permission to have the unapproved minutes sent to NHS Board for inclusion in the Board papers to avoid two month’s delay.
The Committee agreed that this would be in order.

10.3 Presentations
MA asked the view from members around the length of presentations and frequency at future Midlothian Sub Committee meetings.

HR confirmed he would be happy to have short presentations. The Committee agreed that they would be happy to have 45 minutes at the beginning of meetings whether that is two short or one longer presentation, depending on the issue being discussed.

Date and Time of Next Meeting

Thursday 28th March 2013 at 14:00 in the Council Chambers, Midlothian House, Bucchleuch Street, Dalkeith
MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD held within THE STRATHBROCK PARTNERSHIP CENTRE, BROXBRUN on TUESDAY 20 NOVEMBER 2012

Present – Frank Toner (Chair), Mike Boyle, Janet Campbell, Jane Houston, John McGinty, Anne McMillan, Alison Mitchell

Apologies – Morag Bryce; Jim Forrest (CHCP Director)

In Attendance – Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), Gill Cottrell (Chief Nurse), Lynne Hollis (Associate Director of Finance, NHS Lothian), James McCallum (Clinical Director, NHS Lothian), Kenny Selbie (Equality Officer, West Lothian Council), Fiona Duffy (Corporate Communications, West Lothian Council), and John Richardson (PPF)

1. ORDER OF BUSINESS

The Chair ruled as follows:-

(a) An appendix omitted from Agenda Item 15b (Care Governance) was allowed to be tabled and circulated to Board members.

(b) An addendum providing additional information in relation to Agenda Item 18 (2012/2013 Revenue Budget Monitoring Report) was allowed to be tabled and circulated to Board members.

(c) Agenda Item 13 (Winter Resilience Plan) would be deferred to the end of the agenda.

2. DECLARATIONS OF INTEREST

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

3. MINUTE OF MEETING OF THE BOARD – 2 OCTOBER 2012

The Board approved the minute of its meeting of 14 August 2012 as a correct record subject to the following:-

(a) Mike Boyle had tendered his apologies for the meeting but they had not been noted.

(b) Alison Mitchell’s name was incorrectly recorded in the list of members present as “Alison Campbell”.

4. CHCP BOARD RUNNING ACTION NOTE

The Board considered the Running Action Note (which had been circulated).

Decisions

1. To note and agree the contents of the running action note.

2. To agree that Items 3, 4 and 5 had been completed and should be deleted.
3. To agree that Items 1 and 6 were not yet completed and should be carried forward.

4. To update and amend the Running Action Note accordingly.

5. **MINUTE OF MEETING OF CHCP SUB-COMMITTEE – 30 AUGUST 2012**

   The Board noted the minute of the meeting of the CHCP Sub-Committee held on 30 August 2012.

6. **MINUTE OF MEETING OF THE PRIMARY CARE FORWARD GROUP – 4 OCTOBER 2012**

   The Board noted the minute of the meeting of the Primary Care Forward Group held on 4 October 2012.

7. **MINUTE OF MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP – 13 SEPTEMBER 2012**

   The Board noted the minute of the meeting of the Primary Care Joint Management Group held on 13 September 2012.

8. **MINUTE OF MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP – 11 OCTOBER 2012**

   The Board noted the minute of the meeting of the Primary Care Joint Management Group held on 11 October 2012.

9. **EQUALITY IMPACT ASSESSMENTS – PRESENTATION**

   The Board heard a presentation by the council’s Equality Officer describing the work carried out in partnership by the council and the Health Board in relation to the implementation of the “public sector equality duty” and the carrying out of equality impact assessments in relation to functions and policies.

   He described the process followed in assessing proposed policies and decisions, and explained the need to ensure that equality impacts were considered during the development of these issues and at the point where decisions were made.

   He referred to the part of the standard report template for reports to the Board and stressed the importance of providing information there, and elsewhere in the report, to ensure that Board members were making informed decisions.

**Decision**

To note the presentation by the council’s Equality Officer on Equality Impact Assessments and the procedures for applying them to the subject matter of CHCP Board reports.
10. **FAMILIES INCLUDED**

The Board considered a report (which had been circulated) by the Head of Council Services informing the Board of the award of a contract for the delivery of support services to develop and implement a service model to underpin the operational and strategic framework for services to families with multiple and complex needs.

The report explained the need for a service to work with whole families with very complex needs and with the most entrenched social issues, in order to identify the most persistent and deep-rooted issues which create barriers to change. It advised that this was to be done by building strong and persistent relationships between professionals and families, supporting them to navigate and negotiate services and release the strengths already present within the family. It outlined the core characteristics of the approach, and went on to summarise the procurement process which had been followed and that the expected investment was for £150,000 over a two year period.

It confirmed that the contract had been awarded to Gill Strachan Limited (GSL) which had been assessed as the best of the six tenders received.

It concluded by explaining that officers would work alongside representatives from GSL to develop the delivery model, build the skill set of the specialist multi-agency team and support the implementation of the programme for families with multiple and complex needs.

**Decisions**

1. To note that the contract for the delivery of this service had been awarded to Gill Strachan Limited for the period 1 November 2012 to 31 October 2014.

2. To note that although the report was silent in relation to equality impact assessment, the council’s Equalities Officer had confirmed that no such assessment was required.

11. **FOODBANK**

The Board considered a report (which had been circulated) by the Head of Council Services highlighting the creation and purpose of a West Lothian Foodbank.

The report advised that the West Lothian Foodbank was in the process of being developed to become operational from October 2012 in association with Whitburn Pentecostal Church with funding having been secured via Awards for All, and with premises, volunteers and partnerships having been identified. It explained that the Foodbank’s stated intention was to open its first food warehouse in Whitburn with a view to replicating this as soon as possible in other areas to create an accessible network of Foodbanks throughout West Lothian. The sole purpose of the Foodbanks was to provide an emergency supply of up to 3 days of non perishable food to individuals and families in crisis who would be at risk of going hungry otherwise.

The report went on to provide details of the operation of the service, and the manner in which it had been assessed to ensure it was established on a firm and robust basis.
The report concluded that the establishment of Foodbanks was viewed as having the potential to bring about multiple benefits at a number of levels. The opportunity to provide an additional quick response to those in crisis and already experiencing hunger or at risk from it is its primary purpose and function. However the benefits associated with volunteering and community capacity building also had to be taken into account.

Decisions

1. To note the development of a Foodbank within West Lothian and the contribution it can make to those in crisis.

2. To note that a report will be brought to the Board to provide an update on the usage and success of the Foodbank.

3. To note that although the report was silent in relation to equality impact assessment, the council's Equalities Officer had confirmed that no such assessment was required.

12. HEALTH AND WELLBEING PROFILE: UPDATE REPORT

The Board considered a report (which had been circulated) by the Head of Health Services updating the Board on the priorities and actions being taken forward following the presentation and discussion of the Health & Well Being Profile of West Lothian's population at the last Board meeting. As a result of that meeting a number of key priorities had been agreed and the proposed actions to address these and timescales for reporting back were detailed in the report, covering the period from January 2013 to August 2013.

The Board was informed that the action plans would focus on prevention, early intervention and impact and the approaches taken to tackle health inequalities. It was explained that the actions would be reported to the Sub-Committee and monitored there with reports then coming to the Board as part of its scrutiny function.

Decisions

1. To acknowledge the planned actions to take priorities forward.

2. To agree that the actions identified in the report should be remitted to the Sub-committee for inclusion into the CHCP work plan.

3. To agree the timescale set out in the report for follow-up reports to be brought to the CHCP Board.

13. CLINICAL GOVERNANCE: PROTECTING VULNERABLE GROUPS (PVG) SCHEME

The Board considered a report (which had been circulated) by the Clinical Director highlighting the robust system operated by NHS Lothian in relation to the implementation of the Protecting Vulnerable Groups legislation, in particular the rigorous controls in place for independent contractors in the provision of their services.

The report explained the purpose of the legislation and that in order to work as a
GP in Lothian, a doctor was required to be a member of the performers list. That was explained to be the case for principals as for locums and other doctors contracted by a practice. As well as professional accreditation, annual appraisal and membership of the PVG scheme were requirements. It went on to advise that there was a three year phase in process for PVG, and that the Primary Care Contracts Organisation (PCCO) was about to start retrospective PVG checking for all independent contractor groups as directed by Scottish Government.

**Decisions**

1. To note that independent contractors were subject to rigorous controls in determining continuing fitness to practice.

2. To note that Protecting Vulnerable Groups (PVG) legislation was being introduced to replace current Disclosure Scotland processes.

3. To note that NHS Lothian had a robust system for this process and that, although no problems are anticipated, the Clinical Director would be informed if any GPs failed to meet the requirements.

14. **CARE GOVERNANCE: CARE INSPECTORATE INSPECTIONS**

The Board considered a report (which had been circulated) by the Head of Council Services updating the Board regarding recent inspections carried out by the Care Inspectorate into CHCP Council services.

The report explained the function of the Care Inspectorate, its quality indicators (Quality of Care and Support, Quality of Environment, Quality of Staffing and Quality of Management and Leadership), and the inspection and grading methods it used. The appendix to the report summarised the gradings of recent inspections carried out by the Care Inspectorate on CHCP Council service areas and provided hyperlinks to the reports.

It was proposed that an update report would be provided to the Board on a six-monthly basis.

**Decisions**

1. To note the gradings of the inspections carried out, as shown in the appendix to the report.

2. To agree that six-monthly updates should be provided to Board, which should provide trend information in relation to establishments with one or more scores of 3 or less.

15. **STAFF GOVERNANCE**

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services providing an update on staff issues in the CHCP.

The report informed the Board about the E-Learning Module developed in the council in relation to data protection and data security; the availability of the flu vaccine for CHCP staff; and the establishment of a new helpline for back, muscle and joint pain.
Decisions

1. To note the development and implementation of the e-learning data protection.

2. To note the availability of flu clinics for CHCP staff.

3. To note the launch of a new helpline for people with back pain or muscle and joint problem.

4. To agree that a report should be brought to the Board in due course to advise of the usage and success of the new helpline service.

16. RESOURCE TRANSFER MONITORING REPORT TO 30 SEPTEMBER 2012

The Board considered a report (which had been circulated) by the Head of Council Services advising that the council had invested £3.228 million of the total £6.39 million resource transfer monies to the end of September 2012.

The report confirmed that the council had maintained a zero delayed discharge position in the first six months of the financial year.

Decisions

1. To note the maintenance of a zero rate for delayed discharges.

2. To agree that the CHCP continue to invest the resource transfer monies effectively in the prescribed areas and continue to maintain a zero delayed discharge position.

17. 2012/13 REVENUE BUDGET MONITORING REPORT AS AT 30 SEPTEMBER 2012

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services containing a joint report on financial performance in respect of CHCP figures for the period to 30 September 2012. The additional information which had been allowed to be tabled provided more detailed information in relation to the heading “Unallocated” in the summary financial statements.

The report advised that the anticipated draft out-turn for the CHCP as a whole was for an under-spend of £1.654m. In relation to the CHCP council services, the forecast was for an underspend of £1.56m. In relation to the share of the CHCP budget for NHS Lothian, the forecast was for an underspend of £0.094m.

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

Decisions

1. To note the anticipated budgetary figures provided for Council and Health Services, and the CHCP as a whole.

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

3. To agree that there should be a presentation to a future meeting of the Board to explain the legal rules and CHCP procedures for dealing with self-directed payments.

4. To note that officers would advise Board members as to whether a service user electing to take self-directed payments was able to purchase services from other local authorities.

5. To agree that officers should provide Board members with copies of two finance briefing papers in relation to Prescribing and Primary Medical Services.

18. DIRECTOR’S REPORT

The Board considered a report (which had been circulated) by the CHCP Director setting out key areas of work in which the partnership had been involved since the last meeting of the Board.

The Board was provided with information in relation to:-

- The development of classes for those who have a chest or heart condition
- The West Lothian Walking Week
- The delayed discharge process
- West Life
- The CHCP website usage
- The planned CHCP development session, set to take place on 19 March 2013 from 12 noon until 2 pm at the Strathbrock Partnership Centre.

Decisions

To note the updates provided by the CHCP Director.

19. WINTER RESILIENCE PLAN

The Board considered a report (which had been circulated) by the Head of Council Services and the Head of Health Services informing the Board of the steps taken to prepare for potential severe winter weather and highlighting the arrangements and contingencies to respond to the expected pressures over the forthcoming winter period.

The report stressed that the continuity of care services was a major priority in relation to the CHCP’s response to severe weather, as was the safety and well being of children, adults and older people in the community and staff. It outlined the arrangements that would be put in place to ensure that all required care continued to be delivered during a period of disruption and when demand for services were likely to be at their highest level, and confirmed that the CHCP had established clear roles and accountabilities for services to ensure robust arrangements are in place to manage the winter period. There had been proactive engagement of all partner agencies in the planning and preparation of the resilience plan and clear escalation and communication processes were in place across the health and care functions to support implementation.

The full West Lothian CHCP Winter Resilience Plan 2012/13 was attached as an
appendix to the report.

Decisions

1. To note the progress made with winter preparedness and the required outcomes of winter planning.

2. To agree the priorities and action plan which covers the 9 key areas as highlighted in the report.

3. To support the implementation of the plan as set out in the appendix to the report.

4. To record the Board’s appreciation of the efforts of CHCP staff in dealing with winter weather and its impact on services and service users.
NHS LOTHIAN

Board Meeting
27 February 2013

Chairman

CHAIRMAN’S REPORT

1. Internal

1.1 Committee Chairs

I chaired the inaugural meeting of the NHS Lothian committee chairs on 30 January. The sessions will co-ordinate committee business planning in support of assurance.

1.2 Official opening of Royal Victoria Building

On 5 February I hosted the official opening of the Royal Victoria building at the Western General site. The building was opened by the Cabinet Secretary for Health and Wellbeing, Mr Alex Neil. He met members of staff and was shown selected areas of the building.

The building has 100% single rooms for patients, which was discussed in the media.

1.3 MSP briefing

MSPs from our region were given their quarterly briefing on 22 February.

1.4 Other duties

In other duties during this period:

• I assessed Foundation grants applications (using new Grant Benefactor software).
• I assisted the National Community Planning Group review of Fife CPP.
• I met the Chair of an English health trust being briefed on our integration of health and social care in Edinburgh.
• I met David Griffiths of the Edinburgh Partnership Board to discuss the sharing of data between partners.
• I met the Chief Executive to discuss his proposed annual objectives.

Charles Winstanley
Chairman
14 February 2013
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the updated Quality Report for January 2013.

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

2 Recommendations

The Board is asked to:

2.1 Review the quality measures.

3 Discussion of Key Issues

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

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

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

3.4 The 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
Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

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

3.6 The Scottish Government commenced production of a Hospital Scorecard in 2012. There is significant overlap between this and the dashboard. The Hospital Scorecard measures not captured in the dashboard and not reported elsewhere, (e.g. A&E waiting times), have therefore been added to the front sheet. These are not currently accompanied by background trend charts.

3.7 Exception Reporting – Quality Dashboard

3.7.1 Hospital Scorecard data continues to show that NHS Lothian has a higher rate of medical and surgical readmissions and length of stay than the Scottish rate. Further work is being undertaken to analyse this data and integrate into work already being progressed through medical profiles. Discussions have taken place with ISD about the hospital scorecard readmissions data. As a result of the discussions they are providing more detailed data so that we can attempt to pinpoint where within our system the rates are highest. This has involved ISD doing work to align the methodologies for the scorecard and medical profiles. The first cut of these data were received before Christmas; further analyses have been requested and are awaited.

3.7.2 Compliance with Incident Management Key Performance Indicators (see graph 7) of completing Significant Adverse Events investigation within 60 working days of being reported continues to reduce. This is reflective of a new Lothian-wide process being put into place to strengthen accountability for management and approval of these events through line management structures from service to Executive Management. This will take a few months to reliably embed. A monthly monitoring of compliance with this KPI for all services has been developed to support system-wide monitoring of this process.

3.7.3 Meeting the HEAT target for Staph. Aureus Bacteraemia remains a challenge (see graph 13) and is described in more detail in the Healthcare Associated Infections paper.

3.7.4 The number of cardiac arrest calls increased in October and November 2012 (Graph 15). The October figures are due to increases in cardiac arrest calls at St. John’s Hospital and the Western General Hospital. The November increase is predominantly due to calls from the Royal Infirmary of Edinburgh. There is normally an increase in calls at this time of year which is also reflected in an increase in HSMR between October to December. The HSMR and Harm Reduction Plan, presented to the Board in January 2013, aims to put a range of interventions in place to reduce cardiac/respiratory arrest and improve the management of the deteriorating patient.

3.7.5 Compliance with the three stroke standards also remains a challenge (see graphs 22 – 24).
Quality Dashboard - January 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.\(^1\) Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focusing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.

### Quality Ambition: Person-centred

**Process Measures**
- 20-day Complaints Response Rate
- 3-day Complaints Response Rate

**Outcome Measures**
- Number of complaints

### Quality Ambition: Safe

**Process Measures**
- Incident Management Key Performance Indicator *
- Hand Hygiene Compliance *
- Peripheral Vascular Catheter Compliance *
- Early Warning Score Compliance *
- Medicine Reconciliation Compliance *

**Outcome Measures**
- Hospital Standardised Mortality Ratios for RIE, WGH & St. John’s Incidents with harm *
- Adverse Event Rate *
- C. Difficile Rate *
- Staph. Aureus Bacteraemia Rate *
- Number of Cardiac/Respiratory Patients 2222 Calls *

### Quality Ambition: Effective

**Process Measures**
- Falls Prevention Compliance *
- Pressure Ulcer Compliance *
- Admission to stroke unit on day or day after admission*
- Stroke Treatment Measure: CT Scan *
- Stroke Treatment Measure: Swallow Screen*

**Outcome Measures**
- Inpatient Falls with Harm *
- Inpatient Pressure Ulcers Grade 2 or above *
- Nursing Medication Administration Incidents *

### Additional Quality Measures

**Hospital Scorecard: July 2011-June 2012 (Next release March 2013) *\)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian Rate (Per 1000 admissions)</th>
<th>Scottish Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>21.76</td>
<td>20.23</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>42.77</td>
<td>38.83</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>50.42</td>
<td>45.18</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>111.57</td>
<td>101.56</td>
</tr>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>0.90</td>
<td>1.00</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

---

\(^1\) Note that these arrows have not been assigned following a formal set of rules; they are more of a general indication of the last period’s data. For example HSMR is shown to be remaining stable across Lothian, although the actual ratios for the last quarter show slight reductions (2 sites) or a slight increase (1 site).
Quality Ambition: Person-Centred
“Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.”

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

**Goal:** Reduction in number of complaints

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

**Data Source:** Datix

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

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

**Data Source:** Datix

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

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

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

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

**Safe: Reduction in mortality**

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

**Outcome Measure**

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

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

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

**Outcome Measure**

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

Data Source: ISD (Quarterly)
### Incident Management Key Performance Indicators (KPIs) (Graph 7)

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Number of incidents with major harm or death and/or graded as very high/high.</td>
</tr>
<tr>
<td>Goal:</td>
<td>Compliance target – 100%</td>
</tr>
</tbody>
</table>

Data Source: Datix

### Incidents with harm (Graph 8)

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Number of incidents associated with serious harm reported per month in NHS Lothian (Apr 2010-Mar 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal:</td>
<td>There are specific goals for reductions in Falls, Pressure Ulcers &amp; Medication Incidents. See separate graphs for progress against these.</td>
</tr>
</tbody>
</table>

Data Source: Datix

### Adverse Event Rate (NHS Lothian Acute Hospitals) (Graph 9)

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>The number of adverse events (AE) in a monthly random sample of closed case notes (deaths and live discharges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>The total number of patient days (PD) in the month for the randomly drawn patients in the sample.</td>
</tr>
<tr>
<td>Goal:</td>
<td>30% reduction in Adverse Events from a 2007 baseline by 2012</td>
</tr>
</tbody>
</table>

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

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

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

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

**Goal:** 95% Compliance

---

**Title:** C. difficile associated disease rate against HEAT Target 2011-12  
(Graph 11)

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

**Goal:** Further reduce healthcare associated infections so that by March 2013 NHS Boards’ rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less. **Rate at Jan 2013 – 0.34**

---

**Process Measure**

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

**Outcome Measure**

- **Data Source:** Health Protection Scotland
**Safe: Compliance with Peripheral Vascular Bundles**

**Title:** Percent compliance with PVC Bundle (NHS Lothian Acute Hospitals)  (Graph 12)

**Numerator:** Total number of patients who have all elements of the PVC bundle in place

**Denominator:** Total number of patients reviewed per month. \( n=1000 \)

**Goal:** 95% Compliance

---

**Title:** Staph. aureus bacteraemias (SABs) rate against HEAT Target 2011-12  (Graph 13)

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

**Goal:** Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less. **Rate at Jan 2013 – 0.32**

**Outcome Measure**

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

**Data Source:** Health Protection Scotland
### Safe: Improved management of the deteriorating patient. Compliance with Early Warning Score Bundle

<table>
<thead>
<tr>
<th>Title:</th>
<th>Percent compliance with the EWS Bundle (NHS Lothian Acute Hospitals) (Graph 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>The total number of SEWS observations completed correctly</td>
</tr>
<tr>
<td>Denominator:</td>
<td>The total number of observations reviewed per month. n=11,265</td>
</tr>
<tr>
<td>Goal:</td>
<td>95% Compliance</td>
</tr>
</tbody>
</table>

### Cardiac/Respiratory Arrests

<table>
<thead>
<tr>
<th>Title:</th>
<th>Total number of Cardiac &amp; Respiratory Arrest Calls (three acute sites) (Graph 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Arrest – Number of 2222 calls which were for a cardiac or respiratory arrest Medical Emergency – calls which were not for a cardiac or respiratory arrest Call relating to staff, visitors, False Alarms, Cancelled Calls and Out of Hospital Arrests are excluded.</td>
</tr>
<tr>
<td>Goal:</td>
<td>30% reduction in Cardiac/Respiratory Arrest calls from February 2012 baseline within 2 years from baseline</td>
</tr>
</tbody>
</table>

**Process Measure**

Source Data: Local Audits (QIDS)

**Outcome Measure**

Source Data: Local Audits (Resuscitation Officer Database)
Safe: Improvement in Medicines Reconciliation

Title: Percent of patients with medication reconciliation performed (NHS Lothian Acute Hospitals) (Pilot Site=One Ward) (Graph 16)

Numerator: Total number of patients with medication reconciliation performed
Denominator: Total number of patients reviewed. n=15 per month
Goal: 95% Compliance

Source Data: Local Audits (QIDS)

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.

<table>
<thead>
<tr>
<th>Effective: Reduction in in-patient Falls - Delivering Better Care</th>
<th>Patient Falls with Harm (Graph 18)</th>
</tr>
</thead>
</table>
| **Title:** | **Title:**
| Percent compliance with Falls Prevention CQI (NHS Lothian Acute Hospitals) | Patient Falls with Harm |
| **Numerator:** | **Numerator:**
| No. of patients fully compliant | Number of falls reported with harm, moderate, major/ death |
| **Denominator:** | **Goal:** |
| Total no. of patients reviewed per month n=964 | 95% Compliance |
| **Goal:** | 20% reduction in inpatients falls and associated harm by March 2013. |

Data Source: QiDS

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)

Data Source: QiDS

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

Number of Nursing Administration of Medication Incidents: All incidents

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

**Title:** Admission to Stroke Unit within 1 day of admission  (Graph 22)

**Numerator:** Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission

**Denominator:** Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board

**Goal:** By March 2013 90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

**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 on the day of admission

**Denominator:** Number of patients admitted with initial diagnosis of stroke

**Goal:** 80% of patients with initial diagnosis of stroke should receive a brain scan on day of admission

**Data Source:** ISD
4 Key Risks

4.1 Achieving the national 3-day and 20-day response rate target for complaints, achieving the HAI SABs Infection HEAT target and meeting stroke target and standards.

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

5 Risk Register

5.1 Maintaining the national complaints targets is captured on the Risk Register under Litigation Exposures (1082) and is identified as a high risk. Achieving HAI targets is also on the Corporate Risk Register (Risk 1076). Access to Acute Stroke Unit is on the University Hospital Division Risk Register – Medicine and Associated Services (Risk 2444).

6 Impact on Inequality, Including Health Inequalities

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

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

7 Involving People

7.1 Not applicable.

8 Resource Implications

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

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11 February 2013
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List of Appendices

Appendix 1: Supporting Technical Appendix
APPENDIX 1

Technical Appendix

**Hospital Standardised Mortality Ratio (HSMR)**

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

**Adverse Events**

Adverse events are currently measured at the three main acute sites using retrospective case note reviews using the ‘Global Trigger Tool’. An external review by the Institute for Healthcare Improvement (IHI) in February 2010 confirmed that NHS Lothian’s case note review process was robust and set the baseline for adverse event rates at 52 adverse events per 1,000 patient days. For Patient Safety Measures, please refer to measurement plan on the NHS Lothian Intranet - [http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGovernanceinNHSLothian/SPSP/Workstreams/Documents/SPSP%20Measurement%20Plan.pdf](http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGovernanceinNHSLothian/SPSP/Workstreams/Documents/SPSP%20Measurement%20Plan.pdf)

**S.aureus Bacteraemia (SAB) rate**

This represents a HEAT target. From April 2011, new targets were set based on Acute Occupied Bed Days (AOBD). For NHS Lothian the target is to achieve a rate of less than 0.26 episodes of SABs per 1,000 AOBD by year ending March 2013.

**C.difficile Infection (CDI) rate**

This represents a HEAT target. From April 2011, new targets were set based on Total Occupied Bed Days (OBCD). For NHS Lothian the target is to achieve a rate of less than 0.39 episodes of CDI per 1000 AOBD by March 2013.

**Incidents associated with harm**

Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.

**Surgical readmissions within 7 days**

This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty.

The data are presented for calendar year 2011.

This measure has been standardised by age, sex and deprivation (SIMD 2009).

**Surgical re-admissions within 28 days**

As for 7 day readmissions.

**Medical Re-admissions Within 7 Days**

This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.

The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

**Medical Re-admissions Within 28 Days**
As for 7 day readmissions.

**Average Length of Surgical Stay (Adjusted)**
Ratio of ‘observed’ length of stay over ‘expected’ length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

**Average Length of Medical Stay (Adjusted)**
Ratio of observed length of stay over expected length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations. [http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs](http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs)
HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to support the following activities, under the overall direction of the Director of Public Health and Health Policy, in delivering the agenda to reduce and manage Healthcare Associated Infection:

- Maintain enhanced weekly surveillance of Meticillin Resistant *Staphylococcus aureus* and Meticillin Sensitive *Staphylococcus aureus* Bacteraemia to target resources for a sustained reduction.
- Support the implementation of the Escalation Policy for non-compliance with hand hygiene.
- Support the reduction of healthcare associated *Clostridium difficile* Infection by promoting compliance with the antimicrobial stewardship recommendations.
- Support the ongoing work with Meticillin Resistant *Staphylococcus aureus* screening programme by promoting compliance with Clinical Risk Assessment and swabbing.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 17 episodes of *Staphylococcus aureus* Bacteraemia in January 2013 (2 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*), compared to 28 in December 2012 (5 Meticillin Resistant *Staphylococcus aureus*, 23 Meticillin Sensitive *Staphylococcus aureus*). NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.26 cases or fewer per 1000 acute occupied bed days by March 2013, with a current rate of 0.31 (updated to January 2013). In order to achieve the target, NHS Lothian has to average no more than 17 episodes per month for the twelve month period, with a current average of 20.5 episodes per month.

3.2 *Clostridium difficile* Infection: there were 24 episodes of *Clostridium difficile* Infection in patients aged 65 or over in January 2013, compared to 18 in December 2012. NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.39 cases or fewer per 1000 total occupied bed days by March 2013, with a current rate of 0.34 (updated to January 2013). In order to achieve the target, NHS Lothian has to average no more than 27 episodes per month for the twelve month period, with a current average of 22.5 episodes per month.
3.3 Norovirus outbreaks: within NHS Lothian the first case of norovirus outbreak for season 2012-2013 was recorded at the Royal Infirmary Edinburgh during August 2012. Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to service. Since 1/1/2013 there have been 85 patients identified as norovirus positive in all acute sites.

3.4 The 23rd bi-monthly national hand hygiene audit report was published by Health Protection Scotland on 30/1/2013. This indicated NHS Lothian achieved a hand hygiene compliance of 99%, exceeding the national compliance of 96%. Currently, the escalation policy for non-compliance with hand hygiene is being communicated throughout appropriate forums to support implementation.

3.5 The Meticillin Resistant Staphylococcus aureus Key Performance Indicators have been agreed and the compliance levels have been set at a minimum of 90% for Clinical Risk Assessment. Work is ongoing with the surveillance team to improve compliance rates with regular audits and where there is continuing failure to meet 90% target, training is provided to ward staff with clinical nurse managers receiving reports on the quarterly audits.

3.6 Mandatory Surgical Site Infection Surveillance: For the period 1-30/11/2012, in NHS Lothian there were 376 procedures performed and three Surgical Site Infections detected, with a Surgical Site Infection rate of 0.8%.

3.7 Incident updates for February 2013: the Infection Prevention and Control Team have been involved in investigating several incidents, including: ongoing norovirus outbreaks; influenza A outbreak; Enterobacter Cluster.

3.8 Antimicrobial Management Team:
3.8.1 The Alert Antibiotic Policy was introduced at the Royal Infirmary Edinburgh in February 2012 and St John’s Hospital November 2012. The implementation at Western General Hospital commenced on 4/2/2013.
3.8.2 Antibiotic Prescribing Indicators: the target level for compliance with the University Hospitals Division Antimicrobial Prescribing Guidelines and documentation of antibiotic indication is 95%. In-scope clinical areas within the Western General Hospital and the Royal Infirmary Edinburgh are currently achieving 100% compliance for both Prescribing Indicators and documentation compliance. St John’s Hospital is achieving 90% for Prescribing Indicators and 100% for documentation compliance. For surgical prophylaxis, the data collection focuses on colorectal surgery. Compliance remains at 100% for areas being measured.

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.
- Funding for Meticillin Resistant Staphylococcus aureus screening and monitoring of Key Performance Indicators set by Health Protection Scotland is non-recurring.
• Increased numbers of Healthcare Associated Infections leads to adverse patient harm, as well as failure to comply with Health Efficiency Access Treatment targets.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register is currently graded medium. The risk register covers norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

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14 February 2012  
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List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
SAB There were 17 SAB recorded during January 2013 (2 MRSA & 15 MSSA). The lowest number recorded in the last 12 month period is 15 (August 2012).

CDI There were 32 CDI recorded in January 2013, 24 were in aged 65 & over. February 2012 recorded the lowest number in the last 12 month period with 20 cases.

SAB HEAT Target Currently, NHS Lothian is not on trajectory to achieve the set target of 0.26 or less cases per 1000 AOBDS by March 2013.

CDI HEAT Target for Patients aged 65 and over Currently, NHS Lothian is on trajectory to achieve the set target of 0.39 or less cases per 1000 OBDS. The challenge going forward is to maintain this or reduce even further.

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

Hand Hygiene Monitoring Compliance

<table>
<thead>
<tr>
<th>Month</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
<th>N-12</th>
<th>D-12</th>
<th>J-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over

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MRSA Bacteraemia Cases

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MSSA Bacteraemia Cases

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Quarterly Rolling Year *Clostridium difficile* Infection Cases per 1000 Total Occupied Bed Days for HEAT Target Measurement

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Quarterly Rolling Year *Staphylococcus aureus* Bacteraemia Cases for HEAT Target Measurement

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Royal Infirmary of Edinburgh

**Staphylococcus aureus Bacteraemia (SAB)**
There were 3 SAB recorded during January 2013.

**Clostridium difficile Infection (CDI)**
There were 11 CDI recorded during January 2013.

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

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Western General Hospital

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

Clostridium difficile Infection (CDI)
There were 5 CDI recorded during January 2013.

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

Hand Hygiene Monitoring Compliance

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

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St John's Hospital

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

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during January 2013.

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

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

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Liberton Hospital

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

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

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

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

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**Royal Hospital for Sick Children**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB with the onset greater than 48 hours after admission recorded during January 2013.

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

For the purpose of this report we include all NHS Lothian Patients aged 15 and over who have tested positive for CDI.

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

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
Royal Victoria Hospital

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

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

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

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

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

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**MRSA Bacteraemia Cases**

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**MSSA Bacteraemia Cases**

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Community Hospitals

**Staphylococcus aureus Bacteraemia (SAB)**
There were only 2 SAB recorded in the last 12 month period.

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

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

Staphylococcus aureus Bacteraemia (SAB)

Patients who are identified with a SAB within 48 hours of admission to Hospital are included in this report card. During January 2013 there were 12 SAB recorded.

Clostridium difficile Infection (CDI)

This report card shows the number of CDI Episodes identified from specimens submitted from General Practice's. During January 2013 there were 10 CDI recorded.

This is the new Report Card Format introduced by Scottish Government July 2011
PROGRESS REPORT ON THE ESTABLISHMENT OF EAST LOTHIAN HEALTH & SOCIAL CARE PARTNERSHIP

1 Purpose of the Report

1.1 This report is to inform and update the Board on progress towards the establishment of a Health and Social Care Partnership in East Lothian.

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

2 Recommendations

2.1 The Board is recommended to:

i) Note the contents of this report

ii) Request that a further report with detailed proposals to establish shadow partnership arrangements is brought forward to the Board for approval in March 2013. These detailed proposals will also be submitted to the Cabinet of East Lothian Council.

3 Discussion of Key Issues

3.1 In September 2012, the CHP sub committee approved the joint CHP and East Lothian Council response to the Scottish Government consultation on proposals to integrate adult health and social care. Alongside this, on November 15th 2012, a meeting between the Chairman and Chief Executive of NHS Lothian, the Chairman of East Lothian CHP sub committee, the Leader and the Chief Executive of East Lothian Council and the ELC spokesperson for health and social care agreed and requested that detailed planning towards the establishment of a single Health and Social Care Partnership (HSCP) in East Lothian should commence, taking account of national guidance and legislation as available. This joint agreement included the establishment of a shadow partnership board from April 2013.

3.2 Subject to the publication of a Bill and following legislation we anticipate that HSCPs will be legally established from 2014 onwards. Prior to the establishment of a formal HSCP, it is intended that a shadow partnership arrangement will be created in East Lothian to allow detailed planning and development in advance of formal constitution. As outlined in paragraph 3.1, it is anticipated that this shadow agreement will be in place by April 2013 and will function as an entity until the formal HSCP Committee is established.
3.3 Joint work across the NHS and East Lothian Council is currently underway to draft terms of reference for this shadow group including its remit, function and membership. Detailed proposals for this will be brought forward to the Board for approval at the earliest opportunity.

3.4 Planning progress has already been made across a number of areas, namely:

i) Five principal workstreams have been agreed, to be led jointly by senior Council and NHS officers in order to ensure that we are focused on the key issues arising from the proposals to establish a HSCP. The workstreams, which mirror national structures, are Finance and IT, Governance, Outcomes, Strategic Commissioning and HR and Workforce Development.

ii) Workstream leads will be tasked to identify those actions required to effectively deliver a HSCP and to report these into the proposed shadow partnership arrangements at agreed intervals throughout 2013/14.

iii) A key aspect of this work will be to ensure we build the views of staff, service users and carers into our plans, with workstream leads establishing appropriate mechanisms to enable the views of these groups to be heard.

3.5 The establishment of Health and Social Care Partnerships is designed to improve outcomes for our population by shifting the balance of care and encouraging greater use of preventative services. The shadow partnership will focus on rethinking and redesigning the model of health and social care for East Lothian in order to deliver safe, high quality, clinically and cost effective services for our population.

3.6 It has been agreed that the Chair of the shadow partnership arrangement from April 2013 will be led by a health member of the Board.

3.7 The appointment to the Chair will be made by the Chairman of NHS Lothian prior to the establishment of the shadow partnership arrangement. The appointment of the remaining health members, including partnership representation, will also be determined in this way.

3.8 Following the publication of the Scottish Government response to the consultation on health and social care partnerships, it is clear that the Scottish Government will legislate for the role of the Jointly Accountable Officer. Work is now underway, led by the Director of Human Resources of NHS Lothian, to establish the detail of this role and the process to be followed.

3.9 Discussions regarding supporting planning structures to ensure effective and meaningful professional dialogue and engagement are at an advanced stage.

4 Key Risks

4.1 No risks have been identified in this information report.

5 Risk Register

5.1 A robust process of regular review on progress towards the establishment of a HSCP in East Lothian will ensure that risks are identified, addressed and escalated
as required, minimising the need for any to be added to the NHS Lothian risk register.

6 Impact on Health Inequalities

6.1 The creation of a partnership between health and social care will enhance the capacity to address health inequalities experienced by our population. The emphasis on ‘localism’ will make it more likely that health inequalities occurring within particular communities will be actively considered and addressed.

7 Impact on Inequalities

7.1 An impact assessment is not required for this information report.

8 Involving People

8.1 A key aspect of the planning and development work for the HSCP will be to ensure we build the views of staff, service users and carers into our plans. Workstream leads will establish appropriate mechanisms to enable the views of these groups to be heard.

9 Resource Implications

9.1 There are no immediate resource implications.

David Small
General Manager, East and Midlothian CHPs
2 February 2013
David.Small@nhslothian.scot.nhs.uk
WAITING TIMES PROGRESS AND PERFORMANCE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on both waiting times performance and progress made in reducing the number of patients waiting longer than national targets and standards.

1.2 It also outlines other areas where patients are facing delays, where action is being pursued and stresses the need for ongoing vigilance on the shortening of waits.

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

2 Recommendations

The Board is recommended to:

2.1 Receive the report outlining progress with provisional information showing the latest position on inpatient waits and outpatient numbers, where outturn was consistent with expectations;

2.2 Note the work ongoing to reduce the long delays experienced by patients waiting for diagnostic, surveillance and other “repeat” endoscopies;

2.3 Recognise that, with the exception of 2 posts where recruitment was unsuccessful and are to be re-advertised, all additional posts pursued as the first step to establish sustainable capacity have been appointed to and either have or in the process of taking up post; and

2.4 Recognise the variables, risks and areas of uncertainty around these actions.

3 Background

3.1 As reported to the Board and its subcommittees over recent months, additional activity was commissioned both internally and externally to reduce the number of patients waiting longer than current national standards due to the inappropriate practices identified by PricewaterhouseCoopers last year and to prepare services for the introduction of the Treatment Time Guarantee (TTG). This guarantee, outlined in the Patients’ Rights Act, came into force on 1 October 2012 and requires that Health Boards treat patients within 12 weeks from the date of agreeing their treatment.

For more information see http://www.scotland.gov.uk/Resource/0039/00390166.pdf
3.2 To address the long waits facing some patients, NHS Lothian has developed and is implementing detailed plans to improve performance.

4 Current Position – Inpatients and Daycases

4.1 The table below shows the numbers of Inpatients and Daycases (IPDC) waiting more than 12 and 9 weeks, as well as availability levels and overall list size since April 2012. It shows that those over 12 weeks had reduced to 451 by the end of January, with list sizes also down on previous months. The figure falls by more than a quarter when the categories of patients not included within the TTG are removed. At its high point in June 2012, 1963 patients were over 12 weeks.

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<td>Total List Size</td>
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<td>Percentage Unavailable</td>
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Source: MMI returns; Performance Review

4.2 The trend since April 2011 is shown in Figure 1 alongside changes in overall list size and unavailability. The reduction in overall list size shown in the figure is marked—a third lower than when at its largest in September 2011. The changes over the last 12 months in overall list sizes in four specialties which faced a particular challenge are shown in Figure 2.

4.3 As one would anticipate this reduction has occurred in tandem with both a reduction of number of patients exceeding waiting time standards and the length of time patients wait taking no account of any periods of unavailability or clock resets. The shift over recent months in the latter group is shown in Figure 3. The direction of all of these measures demonstrate the progress made towards improving the waiting time position.

4.4 Figure 4, using operational information, shows that the overall reduction of waits over 12 weeks has continued past the end of January. Board members will notice that the falls in numbers waiting over 12 weeks in both General Surgery and Head and Neck CMTs. Both areas now have less long waiters than Women and Children’s, the vast majority of whom are not included within the treatment time guarantee. The largest group amongst these are spinal patients, to whom the guarantee is expected to apply to from this coming October. Three neurosurgery consultants have been recently appointed to help with reducing waits of patients waiting for these procedures (see Table 3, Page 10).

4.5 As indicated last month the TTG came into force for those agreeing treatment from 1 October 2012, it became possible to breach this standard towards the end of December 2012. During January 2013, 221 patients breached the TTG. Of those 221 patients, almost three quarters (163 patients) have now been admitted or not longer require treatment. Of the 58 remaining on the waiting list, 34 either have a date internally or are in the process of receiving an offer at an external hospital.
The trend in reported patients over 12 weeks at the end of each month by specialty is shown in appendix 1.

![Figure 1 – Inpatient and Daycase Waiting List](chart1)

**INPATIENT/DAY CASE WAITING LIST - MONTH END**

Source: Management MMI; ISD Data Warehouse

**Figure 2 - Change in Inpatients Waiting List Size (2012-2013)**

**Changes in Specialty List Size**

Source: Performance Review (report issued for operational management), 15 February

**Figure 3 - Change in Numbers with Long Calendar Waits**

2 The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
4.7 As will be recalled from last month’s report, the DCAQ exercise expects use of theatre sessions to be at least 88%. Combined utilisation includes both uptake of
sessions and duration of sessions used in previous reports and presents them as a percentage total.

4.8 Figure 5 shows January’s theatre utilisation in this manner and also takes account of the improvement in the measurement of theatre usage taken forward by the Theatre Management Board. Performance in January was impacted to some extent by cancellation of operations due to demand on beds from emergency admissions, which tend to impact particularly on specialties based at the Royal Infirmary, such as Orthopaedics.

4.9 The CMT’s improvement plans are required to detail how the minimum utilisation will be achieved.

Figure 5 – Internal Theatre Utilisation (Selected Specialties)

Source: Theatres and Anaesthetics, 15 February

5 Current Position - Outpatients

5.1 The table below outlines the number of outpatients over 12 weeks, unavailability and overall list size since April 2012. Figure 6 presents a longer time period graphically.

5.2 At the end of January 2013, 2942 people were waiting for more that 12 weeks to be seen in outpatients. This includes 242 endoscopy patients waiting over 12 weeks, covered in section 7. This slight rise on the previous month was anticipated in the last Board paper.
Table 2 - Outpatient Waiting List Characteristics

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Source: MMI returns; Performance Review

Figure 6 - Outpatient Waiting List

As with inpatients, waiting list size has reduced, on this occasion by 10% from levels reported at their peak in July 2011. The changes in list size in selected specialties is shown in Figure 7.

5.3 As with inpatients, waiting list size has reduced, on this occasion by 10% from levels reported at their peak in July 2011. The changes in list size in selected specialties is shown in Figure 7.

[^3]: The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
6 Timescales and Routes to Recovery of Inpatient and Outpatient Waits

6.1 The number of inpatients and daycases waiting longer than 12 weeks continues to reduce with a further fall anticipated during February. At the time of writing operational information suggests that, of those who will be over 12 weeks at the end of February, 321 patients are to be seen internally – the majority of whom already have a date for admission but after the end of month - and options for a further 78 are being explored by external providers.

6.2 The rate of reduction has slowed, as anticipated last month, as the patients remaining are increasingly those requiring complex treatment or waiting for admission for a procedure not covered by the treatment time guarantee. However, the slow down has been sharper than was expected.

6.3 This suggests that outturn at the end of March will be at the upper end or above the 200-300 forecast last month. Clinical Management Teams are working to ensure that as many patients as possible are seen within the appropriate timescales.

6.4 Last month, it was reported that although the number of outpatients waiting over 12 weeks has increased, booking information suggested that the reduction would shortly recommence. As the operational information in Figure 8 below shows, there was indeed an improvement towards the end of the month, however that was not sustained and numbers over 12 weeks have remained stable in recent weeks.

6.5 The lack of movement can be traced to a number of key specialties – general surgery, urology, neurology, neurosurgery and ophthalmology. The majority of these areas have been impacted by the unplanned absence of consultant staff and the additional posts in place to assist in the reduction have, consequentially, only made up for their colleagues’ absence. Additionally there has been difficulty identifying patients suitable to for “see and treat” initiatives which had been expected to make further inroads and mitigate for these absences. While operational information shows that the numbers are set to fall, the Medical Director
is leading efforts to hasten this reduction, and although it is expected that reductions will recommence, it is now felt unlikely that the projection of 1500-2000 at the end of March, made in last month’s paper, will be fulfilled.

Figure 8 – Outpatients over 12 week – management reporting

source: Performance Review, 15th February

7 Current Position – Diagnostics

7.1 In line with the agreement with the Scottish Government Health and Social Care Directorates, waiting times for some tests covered by the diagnostic standard (upper and lower endoscopy and colonoscopy) will fluctuate between four and six weeks.

7.2 At the end of January 1555 endoscopy patients were beyond six weeks, a rise on the previous month (1439). As indicated in November, January has expected to be the point at which the waiting numbers peak as thereafter the additional capacity put in place begins to reverse the trend. The position is expected to be fully recovered by August/September.

7.3 Operational information suggested that that the numbers of patients waiting beyond six weeks are currently falling markedly.

7.4 As had been anticipated the number of diagnostic patients waiting longer than 6 weeks continued to rise at the end of December. The trend in endoscopy numbers over the 6 week standard is shown in Figure 9 with 1439 waiting over six weeks, rising from 1356 the previous month.

7.5 Cystoscopy numbers over 4 weeks reduced on December with 138 beyond standard at the end of January as opposed to 175 the month previously.
7.6 No patient was waiting longer than 4 weeks for any of the radiological examinations covered by the national standard.

![Figure 9 - Endoscopies over Diagnostic Standard (April 2012 – January 2013)](source: DMMI)

8 Current Position – Surveillance and Review Waits

8.1 The reduction in endoscopy surveillance waits continued in January with 2,439 beyond their planned date. This is a fall from 2,531 the previous month.

8.2 Both figures, drawn from national returns, exclude a small number of patients who were not able to be categorised and thus in addition to the numbers cited above (December: 96; January: 79).

8.3 In previous Board papers it has been anticipated that the backlog will have been addressed by the end of 2013 through the use of both existing internal sessions and capacity being arranged through the independent sector. Last month it was suggested that facilities in one of these hospitals were likely to be delayed. This has subsequently been confirmed and the situation is being monitored.

8.4 It is not felt necessary at this time to revise the expected date of recovery.

9 Recording and Management of Patient Waiting Times

9.1 Work described to the Board previously on ensuring robust arrangements for the management of waiting times continues.

9.2 Earlier this month, the Audit Committee received an update on the actions being pursued following the Internal Audit report. It was agreed that the Audit Committee would receive a further update at its next meeting in early April to enable the latest
position to be reported to Scottish Government by the end of that month by the Chair of the Audit Committee’s, in line with the expectations outlined by the Cabinet Secretary to Parliament on 20 December.

9.3 One of the 5 actions within the internal audit report was that Board members be offered a development session to consider waiting times arrangements and members’ requirements for governance purposes. Following agreement from the Chairman and the Chief Executive this session is to occur in the afternoon following the next Board meeting on 27 March.

9.4 As Board members will know an audit was been undertaken into waits for services not covered by standards. Initial results of this have been discussed at the Chief Executive’s waiting time group and the Associate Medical Director and Associate Director in Strategic Planning are meeting with those areas with waits in excess of 12 weeks to determine the best way forward. The Board will be kept appraised of this work.

10 Investment in Sustainable Capacity

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10.1 Board members have previously supported steps to invest in sustainable capacity to ensure that those receiving care from NHS Lothian do not wait too long nor that delivery is inappropriately reliant on parties outside of the NHS.

10.2 As indicated last month, planning for further investments is underway informed by the Demand Capacity Activity and Queue exercise undertaken with the support of the Government’s Quality and Efficiency Support Team. As Table 3 indicates almost all posts identified in the first round of investments have now been appointed to.
10.3 These are the first steps towards providing sustainable capacity for the prompt treatment of patients and in addition to the changes in job plans for consultants already in post. For example, 6 programmed activities within existing consultant contracts were agreed to support the breast pathway in plastics.

10.4 As the table below shows, all the posts pursued within this round of investment have been appointed to, save 2 consultant posts, in anaesthetics and plastic surgery, which are to be readvertised.

11 Key Risks

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

11.2 The logistical challenges that have to be met over a short period of time to offer large volumes of patients both outpatient and inpatient appointments; co-ordinate treatment with external providers; arrange transport; provide information to patients; liaise with significant numbers of clinical and administrative staff and ensure that the whole process ‘hangs together’ and is co-ordinated, should not be underestimated. The complexity and sheer scale of the recovery programme is a risk in itself, but it is clear that the staff in Lothian are progressively meeting the challenge of this risk.

11.3 Particular risks reside around the extent to which patients will be willing to travel outside Lothian for treatment. The establishment of the External Provider Office is an attempt to mitigate this risk. However, should this mitigation prove insufficient, recovery will be delayed.

11.4 It is possible that some specialist work will be unable to be accommodated elsewhere. Where possible, expertise will be concentrated on such cases and the capacity for this maximised by displacing routine work so that it can be undertaken by others. This will further be sought to be minimised by seeking out providers able to undertake such procedures.

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

11.6 Sustained progress will also be dependent upon the willingness of staff to undertake additional hours above contractual levels for a prolonged period. To reduce the level of risk this presents it will be necessary to continue to invest in core capacity and also to seek alternative capacity to see those patients potentially affected.
11.7 Seasonality will affect patient availability as an unwillingness for patients to be treated for routine conditions was seen during the holiday period. Future plans will take better account of this through phasing. Core capacity could also be affected by further industrial action in light of the ongoing discussions over public sector pensions.

11.8 As reported at the Board in January, as the new guidance has changed how waiting time is calculated in a small number of instances, there are situations where Trakcare is not currently able to report the patient’s correct waiting time. This will be resolved for all Boards using trak once updated software is unavailable, anticipated to be later this year. In the interim, colleagues in eHealth are progressing an alternative software development which should address this issue. Until this local enhancement is available – it is expected in the spring – there is a risk that a small number of patients waiting times will be incorrect.

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

Andrew Jackson
Associate Director, Strategic Planning
25 February 2013
Andrew.C.Jackson@nhslothian.scot.nhs.uk

List of Appendices

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

Previously activity information was included in these appendices. Equivalent tables are now located in the paper reporting the Financial Position.
Trend in Patients reported over 12 weeks since April 2011

BREACHES OF WAITING TIME STANDARDS REPORTED ON MONTHLY MMI RETURNS

APPENDIX 1

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Historical figures relating to levels of attainment of the waiting times standard and levels of patient unavailability are known to be inaccurate. Further information can be found in the Pricewaterhouse Coopers report published in March 2012. (http://www.scotland.gov.uk/Resource/0039/00390166.pdf) Source: MMI returns
## Time since added to the Inpatient List for those Currently Waiting

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**Total** | **132** | **92** | **52** | **20** | **8**

February 2013 Extract

Takes no account of periods of unavailability nor clock resets

Figures should not be added – eg 132 patients were waiting longer than 6 months, of whom 92 were waiting longer than 9 months

Source: Performance Review

22 February 2013
Time since added to the Outpatient List for those Currently Waiting

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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RHEUMATOLOGY</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DERMATOLOGY</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PAEDIATRICS</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GENERAL MEDICINE</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NEUROSURGERY</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>395</td>
<td>197</td>
<td>92</td>
<td>35</td>
<td>11</td>
</tr>
</tbody>
</table>

The figure below shows how the position has changed since August.

February 2013 Extract
Takes no account of periods of unavailability nor clock resets
Figures should not be added – eg 395 patients were waiting longer than 6 months, of whom 197 were waiting longer than 9 months
Source: Performance Review 22 February 2013
UNSCHEDULED CARE UPDATE - FEBRUARY 2013

1 Purpose of the Report

1.1 The purpose of this report is to provide a summary to the Board, of NHS Lothian’s’ unscheduled care performance for January 2013.

1.2 It will provide challenges across the system and work which is being progressed to improve unscheduled care performance.

2 Recommendations

The Board is recommended to:

2.1 Receive the report outlining progress showing the latest position against the 4 hour Emergency Care standard at January 2013.

2.2 Note the ongoing work to improve compliance against the standard, for patients who attend as an unscheduled patient.

2.3 Recognise the variables, risks and areas of uncertainty around these actions.

3 Discussion of Key Issues

Background

3.1 As reported in previous months, performance against the 4 hour standard has declined.

3.2 To address the current position, NHS Lothian has developed an action plan to improve sustained compliance against the 4 hour standard, which includes significant investment and capital works to increase unscheduled care capacity.

Current Position

3.3 Table 1 below demonstrates performance against the 4 hour standard, for the last 13 months.

3.4 Percentage compliance since November has dropped to the 80’s, with January performance reported at 88.17%.
<table>
<thead>
<tr>
<th>Month</th>
<th>Total Breaches</th>
<th>Total Attendances</th>
<th>8hr breaches</th>
<th>12hr breaches</th>
<th>Monthly %</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2012</td>
<td>1492</td>
<td>19645</td>
<td>156</td>
<td>29</td>
<td>92.41%</td>
</tr>
<tr>
<td>February 2012</td>
<td>1746</td>
<td>19325</td>
<td>165</td>
<td>14</td>
<td>90.97%</td>
</tr>
<tr>
<td>March 2012</td>
<td>1407</td>
<td>22420</td>
<td>112</td>
<td>8</td>
<td>93.27%</td>
</tr>
<tr>
<td>April 2012</td>
<td>1745</td>
<td>20205</td>
<td>161</td>
<td>27</td>
<td>91.36%</td>
</tr>
<tr>
<td>May 2012</td>
<td>1450</td>
<td>21472</td>
<td>124</td>
<td>17</td>
<td>93.25%</td>
</tr>
<tr>
<td>June 2012</td>
<td>1555</td>
<td>20800</td>
<td>120</td>
<td>7</td>
<td>92.52%</td>
</tr>
<tr>
<td>July 2012</td>
<td>1012</td>
<td>19825</td>
<td>80</td>
<td>15</td>
<td>94.90%</td>
</tr>
<tr>
<td>August 2012</td>
<td>1366</td>
<td>21296</td>
<td>72</td>
<td>7</td>
<td>93.59%</td>
</tr>
<tr>
<td>September 2012</td>
<td>1441</td>
<td>20803</td>
<td>110</td>
<td>12</td>
<td>93.07%</td>
</tr>
<tr>
<td>October 2012</td>
<td>1457</td>
<td>20502</td>
<td>120</td>
<td>7</td>
<td>92.89%</td>
</tr>
<tr>
<td>November 2012</td>
<td>2391</td>
<td>20084</td>
<td>248</td>
<td>34</td>
<td>88.10%</td>
</tr>
<tr>
<td>December 2012</td>
<td>2734</td>
<td>20517</td>
<td>275</td>
<td>67</td>
<td>86.67%</td>
</tr>
<tr>
<td>January 2013</td>
<td>2334</td>
<td>19736</td>
<td>300</td>
<td>75</td>
<td>88.17%</td>
</tr>
</tbody>
</table>

Table 1: NHS Lothian Performance against 4 hour Emergency Care Standard

3.4 Graph 1 demonstrates the trend in performance for both 4 hour and 12 hour breaches, demonstrating a continued deterioration in respect of both performance markers.
3.5 The number of attendances for January 2012 compared to January 2013 demonstrates an increase of 91, which is equivalent to a rise 0.41%, with all sites showing a minimum variation with regards to the number of attendances.

3.6 However the number of 4 hour breaches comparing the same reference period has increased by 842, which is equivalent to 36%. This is a similar position with 8 hour breaches which have shown an increase of 48% and a 61% increase in 12 hour breaches.

3.7 To analyse the change in pattern, it has been anecdotally raised that the age profile and frailty of patients attending has increased. Graph 2 shows the median age of patients admitted into Acute Medical Unit at the Royal Infirmary has increased, but further analysis around this change requires to be undertaken.

3.8 The number of patients with a length of stay greater than 28 continues to rise and graphs 3 and 4 demonstrate that this is an increasing trend at both Acute and Rehabilitation sites.
Graph 3

Graph 4
3.9 The impact of Norovirus for January resulted in 102 bed days being lost across NHS Lothian, which was down significantly compared to December.

3.10 The demand for rehabilitation beds increased in January, which resulted in additional beds being opened to accommodate this flow of patients. Criteria in accessing certain beds was revised to assist in accommodating this pressure.

3.11 Graph 5 demonstrates the amount of boarding across the adult sites which shows a significant spike in boarding in January and can be attributed to the number of unscheduled attenders of the weeks commencing 31 December and 6 January.
4 Actions being taken to improve flow

Discharges supported by Health and Social Care

4.1 City of Edinburgh Health and Social Care have supported 413 discharges in the five weeks covering January compared with a target of 360, i.e. an additional 53. Disregarding the first week, because of the public holidays at New Year, the average number of discharges achieved has been 95 per week compared to a target of 72.

![Graph showing discharges over time]

Improvements within NHS Lothian

4.2 The following actions are being put in place to improve Unscheduled Care performance:

- A Short Life Working Group has been established at Royal Infirmary, focusing on time to admit and lack of flow in the system. Key actions have been identified in relation to principals associated with direct referral and admission. Key stakeholders from the group are planning to meet with services to gain support which will allow an improved flow model within the site.

- A whole system Capacity & Demand exercise to develop a cost capacity plan to reach demand/capacity equilibrium for unscheduled care across primary, secondary and social care is being scoped, led by City of Edinburgh but jointly involving NHS Lothian representatives from primary and secondary care.

- Ongoing work to explore the pathways for rehabilitation/awaiting rehabilitation delays which has been highlighted as a key cause of delay in the Day of Care Audit held on 18 January at the Royal Infirmary with Scottish Government
support/facilitation which demonstrated that 25% of patients on the Royal Infirmary site, care could be delivered either on other sites or in the Community.

- A real time demand and capacity model is being embedded within the sites, which will allow a focus on flow, rather than purely focusing on capacity. Meetings will allow wards to identify any blockages within their respective areas, with a view that actions are agreed to diminish blockages.

- Within Surgical Observation Unit, a dedicated Charge Nurse has been appointed who will focus on flow. A process is also being established where all breaches will be reviewed with a view of reviewing pathways in line with the outcomes.

- Within the Emergency Department at the Royal Infirmary a new triage model commenced 21 January, which will bring forward the time for first assessments, thus aiming to improve processes for patients to be treated within the 4 hour standard.

- In respect of the Western General triaging processes are being revisited and the amount of admission documentation is to be reduced, which will assist in improving admission flows.

5  Key Risks

5.1 NHS Lothian is engaged in significant investment to assist in improving Unscheduled Care.

5.2 Part of this investment includes an increase in workforce and there is a risk that recruiting to these new posts could be very challenging, in respect of recruiting staff with the required skills and knowledge to these posts.

5.3 The number of patients being discharged and requiring packages of care has increased significantly and there is a risk that Social Work teams across Lothian will be unable to meet this demand.

6  Risk Register

6.1 The risk of NHS Lothian not complying with the 4 hour Emergency Care standard has been included on the Risk Register

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12 February 2013  
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PERFORMANCE MANAGEMENT

1 Purpose of the Report

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

2 Recommendations

The Board is recommended to:

2.1 Receive this update on the current performance against each of the current HEAT targets, standards and a number of other local and national targets, as outlined in Appendix 1. And to note that only areas of exception are being reported in the main report. Updates will be provided at the meeting.

3 Discussion of Key Issues

3.1 Of the 42 items monitored within Appendix 1, the most recent data indicates NHS Lothian is off trajectory / does not meet the overall target on 24 occasions.

4 Key Risks

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

4.1 Heat Targets

4.1.1 A&E Attendances (T10) (Responsible Director: Nurse Director and Joint Director, Edinburgh)

Work to redesign the St John’s Hospital Primary Assessment Area standard operating procedures will, where appropriate, direct patients out of an assessment/admission pathway into an ambulatory care pathway, therefore reducing the number of A&E attendances and unscheduled admissions recorded in the future. This has been notified to ISD and Scottish Government and there is an annual review of T10 on the 5th March.

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

Data for the period from 1 April 2011 to 30 June 2012 shows NHS Lothian provided two fluoride varnishing applications to 31.11% of three year old and 36.58% of four
year olds in the most deprived SIMD quintile (quintile 1). Performance overall is reported on the lowest performing quintile, which was Quintile 5 at 1.3%.

4.1.3 **Staphylococcus Aureus Bacteraemia** (Responsible Director: Director of Public Health and Health Policy)

NHS Lothian is currently not on target to achieve the set HEAT target. The Infection Prevention & Control Team is working with Health Protection Scotland support team to review data and systems, and identify possible modifications that could reduce healthcare associated Staphylococcus aureus bacteraemia. Recommendations include further work by clinical teams to review device use and associated practices. Additional work is also underway to reattribute the source of *Staphylococcus aureus* bacteraemia when links can be established to a healthcare contact out-with the current patient location e.g. from the front door areas to other clinical areas and points of the patient pathway.

4.1.4 **Faster Access to CAMHS** (Responsible Director: Nurse Director)

Further review of the data quality and reporting processes identified the need for more detailed "drilled down" reporting. The performance data for the last quarter of 2012 was therefore reviewed. There were 51 patients who had waited longer than 26 weeks for treatment. Plans are in place to ensure these patients are seen as soon as possible, this includes additional evening clinics to increase clinical capacity.

4.1.5 **Faster Access to Psychological Therapies (PT's)** (Responsible Director: Jim Forrest)

The National Early Implementer Site report on East and Midlothian has now been completed and was distributed to all national HEAT A12 leads. The model for data collection, reporting and delivery of PT's will now be rolled out across Lothian. Trajectory will be set for the target by 28th Feb 13. The Scottish Government plans to publish initial performance data in May 2012. The newly recruited "Lothian Meets A12" team will increase service capacity to implement the agreed processes and data model.

4.1.6 **Drug and Alcohol waiting times – 90% clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery** (Responsible Director: Director of Strategic Planning, Performance Reporting and Information)

Performance dipped in December and is 1.9% (currently at 85.3%) behind trajectory but it is anticipated that the HEAT A11 target will be achieved by March 2013. Services behind trajectory have robust plans in place to increase access to treatment.

4.1.7 **CO2 Emissions and Energy Consumption** (Responsible Director: Director of Human Resources and Organisational Development)

Energy costs and CO2 emissions remain challenging. Energy consumption is rising due to a combination of poor weather, failure of critical plant, rising bed occupancies, increased client demand from patients and staff. In addition energy
tariffs are increasing year on year. NHS Lothian has embarked on an investment programme, and has also succeeded in renewing the quality management standard “the Carbon Trust Standard” for another 2 years.

4.1.8 Stroke (Responsible Director: Nurse Director)

Performance data against the HEAT target for December shows 59% adherence across Lothian down from 64% in November and against a 90% target to be delivered by March 2013. There continues to be significant front door pressure including a distinct increase in the number of 12 hour breaches since October 2012 and this pressure has also contributed adversely to the number of patients admitted to the stroke unit on the day of admission, or the day following presentation.

SJH is an Integrated Stroke Unit and the WGH converted to an Integrated Stroke Unit on 4th December 2012. Discussions are on-going regarding an integrated stroke unit in the South.

Weekly exception reporting has started on all sites in order to identify trends and develop actions for improvement. A project plan is underway on the steps required to improve performance and an improvement event is being planned for stroke teams across Lothian. Additional nursing resource is being funded to support the ‘pull’ of patients out and in to stroke beds.

4.2 HEAT Standards

4.2.1 Inpatient, Daycase, outpatient, diagnostic (inc endoscopy) Waiting Times (Responsible Director: Medical Director)

Performance on the above areas of activity is reported through the Medical Directors report on waiting times.

4.2.2 4-hour Emergency Access (Responsible Director: Nurse Director)
For November was 88.1% and 86.7% for December and 88.2% in January, against a target of 98%.

4.2.3 12hr Breaches – October 2012 (Responsible Director: Nurse Director)
For November there were 34 and for December 67 and 75 in January.
4.2.4 **Cancer Waiting Times** (Responsible Director: Medical Director)

Overall, cancer waiting times for December were:

- 62 days – 96.8%
- 31 days – 99.4%

Performance data for Quarter 4 2012 is due to be published by ISD Scotland in March 2013.

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

The table gives a summary of headline figures from the January 2012 census

<table>
<thead>
<tr>
<th>January</th>
<th>Total ISD Delays (incl. x-codes)</th>
<th>Total Delays (Excel. x-codes) NHSL target 66</th>
<th>Complex Codes</th>
<th>6 Weeks+ (National standard - 0)</th>
<th>4 Weeks + (National standard due April 2013-0)</th>
<th>Short Stay (Target - 0)</th>
<th>Average length of stay as a delayed discharge Days (non-x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>177</td>
<td>96</td>
<td>42</td>
<td>8</td>
<td>24</td>
<td>14</td>
<td>18</td>
<td>96 indicates an increase or decrease from the previous month</td>
</tr>
</tbody>
</table>

- 177 overall including X codes (139 Dec, 151 Nov, 164 Oct, 187 Sept)
- 96 delays after X codes removed (78 Dec, 112 Nov, 120 Oct, 143 Sept)
- 8 Patients delayed >6wks (16 Dec, 14 Nov, 21 Oct, 21 Sept)
- 18 days is the average length of stay (29 Dec, 25 Nov, 26 Oct, 26 Sept)
- 1 Non-Lothian delays (2 Dec, 3 Nov, Oct, 5 Sept)
- 42 X codes (61 Dec, 39 Nov, 44 Oct, 44 Sept)
- 365, Overall number of patients held on the delayed discharge database on census day (328 Dec, 321 Nov, 331 Oct 350)

Edinburgh have 96 (8 >6 wks). This is high, but rule changes over the last year have increased the number falling into reportable delays to ISD (counting those delayed 3 days before census, plus from this month census validation is done in a week not two). By way of comparison in Jan 2012 Edinburgh had 60 delays and this month’s 96 would be 66 if still using same rules.

East have 24 delays which is double their ‘norm’, this against having a full complement of care homes open with better capacity than has been the case for some months. They are struggling to attract a workforce into the care market place, in areas like Musselburgh and Tranent, so packages of care taking longer to arrange.

West and Midlothian, remain on track to meet the 4 weeks standard, (due to replace the 6 week standard in April this year). Work is on-going with both East and City of Edinburgh in how we can get down to the 4 week standard. The following table gives both the overall delays in our hospitals and those that fall into the ISD reporting rules. We have a third more patients who are delayed in our system than in April 2011. However the average length of delay has come down from 33 days in January 2012 to the 18 days from this month’s census.
4.2.6 Vasectomy: 12 week OP and 18 week RTT (Responsible Director: Joint Director Edinburgh CHP)

The service is now achieving both 12-week outpatient and 18 week RTT targets.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

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12 February 2013
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Alex McMahon
Director of Strategic Planning
alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Performance Management Scorecard
## Summary of NHS Lothian Performance Measures - HEAT Targets, Standards and other Local / National Targets

### Health Improvement

<table>
<thead>
<tr>
<th>HEAT Target</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Dtrr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Healthy Weight</strong> - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14 (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)</td>
<td>Mar-14</td>
<td>2,268</td>
<td>Apr 11 - Mar 12</td>
<td>662</td>
<td>Apr 12-Dec 12</td>
<td>467</td>
<td>265</td>
</tr>
</tbody>
</table>

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

### Efficiency

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Dtrr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce Carbon Emissions</strong> - % reduction year-on-year (Tonnes of CO2)</td>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qtr 12, 12/13</td>
<td>6.36%</td>
<td>Qtr 3, 12/13</td>
<td>6.57%</td>
<td>5.91%</td>
</tr>
</tbody>
</table>

- Performance dipped in December and is 1.9% behind trajectory but it is anticipated that the HEAT A11 target will be achieved by March 2013. Services behind trajectory have robust plans in place to increase access to treatment.

### Access to Services

<table>
<thead>
<tr>
<th>Access to Services</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Dtrr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug and Alcohol waiting times</strong> - 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery</td>
<td>Mar-13</td>
<td>90%</td>
<td>Nov-12</td>
<td>86.50%</td>
<td>Dec-12</td>
<td>85.20%</td>
<td>87.10%</td>
</tr>
</tbody>
</table>

- Performance doped in December and is 1.9% behind trajectory but it is anticipated that the HEAT A11 target will be achieved by March 2013. Services behind trajectory have robust plans in place to increase access to treatment.

### Treatment Appropriate for Patient

<table>
<thead>
<tr>
<th>Treatment Appropriate for Patient</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Dtrr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A&amp;E Attendances</strong> - rate of A&amp;E attendances per 100,000 population</td>
<td>Mar-14</td>
<td>1,911</td>
<td>Nov-12</td>
<td>2,023</td>
<td>Dec-12</td>
<td>2,065</td>
<td>1,946</td>
</tr>
</tbody>
</table>

- Now sits within the Unscheduled Care Group set up and chaired by the Nurse Director and the Joint Director, Edinburgh.

Further review of the data and reporting processes identified the need for more detailed "drilled down" reporting. The performance data from the last 1/4 of 2012 has been reviewed and this report has been updated accordingly.

Analysis of waiting times performance is now being reported. An NHS Lothian baseline and action to support performance improvement has been developed for the 1/4 period from 1st April 2013.
## Summary of NHS Lothian Performance Measures - HEAT Targets, Standards and other Local / National Targets

### Appendix 1

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Target</th>
<th>Mar-13</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>2012-2013</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MRSA / MSSA Reductions</strong> - achieve a reduction in the infection rate of staphylococcus aureus bacteremia (including MRSA) cases to 0.26 or less per 1,000 acute occupied bed days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AKM See the Director of Public Health's report to the Board</td>
</tr>
<tr>
<td></td>
<td>0.26</td>
<td>0.32</td>
<td>0.31</td>
<td>0.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C.diff Infections</strong> - achieve a reduction of the rate of Clostridium difficile infections in patients aged 65 and over to 0.39 cases or less per 1,000 total occupied bed days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AKM See the Director of Public Health's report to the Board</td>
</tr>
<tr>
<td></td>
<td>0.39</td>
<td>0.34</td>
<td>0.34</td>
<td>0.39</td>
<td></td>
<td></td>
</tr>
<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>AMcM NHSL currently Board with 3rd highest Emergency Bed Day Rates to population in Scotland behind GG&amp;C and Western Isles.</td>
</tr>
<tr>
<td></td>
<td>5,143</td>
<td>5,073</td>
<td>5,371</td>
<td>5,097</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delayed Discharges</strong> - no people to wait more than 28 days to be discharged from hospital into a more appropriate care setting from April 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMcM Now sits within the Unscheduled Care Group set up and Chaired by the Nurse Director and the Joint Director, Edinburgh.</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>28</td>
<td>24</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delayed Discharges</strong> - no people to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMcM Now sits within the Unscheduled Care Group set up and Chaired by the Nurse Director and the Joint Director, Edinburgh.</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>47</td>
<td>58</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stroke Unit</strong> - 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MH A pilot of exception reporting at St Johns will commence in February</td>
</tr>
<tr>
<td></td>
<td>90%</td>
<td>64%</td>
<td>59%</td>
<td>85%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Assessment

- ✓ ✓ Meets the overall target
- ✓ Is on trajectory to meet, but has not yet met, the final target
- × Is off trajectory
- × × Does not meet the overall target

---

*Summary of Targets & Standards Page 2 of 4 Z:\Secretariat\MEETINGS\Peter\Board\General\Papers\2013\27-02-13\BOARD (AMcMAM) Appendix 1 - Performance Management 27 02 13*
### Alcohol Brief Interventions - maintain the same total level of delivery of ABIs as under the HEAT H4 target for 2011-12 - at least 90% of delivery to be in priority settings.

<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standard</td>
<td>9,938</td>
<td>2011-12</td>
<td>Apr to Oct 2012</td>
<td>9,755</td>
<td>AKeM</td>
<td>Current performance does not include ABIs delivered by Lothian and Borders Police which was not available at the time of the report.</td>
</tr>
</tbody>
</table>

- **Breast**: 100.00% 90.00%
- **Cervical**: 100.00% 90.00%
- **Colorectal**: 92.00% 95.00%
- **Endometrial**: 100.00% 90.00%
- **Head & Neck**: 100.00% 100.00%
- **Lung**: 100.00% 95.30%
- **Lymphoma**: 100.00% 100.00%
- **Melanoma**: 90.00% 100.00%
- **Ovarian**: 100.00% n/a
- **Upper GI**: 100.00% 98.00%
- **Urological**: 88.00% 92.00%
- **35%**: 96.70% 96.80%

### 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>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Waiting Times</td>
<td>Standard</td>
<td>Nov-12</td>
<td>Dec-12</td>
<td>99%</td>
<td>DF</td>
<td>Due to the recent downward trend in cancer waiting times performance, details of the monthly performance will be included in future performance reports. We are also reporting weekly to the Scottish Government on performance.</td>
<td></td>
</tr>
</tbody>
</table>

- **Breast**: 100.00% 100.00%
- **Cervical**: 100.00% 96.90%
- **Colorectal**: 98.00% 96.90%
- **Endometrial**: 100.00% n/a
- **Head & Neck**: 100.00% 100.00%
- **Lung**: 96.70% 100.00%
- **Lymphoma**: 96.70% 100.00%
- **Melanoma**: 91.70% 100.00%
- **Ovarian**: 100.00% n/a
- **Upper GI**: 100.00% 100.00%
- **Urological**: 94.80% 100.00%
- **35%**: 95% 98.20%

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

<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Waiting Times</td>
<td>Standard</td>
<td>Nov-12</td>
<td>Dec-12</td>
<td>99%</td>
<td>DF</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 18 weeks Referral To Treatment - 90 per cent of patients to wait no longer than 18 weeks from referral to first treatment for a full consultation.

<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standard</td>
<td>90%</td>
<td>Nov-12</td>
<td>Dec-12</td>
<td>90%</td>
<td>DF</td>
<td>Reported through the Medical directors report to the Board</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standard</td>
<td>0</td>
<td>Nov-12</td>
<td>Dec-12</td>
<td>0</td>
<td>DF</td>
<td>Reported through the Medical Directors report to the Board</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-hour A&amp;E</td>
<td>Standard</td>
<td>Dec-12</td>
<td>Jan-13</td>
<td>98%</td>
<td>NS</td>
<td>Now sits within the Unscheduled Care Group set up and Chaired by the Nurse Director and the Joint Director, Edinburgh.</td>
<td></td>
</tr>
</tbody>
</table>

- **RIE**: 81.9% 83.6%
- **WGH**: 86.3% 83.4%
- **SJH**: 87.9% 94.5%
- **RHSC**: 97.3% 98.1%
- **86.97%**: 88.20% 88.20%

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

<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Access</td>
<td>Standard</td>
<td>n/a</td>
<td>n/a</td>
<td>11/12</td>
<td>90.0%</td>
<td>AMcM</td>
<td></td>
</tr>
</tbody>
</table>

### Assessment

- ✔️ ✔️ Meets the overall target
- ✔️ Is on trajectory to meet, but has not yet met, the final target
- ❌ Is off trajectory
- ❌ ❌ Does not meet the overall target
<table>
<thead>
<tr>
<th>Other Local / National Target</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Delayed Discharges over 6 weeks (monitor nationally)</td>
<td>Ongoing</td>
<td>0 Dec-12 16</td>
<td>Jan-13 8</td>
<td>0</td>
<td>AMcM</td>
<td>Now sits within the Unscheduled Care Group set up and Chaired by the Nurse Director and the Joint Director, Edinburgh.</td>
</tr>
<tr>
<td>Total number of Delayed Discharge in Short-Stay setting (monitor locally)</td>
<td>Ongoing</td>
<td>0 Dec-12 8</td>
<td>Jan-13 14</td>
<td>0</td>
<td>AMcM</td>
<td>Now sits within the Unscheduled Care Group set up and Chaired by the Nurse Director and the Joint Director, Edinburgh.</td>
</tr>
<tr>
<td>Inpatient/Day Case Max 12 wks</td>
<td>Ongoing</td>
<td>0 Nov-12 703</td>
<td>Dec-12 568</td>
<td>0</td>
<td>AMcM</td>
<td>Reported through the Medical Directors report to the Board</td>
</tr>
<tr>
<td>Inpatient/Day Case Max 9 wks</td>
<td>Ongoing</td>
<td>0 Nov-12 1160</td>
<td>Dec-12 984</td>
<td>0</td>
<td>AMcM</td>
<td>Reported through the Medical Directors report to the Board</td>
</tr>
<tr>
<td>Wait for key diagnostic tests &gt; 4 weeks (Monitor Nationally)</td>
<td>Ongoing</td>
<td>MSC Nov-12 0</td>
<td>Dec-12 8</td>
<td>0</td>
<td>AMcM</td>
<td>Now sits within the Unscheduled Care Group set up and Chaired by the Nurse Director and the Joint Director, Edinburgh.</td>
</tr>
<tr>
<td>Cataract Waiting Times - max wait 18 wks outpatient and inpatient combined (Monitor Locally)</td>
<td>Ongoing</td>
<td>0 Nov-12 120 day cases and 100 outpatients</td>
<td>Dec-12 157 day cases and 80 outpatients</td>
<td>0</td>
<td>AMcM</td>
<td>Work is being done to improve this position through the Demand, Capacity and Queue work and also through Treatment Time Guarantee</td>
</tr>
<tr>
<td>Hip Surgery - waiting times % of Hip Fracture operations within 24 safe operating hours (Monitor Locally)</td>
<td>Ongoing</td>
<td>98% Dec-12 89.0%</td>
<td>Jan-13 97.6%</td>
<td>98%</td>
<td>AMcM</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Wait for cardiac intervention to be &lt; 12 wks (angiography, angioplasty and CABG) (Monitor Locally)</td>
<td>Ongoing</td>
<td>0 Nov-12 0</td>
<td>Dec-12 0</td>
<td>0</td>
<td>AMcM</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Audiology (Adults) - number of patients waiting over 9 weeks</td>
<td>Ongoing</td>
<td>0 Nov-12 0</td>
<td>Dec-12 0</td>
<td>0</td>
<td>AMcM</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Audiology (Paediatrics) - number of patients waiting over 12 weeks</td>
<td>Ongoing</td>
<td>0 Nov-12 0</td>
<td>Dec-12 0</td>
<td>0</td>
<td>AMcM</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in acute hospital</td>
<td>Dec-15</td>
<td>38% Qrt 1 2012/13</td>
<td>Qrt 2 2012/13</td>
<td>E4-42.0%</td>
<td>AMcM</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in community residential settings</td>
<td>Dec-15</td>
<td>39% Qrt 1 2012/13</td>
<td>Qrt 2 2012/13</td>
<td>E4-38.1%</td>
<td>AMcM</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Vasectomy - 12 Week OP Breach</td>
<td>Ongoing</td>
<td>0 Dec-12 5</td>
<td>Jan-13 0</td>
<td>0</td>
<td>PG</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Vasectomy - 18 Week RTT Compliance</td>
<td>Ongoing</td>
<td>90% Dec-12 100.0%</td>
<td>Jan-13 95.7%</td>
<td>90%</td>
<td>PG</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Wheelchair - referral to fitting - Patients still waiting 18 weeks+</td>
<td>Ongoing</td>
<td>90% Nov-12 93.09%</td>
<td>Dec-12 92.17%</td>
<td>100.0%</td>
<td>PG</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>Mar-13</td>
<td>4% Nov-12 4.35%</td>
<td>Dec-12 4.72%</td>
<td>4.0%</td>
<td>AMcM</td>
<td>Latest data (SWISS) is at December 2012. This is the highest monthly rate since a high of 5.3% recorded in January 2011. NHS Lothian’s Year to Date Average (April - Dec ’12) = 4.26%. NHSScotland’s Year to Date Average (April - Dec ’12) = 4.73%. Sickness absence figures reported monthly. (SWISS data) NHS Lothian has lowest absence (Av YTD) rate of all Teaching Boards in Scotland.</td>
</tr>
</tbody>
</table>
FINANCIAL POSITION TO 31 JANUARY 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 January 2013 and to confirm that NHS Lothian continues to forecast delivery of break even against the in year Revenue Resource Limit target for 2012/13.

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 Members of the Board are asked to note the:

• Financial position for the ten months to the end of January 2013;
• Forecast break even position for 2012/13; and
• The key associated risks.

3 Discussion of Key Issues

Overview

3.1 As previously reported, the mid year review concluded that in year financial break even was achievable. The key issues raised included the impact of both unscheduled and elective capacity investment; slippage on the delivery of recurring savings from the efficiency workstreams, and a number of emerging pressures such as energy, UNPACs, non Lothian income, equipment, and clinical / other supplies costs. All of these costs are offset by a range of benefits including slippage on allocations and financial plan investments; unutilised reserves and the brokerage from the SGHSCD to support the additional cost of waiting times.

3.2 The position reported at the end of January is in line with the mid year review forecast. There is a net underspend of £0.5m, encompassing a baseline underspend of £4.7m offset by unachieved efficiency savings of £4.1m. Table 1 below provides a summary of the position; a detailed analysis by expenditure type is attached as Appendix 1 and by operational unit in Appendix 2.
Table 1: Financial Position to 31 January 2013

<table>
<thead>
<tr>
<th></th>
<th>In month</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline position</td>
<td>2,830</td>
<td>(2,756)</td>
</tr>
<tr>
<td>Outstanding efficiency savings</td>
<td>(3,005)</td>
<td>(4,068)</td>
</tr>
<tr>
<td>Operational position</td>
<td>(175)</td>
<td>(6,825)</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>(407)</td>
<td>(4,067)</td>
</tr>
<tr>
<td>Release of provisions and reserves</td>
<td>565</td>
<td>11,432</td>
</tr>
<tr>
<td>Total under/(over) Spend</td>
<td>(17)</td>
<td>540</td>
</tr>
</tbody>
</table>

Baseline Position

3.3 The 0.5m underspend in January was consistent with the underspend of 0.6m in December, and no change to underlying trends is evident. As we move into 2013/14, the reporting of activity as part of the routine Finance Report will be reinstated, to ensure there is appropriate opportunity to link movements in cost with movement in activity. Whilst this is only one component of cost drivers, it is an important consideration as part of the dialogue on financial governance and reporting. Activity data for the period to 31 January is attached for information only, at Appendix 3.

3.4 The key financial issues underpinning the position to the end of January are consistent with those reported in previous months. Particular areas to be highlighted are pay costs, clinical supplies and equipment costs.

3.5 In relation to pay costs, vacancies in a number of staff groups, mainly medical and dental and Allied Health Professionals (AHPs), are offset by pressures on nursing costs, driven by incremental drift and increased cost of enhancements. The financial impact of the current nursing recruitment drive will become evident in 2013/14 when the ability to manage these pressures through vacancies will be significantly reduced;

3.6 With regard clinical supplies and equipment costs, despite an anticipated improvement during January caused by reduced December activity, the upward expenditure trend continues, with a combined variance of £3.4m. The variance is driven by factors including: historical pressures; changes in case mix; and specific service issues. In addition to the ongoing work to better understand the drivers, the unscheduled care investment proposals are being revisited to incorporate provision for related clinical supplies costs. The position with expenditure related to elective activity will be reviewed in 2013/14 when the waiting times backlog has been addressed;
3.7 There are many other areas of offsetting overspend and underspend which are actively being managed by operational units. It should also be noted that prescribing costs remain on trajectory to break even.

3.8 Board members are asked to note that the Draft Financial Plan for 2013/14 and beyond has been scrutinised by the Joint Management Team and the Finance & Resources Committee earlier this month, and is contained with the Draft Local Delivery Plan submitted to the Scottish Government Health Directorates on 15 February. The Financial Plan will be presented to the NHS Board in March for approval.

**Efficiency & Productivity**

3.9 For the 10 month period to January, efficiencies of £23.6m have been delivered against a plan of £27.7m, an under delivery of £4.1m. This remains in line with the quarter three forecast of in year under delivery of £4.9m and an estimated carry forward of £12.8m. Over the next 2 months significant effort will focus on ensuring the forecast (both in year and recurring) can be met and, indeed, improved upon.

3.10 The figures are summarised in table 2 below:

**Table 2: Efficiency and Productivity 2012/13**

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target</th>
<th>Slippage to January</th>
<th>Forecast Slippage to 31 March</th>
<th>Forecast carry forward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Reduction in Interventions of Low</td>
<td>537</td>
<td>(406)</td>
<td>(523)</td>
<td>(507)</td>
</tr>
<tr>
<td>Clinical Value</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary &amp; Community</td>
<td>650</td>
<td>(314)</td>
<td>(489)</td>
<td>63</td>
</tr>
<tr>
<td>Care Bed Reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Flow &amp; Capacity Management</td>
<td>3,233</td>
<td>(81)</td>
<td>(675)</td>
<td>(779)</td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,894</td>
<td>(1,261)</td>
<td>(1,655)</td>
<td>(1,894)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>11,411</td>
<td>(784)</td>
<td>(829)</td>
<td>(17)</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,631</td>
<td>(3)</td>
<td>(1,869)</td>
<td>(558)</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,758</td>
<td>(107)</td>
<td>(699)</td>
<td>(1,522)</td>
</tr>
<tr>
<td>Corporate/Strategic Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,945</td>
<td>(181)</td>
<td>(115)</td>
<td>(962)</td>
</tr>
<tr>
<td>Primary &amp; Community</td>
<td>1,779</td>
<td>(523)</td>
<td>(840)</td>
<td>(651)</td>
</tr>
<tr>
<td>UHD Local</td>
<td>5,171</td>
<td>338</td>
<td>179</td>
<td>(881)</td>
</tr>
<tr>
<td>LAMS</td>
<td>3,893</td>
<td>1,997</td>
<td>2,345</td>
<td>(2,110)</td>
</tr>
<tr>
<td>Total Planned Savings</td>
<td>37,902</td>
<td>(1,325)</td>
<td>(5,283)</td>
<td>(9,918)</td>
</tr>
<tr>
<td>Residual Gap</td>
<td>(362)</td>
<td>(2,740)</td>
<td>361</td>
<td>(2,865)</td>
</tr>
<tr>
<td>Total</td>
<td>37,540</td>
<td>(4,065)</td>
<td>(4,922)</td>
<td>(12,783)</td>
</tr>
</tbody>
</table>
Waiting times

3.11 The total cost of delivering additional elective capacity to meet waiting times to the end of January is £22.1m, an increase of £2.4m in the month. In addition to the cost of reducing the backlog, expenditure includes recurring investment in core capacity.

3.12 The position remains in line with the mid year review forecast of £26.8m. The key risks associated with full delivery include case mix, which is likely to increase internal costs, and continued reliance on independent sector providers.

Capital

3.13 The in year investment programme for property and assets is £48.5m, of which £22.3m has been invested to the end of January 2013. The detail relating to individual schemes is included in Appendix 4.

3.14 The Quarter 3 review of the capital programme identified further slippage in schemes where building has not yet commenced. A detailed report was presented to the Finance & Resources Committee this month, to provide assurance that the Capital Resource Limit is achievable this year. In order to manage the capital investment over the year end, a number of priority medical and other equipment, energy efficiency and e-health project are being accelerated. The programme is currently showing a manageable over commitment (£1.3m).

4 Key Risks

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

- Delivery of the agreed recurrent efficiency schemes and the need to identify further plans to address the shortfall;

- Continued management of the financial exposure on waiting times’ related additional activity delivery;

- The solution(s) agreed to address the system wide unscheduled care pressures, including any double running costs associated with any continued use of the Royal Victoria Hospital;

- The potential cost of changes to pay terms & conditions (including revised on call arrangements); and

- The increasing trend of expenditure on clinical supplies, hotel and equipment costs.

- The backlog maintenance programme represents the most significant risk in the capital programme. Whilst the programme is underway with 281 individual
schemes agreed to tackle the areas of high and significant risk, full delivery of the £5m in year budget will be challenging.

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.

Carol Potter
Associate Director of Finance
14 February 2013
carol.potter@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Income & Expenditure Summary January 2013
Appendix 2: NHS Lothian Summary by Operational Unit January 2013
Appendix 3: NHS Lothian Acute Inpatient & Day Case Activity January 2013
Appendix 4: NHS Lothian Capital Expenditure Programme January 2013
### NHS Lothian Income & Expenditure Summary to January 2013

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget</th>
<th>YTD Budget</th>
<th>YTD Actuals</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS LOTHIAN CORE POSITION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from other health systems</td>
<td>(115,772)</td>
<td>(82,869)</td>
<td>(81,366)</td>
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APPENDIX 1
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Total Planned Admission 75,107 7,731 8,422 69,133 7,117
## APPENDIX 3
### NHS Lothian Acute Inpatient & Day Case Activity January 2013

#### YTD M10 2012/13

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### Grand Total

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### NHS Lothian Capital Expenditure Programme 2012/13

#### Agreed Programme

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#### Programmed, but unapproved

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#### Over/ (Under) Commitment on Specific Funding

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#### NHS Lothian Formula and Other Funding Programme

#### Rolling Programmes

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#### Approved

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<td>£k</td>
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Total (over)/ under commitment (1,272)
NHS LOTHIAN STRATEGIC CLINICAL FRAMEWORK 2012-2020

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with the NHS Lothian Strategic Clinical Framework (appendix 1) for formal consideration and approval.

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

2 Recommendations

The Board is recommended to:

2.1 Approve the strategic clinical framework as a statement of NHS Lothian’s approach to health and healthcare planning from 2012-2020, expressed through six strategic aims.

2.2 Recognise the importance of working in partnership with internal and external stakeholders to achieve our aims.

2.3 Support the role of the Strategic Planning Group and individual Programme Boards in driving forward service redesign across NHS Lothian, in line with the principles, aims and actions set out in the Framework.

3 Discussion of Key Issues

3.1 Engagement with staff, patients, public and other partners has been underway since 2011 to develop a Strategic Clinical Framework which will set out the principles and aims to guide NHS Lothian’s plans for service redesign and decisions about delivery of health and healthcare in future years. It is important that we communicate to all stakeholders, including staff, a shared understanding of the need for change in how we operate to meet the economic, demographic, health inequality and workforce challenges we are facing. A Programme Board has overseen this work and a wide variety of internal and external partners have been involved (see Appendix 3 of Framework).

3.2 The attached Framework is a statement of the context, aims, approaches and actions NHS Lothian will take to deliver the Scottish Government’s vision for health and healthcare by 2020. It incorporates important national drivers such as the Christie report recommendations and integration - between health and social care, and primary and secondary care - as an essential enabler for transformational change.
3.3. The Framework includes key principles for health and healthcare planning as follows:

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

3.4. The Framework further sets out six aims and associated actions as follows:

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

3.5. The application of the aims and principles to specific service areas will be articulated in individual service strategies and action plans which will seek to apply the Framework principles in practice. The Framework provides a checklist against which service change and pathway redesign plans, investment and disinvestment plans and other key plans such as workforce, estates, efficiency and productivity can be tested to ensure fit with our strategic direction.

3.6. The detailed oversight of the application of the Framework and the strategic direction of services will be undertaken by the recently established Strategic
Planning Group (replacing the former Service Redesign Committee and Improving Care Investing in Change Executive Group), with regular reports to the Board.

3.7. Progress with the three aspects of integration locally – between primary and secondary care, health and social care, and corporate and operational divisions – will be key to achieving these aims, and are fundamental to delivery of the Framework.

4. Key Risks

4.1. If we fail to use the Framework actively and effectively as a checklist to support the transformation of services and maximise the use of public resources, this will impact on achievement of the aims. The Strategic Planning Group’s oversight will be key to mitigating this risk.

4.2. Failure to work in partnership with all stakeholders to change how health and healthcare is delivered in response to challenges and opportunities could mean that NHS Lothian will be unable to meet the population health and healthcare needs as set out in the Scottish Government’s 2020 vision. Communicating our strategic aims to staff, partner agencies and the public is an important step to mitigate this risk.

5. Risk Register

5.1. There are no specific risks for the NHS Lothian risk register at this point.

6. Impact on Inequality, Including Health Inequalities

6.1. A Rapid Impact assessment of the Framework was undertaken in June 2011 and updated in May 2012. This confirmed that it will have a broadly positive impact on all groups in relation to equality and the elimination of discrimination, as it will encourage greater linkage and co-ordination of plans, policies and services, so that inequalities should be better addressed. Through encouraging preventative approaches and greater participation of patients in their own care the strategy will impact positively on lifestyles and quality of services. It is expected that specific developments and changes will continue to be impact assessed.

7. Involving People

7.1. A wide range of stakeholders have been involved in the development of the Framework over an extended period, including representation on the Clinical Strategy Programme Board. A list of specific groups engaged is attached as an appendix to the Framework.

7.2. A key purpose of the Framework is to aid communication with patients, staff and the public and the proposed communication plan which will include:

- External communications explaining the changed models of healthcare we are aiming for with examples of services changes already underway which illustrate our aims- e.g. reshaping older people’s care jointly with council partners, health
improvement initiatives such as Keep Well and Health Works, improved access to care through One stop clinics, redesigned pathways such as the acute cancer care pathway.

- Collaboration with council partners on joint communication of our key messages as part of planned communication on integration and joint older people’s service improvement plans.

- Internal communication to staff at all levels via team brief, connections, and the intranet. The successful implementation of the framework will also be closely linked with the work of the Management Culture Steering Group and the development of a statement of organisational values and behaviours currently underway.

8. Resource Implications

8.1. There are no specific resource implications arising from agreeing this framework. Financial plans and resource decisions will require to take account of the impact on our strategic aims.

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List of Appendices

Appendix 1: Our Health Our Future NHS Lothian Strategic Clinical Framework 2012-2020
Our Health, Our Future
NHS Lothian Strategic Clinical Framework
2012 – 2020
1 Introduction

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

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

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

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

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

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

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

2 The vision for health and healthcare in Scotland

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

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

- Everyone is able to live longer healthier lives at home, or in a homely setting.
- We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management.
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.
Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.

There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

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

- developing a fairer society and reducing inequalities in health
- addressing the needs of disadvantaged groups
- promoting health in all policies and prioritising prevention, for example by ensuring children get the best start in life

3 The NHS Lothian context - challenges and opportunities

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

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

- Between 2011 and 2020 the population of Lothian is predicted to increase by 9.3%, from 846,104 to 925,207. The greatest increase will be in the over 75 age group, which will increase by 22.2% over the same period.
- The Lothian population aged 0-15 years is also growing, with a projected 14.6% increase in the number of children and young people by 2030.
- While the overall health of our population is improving, evidenced by reductions in deaths from coronary heart disease and stroke, there remains a fivefold socioeconomic gradient in the rate of premature death from heart disease. In addition, the risk of multiple morbidity increases with increasing age and lower socioeconomic status. The overall incidence of cancer is expected to rise by 1.4% per annum, and the prevalence of dementia to increase by 70% over the next 20 years. Issues such as obesity, poor diet and limited physical activity, smoking and excessive consumption of alcohol present significant public health challenges and are often closely associated with long term conditions such as cardiovascular disease and diabetes.
- Despite some good progress, inequalities remain in health outcomes across different social groups in Lothian and people in our poorest communities continue to die younger and live less healthy lives.
- The shape of our workforce is changing. There will be fewer doctors overall and where doctors skills are needed in specialist areas of care, these may need to be provided on fewer sites to ensure that services are safe. There are however opportunities to develop and use the skills of many staff groups and professional disciplines more effectively.
The global economic downturn means that real terms growth in health spending is not expected to return to the level of 2009/10 until 2025/25, so we have to deliver better health and healthcare while making best use of limited public resources.

Key principles of our planning framework are therefore:

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

4 Our strategic aims

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

1. Prioritise prevention, reduce inequalities and promote longer healthier lives for all
2. Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
3. Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
4. Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
5. Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
6. Use the resources we have – skilled people, technology, buildings and equipment - efficiently and effectively
The specific areas of focus and the actions we will pursue to achieve each of these aims are described in more detail in the following pages.

Aim 1

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

- providing services designed to prevent future illness,
- taking opportunities to provide advice and support to people to help them to take care of their own health and
- working with partners to promote the health and well being of communities and the whole population.

On average, people who are better off have better health than those who are less well off. Social inequalities in health are widest between the most well off and the least well off, with people living in poverty more likely to die at a younger age and to have more than one illness than the rest of the population. Health inequalities are an example of social injustice.

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

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

- We must make sure health services deliver high quality care to the whole population. We will measure the way people use health services and the health outcomes for different population groups. This will help us make sure services are working well for everyone.

- We will tailor services and health interventions to people who are at highest risk of ill health to prevent illness where possible and reduce socioeconomic differences in health.

- We will strengthen the role of clinical services in preventing illness and supporting people who have health problems to access the help and support they need to maintain their well being and social and economic welfare. For example developing the role of the NHS in pathways which support employability and retention of employment and access to welfare rights advice.

- Our primary care services are central to identifying the majority of people who are at highest risk of ill health while they are still healthy. We will work with GPs and other community health professions to offer evidence based interventions, identify and reduce risk, and make the most of contacts with patients as opportunities for prevention and health promotion.
• We will work closely with local authorities and other agencies to address the social determinants of health, to make sure people have the best chance of living a healthy life and that places they live are designed to promote good health.

Aim 2
Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care settings

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

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

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

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

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

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

Aim 3
Ensure that healthcare is evidence-based, incorporates best practice, and achieves seamless and sustainable care pathways for patients

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

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

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

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

Patient information will be shared with relevant professionals in real-time along pathways to support timely clinical decisions.
Using evidence, we will identify best practice and adopt it as an innovative learning organisation. We will continuously assess and improve our performance at individual, care condition and organisation level through transparent information sharing and learning discussions across care settings.

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

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

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

**Aim 4**

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

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

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

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

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

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

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

Both elective (planned) and unscheduled care will be provided through robust and reliable specialist capacity to meet patient needs in a timely and efficient way.

We will improve availability of generalist healthcare, especially for those with complex needs, while facilitating access to expert specialist health advice when required.
Aim 5
Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families

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

We will reaffirm our core values, engaging with staff teams and with patients to develop, share and demonstrate our beliefs about what excellent quality care means for patients, carers and staff.

We want to ensure stronger public involvement in the design and delivery of health services, and recognise the value that can be added by such participation.

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

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

We want to encourage and support people of all ages to be able to participate positively to health and wellbeing in their local communities.
Aim 6
Use the resources we have – skilled people, technology, buildings and equipment - efficiently and effectively

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

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

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

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

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

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

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

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

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

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

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

We will manage our costs to be financially sustainable while maintaining or improving health outcomes through waste reduction, lean processes and enabling staff to work to their full potential.
Care pathways will be designed to reduce wasteful activities for patients and staff: unnecessary duplication of tests, appointments, recording of information; unnecessary waiting for patients; avoidable transfers and travel.

**Buildings and Estates**

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

We will continue a programme of primary care premises development providing accessible community-based healthcare facilities.

Less hospital in-patient care may mean we need fewer hospital beds, with those that we do need provided in appropriate and fit for purpose accommodation.

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

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

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

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

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

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

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

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

Our initial priorities will therefore be:

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

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

6 The process we will adopt

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

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

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

Priority areas of focus for teams will be:

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

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

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

Appendices:
1 Future state diagram - unscheduled elderly care model
2 Future state diagram - planned care model
3 List of Stakeholder Groups engaged in development of the Framework
Future State Unscheduled Elderly Care Model

**Prevent Admissions**

**HOME:**
- Self-care
- Primary care
- Social care
  (prevention, telehealth and telecare, early intervention, community support)

**Accident & Emergency**
- Minor Injuries

**Hospital assessment units**

**Elderly care Specialist Team (Compass)**
- 24/7 Specialist advice

**No Boarding**

**Acute Hospital**
- In-patient care / specialties
  (LOS >= 75th percentile)

**Community Hospital**
- Rehabilitation
  (LOS >= 75th percentile)

**Intermediate Care / Step Down Facility**

**Residential Care / Long-term care**
  (LOS < 2 years)

**HOME:**
- Self-care
- Primary care
  (reablement, crisis care, health improvement, telehealth and telecare, community support)

Integrated care pathway supported by: shared information, evidence based protocols, engaged patients and carers, lean processes, optimised staff skills
Future State Planned Care Model

Prevention/Early Detection

Diagnosis

Treatment

Follow up

18 weeks

HOME:
- Self-care
- Primary care
- Social care
- Screening & Monitoring
- Prevention
- Early Intervention

GP

Other Community professional

One-stop clinics

Access To Diagnostic tests

Out-patient assessment and treatment

Day Case

XX%

In-patient Stay

Complex cases

Hospital

Out-patient Follow-up Complex cases only

Phone, e-follow-up, surveillance

Surgical Pre-assessment

pro-active after-care planning

Enabled by electronic booking, shared patient records
NHS Lothian Clinical Strategy Engagement Events

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

1 Purpose of the Report

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

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

2 Recommendations

The Board is recommended to:

2.1 Review progress towards NHS Lothian’s Corporate Objectives for 2012-13 and note that a final year performance paper, with validated information will be presented to the May Board.

2.2 Agree the set of proposed Corporate Objectives for 2013-14 some of which are still in development.

2.3 Note that the Clinical Strategy Framework (also a paper at the Board) will assist in the organisational delivery and development of further corporate objectives during 2013-14.

2.4 Note that the Local Delivery Plan is being tabled at the February Board. This also includes further narrative, trajectories and financial and workforce plans aligned to a number of the 13/14 objectives.

2.5 Note that for the first time it is proposed to set a new team objective for the Executive Directors on ensuring patient and staff safety and delivery of high quality patient care.

3 Discussion of Key Issues

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

3.2 Significant progress has been made across the range of objectives set during 12/13 and these are highlight within the report. Of the 57 actions, progress for is Green for 38 actions, Amber for 14 and Red for 2 actions respectfully. A further 3 actions have both Green and Amber elements to report.
3.3 The proposed Corporate Objectives for 2013-14 comprise 50 actions, including the revised HEAT targets and standards for 2013-14. We are bringing these to the Board at this earlier stage in the year in order to allow the personal objectives for Directors and the Executive cohort to be developed and submitted to the Remuneration Committee for approval by the end of March/beginning of April 2013. This is much earlier than in previous years but was agreed by the Remuneration Committee earlier this year to enhance the performance management system. A final paper describing final year end performance with validated performance data will be submitted to the Board in May 2013 as referenced above.

3.4 The 13/14 corporate objectives build on the 12/13 objectives because many of the objectives relate to programmes of work over several years requiring persistent attention to achieve sustainable long term outcomes. New targets and standards set by Scottish Government have been incorporated appropriately.

4 Key Risks

4.1 Risks associated with the delivery of HEAT targets and standards are detailed within the draft Local Delivery Plan Risk Management Plan which is also being discussed at the February Board.

5 Risk Register

5.1 Once approved, the proposed Corporate Objectives for 2013-14 will be linked directly to and where appropriate placed on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 All existing HEAT Targets and standards have been fully impact assessed as have many of the other targets within the set of objectives. A meeting is arranged on 14th March to impact assess the Delivery Plans for new HEAT Targets.

7 Involving People

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

8 Resource Implications

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

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15 February 2013
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Alex McMahon
Director of Strategic Planning

List of Appendices

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

### OBJECTIVE 1:
**DEVELOP THE NHS LOTHIAN CLINICAL STRATEGY TO PROVIDE A FRAMEWORK FOR SERVICE REDESIGN ACROSS THE ORGANISATION**

<table>
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<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>March 2013</td>
<td>AMcM</td>
<td>Framework will go to the Feb Board meeting for sign off. Strategic Planning Group established and will oversee the development of future strategies and implementation. Modernisation Team/Improvement Support is aligned to this work.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>AB / AMcM / MH</td>
<td>Work programme being developed and will go to the February Strategic Planning Group in the first instance.</td>
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- Develop a clinical framework to support the redesign of clinical services which will meet the changing needs of our population and which are available to all of them who may benefit. Adopt evidence based best practice and models of health care which focus on patients and clients to ensure that we achieve the best outcomes for our population, using tool such as LEAN as appropriate.

- Design and implement phased changes to roles and working patterns to deliver the future service models.

### OBJECTIVE 2:
**FURTHER DEVELOP CAPACITY PLANS TO ENSURE THAT NHS LOTHIAN MEETS THE SCOTTISH GOVERNMENT WAITING TIMES TARGETS AS REQUIRED**

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<th>TIMING</th>
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<th>COMMENTS</th>
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<tr>
<td>Ongoing / October 2012</td>
<td>DF / SG</td>
<td>Weekly waiting times meeting chaired by the Chief Executive monitoring progress towards reducing the backlog of patients requiring out patient/day case/in patient treatment. Senior operational managers meet every Friday morning to review the implementation of Demand and capacity plans to ensure that there are sustainable solutions to meet the 12 week Treatment Time Guarantee and 18 week Referral To Treatment Target. Financial budgets agreed. Step up in capacity now being reviewed for scrutiny at March JMT.</td>
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- Continue to develop capacity plans and supporting financial plans to support the delivery of national access targets across all specialities, working with the Scottish Government Team to put plans in place which are sustainable, including the 12 weeks treatment time guarantee (TTG) for inpatient and day case treatment coming into effect from 1 October 2012; and for delivery of the 90% composite target for 18 week Referral to Treatment across appropriate specialities.
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

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<tr>
<th>OBJECTIVE 2: FURTHER DEVELOP CAPACITY PLANS TO ENSURE THAT NHS LOTHIAN MEETS THE SCOTTISH GOVERNMENT WAITING TIMES TARGETS AS REQUIRED</th>
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<tr>
<td>Continue to deliver the Scottish Government standard for 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.</td>
<td>Ongoing</td>
<td>DF</td>
<td>Weekly monitoring of both 31 &amp; 62 day treatment times continue. Latest monthly review shows performance above 95% for both standards.</td>
</tr>
<tr>
<td>Develop a Performance Management System to ensure quality and transparent data is routinely reported to appropriate Board Committees.</td>
<td>March 2013</td>
<td>AMcM</td>
<td>Following approval of the committee structure, the Corporate Governance &amp; Value for Money Manager and Associate Director of Analytical Services have started to meet with Chairs and Executive Leads to review each committee’s information needs. In particular, the Corporate Governance &amp; Value for Money Manager is using a Board Assurance Map model to set out the main assurance topics for the Board and indicate the various sources of assurance, with sources categorised into:</td>
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<td>- First Line of Defence – management controls and reporting;</td>
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<td>- Second Line of Defence – Board and committee oversight; and</td>
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<td>- Third Line of Defence — independent review or regulatory oversight.</td>
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</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th><strong>OBJECTIVE 2:</strong> FURTHER DEVELOP CAPACITY PLANS TO ENSURE THAT NHS LOTHIAN MEETS THE SCOTTISH GOVERNMENT WAITING TIMES TARGETS AS REQUIRED</th>
<th><strong>TIMING</strong></th>
<th><strong>LEAD CMT MEMBER</strong></th>
<th><strong>COMMENTS</strong></th>
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<tr>
<th><strong>OBJECTIVE 3:</strong> TO PROMOTE AND ENSURE THAT ALL EMPLOYEES ARE SUPPORTED APPROPRIATELY IN LINE WITH STAFF GOVERNANCE POLICIES WITHIN NHS LOTHIAN</th>
<th><strong>TIMING</strong></th>
<th><strong>LEAD CMT MEMBER</strong></th>
<th><strong>COMMENTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete the Critical Incident investigation in regard to Waiting Times and follow up actions as appropriate.</td>
<td></td>
<td>AB</td>
<td>COMPLETED</td>
</tr>
<tr>
<td>Complete the review of management culture within NHS Lothian and follow up actions as appropriate.</td>
<td></td>
<td>CHAIR /CE</td>
<td>THIS IS A TWO YEAR PROGRAMME AND WILL TAKE ON BOARD THE 5X5X5 VALUES WORK WORK TO DATE IS ON TARGET</td>
</tr>
<tr>
<td>Refresh and implement the HR&amp;OD Strategy, in light of findings from recent investigation(s) and reviews.</td>
<td>Ongoing</td>
<td>AB /CE</td>
<td>REFRESHED AT NOV 2012 BOARD</td>
</tr>
<tr>
<td>NHS Boards to achieve a sickness absence rate of 4%.</td>
<td>Ongoing</td>
<td>AB</td>
<td>CURRENTLY CIRCA 4.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OBJECTIVE 4:</strong> FURTHER DEVELOP WORK RELATING TO NHS LOTHIAN UNSCHEDULED CARE IN ORDER TO SUPPORT THE ORGANISATION TO ACHIEVE REQUIRED STANDARDS OF PATIENT CARE</th>
<th><strong>TIMING</strong></th>
<th><strong>LEAD CMT MEMBER</strong></th>
<th><strong>COMMENTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to work with Partner Authorities to deliver the Delayed Discharge targets contained in the Local Delivery Plan - no people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.</td>
<td>March 2013</td>
<td>AMcM</td>
<td>Delayed discharges are still above the trajectory to meet this target. The January figures where that 24 people were delayed longer than 28 days.</td>
</tr>
</tbody>
</table>
### OBJECTIVE 4:
**FURTHER DEVELOP WORK RELATING TO NHS LOTHIAN UNSCHEDULED CARE IN ORDER TO SUPPORT THE ORGANISATION TO ACHIEVE REQUIRED STANDARDS OF PATIENT CARE**

<table>
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<tr>
<th>TIMING</th>
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<tbody>
<tr>
<td>Ongoing</td>
<td>AMcM</td>
<td>Winter Business Continuity Plan delivered and being implemented as per the plan. NHS Lothian along with other Boards did not achieve our desired performance on 4 and 12 hours and delays during the winter period. This year winter planning will be embedded within the operational management. A winter de-brief is planned for the 6th March.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>MH</td>
<td>This remains a challenge but an agreed action plan is now in place and is being driven forward through both the Joint Management Team and the Unscheduled Care Group. January performance was 88.2% against a 98% target.</td>
</tr>
</tbody>
</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>OBJECTIVE 5: DRIVE FORWARD THE WORK ON THE INTEGRATION OF HEALTH AND SOCIAL CARE</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to drive forward the Integration of Health and Social Care as directed by SG guidance.</td>
<td>Ongoing</td>
<td>AMcM/PG/JF/DS</td>
<td>Significant progress made and NHS Lothian and council partners are at the forefront of this agenda in Scotland. Shadow arrangements in place in WL/Edinburgh and will be in place in East Lothian and Mid in April/May this year. Staff engagement underway, partnership agreements being developed, initial services being reviewed are Learning Disabilities; Mental Health; Complex Care; Substance Misuse; Prisons; Health Promotion Next tranche are Dentistry, Children and aspects of acute care during 13/14.</td>
</tr>
</tbody>
</table>
## OBJECTIVE 6: IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHILST IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>Objective Description</th>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
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</table>
| Implement the Quality Improvement Strategy. | March 2013 | DF | A 1-year update on the implementation of the Quality Improvement Strategy (2011-14) was reported to the Board in July 2012. There have been sustained improvements in:  
- HSMR and Adverse Event Rate (see below under SPSP)  
- 20% reduction in Falls with Harm  
- Reduction in medication errors.  
Many of the key measures have been incorporated into the Quality Report which is reported at every Board meeting. |
<p>| Continue to implement the Scottish Patient Safety Programme to deliver reductions in standardised hospital mortality rate (HSMR) and in adverse events recorded. | March 2013 | DF | A 5-year update on SPSP was reported to the Board in November 2012, plus the positive findings of the Autumn Harvest visit from Healthcare Improvement Scotland. Sustained improvements in HSMR against (2006/07 baseline) national 20% reduction goal for 2015: WGH ↓5%, SJH ↓6.30% and RIE ↓10%. The WGH remains the lowest mortality rate in Scotland. We have sustained the reduction in the Adverse Event Rate by 46% against baseline. A HSMR plan was presented to the Board in January 2013 to support further improvements. New workstreams: VTE, SEPSIS, Maternity, Mental Health and rollout of the programmes to General Practice – 91% of practices are taking part. |
| Continue to improve patient experience through “Delivering Better Care”. | March 2013 | MH | Progressing as planned. Work of Hub and Person Centred Programme working with social services, 3rd sector and independent care sector.|</p>
<table>
<thead>
<tr>
<th>OBJECTIVE 6: IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHILST IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Ensure robust arrangements are in place for both emergency planning and business continuity in order to support the management of major incidents.</td>
<td>Ongoing</td>
<td>AKM / AMcM</td>
<td>Through representation at the Lothian and Borders Emergency Planning SCG by the Director of Public Health &amp; Health Policy. Through exercise and training opportunities we evaluate and improve staff abilities to prepare for and manage major incidents and outbreaks. The NHS Lothian Emergency Planning Strategic Advisory Group (EPSAG) is responsible for ensuring that the requirements for emergency planning at a strategic level, in conjunction with the requirements of a Category 1 responder under the Civil Contingencies Act, 2004 are identified and addressed across NHS Lothian. NHS Lothian ensures that this can happen by close working between the Director of Public Health and the Director of Planning, Performance Reporting and Information. NHSL Business Continuity Management (BCM) programme continues to link into Scottish Government guidelines and frameworks to ensure arrangements are current and robust. Formalised reassurance protocols are in place to ensure individual business areas are compliant with the BCM programme, along with triggers of escalation if required. Particular focus is given to plan maintenance and exercising on an annual basis. The corporate risk is now removed for BCM, due to controls in place and the evaluation of the effectiveness of the said processes</td>
</tr>
</tbody>
</table>
## OBJECTIVE 6:
**IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHILST IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE**

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<tr>
<td>Ongoing</td>
<td>AKM</td>
<td>The large outbreak of Legionella during June 2012 required a multidisciplinary response by the whole of the Public Health department led by the Health Protection Team. NHS Lothian and IMT debriefs have been held and the final report for the outbreak is with the Central Legal Office for final sign-off. While the C.Diff target is likely to be met (see objective 12 for details), the team is pursuing targeted actions in areas where new approaches are needed to drive down antibiotic use and to prevent infections, particularly recurrent infections.</td>
</tr>
<tr>
<td>Quarterly</td>
<td>DF</td>
<td>Since September/October the target for SAB has been off trajectory. There is no single cluster – each case is investigated and feedback to staff. A significant proportion are elderly people who have multiple morbidities who have repeated contact with the healthcare system and further work is underway to identify strategic priorities for improvement. Continue to implement NHS Lothian’s Risk Management Policy and Procedure to further embed. A Risk Management Steering Group has been established, chaired by the Chief Executive. As part of a review of governance committees at the Board, Risk Management now reports through the Audit &amp; Risk Committee as a standing item. Draft Corporate Risk Register was reported to the Board in January 2013 and risks pertinent to the 3 governance committees of the Board are being reviewed, and will inform committee agenda setting.</td>
</tr>
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</table>

Ensure robust arrangements are in place to manage communicable disease outbreaks and healthcare associated infection with targeted plans in place to deliver continued reduction in rates of healthcare associated infection (this includes the HEAT Target).

Risk Management arrangements reviewed regularly by both Healthcare Governance & Risk Management Committee at bi-monthly meeting and by Audit committee.
## NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

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<th>OBJECTIVE 6: IMPLEMENT PROGRAMMES OF GOVERNANCE AND EFFICIENCY TO ENSURE QUALITY WHILST IMPROVING PATIENT SAFETY AND PATIENT EXPERIENCE</th>
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<th>LEAD CMT MEMBER</th>
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<tbody>
<tr>
<td>Develop the complaints function to ensure single point of access, pro-active response and learning across the organisation as well as meeting targets to ensure a timely response.</td>
<td>March 2013</td>
<td>SW</td>
<td>A review is set to take place on the future shape of Complaints Department to ensure it is meeting the needs of the organisation as set out in objectives</td>
</tr>
<tr>
<td>Ensure robust systems are in place to manage Freedom of Information requests within the guidelines.</td>
<td>Ongoing</td>
<td>AB</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Complete the action plan for the Equality &amp; Human Rights Scheme 2010-13, and develop future equality &amp; diversity objectives in order to meet legal requirements and ensure that the patient experience is as equitable and safe as possible for all individuals.</td>
<td>March 2013</td>
<td>AB</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Refresh / renew the involving people strategy, taking account of the requirements of the Patients Rights Act, to ensure the involvement and communication with our patients and communities.</td>
<td>March 2013</td>
<td>MH</td>
<td>Draft currently under development.</td>
</tr>
</tbody>
</table>
## OBJECTIVE 7: ENSURE APPROPRIATE STAFFING ARRANGEMENTS ARE IN PLACE ACROSS NHS LOTHIAN AS REQUIRED, INCLUDING MEDICAL STAFF, NURSING, AHPS AND OTHERS

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<tr>
<th>TIMING</th>
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<tbody>
<tr>
<td>March 2013</td>
<td>DF / SG</td>
<td>At a national level the further reductions have been paused in a number of specialties. The NHS Lothian 2013 financial plan includes provision for key areas where there are medical workforce pressures; Emergency Medicine, O&amp;G and Paediatrics. This funding is in place to enable these areas to recruit to both medical and non-medical replacements. The Nurse Director is undertaking a scoping exercise to determine the demand for advanced practice roles. A medical workforce risk assessment process is currently underway within all service/specialties, this will profile risk within the Trained, Training and Non-medical replacement workforces. The assessments will then be used to highlight and address areas of high risk.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>AB</td>
<td>Model developed, risk matrix being implemented</td>
</tr>
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</table>
### OBJECTIVE 8:
**CONTINUE TO DEVELOP STANDARDS OF CARE FOR BOTH OLDER PEOPLE SERVICE AND MENTAL HEALTH SERVICES**

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<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
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</table>
| Increase the balance of care to 40% against a baseline of 30.5% in relation to older people supported with complex packages of care against the number of people in care homes and continuing care. | March 2016 | CH(C)P GMs  
At Nov 2012 – average 42%  
East – 57%  
West – 33.6%  
Mid – 41%  
Edinburgh – 31.4% |
| Continue to develop and take forward the implementation of four change plans in relation to the development of intermediate care services for older people. | March 2013 | CH(C)P GMs  
All Change Fund plans are being implemented. Mid term reviews have been conducted across all partnerships/plans. Discussions now about future areas of investment and these will take place through corporate and local change fund plan groups. Primary and community based responses are the main focus of this investment as are hospital based services to assist the patient pathway and ‘flow’ management. There are two more years of funding till March 2015. |
| Continue to improve care for older people in acute care in line with national standards and HIS Inspection Regime | March 2013 | MH  
Vulnerable peoples Steering Group established in August 2012. New programme of education has been developed and now available. Resource Packs available during February. Dementia champions now in place and a further cohort being recruited to. |
| Continue with the first phase of implementation of the NHS Lothian Mental Health and Wellbeing Strategy 2011-15. | March 2013 | AMcM  
Implementation of the strategy is well progressed. Significant work on driving the actions forward and the redevelopment of the Royal Edinburgh Hospital. Work on tackling issues related to social justice, inequalities; needs of those in prison and also wider work on psychological therapies and dementia well progressed. |
### OBJECTIVE 9: ENSURE THE CAPITAL PROGRAMME IS DELIVERED WITHIN A ROBUST FINANCIAL PLANNING AND GOVERNANCE FRAMEWORK

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<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
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<tr>
<td>Ongoing</td>
<td>SG / AB</td>
<td>Consort performance increasingly managed to Partnership Agreement. Review of Efficiency of soft FM services underway.</td>
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<tr>
<td>Ongoing</td>
<td>SG</td>
<td>Project now progressing and procurement process underway. 3 bidders being evaluated.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>DS / SG</td>
<td>Programme infrastructure now established. Outline bed numbers and capital costs revised. First phase to focus on mental health related services and the second on learning disabilities</td>
</tr>
<tr>
<td>Ongoing</td>
<td>SG/ DF</td>
<td>The Director of Finance and Medical Director are working with colleagues to develop an Edinburgh Bioquarter business plan. This will involve highlighting aspirations for the clinical service from an NHS point of view, research, undergraduate/postgraduate training and the links with the University. A workshop is planned for the Bioquarter Business Plan development early March.</td>
</tr>
<tr>
<td>Ongoing</td>
<td>SG</td>
<td>Ongoing – variety of capital projects now in development and construction.</td>
</tr>
<tr>
<td>OBJECTIVE 10: FINANCIAL BALANCE</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
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<tr>
<td>Ensure a robust financial planning and governance framework is in place, encompassing both capital and revenue, to support NHS Lothian's strategic objectives, to deliver financial balance, and which manages risk in relation to the economic position.</td>
<td>March 2013</td>
<td>SG</td>
</tr>
<tr>
<td>Ensure the Efficiency &amp; Productivity Programme delivers the required recurring savings for 2012/13, and progress is made on detailed, deliverable plans for 2013/14 and beyond</td>
<td>March 2013</td>
<td>SG</td>
</tr>
<tr>
<td>Develop the Integrated Resource Framework as a financial planning tool and to support wider management decision making, particularly in relation to the integration agenda.</td>
<td>March 2013</td>
<td>SG / AMcM</td>
</tr>
</tbody>
</table>
**OBJECTIVE 11: CONTINUE TO DRIVE FORWARD THE PUBLIC HEALTH AGENDA**

Improve health inequalities and health deprivation by providing better access to services and resources to meet the needs of the most vulnerable groups through the following:

- Embedding Keep Well by 2015 —to be in place by 2013
- Eradicating measles and rubella — September 2013
- Complying with best practice in relation to information governance
- Improving the health of the population by reducing premature death, disability and distress
- Providing high quality universal services, targeted and tailored services for individuals and communities with greater levels of need and working with partners to address the social determinants of health
- Developing and testing measures designed to measure and evaluate improvements in the health of the population and reductions in health inequalities.

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</table>
| Ongoing | AKM | - By the end of September, 2494 Keep Well checks were completed, we are on track to meet our annual target of 4800 checks by the end of March 2013 and the phased ‘roll-out’ of Keep Well is on target.  
- Plans for action required to minimise the risk of home-grown measles and rubella have been developed and agreed by JMT. WHO revised the target dates for evidencing elimination of home-grown measles and rubella. 2013 is now the first performance review point. The revised target year to evidence delivery is 2017.  
- The Fair Warning process is an example of action taking place to improve information governance practices and embed best practice across all NHSL staff. Information governance risks will be recorded on the corporate risk register and reviewed regularly.  

We continue to improve the health of the population and work with partners to address the social determinants of health on a number of fronts. This work is encapsulated in the WHO ten essential Public Health Operations (2012): |
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>OBJECTIVE 12: ACHIEVE REQUIRED HEAT TARGETS AND STANDARDS AS EXPECTED WITHIN THE STATED TIMESCALES BY THE SCOTTISH GOVERNMENT</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15.</td>
<td>March 2015</td>
<td>AKM</td>
<td>As at January 2013, details of local trajectories for the three cancers were still to be agreed with the Scottish Government. ISD continues to work on this for all Boards as it is proving difficult to count - this is not routine data.</td>
</tr>
<tr>
<td>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.</td>
<td>March 2015</td>
<td>AMcM</td>
<td>Have agreed definitions and reporting. On track for delivery.</td>
</tr>
<tr>
<td>Improve oral health by providing preventative interventions: ensure at least 60% of 3 and 4 year olds in each SIMD quintile have fluoride varnishing twice a year by March 2014.</td>
<td>March 2014</td>
<td>AKM</td>
<td>Latest figures in January 2013 show that in the year from Oct 2011 to September 2012 a total of 25.4% of registered 2-5 year-old children in Lothian received one fluoride varnish application. Mainland Boards range from 11.0% to 32.7%. In the same time period, 4.8% of registered 2-5 year-old children in Lothian received two fluoride varnish applications. Mainland Boards range from 1.8% to 7.0%.</td>
</tr>
<tr>
<td>Deliver agreed completion rates for child healthy weight intervention programme through combined approach of prevention and treatment (NHS Lothian is required to deliver 1,475 interventions by March 2013 reaching a cumulative total of 2,268 by March 2014).</td>
<td>March 2014</td>
<td>AKM</td>
<td>Over the period July to Dec 2012 interventions were delivered to a total of 348 overweight and obese children (provisional figure yet to be validated by Scottish Government). We are currently recruiting additional schools to take part for the final weeks of 2012/13 and start 2013/14. Funding to deliver these additional programmes has been identified within Public Health budgets. Arrangements have been made to perform the measurements in as sensitive and confidential way as possible to minimise potential harm. With this plan in place we would expect to meet or exceed the target by March 2014.</td>
</tr>
<tr>
<td>Objective</td>
<td>Due Date</td>
<td>Responsible</td>
<td>Notes</td>
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<tr>
<td>Deliver smoking cessation services to support the reduction in the number of people smoking by 2014 (NHS Lothian is required to reach 4,836 successful quits by March 2013 reaching a cumulative total of 7,011 by March 2014).</td>
<td>March 2014</td>
<td>JF/AKM</td>
<td>Target achieved. Smoking cessation amongst the 40% most deprived within-Board SIMD areas over the period 2011/12 to 2013/14 was targeted to be 7,011. This target was reached by September 2012. We are on trajectory to achieve the 2011-14 target.</td>
</tr>
<tr>
<td>Reduce suicide rate between 2002 and 2013 by 20%.</td>
<td>March 2013</td>
<td>AMcM</td>
<td>There were 128 suicides in Lothian in 2011 (16.5% of the Scottish total). This is an increase on 2010 (122) but lower than 2008 (136). 2008 was the highest yearly total in the last 25 years. The 2011 total is made up of 96 males and 32 females. Much of the variation in the Lothian figures over the last 5 years appears to be due to changes in male suicide. Female deaths from suicide have been between 30 and 34 in that period.</td>
</tr>
<tr>
<td>Reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.</td>
<td>March 2013</td>
<td>AB</td>
<td>Reduce Carbon Emissions - 6.36% v -8.73% target</td>
</tr>
<tr>
<td>Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks by December 2014.</td>
<td>March 2013</td>
<td>MH/ AMcM</td>
<td>Work is progressing well in achieving the 26 wk CAMHS target. Further workforce developments and eHealth developments to take place.</td>
</tr>
<tr>
<td>Deliver an 18 weeks referral to treatment waiting time for Psychological Therapies from December 2014.</td>
<td>December 2014</td>
<td>AMcM</td>
<td>Initial work in East/Midlothian now being rolled out on the back of the publication of the demand, capacity and queue work completed. Strategic plan developed. Mental health is under the TTG and therefore we are addressing reporting as well as ensuring definitions are clear. eHealth support is ensuring a migration from PIMS to Trak by March 13 captures all the information needs aligned to meeting this target and other information needs within mental health systems.</td>
</tr>
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### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
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<tr>
<th>Objective</th>
<th>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</th>
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<tr>
<td></td>
<td>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
</tr>
<tr>
<td></td>
<td>March 2013 AMcM /AKM January 13 figures show NHS Lothian at just (1.9%) below the performance trajectory to achieve target of 90% of new patients beginning treatment within 3 weeks of referral. In fact, 85.2% of 358 new patients started their treatment within three weeks of referral. In addition, over 93% of patients started treatment within 5 weeks of referral.</td>
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<tr>
<td></td>
<td>Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15 (NHS Lothian will reach the target of 4,971 by March 2013, 4,799 by March 2014 and 4,629 by March 2015).</td>
</tr>
<tr>
<td></td>
<td>March 2015 AMcM The trajectory for emergency bed days for those 75+yrs continues to rise above NHS Lothian’s agreed stretch target but actions through the unscheduled care and change fund will assist in this being delivered by 2015</td>
</tr>
<tr>
<td></td>
<td>Improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.</td>
</tr>
<tr>
<td></td>
<td>March 2013 MH Not on trajectory because of Unscheduled Care flow. Current January 2013 position is 59% against target. Action plan now in place.</td>
</tr>
<tr>
<td></td>
<td>Further reduce healthcare associated infections so that by March 2013 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.</td>
</tr>
<tr>
<td></td>
<td>March 2013 AKM SAB: SAB target by 31/03/2013 = 0.26 cases per 1000 Acute Occupied Bed Days (213 episodes). Current SAB rate (December 2012) = 0.28 (189 episodes). Therefore, we are not on trajectory to achieve the 2013 target. C.Diff. CDi target by 31/03/2013 = 0.39 per 1000 Total Occupied Bed Days (326 episodes). Current CDi rate (December 2012) = 0.34 (206 episodes) and we are therefore on trajectory to achieve the 2013 target.</td>
</tr>
</tbody>
</table>
### NHS LOTHIAN – CORPORATE OBJECTIVES 2012/13

<table>
<thead>
<tr>
<th>Support shifting the balance of care by achieving a 2% reduction in the rates of attendance at A&amp;E between 2009/10 and 2013/14 (NHS Lothian will achieve a rate of 1,944 by March 2013 and 1,959 by March 2014).</th>
<th>March 2014</th>
<th>MH / PG</th>
<th>In December 2012, NHS Lothian's performance continued to be 5% above the trajectory for accident and emergency attendances. Total number was 17,699 attendances. Work to redesign the St John’s Hospital Primary Assessment Area standard operating procedures will, where appropriate, direct patients out of an admitted pathway into an ambulatory care pathway, therefore reducing the number of A&amp;E attendances recorded in the future. This has been notified to ISD and Scottish Government and there is an annual review of T10 on the 5th March. The T10 workstream will now sit within the unscheduled care group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEAT STANDARDS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team</td>
<td>Ongoing</td>
<td>DS</td>
<td>Annual Survey, NHS Lothian was at 80% against the 90% target</td>
</tr>
<tr>
<td>Maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources.</td>
<td>Ongoing</td>
<td>AMcM</td>
<td>Lothian sits at approx 60% patients on the register above the initial target.</td>
</tr>
<tr>
<td>NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three established settings (primary care, A&amp;E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</td>
<td>Ongoing</td>
<td>AMcM/AKM</td>
<td>NHS Lothian has led the ABI programme on behalf of partners in the 3 Lothian ADPs. The HEAT standard has been achieved and by December 12,793 ABIs had been delivered. The ABI implementation team has trained an additional 604 professionals in 2012/13 to deliver ABIs in a number of organisations including Lothian and Borders Police, Lothian and Borders Fire Brigade, HMP Edinburgh, HMP Addiewell, Local Authorities and Higher Education establishments in Lothian.</td>
</tr>
</tbody>
</table>
Support the implementation of the Palliative Care strategy to achieve a shift in the balance of care in respect of place of death (local targets):

- Decrease the proportion of deaths occurring in Acute Hospitals from 42.3% of all Lothian deaths (2008 baseline) to 38% by 2015
- Increase the proportion of deaths occurring in community residential settings from 34.4% of all Lothian deaths to 38.8% by 2015.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2015</td>
<td>AMcM</td>
<td>Performance in relation to deaths occurring within the acute hospital setting has increased. We are currently reviewing this target and actions required to support this as we see this as a quality and dignity issue.</td>
</tr>
<tr>
<td>OBJECTIVE 1</td>
<td>TIMING</td>
<td>LEAD CMT MEMBER</td>
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<tr>
<td>------------------------------------------------------------------</td>
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</tr>
<tr>
<td>TO TRANSFORM THE MANAGEMENT CULTURE OF THE ORGANISATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that the major performance challenges around waiting times, unscheduled care and finance are tackled with an open, participative and approachable management style.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement the specific Organisational Development Action Plan which flows from the work of the Management Culture Steering Group including specific Board Development and Senior Manager Development programmes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop the team coaching methodology for Corporate Management Team members and their direct reports to reinforce exemplar behaviours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endorse and further develop the work on vision and values as part of the Management Culture review.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## OBJECTIVE 2:
**TO PLAN AND DELIVER THE WAITING TIMES RECOVERY PLAN TO CLEAR THE BACKLOG OF PATIENTS AND DEVELOP RECURRING DEMAND/CAPACITY EQUILIBRIUM**

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Ensure the implementation of the revised Standing Operating Procedures, the required training programme for staff and the phased centralisation of the management of waiting times staff.

Ensure comprehensive monthly performance monitoring to the NHS Board on performance against targets, recovery plan and waiting times management compliance.

Ensure the delivery of a sustainable financial framework to support recovery and maintain performance thereafter.

Ensure delivery of the comprehensive system of compliance monitoring of waiting times systems including real-time scrutiny of changes made on TRAK.

Develop and implement costed capacity plans by specialty to ensure recurring demand/capacity equilibrium, including specific clinical workforce plans, leading to the phased reduction in reliance on external capacity.

---

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

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Develop and implement a costed capacity plan to reach demand/capacity equilibrium for unscheduled care across primary, secondary and social care.
### OBJECTIVE 3: TO IMPROVE UNSCHEDULED CARE PERFORMANCE

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create effective surge capacity for mixed economy of home care, care home and NHS beds able to be deployed rapidly to respond to peaks in demand for specialist health and/or social care through the work of the Unscheduled Care Group</td>
<td></td>
</tr>
<tr>
<td>Achieve sustained improvement of performance towards the 98% 4 hour access standard, reduction in boarding and eradication of 12-hour trolley waits.</td>
<td></td>
</tr>
<tr>
<td>Develop and implement costed clinical workforce plans to sustain vulnerable 24/7 front door clinical services, ensuring that contingency plans are in place to mitigate the impact of staffing vacancies that may arise.</td>
<td></td>
</tr>
</tbody>
</table>

### OBJECTIVE 4: TO develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements.

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a strategic planning process to integrate existing and emerging clinical strategies with workforce, finance, capital investment and property strategies, incorporating a refreshed Vision and Values Framework.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To develop a site master-planning process for the four main inpatient sites of RIE, WGH, SJH and REH to support the implementation of existing and emerging clinical strategies for unscheduled care, elective care, laboratory medicine, children’s services, cancer services, mental health services and learning disability services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NHS Lothian – Corporate Objectives 2013/14

<table>
<thead>
<tr>
<th>Ensure implementation of innovative plans with our 4 Council partners to secure the integration of primary, secondary and social care to drive performance improvement across health and social care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to promote the clinical pathways model to secure management of patients’ journeys across service boundaries through our systems wide managed clinical networks</td>
</tr>
<tr>
<td>Implement revised organisational arrangements which tangibly integrate the management of primary, secondary and social care services and deliver whole-system approaches to the management of unscheduled care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 5: Corporate Team Objective to Improve Patient and Staff Safety and to Drive Forward Qualit and Improved Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timing</strong></td>
</tr>
<tr>
<td>Prepare NHS Lothian to deliver high impact interventions that will support the delivery of the acute Scottish Patient Safety Programme outcome measures to reduce mortality by 20% and achieve 95% harm free care by the end of 2015</td>
</tr>
<tr>
<td>Achieve a 30% reduction in adverse events</td>
</tr>
<tr>
<td>Achieve a 20% reduction in HMSR against 2006/2007 baseline</td>
</tr>
<tr>
<td>Ensure the current Safe Care Patient Safety Programme measures are met and reported</td>
</tr>
<tr>
<td>Ensure the new work streams for the patient safety programme</td>
</tr>
<tr>
<td>OBJECTIVE 5: CORPORATE TEAM OBJECTIVE TO IMPROVE PATIENT AND STAFF SAFETY AND TO DRIVE FORWARD QUALITY AND IMPROVED PATIENT EXPERIENCE</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>are tested and implemented</td>
</tr>
<tr>
<td>- Venous thromboembolic prevention</td>
</tr>
<tr>
<td>- Sepsis prevention programme</td>
</tr>
<tr>
<td>- Mental health</td>
</tr>
<tr>
<td>- Maternity services</td>
</tr>
<tr>
<td>- The Warfarin management bundle across general practice</td>
</tr>
<tr>
<td>Ensure NHS Lothian’s staphylococcus aureus bacteraemia cares are 0.2% or less per 100,000 acute occupied days, and the rate of clostridium difficile infection in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.</td>
</tr>
<tr>
<td>Improve patient experience:</td>
</tr>
<tr>
<td>- Ensure the targets for the implementation for the Liverpool care pathway are implemented as are our targets on end of life care replacement of death.</td>
</tr>
<tr>
<td>To ensure participation and benefit from involvement in the new Maternity Safety programme.</td>
</tr>
<tr>
<td>Ensure that GP practices across NHS Lothian as well as NHS Lothian as an employer benefits from full participation in the primary care patient safety programme</td>
</tr>
<tr>
<td>To ensure that NHS Lothian and its four council partners fully participate in the Early Years Collaborative and to use this to inform our revised children and young people’s strategy and change fund developments.</td>
</tr>
</tbody>
</table>
**OBJECTIVE 6:**
*TO LIVE WITH AVAILABLE FINANCIAL RESOURCES, DEVELOP A SUSTAINABLE FINANCIAL PLAN AND DELIVER THE CAPITAL INVESTMENT PLAN*

<table>
<thead>
<tr>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To achieve a break-even position for 2012/13 to live within the Revenue Resource limit.</td>
<td></td>
<td></td>
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<tr>
<td>To deliver a cash efficiency savings programme to secure the resourcing of the local reinvestment plan for 2012/13.</td>
<td></td>
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</tr>
<tr>
<td>Achieve the implementation of the Board’s Capital Investment Plan with the Capital Resource Limit.</td>
<td></td>
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<tr>
<td>Proceed with the development of the new RHSC/DCN facilities</td>
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<tr>
<td>Proceed with the first phase of the new REH re-provision programme</td>
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<tr>
<td>Take forward the redesign of the front door and bed model within the RIE to support delivery of improved patient experience and safety</td>
<td></td>
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</tr>
<tr>
<td>Improve performance management of the Consort RIE contract</td>
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<tr>
<td>To develop a savings programme for implementation in 2014/15 and beyond.</td>
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</tbody>
</table>
NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

<table>
<thead>
<tr>
<th>OBJECTIVE 7: TO PROTECT HEALTH, IMPROVE HEALTH STATUS AND TACKLE HEALTH INEQUALITIES</th>
<th>TIMING</th>
<th>LEAD CMT MEMBER</th>
<th>COMMENTS</th>
</tr>
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<tbody>
<tr>
<td>Continue reducing the socio-economic gradient in healthy life expectancy and amenable mortality across Lothian by developing, influencing and delivering evidence-informed policies with partners on smoking, Keep Well health checks and alcohol availability and consumption.</td>
<td></td>
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<tr>
<td>Strengthen ill-health prevention and early intervention by ensuring population screening and immunisation programmes, achieve prescribed standards for uptake, coverage, waiting times, quality and outcomes</td>
<td></td>
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<tr>
<td>Protect the public health by assuring emergency preparedness, identifying and implementing appropriate interactions that protect health and limit risk to our communities from communicable diseases and environmental hazards</td>
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<tr>
<td>Ensure that NHS Lothian meets the demand for increase immunization across children, adults and housebound patients during 13/14.</td>
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<tr>
<td>Ensure the review of our children and young people’s strategy is commenced and consulted on during 2013</td>
<td></td>
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<tr>
<td>Commence the review of the learning disabilities strategy, in line with the review milestones and the REAH re-development</td>
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</table>
### OBJECTIVE 8:
**TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS**

<table>
<thead>
<tr>
<th>Timing</th>
<th>Lead CMT Member</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop a robust performance management and reporting system that meets the needs of the Board and its Committee structure, as well as the Operational Management requirements of the organisation.</td>
<td></td>
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<tr>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015.</td>
<td></td>
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</tr>
<tr>
<td>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.</td>
<td></td>
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</tr>
<tr>
<td>At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.</td>
<td></td>
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<tr>
<td>To achieve 2268 completed child healthy weight interventions over the three years ending March 2014.</td>
<td></td>
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</tr>
<tr>
<td>Universal smoking cessation services to achieve at least 11686 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.</td>
<td></td>
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</table>
## NHS LOTHIAN – CORPORATE OBJECTIVES 2013/14

**OBJECTIVE 8:**
**TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS**

<table>
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<th>TIMING</th>
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**Reduce suicide rate between 2002 and 2013 by 20% and to review further actions in line with this direction of travel.**

**Operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.**

**Reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.**

**Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.**

**No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete by April 2015.**

**To support 2% shift in the balance of care in the rates of attendance at A&E between 2009/10 and 2013/14.**

**To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.**

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

**Further reduce healthcare associated infections so that by March 2016 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.**

**HEAT STANDARDS**

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<tr>
<td>OBJECTIVE 8: TO HAVE A ROBUST SYSTEM OF PERFORMANCE MANAGEMENT AND REPORTING ALIGNED TO DELIVERY OF GOVERNMENT TARGETS</td>
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<tr>
<td><strong>TIMING</strong></td>
<td><strong>LEAD CMT MEMBER</strong></td>
<td><strong>COMMENTS</strong></td>
</tr>
<tr>
<td>95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.</td>
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<tr>
<td>90% of planned / elective patients to commence treatment within 18 weeks of referral.</td>
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<tr>
<td>No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census)</td>
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<tr>
<td>Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team</td>
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<tr>
<td>98% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.</td>
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<tr>
<td>90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
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<tr>
<td>To achieve a sickness absence rate of 4% across NHS Lothian.</td>
<td></td>
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<tr>
<td>NHS Lothian and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&amp;E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</td>
<td></td>
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<tr>
<td>To continue to strive to achieve the target of 90% of stroke patients being admitted to a stroke bed within 24 hours f initial diagnosis</td>
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</table>
1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to approve the patients’ funds accounts for the year ended 31 March 2012 for Lothian NHS Board. These accounts were presented to the Audit & Risk Committee for recommendation on 4 February 2012. The Audit & Risk Committee agreed that the accounts were to be presented to the Board.

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

2 Recommendations

The Board is invited to:

2.1 Agree draft the Patients’ Private Funds accounts for the year-ended 31 March 2012.

2.2 Agree that the Chairman and Chief Executive sign the “Statement of Lothian NHS Board Members’ Responsibilities” on the Board’s behalf.

2.3 Agree that the Director of Finance and the Chief Executive sign the “Abstract of Receipts and Payments” (SFR 19.0).

2.4 Agree that the Board approve the draft Patients’ Private Funds accounts for the year-ended 31 March 2012.

2.5 Review the draft letter of representation.

2.6 Agree that the Chief Executive sign the letter of representation on the Board’s behalf.

3 Discussion of Key Issues

3.1 The attached draft Patients’ funds Annual Accounts consist of:

- A statement of members’ responsibilities
- The statement of receipts and payments
- A note on the basis of accounting

3.2 The Auditors, KPMG LLP intend to give an unqualified opinion on the abstract of accounts which have been prepared on the basis required by the NHS Scotland Manual of Accounts. Their full audit report on Patients Private Funds is attached.
The report identifies no unadjusted errors, and includes two moderate risk recommendations which have been implemented.

3.3 International Standard on Auditing 580 requires external auditors to obtain written confirmation of representations received from management and those charged with governance before their audit report on the Annual Accounts is issued.

3.4 Auditors normally obtain evidence of the directors’ acknowledgement of collective responsibility for the provision of financial statements by obtaining a formal letter of representation, alongside the provision of signed accounts which incorporate statements of responsibility in respect of the accounts.

3.5 The Chief Executive normally signs the representation letter on behalf of the Board.

4 Key Risks

4.1 The key risk covered in this process is assurance on the control of Patients’ Private Funds administered by NHS Lothian on patients’ behalf.

5 Risk Register

5.1 There are no new additions to the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 There is no impact assessment needed for this report.

7 Involving People

7.1 Not applicable.

8 Resource Implications

8.1 There are no resource issues arising from this paper.

Susan Goldsmith
Director of Finance
6 February 2013
susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices and Attachments

Appendix 1: Patients’ Private Funds Year Ended 31 March 2012
Appendix 2: Letter of representation (ISA 580)
KPMG Audit report (ISA 260)
LOTHIAN NHS BOARD

Patients’ Private Funds
Year Ended 31 March 2012
STATEMENT OF LOTHIAN NHS BOARD MEMBERS' RESPONSIBILITIES

The Scottish Government Health and Social Care Directorate, through the Unified NHS Board Manual of Accounts, requires Lothian NHS Board ('the Board') to prepare a consolidated abstract of receipts and payments, on a cash basis, of Patients’ Private Funds for each financial year which fairly presents the funds administered by the Board.

NHS Lothian Board members are responsible for ensuring proper accounting records are maintained which disclose with reasonable accuracy at any time the financial position of the Patients’ Private Funds and enable them to ensure that the statement complies with the Unified NHS Board Manual of Accounts. They also have a general responsibility for safeguarding the assets held on behalf of the patients and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As members of Lothian NHS Board, we confirm that the above responsibilities have been discharged during the period 1 April 2011 to 31 March 2012 and in preparing the abstract of receipts and payments.

.......................................................(Chairman)
Dr. Charles J Winstanley

.......................................................(Chief Executive)
Tim Davison

27th February 2013
NHS LOTHIAN

SFR 19.0

PATIENTS PRIVATE FUNDS

FOR THE YEAR ENDED 31 MARCH 2012

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>£</td>
<td>£</td>
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</table>

**RECEIPTS**

Opening Balances:

<table>
<thead>
<tr>
<th>£</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>199,085</td>
<td>Cash in Bank</td>
</tr>
<tr>
<td>10,275</td>
<td>Cash on Hand</td>
</tr>
<tr>
<td>1,149,435</td>
<td>Other Funds</td>
</tr>
<tr>
<td>1,358,795</td>
<td></td>
</tr>
</tbody>
</table>

1,553,651 From or on behalf of Patients

4,328 Interest on Patients' Fund Account

**Total Receipts**

2,916,774

2,874,192

**PAYMENTS**

1,590,257 To or on behalf of Patients

0 Extra Comforts etc.

Closing Balances:

<table>
<thead>
<tr>
<th>£</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>205,270</td>
<td>Cash in Bank</td>
</tr>
<tr>
<td>10,275</td>
<td>Cash on Hand</td>
</tr>
<tr>
<td>1,110,972</td>
<td>Other Funds</td>
</tr>
<tr>
<td>1,326,517</td>
<td></td>
</tr>
</tbody>
</table>

**Total Payments**

2,916,774

2,874,192

Closing Balances accounted for as:

<table>
<thead>
<tr>
<th>£</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1,327,437</td>
<td>Credit Balances</td>
</tr>
<tr>
<td>(920)</td>
<td>Less: Debit Balances</td>
</tr>
<tr>
<td>1,326,517</td>
<td></td>
</tr>
</tbody>
</table>

0 Interest Received but not Credited

**Total Closing Balance**

1,326,517

1,420,486

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance ____________________________ Date 27 Feb 2013

The abstract of Receipts and Payments was submitted at the NHS Board Meeting on 27 February 2013 and duly approved.

Chief Executive ____________________________ Date 27 Feb 2013
Note 1

The Scottish Government Health and Social Care Directorate requires Lothian NHS Board to prepare, on an annual basis, an abstract of receipts and payments of patients’ private funds administered by Lothian NHS Board. The abstract of receipts and payments of the patients’ private funds has been prepared by the board, on a cash basis, in accordance with the requirements of the 2011-12 NHS Board Accounts Manual.
Independent auditor’s report to Lothian NHS Board

We have audited the attached abstract of receipts and payments of patients’ private funds administered by Lothian NHS Board ("the abstract") for the year ended 31 March 2012 which has been prepared for the reasons and on the basis of the accounting policies set out in note 1 to the abstract.

Our report has been prepared for Lothian NHS Board, as a body, solely in connection with the audit of the abstract. It has been released to Lothian NHS Board on the basis that our report shall not be copied, referred to or disclosed, in whole (save for Lothian NHS Board’s own internal purposes) or in part, without our prior written consent.

Our report was designed to meet the agreed requirements of Lothian NHS Board determined by Lothian NHS Board’s needs at the time. Our report should not therefore be regarded as suitable to be used or relied on by any party wishing to acquire rights against us other than Lothian NHS Board, as a body, for any purpose or in any context. Any party other than Lothian NHS Board who obtains access to our report or a copy and chooses to rely on our report (or any part of it) will do so at its own risk. To the fullest extent permitted by law, KPMG LLP will accept no responsibility or liability in respect of our report to any other party.

Respective responsibilities of board members and auditor

As explained more fully in the Statement of Lothian NHS Board Members’ Responsibilities set out on page 1, the board members are responsible for the preparation of the abstract in accordance with the requirements of the NHS Board Accounts Manual.

Our responsibility is to audit, and express an opinion on, the abstract in accordance with the terms of our engagement letter dated 11 January 2013 and having regard to International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

Scope of the audit of the abstract

An audit involves obtaining evidence about the amounts and disclosures in the abstract sufficient to give reasonable assurance that the abstract is free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances and have been consistently applied and adequately disclosed and the reasonableness of significant accounting estimates made by the board members. In view of the purpose for which the abstract has been prepared, however, we did not assess the overall presentation of the abstract which would have been required if we were to express an audit opinion under International Standards on Auditing (UK and Ireland).
Opinion on abstract

In our opinion the abstract of receipts and payments for the year ended 31 March 2012 has been properly prepared, in all material respects, in accordance with the requirements of the NHS Board Accounts Manual.

KPMG LLP
Chartered Accountants

Saltire Court
20 Castle Terrace
Edinburgh
EH1 2EG
Dear Sirs,

This representation letter is provided in connection with your audit of the abstract of receipts and payments of patients' private funds ("the abstract") administered by Lothian NHS Board ("the Board"), for the year ended 31 March 2012, for the purpose of expressing an opinion as to whether the abstract of receipts and payments for the year ended 31 March 2012 has been properly prepared, in all material respects, in accordance with the requirements of the NHS Board Accounts Manual.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Abstract

1. The Board has fulfilled its responsibilities for the preparation of the abstract which:
   - has been properly prepared, in all material respects, in accordance with the requirements of the NHS Board Accounts Manual
   
   The abstract has been prepared on a going concern basis.

2. All events subsequent to the date of the abstract and for which IFRSs require adjustment or disclosure have been adjusted or disclosed.

Information provided

3. The Board has provided you with:
   - access to all information of which it is aware, that is relevant to the preparation of the abstract, such as records, documentation and other matters;
   - additional information that you have requested from the Board for the purpose of the audit; and
   - unrestricted access to persons within the Board from whom you determined it necessary to obtain audit evidence.
4. All transactions have been recorded in the accounting records and are reflected in the abstract.

5. Expenditure exists and is completely disclosed in the abstract.

6. Income receivable is completely and accurately disclosed in the abstract.

7. The Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of an abstract that is free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

The Board has disclosed to you the results of its assessment of the risk that the abstract may be materially misstated as a result of fraud.

Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

8. The Board has disclosed to you all information in relation to:

(a) Fraud or suspected fraud that it is aware of and that affects the Board and involves:
- management;
- employees who have significant roles in internal control; or
- others where the fraud could have a material effect on the abstract; and

(b) allegations of fraud, or suspected fraud, affecting the abstract communicated by employees, former employees, analysts, regulators or others.

9. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the abstract.

This letter was tabled and agreed at the meeting of the board of directors on 27th February 2013.

Yours faithfully

Tim Davison
Chief Executive
(On behalf of the board)
Appendix A to the Management Representation Letter of Lothian NHS Board

Definitions

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

IAS 1.7 and IAS 8.5 state the following:

Material omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions that users make on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or a combination of both, could be the determining factor.

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in the financial statements to deceive users.

Misappropriation of assets involves the theft of an entity’s assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity’s abstract for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

(a) was available when financial statements for those periods were authorised for issue; and
(b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to “management” should be read as “management and, where appropriate, those charged with governance”. 
Lothian NHS Board: Patients’ Private Funds

Report to those charged with governance
Year ended 31 March 2012
17 January 2013
The contacts at KPMG in connection with this report are:

David Watt
Director, KPMG LLP
Tel: 0141 300 5695
Fax: 0141 204 1584
david.watt@kpmg.co.uk

Michael Wilkie
Manager, KPMG LLP
Tel: 0141 300 5890
Fax: 0141 204 1584
michael.wilkie@kpmg.co.uk

About this Report
We have prepared this Report in accordance with our audit engagement letter dated 11 January 2013.

Purpose of this report
This Report is made to directors of Lothian NHS Board, ‘the Beneficiaries’, in order to communicate matters of interest as required by ISAs (UK and Ireland), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this Report, or for the opinions we have formed in respect of this Report.

Restrictions on distribution
This Report is subject to disclosure restrictions as set out in the engagement letters.

Limitations on work performed
This Report is separate from our audit report and does not provide an additional opinion on the Beneficiaries abstract of receipts and payments of patients’ private funds, nor does it add to or extend or alter our duties and responsibilities as auditors reporting to the Beneficiaries.

We have not designed or performed procedures outside those required of us as auditor for the purpose of identifying or communicating any of the matters covered by this Report.

The matters reported are based on the knowledge gained as a result of being your auditor. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

We have also aimed to use our knowledge of the business gained during our audit work to make useful comments for management to consider. However, our audit work is designed to enable us to form our opinion on the financial statements, viewed as a whole. As a result, the points raised should not be relied upon to disclose all internal control matters that may exist across the Board, nor to disclose errors that are not material in relation to the abstract of receipts and payments of patients’ private funds.
Background and scope
This report sets out the key findings from the audit of the abstract of receipts and payment of patients’ private funds (“the abstract”) administered by Lothian NHS Board (“the Board”) for the year ended 31 March 2012. It has been designed to support the opinions and conclusions that we are required to provide you with. We are required to audit the abstract of receipts and payments and give an opinion on whether the abstract has been properly prepared in accordance with the basis of preparation set out in the note to the abstract.

Our audit work is carried out in accordance with the requirements of International Standards on Auditing (UK and Ireland) (“ISA”).

Financial commentary
Patients’ funds are held and administered on behalf of patients at hospital and nursing home sites in the Lothian region. At 31 March 2012 the closing balance of funds held increased by £0.1 million to £1.4 million compared with the prior year. Amounts held in the central treasury investment bank account increased by £0.2 million to £1.3 million.

Action plan
This report includes an action plan containing areas for development or improvement identified during our audit fieldwork. Recommendations raised would improve the control efficiency and effectiveness in the day to day management of patients’ private funds. Responsibility for taking action and monitoring progress in response to all our recommendations lies with Board management.

This report also includes confirmation of our independence.

Acknowledgement
We wish to record our appreciation of the continued co-operation and assistance extended to us by your staff during the course of our work.
Abstract of receipts and payments

Acknowledgement
We have completed audit work on the abstract in accordance with the timetable agreed with management and expect to issue an unqualified opinion following consideration and approval by the Board. Within this section we summarise our audit approach. We received a draft abstract prior to the start of our fieldwork, along with supporting working papers. Management provided high quality responses to our queries in a timely manner.

The table below outlines the stages of the audit process we followed in our consideration of the abstract.

<table>
<thead>
<tr>
<th>Area of audit emphasis</th>
<th>Audit coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial reporting</strong>: Consider the impact of changes in the</td>
<td>There have been no significant changes to the format or production of the abstract compared to prior periods.</td>
</tr>
<tr>
<td>reporting format.</td>
<td></td>
</tr>
<tr>
<td><strong>Controls testing</strong>: Taking into consideration the coverage of</td>
<td>We identified two recommendations to enhance the operating effectiveness of controls; these are included in the action plan in appendix one. Overall, the controls were found to be designed and operating satisfactorily.</td>
</tr>
<tr>
<td>internal audit, we perform key controls testing to confirm that</td>
<td></td>
</tr>
<tr>
<td>the design and implementation of controls is effective and that</td>
<td></td>
</tr>
<tr>
<td>these controls, on a sample basis, are operating effectively.</td>
<td></td>
</tr>
<tr>
<td><strong>Abstract of receipts and payments production process</strong>:</td>
<td>The entries in the abstract were agreed to underlying source documentation.</td>
</tr>
<tr>
<td>Consideration of the abstract of receipts and payments</td>
<td></td>
</tr>
<tr>
<td>production process.</td>
<td></td>
</tr>
<tr>
<td><strong>Testing of balances</strong>: We test and confirm material or</td>
<td>Substantive testing of material balances was undertaken. All material bank balances were agreed to independent bank confirmations.</td>
</tr>
<tr>
<td>significant balances.</td>
<td></td>
</tr>
<tr>
<td><strong>Representations and opinion</strong>: We seek and obtain</td>
<td>We document in this report the representations required from management. Our audit opinion will be issued following receipt of these representations and the signed abstract.</td>
</tr>
<tr>
<td>representations before issuing our opinion.</td>
<td></td>
</tr>
</tbody>
</table>

Amendments and uncorrected differences
We are required by ISA (UK and Ireland) 260: Communication with those Charged with Governance, to communicate all uncorrected misstatements, other than those which are trivial, to the Board. We did not identify any required adjustments during the audit and there are therefore no uncorrected differences.
**Abstract of receipts and payments**

**Opinions and representations**

**Confirmation of our independence**
As part of the audit finalisation process, we are required to provide you with confirmation of our independence and ability to act as the auditors of the patients’ private funds administered by the Board. We have provided this in appendix two.

**Draft management representation letter**
You are required to provide us with representations on specific matters such as your financial standing, application of accounting policies, and whether the transactions within the financial statements are legal and unaffected by fraud. We provided a draft of this representation letter to management.

In the representation letter, we are requesting your confirmation that:

• expenditure exists and is completely and accurately disclosed in the abstract; and

• income receivable is completely and accurately disclosed in the abstract.

**Completion**
Once the abstract has been approved by the Board and we have received your representations as outlined above, we issue our audit opinion. Excepting for our commentary in this report, we do not have any other matters we wish to bring to your attention prior to the issuing of this opinion.
Appendices
The action plan summarises specific recommendations, together with related risks and management’s responses.

- **High risk** issues are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.

- **Moderate risk** issues have an important effect on internal controls, but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately, but the weakness remains in the system.

- **Low risk** issues would, if corrected, improve the internal control in general, but are not vital to the overall system. These are generally issues of best practice that we feel would be of benefit to you if introduced.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue and risk</th>
<th>Recommendation</th>
<th>Management response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Order forms are not consistently completed across all wards. There is a risk</td>
<td>We recommend that staff are reminded of the requirement to complete order forms to ensure orders are appropriately authorised prior to purchase.</td>
<td>The Patient Funds Officers will write to all CSDM’s explaining what the correct procedure is for ordering goods on behalf of a patient and request that they ensure that their staff are made aware and work to this.</td>
</tr>
<tr>
<td></td>
<td>that purchases may not be authorised appropriately prior to a purchase being</td>
<td></td>
<td>Responsible officer: Financial Controller</td>
</tr>
<tr>
<td></td>
<td>made.</td>
<td></td>
<td>Implementation deadline: Implemented</td>
</tr>
<tr>
<td></td>
<td><strong>Moderate risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>We were unable to obtain a listing of people who had been discharged or were</td>
<td>While management are aware of this matter and are working to develop appropriate reports, we recommend that the process is completed and that reports are regularly reviewed to ensure money and valuables are returned to patients or next of kin in a timely manner.</td>
<td>There has been an enhancement to the Patient Funds System which has updated the functionality to generate a report for the discharged and deceased patients.</td>
</tr>
<tr>
<td></td>
<td>deceased as the new records system was not capable of producing the require</td>
<td></td>
<td>Responsible officer: Financial Controller</td>
</tr>
<tr>
<td></td>
<td>report. There is a risk that the Board is unable to ensure it has returned all</td>
<td></td>
<td>Implementation deadline: Implemented</td>
</tr>
<tr>
<td></td>
<td>monies and valuables to patients or next of kin in a timely manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Moderate risk</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix two

Independence confirmation

Dear Sirs

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP’s objectivity and independence, the threats to KPMG LLP’s independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP’s objectivity and independence to be assessed. This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence.

We have considered the fees paid to us by Lothian NHS Board for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners, audit directors and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings. Our Ethics and Independence Manual is fully consistent with the requirements of the APB Ethical Standards. As a result we have underlying safeguards in place to maintain independence through:

• Instilling professional values
• Communications
• Internal accountability
• Risk management
• Independent review

Please inform us if you would like to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the directors of Lothian NHS Board.

Confirmation of audit independence

We confirm that as of 11 January 2013 in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of David Watt and the audit staff is not impaired.

This report is intended solely for the information of the directors of Lothian NHS Board and should not be used for any other purposes.

Yours faithfully

KPMG LLP
**COMMUNICATIONS RECEIVED**

1 **Purpose of the Report**

1.1 The purpose of this report is to ask the Board to note the list of communications below received from the Scottish Government:

<table>
<thead>
<tr>
<th></th>
<th>Purpose</th>
<th>Date</th>
<th>Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CEL 02 (2013) National Primary Care Workforce Survey 2013</td>
<td>23/01/2013</td>
<td>AB, PG, JF, CB SF</td>
</tr>
<tr>
<td>2</td>
<td>CEL 01 (2013) Speciality and Associate Specialist (SAS) Grades: Job Planning Guide</td>
<td>23/01/2013</td>
<td>AB DF</td>
</tr>
<tr>
<td>3</td>
<td>PCA(P)(2013)3 British National Formulary (BNF) and the British National Formulary for Children (BNFC)Apps</td>
<td>24/01/2013</td>
<td>DF SF</td>
</tr>
<tr>
<td>4</td>
<td>PCA(P)(2013)004 Pharmaceutical services, reimbursement of special preparations and imported unlicensed medicines</td>
<td>01/02/13</td>
<td>DOF, GMEMCHP, PCCO</td>
</tr>
<tr>
<td>5</td>
<td>PCA(P)2013)001 PCA(M)2013)001 Seasonal influenza immunisation 2013-14 Vaccine supply arrangements</td>
<td>01/02/12</td>
<td>DPHHP, GMEMCHP, PCCO</td>
</tr>
</tbody>
</table>

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Douglas Weir  
**Corporate Services Manager**  
15 February 2013

- **AFC** Agenda for Change  
- **CEL** Chief Executive Letter (the designation for general circulars)  
- **CMO** Chief Medical Officer  
- **SAN** Safety Action Notice (a standard priority notice where action can be planned rather than immediate)  
- **HAZ** Hazard Notice (a high priority notice where immediate action is required)  
- **MDA** Medical Devices Agency  
- **PCA** Primary Care Administration (circulars relating to Primary Care staff i.e. P - Pharmacy, D - Dentistry)  
- **PCS** Pay & Conditions of Service (circulars relating to the pay and conditions of service of staff)  
- **SHS** Scottish Health Service  
- **SPPA** Scottish Public Pensions Agency  
- **SSI** Scottish Statutory Instrument