·EDINBVRGH·
THE CITY OF EDINBURGH COUNCIL

Item no 7.4
Report No CEC/64/05-06/E

Royal Infirmary of Edinburgh - "Lauriston Place to Little France"

City of Edinburgh Council

18 August 2005

Purpose of report

1 To refer to the Council for consideration a report by the Community Services Scrutiny Panel on the Royal Infirmary of Edinburgh - "Lauriston Place to Little France".

Details

2 As part of its workplan, the Community Services Scrutiny Panel had commissioned a review of the Royal Infirmary of Edinburgh - "Lauriston Place to Little France".

3 On 9 August 2005, the Executive considered the attached report by the Community Services Scrutiny Panel detailing the findings of the review.

4 **The Executive agreed to refer the report by the Community Services Scrutiny Panel to the Council on 18 August 2005 for consideration.**

Recommendation

5 That the Council consider the report.

Ian Perry
Deputy Leader

Appendix	Report no E/125/05-06/CSSP by the Community Services Scrutiny Panel
Contact/tel	Lesley Birrell, Committee Services Tel: 529 4240 Fax: 529 7607 e-mail: lesley.birrell@edinburgh.gov.uk
Wards affected	
Background Papers	None

h:cmtserv/common/lesley/executive/reports/090805/Royal Infirmary of Edinburgh

·EDINBVRGH·
THE CITY OF EDINBURGH COUNCIL

Item no
Report no E/1251/05-CE/CSP

Royal Infirmary of Edinburgh – "Lauriston Place to Little France"

Executive of the Council

9 August 2005

Purpose of report

1 To refer to the Executive the recommendations of the Community Services Scrutiny Panel in relation to one of its commissioned reviews on the Royal Infirmary of Edinburgh – "Lauriston Place to Little France".

Main report

2 The Royal Infirmary of Edinburgh – "Lauriston Place to Little France" is the fourth of the commissioned reviews undertaken by the Panel in terms of the workplan approved by Council on 18 September 2003.

3 The review report sets out the methodology employed, relevant definitions and the resource limitations.

4 Fourteen main findings are identified, leading to the drawing up of 12 recommendations. Where possible timescales and lead officers for delivering these recommendations are identified.

5 The report was approved at the Panel's meeting on 28 June 2005. Councillor Davies dissented from the decision.

Recommendations

6 The Executive is asked to approve the recommendations in the report.

Councillor Mrs Marilyne MacLaren
Convener, Community Services Scrutiny Panel

Appendices	Royal Infirmary of Edinburgh – "Lauriston Place to Little France" – review report.
Contact/tel	Allan McCartney Tel: 529 4246 e-mail: allan.mccartney@edinburgh.gov.uk
Wards affected	All
Background Papers	Minute of the City of Edinburgh Council, 18 September 2003; minute of the Community Services Scrutiny Panel, 28 June 2005.

LAURISTON PLACE TO LITTLE FRANCE

The New Royal Infirmary of Edinburgh

Community Services Scrutiny Panel
Commissioned Review
2005

Contents

Forward

This review of the RIE has been a most challenging exercise, examining a not only complex but very controversial issue. Our brief is community based – looking at the impact of the new hospital on the community and how it has affected the provisioning of health care services to the community. We looked at issues such as the number of beds, Delayed Discharge, provision of local step down facilities, and support given to discharged patients in the community. We looked at the location of the hospital, and how this has affected the provision of health care services such as A&E, staff retention and recruitment, the transport and parking challenges. It is important to say that our remit did not cover medical services at the hospital.

The new hospital has not had its problems to seek in the first two years of its existence. Hailed as the flagship of PFI from the moment of its inception, it has drawn a barrage of press criticism, sometimes bordering on the hostile. This has had a marked impact on staff and many, especially in 2004, felt demoralised and unappreciated. I would not wish to add to these negative perceptions, but ask that the Review be seen as a positive and constructive piece of work, enabling decision-makers to learn from past mistakes. There are many aspects of the RIE of which we can be proud, for example, the excellent health care, the innovations like the Patients' Hotel and the Healthcare Academy.

I believe that from a public accountability aspect it is very important that the council takes a strategic and scrutinising view of partnership working with the hospital and NHS Lothian. In the past, managers could be combative and defensive, but now what is needed is a collaborative atmosphere. Already there is an improvement, but it will take time.

Some of the important issues raised such as the bed capacity and inappropriate discharge remain unresolved, and the Panel maintains that, because these are controversial issues giving rise to public concern, they warrant more detailed research and examination. We therefore recommend that the Scottish Executive undertakes such work, and I hope very much that this happens.

My thanks go to all the many witnesses who gave of their valuable time and contributed evidence to us; to my Council colleagues on the Panel, and most especially to Derek Janes, Allan McCartney, Peter Matthews and Sian Millard, the members of the support team who have endeavoured to keep me on the straight and narrow!

Councillor Marilyne MacLaren
Convener, Community Services Scrutiny Panel

1. Introduction

Present political management arrangements

In mid 2000, the City of Edinburgh Council (CEC) introduced "cabinet-style" government under which the main policy-making body is the Executive. Seven theme-based Scrutiny Panels and six Local Development Committees are also part of the new political management arrangements.

The Community Services Scrutiny Panel (CSSP) first met in June 2000 and its remit is contained at Appendix 1. As well as "calling in" decisions of the Executive, Scrutiny Panels monitor performance and review "Best Value" within their designated area of responsibility. In addition, Panels can commission a small number of Initiated Reviews and in the case of the CSSP this is its fourth such Review: *Lauriston Place to Little France – The New Royal Infirmary of Edinburgh*.

The review subject

The remit for the review was agreed by the CSSP at its meeting on 15 January 2004. This should be understood within the context of the Guidelines for Commissioned Reviews, that are allowed to consider matters which "affect the economic, environmental and social wellbeing of the City."

"The proposed review of the working of the new Royal Infirmary of Edinburgh will focus on the health care services that the hospital provides to the community and their impact on and integration with the services provided by the Council, voluntary organisations and other community planning partners. In particular it will consider:

- How the location of the hospital affects the provision of health care services to the community
- How the number of beds in the hospital affects the provision of health care services to the community
- How the nature and quality of the facilities in the hospital affect the provision of health care services to the community."

Methodology

Two principal considerations informed the approach to this review:

- To obtain a wide range of views from professionals, other relevant organisations and individuals.

- To be open-minded and to consider all evidence that is available in a fair and equal manner

To consider the review subject in a comprehensive manner, the Panel requested that a broad range of evidence be collected. A principal means of collection was through direct evidence given by interviewees who had been invited to the Panel. There was also some additional, small scale, evidence gathered outwith normal meetings.

Contributions to this review were received from representatives of the following organisations: -

- Lothian Health Board
- RIE Trust
- Consort Healthcare
- Royal College of Nursing
- Lothian Local Medical Committee
- UNISON
- City of Edinburgh Council (Departments of Housing, Social Work, and City Development)
- Academic researchers
- Patient Organisations
- Community representatives
- Special interest groups.

Use was made of public documents held by the NHS and the City of Edinburgh Council. Research papers and newspaper articles have also been utilised during the review, principally to compliment evidence gathered at Panel meetings. Finally, rudimentary analysis of data sets was undertaken, including those relating to Delayed Discharge and published by the Information and Statistics Division of the NHS.

During the gathering of all evidence, care was taken to indicate where and from whom evidence had been obtained, with the result that all material contained in this report has its source noted.

A support team was set-up to lead this review, and comprised: -

Councillor Mrs Marilyne MacLaren, Convenor of the Community Services Scrutiny Panel
Derek Janes, Lead Officer, Community Services Scrutiny Panel
Sian Millard, Strategic Support Services, Department of Corporate Services, CEC
Allan McCartney and Peter Matthews, Committee Services, Department of Corporate Services, CEC

2. The Royal Infirmary of Edinburgh

Building work on the new Royal Infirmary of Edinburgh (RIE) at Little France commenced in 1998, with initial occupation of the building following in 2001. Planning the move to the new RIE, however, had started in back in 1992. The transition period had involved the operation of the hospital from two separate sites. The new RIE started admitting patients in January 2002 and has been fully operational from May 2003.[i]

Lying behind much of the controversy surrounding the move of the Royal Infirmary away from the City Centre and its current role within the Acute Services Strategy for the Lothians is the particular regard that the people of Edinburgh have traditionally had for "their" hospital. This feeling can also be seen in the reaction of the people of West Lothian to proposed changes to the relatively new St John's Hospital, Livingston.

Founded in 1729 as the "Hospital for the Sick Poor" the Royal Infirmary was the first voluntary hospital in Scotland. It moved from Infirmary Street to Lauriston Place in the 1870s, into an impressive range of buildings designed by David Bryce, with advice from Florence Nightingale.

From the beginning, until the creation of the NHS in 1948, the Infirmary was run by a "Court of Contributors" including representatives of the Town Council, who elected annual Managers drawn from the main occupational and professional groups in the city. It was regarded as very much part of the fabric of Edinburgh.

At the cutting edge of hospital design when it was built, by 1946 the hospital buildings were plainly inadequate. After a number of false starts – including a proposal to create a new Southern General Hospital – plans were prepared to redevelop the existing site. For various reasons, including the difficulties involved with the number of historic buildings on the site, these plans were shelved.

Subsequently, the decision was made to re-site the hospital away from the cCity Centre and let the project benefit from realising the value of the site in Lauriston Place.

Little France was selected from a shortlist of 13 potential sites, against a range of appropriate criteria, including the need to recognise the RIE's developing role in providing specialist services for people in south and central Scotland – and, indeed, for the whole country in some fields.

Somewhere along the line, there has been a failure to convey successfully to the public why changes were being made. The impression that some of these changes were financially driven, reinforced by the choice of the controversial PFI system to build the new hospital, has made the Hospital vulnerable to the smallest criticism, which coverage in the press has exploited.

Any consideration of the RIE requires that it be placed in the broader context of health care for all of Lothian. In 2004, NHS Lothian employed some 27,000 staff and provided services with a current budget of £850m. Around 90% of patient contact

was made through primary care rather than through the hospital acute sector. In these respects, the RIE could not be seen in isolation from the NHS Lothian network, rather it formed a key part of the regional service.[ii]

Over the years, there has been a developing strategy to shift resources away from the acute sector to the community, something that was viewed by NHS Lothian as a major improvement in the delivery of health services. Benefits include: -

- higher quality care overall
- better teaching and research facilities in the acute sector
- the improved ability to recruit and retain staff.[iii]

This review broadly agrees with the above rationale, and will give detailed consideration to the broader context of health service provision across Edinburgh and where appropriate across Lothian. One starting point for this review reflects this broader context, as concern had been expressed about the impact of the geographical location of the RIE and its impact on overall healthcare provision for the people of Edinburgh.[iv]

It is important to recognise that the team conducting this Review are not health professionals, so the quality and nature of health care is not within its remit. The focus is on the impact of the siting of the new RIE on the people of Edinburgh in the broadest sense.

3. The capacity of the RIE

This has turned out to be the most important section of the Review. Capacity in this sense covers three related issues:

- the provision of "step down" and community based facilities
- the number of beds provided in the new RIE
- the impact of Delayed Discharge on the RIE

These three areas are dealt with separately, but it is clear that each impinges on the other and this has to be borne in mind when reading this section.

3.1 "Step Down" and Community Based Facilities

3.1.1 Definitions

This is a complex area, with a range of facilities being grouped under the two broad headings.

"Step down facilities", are not clearly defined, but are described by NHS Lothian as "creating additional inpatient post acute care and rehabilitation capacity to support earlier transfer of older people from the RIE and other acute sites to more appropriate post-acute rehabilitation care." NHS Lothian see the collapse of the nursing home sector in Edinburgh as a key contributor to delayed discharge and related capacity problems.[v]

Community based facilities include Community Treatment Centres (CTCs) and are defined by NHS Lothian as providing "access to routine outpatient and ambulatory care for patients with chronic illness", as well as day hospitals and other facilities that might fall under the definition of "step down".

3.1.2 Community Health Care

One of the principal aims of the review was to investigate the role of the RIE in relation to its impact on community health care provision in Edinburgh. There was a concern with the effects on, and integration with, the services provided by the Council, voluntary organisations and other community planning partners.

NHS Lothian provided details of the strategy for reallocating resources whereby funding streams had been transferred from the acute hospital sector toward primary care, with the aim of trying to shift the balance of care from hospital towards the community and the home.

This approach is laudable and in keeping with the objectives that are supported by the City of Edinburgh Council as, for example, contained in such documents as the *Community Care Plan, 2003-6.*[vi] In relation to health care, examples of services in the community that were to be developed or extended included: -

- patient reviews being held in GPs surgeries and,
- the provision of a range of specialist outpatient clinics in local health centres and GP surgeries.

3.1.3 "Step Down" and community based facilities

There is an ongoing debate about the provision of so called "Step Down" facilities – health care provision in the community that would take some of the weight from the major acute sector facilities.

In 1998 Dr Sam Galbraith, then the Minister for Health and the Arts at the Scottish Office said *"The Health Board's strategy involves the development of community based health care which it is anticipated will lead to a reduction in the need for hospital admission. I am satisfied that the Health Board recognises that future plans must be flexible and must reflect clinical practice and that if experience indicates that the proposed balance between hospital and community services requires to be adjusted than that will be done."*[vii]

NHS Lothian has recently described the proposals for such facilities:

"The principle of step down facilities had always been seen as an integral part of planning. The very high acuity services, such as those at Little France, are only needed during part of a patient's care. Where necessary or more appropriate, they will be offered further care in other, perhaps more local, but certainly less intense environments. There are a variety of such facilities throughout Lothian.

"The development of such facilities has continued and will continue to support changing healthcare needs and technological changes.

"As far as I am aware, there were no detailed plans for specific community facilities linked to the Little France development, however, it was built with the expectation that alternative care facilities would be available and used. We have access to a range of care of the elderly and rehabilitation facilities for this purpose."[viii]

It was also intended from at least the mid-1990s that a suite of community based facilities would be provided in parallel with the development of the new RIE. These were specifically referred to in the Full Business Case for the New Royal Infirmary, produced in 1997: -

"A key plank of the Lothian Strategies is the provision of outpatient services which are more accessible to patients. This will be achieved by the provision of local Community Treatment Centres (CTCs)."[ix]

To date there is one new Community Treatment Centre, at Leith, opened in 2004. This does, indeed, provide the style of community based health care intended but, in addition to supporting the acute services it can also to be seen as a replacement for the Eastern General and, in historic terms for Leith Hospital. Work on the CTC in Dalkeith has yet to start, although the site has been identified. Health professionals in Midlothian had expected this to be more in the nature of a combined CTC/day hospital/post acute care facility.

The failure to ensure the adequate provision of "step down" and community based facilities in time to support the new RIE has led to concerns being expressed by a number of witnesses. It has led to there being some scepticism about NHS Lothian's future plans and the ability to deliver on promises.[x]

3.1.4 Planning the CTCs in the 1990s

One of the problems regarding the provision of community based facilities to support the new RIE was the structure of the NHS in the mid-1990s. For example the RIE was operated by the Royal Infirmary of Edinburgh NHS Trust, there was the Edinburgh Healthcare NHS Trust and the East and Midlothian NHS Trust.

Correspondence provided by NHS Lothian illustrates the difficulties of ensuring co-ordinated planning in the context of that structure. It is apparent that relationships between the various Trusts were not all that they might have been, and that the then Lothian Health Board had to play a mediating role.

It appears to be the case that, although the provision of community based facilities was seen as a crucial element in the mix of health care provision associated with the planning of the new RIE, responsibility for such facilities lay with separate Trusts and that the planners of the RIE had no direct influence over relevant decisions.

Extracts from key correspondence are attached in Appendix 2.

3.1.5 Other Community Based Services

As well as the provision of CTCs, support for patients on discharge is also of vital importance to the successful operation of a modern hospital.

In 1997, the City Council expressed concern about the impact of the changes in Acute Services:

"At recent meetings the Health Board have noted that they do not see the Acute Services as an area where changes in health services have material effects on local authority services. This view is not shared by major service departments and especially Social Work, since changes in hospital care patterns can require substantial responses from domiciliary and other community care services."[xi]

In mid-2004, it was the perception of the Social Work Department that:

"Community health provision has not kept pace with changes related to the opening of the RIE. In recent months, however, the development of relevant services was beginning to have an impact."[xii]

By January 2005, however, the situation had improved considerably: -

"On the whole, hospital discharges are much better planned these days particularly when they include the use of the Community Rehabilitation Team or Crisis Care and, now, the new Hospital Discharge Home Care Teams being funded by the Council across the city, in the period Dec 04 - Oct 05.

"It is also very difficult to assess, in a hospital ward, whether someone will manage at home - some will manage much better than expected; others much worse. It's notoriously hard to predict, and compounded when the patient is desperate to go home and optimistically overstates their level of recovery in the hope of achieving this."[xiii]

In May 2004, evidence from the Social Work Department suggested there was a perception that, although investment had been made in community rehabilitation and crisis care, there were difficulties with regard to staffing. The implications of such staffing shortages are many and have the potential to place greater pressure on other staff groups. In considering how this problem could be further addressed, it was the view that NHS Lothian and the Council should seek solutions through the Joint Future work.[xiv]

It is to be expected that the creation of the new joint Department of Health and Social Care, together with the creation of Community Health Partnerships and the full engagement of NHS Lothian in the Community Planning process, as required by the Local Government (Scotland) Act 2003, will bring about a substantial improvement to the working relationships between the Council and the NHS.

Finding 1: There has been a failure to deliver to an acceptable timetable the Full Business Case on which the new RIE was based, particularly in regard to the provision of community based services. This latter element was the subject of generalised statements of intent, rather than clear commitments, which has led to a considerable degree of misunderstanding and disappointment.

Finding 2: In the past, there has been insufficient effective dialogue both within the health service itself, and between the health sector and other key agencies. This is now improving.

3.2. Hospital Bed Numbers

3.2.1 The Bed Numbers Debate

The issue of bed numbers is contentious, and does have an impact on other services provided for the citizens of Edinburgh.

It is clear that medical advances have resulted in shorter hospital stays, leading – in turn – to a reduction in the number of beds required for acute services. In addition, the provision of additional support in the community, discussed above, is intended to reduce the pressure on major acute hospitals.

It is, however, the scale of the reduction in bed numbers that is the subject of debate.

On one side is NHS Lothian, responsible for planning and overseeing the development of the new RIE, in the context of overall health provision.

On the other are academics, health service campaigners and professional organisations, such as the BMA.

3.2.2 NHS Lothian

Dr Charles Swainson, Medical Director, NHS Lothian, who was involved in the planning of the new RIE, disagrees fundamentally with the proposition that there are inadequate bed numbers. His view, reiterated by Mike Grieve, NHS Lothian's nominated contact officer for this review, is that the key issue affecting capacity in

the acute sector, particularly the RIE, is Delayed Discharge. The original planning assumptions allowed for little if any Delayed Discharge. This issue is explored in more detail in section 3.3, below.[xv]

In response to points raised by its critics, NHS Lothian has emphasised the importance of considering the capacity of the total health economy within Lothian. The characteristics of 'outflow systems', i.e. how patients are moved through the health economy and back into the community, must be taken into account. One example cited by NHS Lothian is the tremendous improvement in stroke and cardiac care, resulting patients spending less time in hospital.[xvi]

In addition, Lothian's emergency receiving services are considered amongst the finest in the UK. Staff from the RIE are involved in both the NHS England and Wales Modernisation Agency work and the Scottish Centre for Change and Innovation programmes, to spread good practice to other parts of the NHS system.[xvii]

3.2.3 Dr Matthew Dunnigan

One of the most active researchers in this field is Dr Matthew Dunnigan, a former Consultant and Senior Research Fellow at the University of Glasgow. He made a presentation to the Panel on 17 February 2004, the content of which is summarised below. The Bibliography to this Report draws attention to some of Dr Dunnigan's principal publications, including refereed articles in academic journals.

Dr Dunnigan has undertaken research and amassed documentation relating to Lothian Health Board's integrated health care 1996-2003 and the Private Finance Initiative Project for the New RIE. In summary, Dr Dunnigan is of the view that the RIE has experienced difficulties due to a lack of beds and he has projected a serious under capacity of acute care beds in Lothian in future:

"Reduced capacity in the last eight years had resulted in increasing delays in gaining hospital admission from the accident and emergency departments of the old and new RIE, with prolonged trolley waits. Reduced capacity has also resulted in cancelled and deferred in-patient admissions, including multiple cancellations for individual patients."[xviii]

3.2.3 Summary

Evidence received by the Panel has therefore focussed on whether the reduction in bed numbers has been too great. Furthermore, the progress made in developing "step-down" and community based services has also been questioned, particularly in that these services have not developed sufficiently to complement the reduction in bed numbers that has actually taken place. This is discussed in Section 3.1, above.

What is clear is that Dr Dunnigan and NHS Lothian have strongly opposing views on this issue, with the BMA agreeing with Dr Dunnigan. The Panel is not in a position to make a judgement on this matter, hence the recommendation for an enquiry (recommendation 1).

3.2.4 Other views

The BMA explained that it had raised concerns from the outset regarding planning assumptions for bed capacity at the RIE. In 1999 the BMA had called for an open enquiry into bed provision at the new RIE *"as fears mount in the medical profession that the new hospital does not have the capacity to effectively serve the people of Edinburgh and the Lothians."*[xix]

Dr George Venters (*Chair of the Scottish Health Campaigns Network)* challenged the robustness of the planning assumptions for the number of beds required. He also commented on the present situation, and listed specific problems with the RIE planning assumptions:

i) A lack of contingency planning due to the limited bed space.
ii) No allowance to cope with changes in demand between winter and summer beds.
iii) The total bed days required for heart care increased.

The above list of problems held the potential to impact negatively on the quality of patient care. Dr Venters stated that patients were sometimes discharged with unresolved problems due to the pressure on beds.[xx]

NHS Lothian disagree with Dr Venters on all of the points he makes. In particular, they explain that readmissions to the RIE have been decreasing since the advent of the Combined Assessment Unit.[xxi]

The official definition of a readmission, from NHS Scotland's Information Service (ISD) Data Dictionary "occurs when a patient is admitted to any speciality in any hospital within a specified time period following discharge from a continuous inpatient stay"

The concerns expressed about bed numbers are supported by the experience of some GPs, who are of the view that they have treated patients who have been prematurely discharged, in their opinion, from the RIE.[xxii]

It is impossible to come to any definitive conclusion about this issue and it is therefore a subject that warrants detailed research.

3.3 Delayed Discharge

Cutting across the concern with bed numbers is the ongoing issue of Delayed Discharge from hospital (the subject of an earlier report by this Panel). The Delayed Discharge of patients, largely, but not exclusively, older people, to appropriate care and support is an issue that is of national concern. With regard to nursing home places specifically, Delayed Discharge does impact on Edinburgh disproportionately due to the greater pressures associated with inflated property prices and operating costs on the care home sector.

Evidence provided by the Department of Social Work demonstrated concern about bed numbers in relation to Delayed Discharge. During consultation on the proposed RIE in the early 1990s, Social Work received information that assumptions were

being made that there would be no Delayed Discharges by the time that the new RIE was fully operational. At that time, the Director of Social Work had questioned this assumption with the Health Board's General Manager, though the matter was not pursued further. The ongoing issue of Delayed Discharge clearly illustrates that this planning assumption has proved to be incorrect and has had a significant impact on the availability of hospital beds at the RIE.

It is fair to say that the impact of the Edinburgh property market on the provision of private care home places in the City has been substantial and that it has, inevitably, taken the City Council time to react effectively to this. Equally as Delayed Discharge is still an issue in every part of Scotland – not just Edinburgh - the NHS could be regarded as being over-optimistic in its original projections.

The following numbers relate to Edinburgh residents who are hospital patients waiting to be discharged from hospital for more than six weeks. The majority of these patients are older people who are waiting for a care home place.

Date of count of numbers delayed	**Total whose Delayed Discharge exceeded 6 weeks**	**Percentage change on previous figure reported**
July 2003	154	-
October 2003	175	+13.6
January 2004	158	-9.7
April 2004	129	-18.3
July 2004	153	+18.6
October 2004	163	+6.5
January 2005	169	+3.7

(Source: ISD Scotland Website).

Additional funding has been allocated by the Council and NHS Lothian to reduce the numbers of patients awaiting discharge in order to meet Scottish Executive targets (which required a reduction of 20% in numbers by April 2005) and to deal with immediate problems at the RIE in particular. Full details of funding and the wider pressure on services associated with Delayed Discharge are detailed in a recent report to the Council Executive. The provision of this additional funding has had an immediate impact, with the target for April 2005 being exceeded. A further decrease of 26% has been set as a target by the Scottish Executive for April 2006. The result for 2005 has been achieved by collaborative working between NHS Lothian and the City of Edinburgh Council. Future success will depend on the continued commitment to the level of investment set out in the Joint Delayed Discharge Action Plan.[xxiii]

Despite this, Delayed Discharge will persist as a pressing issue for some considerable time, and so the number of beds available at Edinburgh's hospitals, including the RIE, will be less than planned for. Indeed, from July 2004 to October 2004, the number of patients waiting for more than six weeks increased by 6.5%, yet over the same time the equivalent figure for Scotland fell by 1.9%. Therefore, additional funding may, at best, bring the numbers of Delayed Discharge patients that have waited for more than six weeks to levels that prevailed in the first half of 2004. Little if any progress would have taken place in reducing the actual Delayed Discharge figures from the levels that they were in previous years.

Edinburgh has a particular problem with regard to care homes due to the high land and property prices. These have, on the one hand, encouraged some owners to close their homes to realise their property value and, on the other, made it difficult for the Council to identify sites for new homes in the City. The number of care home places in Edinburgh has declined from 3,750 in 1998 to 2,980 in 2005. The typical land costs per bed space in Edinburgh are approximately five times the Scottish average. In terms of the weekly cost of looking after a person in a care home, the Scottish figure, agreed by COSLA is £417 per week, the actual Scottish average is £420, but the average cost in Edinburgh is £506.

The ongoing development of Community Health Partnerships will further help to address the Delayed Discharge issue, by, among other things, seeking to prevent admission to hospital in the first place and secondly by putting in place support mechanisms to support early discharge.[xxiv]

The Chief Executive, University Hospitals Division, NHS Lothian, explained that "winter beds" had been planned for and there had been an allowance made for 40,000 bed days per annum for limited Delayed Discharge. This was the equivalent of 106 beds of capacity with a six-week margin. Anything above this is referred to as "undue delay". On average, there have been 35 beds occupied beyond capacity, the equivalent of one ward, or 5% of capacity.[xxv]

It is also clear that the new ways of working in the acute sector generally, leading to an increased pace of patient throughput, have, unintentionally, put greater pressure on the mechanisms for supporting people leaving hospital, particularly into the various ranges of care packages.

There is almost a circular problem, akin to gridlock in traffic, where the faster throughput of patients exacerbates Delayed Discharge, which – in turn – causes delays to and postponements of elective procedures, which – in their turn – lead to higher costs.

3.4 The consequences of a high turnover of patients

A high throughput of patients is very desirable in that it allows more people to receive treatment and it minimises the length of stay in hospital.

Dr Sheila Burns, Clinical Director of Laboratory Medicine and Infection Control in the Lothian University Hospitals Division has said that a high throughput places pressure on a wide range of support services, particularly cleaning and laundry and, therefore, may be a contributor to the difficulty of controlling infection.

At the RIE there is pressure on the single bed units attached to wards, which would be useful for isolating patients with infections, but are frequently used for regular patients due to the pace of throughput.

These are not problems caused by the RIE itself, but are a consequence of the pressure brought about by the culture of target setting which pervades all areas of the public sector. Recognition is growing that a calmer approach needs to be taken to targets to ensure that the quality of patient support services can match that of

medical treatment. In addition, these services need to be resourced to ensure effective support for patients.[xxvi]

Finding 3: The original planning assumptions for bed numbers did not provide sufficient flexibility to cope with changing circumstances, such as the decline in the availability of care home places and other pressures causing delayed discharge. The creation of the post of Delayed Discharge Manager in the Department of Health and Social Care will help to ensure a co-ordinated approach to this issue.

Finding 4: The issue of early discharge, leading to subsequent re-admission of patients or the need for additional support by GPs, needs to be further investigated.

Finding 5: In an acute hospital, the high turnover of patients can cause problems relating to cleaning and infection control.

4. How the location of the hospital affects the provision of health care services to the community

4.1 The take-up of out patient appointments

Statistics supplied by NHS Lothian show the comparative Did Not Attend (DNA) rates for new outpatient appointments at Lauriston Place (2003) and Little France (July 2003 – June 2004).

Taken overall the DNA rates at the two sites for the periods concerned are identical at 11%. There are variations by speciality – fewer DNAs for some specialisms at Little France, and more for others, but nothing significant. In terms of the home addresses of the patients, the variations are also insignificant.[xxvii]

4.2 Accident and Emergency Services

The former RIE in Lauriston Place was easy to access from most of the city and was also particularly close to the main centres for nightlife.

Experience at Little France, reported in May 2004, was that A&E attendances at Little France were about 1,000/1,500 per month down on Lauriston Place, whereas the minor injuries clinic at the Western General was experiencing an increase of around 200 attendances per month.

There are three areas of A&E activity –
- Acute admissions to subspecialities, mediated by A&E
- Minor illness attendances
- Minor injury attendances.

At the beginning of this review process in early 2004, it was drawn to the Convener's attention that there were problems with the installation of a large sign indicating the entrance to the Accident and Emergency Department. Only a year later was the sign finally erected. This is one example where the addition of an extra layer of bureaucracy – Consort – has been unhelpful.

4.3 Ambulance Services

The Scottish Ambulance Service *et al* undertook a study of ambulance journey times for patients with the acute onset of chest pain, by a comparison of average times during the months May to November 2002 to the same time period in 2003. During 2002, journey times were to the old RIE site and the Western, and during 2003, journey times were to the new RIE site and the Western.

Journey times clearly are dependent on the starting point of the journey, and the study found that, predictably, from some locations within Edinburgh journey times reduced whereas others increased. Overall, it was found that the median time of journey increased by 37 seconds. Central Edinburgh experienced significantly longer response times, and the maximum increase in time was for the post code area of EH2, where there was a wait of 3.26 minutes longer.[xxviii]

Lothian Health explained that ambulance journey times are not significant. The view is held that with ongoing developments in medical treatment, the significance of ambulance journey times has diminished, and of greater importance is the time taken for an ambulance to arrive and for treatment to be administered by onboard paramedics.[xxix]

Finding 6: Some ambulance journey times to A&E now take longer on average than previously. Most notably, journey times from the city centre have increased. The view of health witnesses, however, is that patient health is not compromised as a consequence.

5. Accessibility of the RIE by public and private transport

5.1 Public transport: buses

Access to the hospital depended to some extent on the availability of public transport, principally buses. The 2004 Travel Survey found some spatial variation in the use of the bus service:

- For Edinburgh, 44% of staff used the bus, as did 38% of patients and 35% of visitors.

- Not surprisingly, numbers begin to fall-off with increasing distance from the hospital, i.e. 27% of all participants from Midlothian used the bus; falling to 19% for East Lothian; 10.5% for West Lothian; 12% for Scottish Borders; and 5% for Fife. [xxx]

Although considerable developments had taken place with regard to bus routes and timetables, there were still locations from which the RIE was not sufficiently accessible. These areas were East and West Lothian; the north west of the City and Penicuik. In relation to Pencuik, the RIE had been unable to secure an adequate bus service.[xxxi]

The fact that over half of Edinburgh-based staff do not use public transport may be explained by the shift patterns of staff. Many work a 12.5 hour shift and often travel to and/or from work outside the traditional peak hours, at times when public transport services are reduced.

A large proportion of respondents had no alternative means of getting to the hospital if their first choice was not available. Overall, 46% of people could use the bus if their main mode of transport was not available.

Suggestions for improving accessibility by bus made by respondents to the survey: -

- Increase bus frequency (suggested by 391)
- Increase night, weekend and off peak bus services (159)
- Increase number of direct or express bus services (145)
- Implement bus services to areas that are not presently served (132)
- Improve shuttle bus service (34)
- Improve sign posting/bus information provision (33)

An issue raised by City Development as part of the consultation on *Improving Care, Investing in Change* is that NHS Lothian has a tendency to make decisions that have an impact on transportation without any in depth discussions with the Council. This means that – as with the RIE – there is a tendency for public transport arrangements to have to be adjusted at short notice to meet the changing needs of the users of the health service. The nature of public transport provision can make this quite difficult to manage. NHS Lothian described how it carried out extensive preparation for the move to Little France, in terms of consultation with appropriate partners and negotiation with the bus companies.[xxxii]

5.2 Private Transport

Car Parking in all contexts arouses controversy. Car Parking at a Hospital, particularly on an out of town site, will be especially controversial.

Planning consent was granted originally for 980 parking spaces at the RIE. The precise allocation of spaces for staff and visitors was not specified in the planning consent, though Consort allocated spaces as follows:

- 400 for Hospital staff,
- 30 for University staff, and
- 550 for public.

The number of disabled or easy access spaces originally allocated is not known, but would have been included in the total of 550 spaces for the public.

Planning consent was later granted for a further 765 spaces to augment visitor and staff parking, though the spaces available for University staff remained at 30.

Presently there are 592 parking spaces for staff and 1108 for visitors. Included in the 1108 are 86 disabled or easy access spaces available at the new RIE, located at one of four car parks. There are also disabled spaces at key locations, i.e. at the Front Main Entrance (3), Reproductive Health (6) and the Rear Main Entrance (16).[xxxiii]

Proportionately, the spaces available to people with a disability account for around 8% of total public parking spaces, and those for which no charge is required account for 2% of spaces available to the public.

Car parking charges are dependent on the length of stay, for example up to 1 hour the cost it is £1.20; up to 2 hours – £2.20; up to 6 hours – £6.50; and between 6 and 24 hours – £10.00. For visitors who need to park for longer than normally expected or attend the hospital on a frequent basis concessionary parking may be available through a discounted voucher system that is operated at the discretion of the Ward or Department Manager: -

i) *A Red Voucher provides car parking free of charge and is offered to relatives where attendance at the hospital relates to a case of extreme trauma or bereavement.*

ii) *A Blue Voucher entitles a patient or relative to park for a total cost of £3.00, issued when a patient or visitor's vehicle is on site for longer than 24 hours or when visitors have to attend hospital on a regular basis over a prolonged period of time.*

The Travel Survey illustrates how car parking facilities can influence perceptions of accessibility to the RIE. Most drivers park on-site, either in paid parking or in permit parking areas. A significant minority, however, park off-site -- 13.5% of staff, and 7.7% of all respondents, i.e. some 188 cars. The Travel Survey also sought further information on off-site parking, but this proved to be a sensitive issue, with just over

half of off-site parking respondents declining to answer this questions, while the rest gave answers that were not suitable for collation.[xxxiv]

There is a significant number of car users parking in roads that are close to the RIE, which is likely to have a negative impact on the quality of life of local residents. For example cluttered side roads can cause potential road safety problems, such as reduced visibility when crossing.

Two principal suggestions for improving accessibility if travelling by car were made by Travel Survey participants: -

- Reduce the car parking charge (suggested by 321 participants or one-quarter of sample)
- Increase the availability of disabled parking (44)

The perception of whether the new site is easier or more difficult to reach is strongly influenced by home location. Whilst overall, 51% of people think that it is harder to reach, 30% of respondents think it is easier and 14% feel that there has been no change. There are distinctions with regard to ease of movement to the new RIE from different local authority areas: -

- Residents of Midlothian and the Scottish Borders find it easier to travel to, given its relative close proximity to these areas.

- Those from Edinburgh, West Lothian and Fife find it more difficult due to the site being further away and less accessible.

- East Lothian residents are evenly divided. This is probably due to car users finding it much easier while public transport users find it more difficult.

The Edinburgh Evening News on 8 March 2005, reported that the chairman of NHS Lothian had called upon Consort to cut the prices for parking. This is in the context of an overall review by NHS Lothian of patient access to NHS services in Lothian. It was reported that they were seeking standard arrangements for access to hospital car parks across the region. St John's Hospital at Livingston, for example, charges only £1.00 per day.

Finding 7: Some car users thought that the car parking charges were too high and should be reduced.

Finding 8: There has been a lack of awareness amongst the public of the car parking voucher scheme. This lack of awareness may in part be related to low levels of publicity and advertising of the car parking voucher scheme. NHS Lothian report that this is now being addressed.

Finding 9: Further collaborative work needs to be undertaken to address the problem of those who currently do not use the bus regularly due to poor connections and excessive travel times. This work should also take into account shift patterns of workers at the RIE. However there is likely to be a substantial number who continue to drive.

6. Staff Recruitment and Retention

There are around 5,500 NHS employees at Little France, broadly the same as at Lauriston Place, except for nursing where there are about 100 FTE more.

In May 2004, it was reported that turnover was the same as at the previous site – around 1.5% per calendar month. Absence levels had risen, however, by 1.5% pcm. This was regarded as acceptable in the context of change.

Overall vacancy rates are comparable to the old RIE, except in nursing, where this had risen from 5% to 8% – representing about 200 vacancies at any one time. Edinburgh has the highest vacancy factor in Scotland.

The problem was compounded by a perceived reluctance by Bank Nurses (casual staff employed by NHS Lothian) to work at the RIE, leading to a greater use of Agency Nurses.[xxxv]

Recruitment of auxiliary staff has been boosted by the success of the Healthcare Academy. This offers a route into employment in the health sector to local unemployed people, by setting up an eight week pre-employment training programme in conjunction with the South Edinburgh Partnership. The incentive for would-be participants was the promise of a job at the end of the scheme and of further training and opportunities, including advancing to professional nursing. It was accepted that, because the individuals were local, staff retention would become less of a problem.

There are national level issues to consider with regard to staffing and recruitment, that do impact on Edinburgh to a greater extent due to the high cost of property at all levels within the housing market. Two of these issues are: -

i. A projected shortfall of medical staff.
ii. The European Working Time Directive is having a significant impact on the working hours of junior doctors.[xxxvi]

Specific to Edinburgh are further issues and challenges to achieving effective staff recruitment and retention. One of these is the sufficient availability of affordable housing for key workers, foremost nursing and specialist laboratory staff. The Trust was aware of housing and accommodation concerns, and how these were impacting on the recruitment and retention of staff. One means of addressing this issue, was through efforts by the Trust to secure tenancies in the Moredun area.[xxxvii]

NHS Lothian has indicated that it would welcome co-operation with the City of Edinburgh Council to seek to address the issue of affordable housing and key worker accommodation.[xxxviii]

Finding 10: The lack of availability of affordable housing in Edinburgh is a barrier to recruitment in the NHS, as in many other employment areas.

7. The impact of the siting of the RIE on the local area

Reference has already been made to the Health Care Academy which – although looking to a wider catchment area – is successfully attracting local people to work in the sector. There are now four times as many people from postcodes EH15/16/17 working at Little France compared to Lauriston Place.[xxxix]

The Academy programme has now extended its activities to the rest of Edinburgh and the Lothians, and from May 2005 will run a joint Health and Social Care employment programme in conjunction with East Lothian Council.

The staff shop, which has done so much to establish economic links with business in the surrounding communities, still has much more to offer and will undoubtedly go from strength to strength. Plans are well advanced to create a programme of work experience placements for pupils from the local secondary schools, offering increased prospects of employment and careers in the Health Service in the long term.

Staff at the RIE were concerned at the lack of good quality shops in the area – the impact of the scale of the workforce would inevitably encourage the growth of such facilities, which would benefit the local community as well.

Finding 11: The imaginative local recruitment strategy developed by the RIE, working with local community partners, is to be commended and should be applied to a range of similar contexts across Edinburgh.

8. Facilities for staff and patients

8.1 Catering

Concern had been expressed by patients about the quality of food and the way it was served. In addition, a Channel 4 documentary had drawn attention to shortcomings at the meal preparation plant in Wales.

A variety of actions have been taken in response to such criticism. These include:-

- The introduction of a users' group involving a variety of staff and patients and providing a forum for discussion of meal presentation, staff responsibilities and communication.
- Additionally, this group has contributed to the recently completed full menu review intended to improve meal suitability for all patients, including older people. Changes include portion size, the introduction of more traditional foods and the choice of a soft textured meal at each meal service.
- Food awareness sessions have been introduced and to date 55 members of nursing staff have participated. Food presentation, while not the only issue, is emphasised at these sessions.
- The in-patient menu card has been amended allowing patients to record comments on the cards, which are returned to the catering department and used in their performance management system.[xl]

In addition a monthly survey is undertaken to assess patients' views of the food provided.

In terms of processes, each ward and the Combined Assessment Unit has a Ward Host, who liaises with the central catering unit.[xli]

Despite these improvements, UNISON are still of the view that the quality of the food is variable and are concerned at the number of patients using the canteen, primarily intended as a staff facility.[xlii]

It is becoming increasingly clear that pre-prepared meals – of whatever quality – are being seen as less desirable than meals prepared on site using locally sourced ingredients. One of the best known examples in the NHS is Darlington Memorial Hospital, whose Head of Catering won the "Best Dinner Lady/Man" category in the BBC Radio 4 Food and Farming Awards, 2004.

The presenter of the Food Programme, Sheila Dillon said:
"He offers first class food, all cooked on the premises and beautifully presented".

One of the judges, Iqbal Wahhab said:
"Ron's work is a model of how hospital food can be"

8.2 Television and Telephones

These are available to all patients via a commercial service called "Patientline", which operates in Hospitals throughout the UK. Television costs £3.50 per day and outgoing telephone calls cost from 10p per minute. Incoming calls, however, are 39p per minute off peak and 49p at peak times. Radio is provided free of charge. There were some informal comments received from patients, in writing, and from witnesses that these services were regarded as expensive.

8.3 Information for Patients

An information booklet "Going to Hospital" is provided by the University Hospitals Division, together with a further leaflet "Getting to the Royal Infirmary at Little France". The former was "Highly Commended" by the BMA in 2003.

Between them, these two booklets provide a very full picture of what to expect at the RIE, how to get there and to find your way round.

"Going to Hospital" also describes the various means of making good and bad comments on services, from speaking to a member of staff, right through to the formal NHS Complaints procedure.

8.4 The Patients' Hotel

The Patients' Hotel was created in recognition of the role of the RIE as a regional and national resource, drawing patients from a wide area. It currently offers bed-only accommodation to families who have travelled with patents undergoing treatment, or to patients who are attending for day treatment and who require accommodation the night before or after that treatment.

Current capacity within the patient hotel is 12 rooms. Average monthly occupancy is 62% although there are occasions when all of the rooms are in use simultaneously. Double occupancy is around 11% of bookings and patient use is around 8% of bookings with the rest attributed to single relative use.

Lothian Health Board and City of Edinburgh Council have worked jointly to find solutions to the Delayed Discharge problem. This included careful consideration of using the Patients' Hotel, and there is a proposal that this facility be redesigned to provide as care home capacity for selected patients.

The bedrooms are en-suite but do not meet the minimum care commission standard of 12.5 m^2. A joint commissioning for comprehensive design and planning to convert the unit has been completed. Three options are in the process of being considered:-

i) **CEC managed**: this is the easiest to achieve. Additional Revenue of £500,000 above base cost would be required. Discussions on funding are continuing between the Council and Lothian Health Board.
ii) **Lothian Health Board managed**: which cannot be achieved immediately and restrictions may be imposed due to space and training needs.
iii) **Independent Contractor**: this would be very difficult to achieve due to space and contractual difficulties.

If there was a decision to proceed and formally commission, the building works would take between eight and 12 weeks.

A draft business plan has been prepared jointly by NHS Lothian and the City of Edinburgh Council, and a more detailed financial analysis is currently being undertaken.

If the Patients' Hotel were converted, space has been identified to house the current patients in accommodation formally identified as medical on-call accommodation. A total of ten single rooms are available, and although not all have en- suite facilities there are adequate shared facilities. This accommodation is located in the centre of the hospital and is closer to the transplant unit and intensive care / high dependency areas. Couples sharing may prefer to use local bed and breakfast accommodation and competitive deals have been negotiated with a number of local establishments.[xliii]

Finding 12. When the new RIE first opened, there were a number of issues raised concerning the catering. Action has been taken to address these, and the provision of food now appears to be well managed, with extensive involvement of both Dieticians and Services staff from NHS Lothian, working alongside the catering company.
Work at other Hospitals, notably Darlington, demonstrates, however, that it is possible to produce high quality meals using locally sourced ingredients.

9. Communicating with the public and other agencies

At the beginning of this review, we referred to the special place that the Royal Infirmary has in the hearts of the people of Edinburgh. This has meant that any changes to the RIE are always going to be watched very closely, particularly by the local press.

By its nature, the NHS has limited clear links of accountability to the community that it serves. It is important, therefore, that there are effective methods of communication to ensure that the public and other agencies are kept informed of proposed developments, and where appropriate have the opportunity to participate fully in the process of service development.

Communication is a broad term and it can be usefully sub-divided into three areas when the RIE is considered. These three areas, that are not mutually exclusive, are:

- information
- consultation
- partnership

9.1 Information

Conveying information to the public and other agencies about all aspects of the RIE, ranging from initial proposals for the new site at Little France through to ongoing service reconfigurations, is an important consideration.

We refer in 8.3, above, to the excellent leaflets provided for patients attending the new RIE.

9.2 Consultation

When the new RIE was being planned in the early 1990s, the nature and extent of consultation by organisations in general was considerably less sophisticated than it is today. The Social Work Department of the then Lothian Region, for example, does not appear to have been formally consulted – other than in large scale meetings at which sufficient discussion of issues would not have been possible. NHS Lothian have agreed that planning in the whole community was not as joined up in the 1990s as now – it was not as well thought through.[xliv]

With hindsight, it is clear that this approach contained weaknesses, which, it is hoped, would not be repeated with regard to the present day.

The Council's response to the RIE Five Year Plan in 1997 indicated a degree of concern at the likely approach to communications at that time: -

"The plan does give commitment to *Communications* (section 4.5), including a new post of Corporate Affairs Manager, and mentions strengthening links with stakeholders. However this seems to be linked more to promotion of the Trust rather than accountability to partners and their involvement in planning and provision with the Trust."[xlv]

There are, however, still some concerns with the approach to consultation that exists across NHS Lothian and therefore by implication the RIE. The present day issue of the effectiveness of consultation is, in many respects, illustrated by the consultation paper *Improving Care, Investing in Change* (ICIC), which was widely circulated throughout the Lothians and subject to a wide range of meetings, newsletters, etc. Despite this effort, there has been some criticism of the actual consultation process, not least that there has been insufficient time for consultation meetings to effectively feedback into the overall process.

West Lothian Council requested that Birmingham University review the consultation as part of a prepared response to the proposals paper. In summary, Birmingham University found that vital information was lacking in the plans that NHS Lothian unveiled and that the lack of input from the public was unsatisfactory.

NHS Lothian makes the point that "West Lothian Council was openly opposed to the consultation and its content. The points that Birmingham University found about the information lacking in NHS Lothian plans were the very issues which West Lothian council was opposed to."[xlvi]

An NHS Lothian spokesperson has responded to these claims by indicating that the level of consultation met the requirements laid out by the Scottish Executive.[xlvii]

9.3 Partnership working

Partnership working between NHS Lothian and the City of Edinburgh Council in relation to most aspects of service delivery is desirable and often necessary. The Delayed Discharge of patients, for example, requires both partners to work closely together to try and resolve this ongoing issue.

The whole process of building the new RIE and its continued development has taken place over many years. Previously, the potential for partnership working was less developed, and it is likely that the opportunities for NHS Lothian and the Council to work together were limited. Nonetheless, there are now considerably more opportunities for partners to work together in an effective manner. More broadly, there are developments in strategic and operational structures that are encouraging NHS Lothian and the Council to work in partnership wherever possible: -

i) The Local Government (Scotland) Act 2003 places a duty on local authorities and other agencies to participate in Community Planning.
ii) The creation of the new Community Health Partnerships (CHPs).
iii) The Joint Council/NHS Lothian Department of Health and Social Care will provide further avenues for joint working.

There has been much contentious debate around bed numbers when the new RIE opened, and this has been related to the Delayed Discharge issue. It appears that due to a lack of effective consultation with the Council in the planning process for the new RIE, Delayed Discharge was not accurately profiled.

The Panel hopes that the new opportunities for partnership working, referred to throughout this report, will overcome many – if not all – of the difficulties that have been encountered in the past. The circumstances relating to the ICIC consultation,

which embrace the RIE to some extent, illustrate that the situation, whilst improving, is still far from perfect.

A further illustration of where improvements could be made between NHS Lothian and the Council, specifically the Department of City Development, concerns the co-ordination of public transport. The introduction of bus services to complement service developments appears to be viewed as a secondary consideration rather than being integral to issues of access.[xlviii]

9.4 Culture

As with many large organisations, the NHS has developed its own culture. The publication by the NHS Confederation and National Patient Safety Agency in England in early 2003 of a paper entitled *Creating the virtuous circle: patient safety, accountability and an open and fair culture* illustrates that the culture of the NHS has been seen as an issue. In particular, that there is a need to create an open and fair culture.

In some areas, nearer to front line management for example, staff at all levels have gone out of their way to assist the work of the Panel. This has not necessarily been the case within the central bureaucracy.

Difficulties in obtaining information, particularly about community based and "step down" facilities led to the Panel making a request for material under the Freedom of Information Act, which caused further friction with NHS Lothian.

This is unfortunate, as this review presented an opportunity for the Panel, the Council and NHS Lothian to explore the issues together and improve joint working in the future.

Finding 13: NHS Lothian must fully embrace the opportunities presented by both the Edinburgh Partnership Group and the new Department of Health and Social Care. To do so will enable active involvement by all the Community Planning Partners – as envisaged in the Local Government Scotland Act, 2003 – in future proposals that will affect health provision in the City.

Finding 14: NHS Lothian needs to be able reassure its stakeholders and partners that it sees consultation as a genuine two-way process.

10. Conclusion

The Royal Infirmary of Edinburgh enjoys a special place in the hearts and minds of the people of Edinburgh. The current position, whereby the RIE is part of a multi-pronged Acute Service, has undoubtedly been the basis for some misunderstandings.

The new Hospital is regarded as the flagship of PFI ventures, yet there still exist serious concerns about the underlying planning assumptions and financial constraints. In particular, the debates about the overall capacity of the RIE, linked with the (non) provision of "step down" facilities, bed numbers and delayed discharge.

The Panel does not have the remit or expertise to investigate these concerns more fully, but believes that it is very important that the Scottish Executive does so. Not only do lessons need to be learned for the more successful planning of next generation hospitals, but also for the planning of appropriate community facilities to complement and support new acute hospital provision.

Co-operation between health authorities and local authorities in the past has been less than effective. This must improve in the future to ensure the provision of "joined up" services for all our citizens. The steps currently under way in Edinburgh to develop meaningful, active and reciprocal collaboration are to be welcomed.

Its high profile has meant that the new RIE has been placed heavily under the microscope, both before and since it opened at Little France. The least fault has been seized upon by the press and highlighted. The Panel wishes to acknowledge, however, that it recognises the hard work and commitment of all the workers at the RIE that we have met both formally and informally during the course of this review.

What we have found is summarised in the findings listed below. The recommendations that follow are intended to improve the situation, particularly in relation to the way that the RIE is regarded.

10.1 Summary of Findings

Finding 1: There has been a failure to deliver to an acceptable timetable the Full Business Case on which the new RIE was based, particularly in regard to the provision of community based services. This latter element was the subject of generalised statements of intent, rather than clear commitments, which has led to a considerable degree of misunderstanding and disappointment.

Finding 2: In the past, there has been insufficient effective dialogue both within the health service itself, and between the health sector and other key agencies. This is now improving.

Finding 3: The original planning assumptions for bed numbers did not provide sufficient flexibility to cope with changing circumstances, such as the decline in the availability of care home places and other pressures causing delayed

discharge. The creation of the post of Delayed Discharge Manager in the Department of Health and Social Care will help to ensure a co-ordinated approach to this issue.

Finding 4: The issue of early discharge, leading to subsequent re-admission of patients, needs to be further investigated.

Finding 5: A high turnover of patients can cause problems relating to cleaning and infection control.

Finding 6: Some ambulance journey times to A&E now take longer on average than previously. Most notably, journey times from the city centre have increased. The view of witnesses, however, is that there is no detriment to patient health as a consequence.

Finding 7: Some car users thought that the car parking charges were too high and should be reduced.

Finding 8: There has been a lack of awareness amongst the public of the car parking voucher scheme. This lack of awareness may in part be related to low levels of publicity and advertising of the car parking voucher scheme. This is now being addressed.

Finding 9: Further collaborative work needs to be undertaken to address the problem of those who currently do not use the bus regularly due to poor connections and excessive travel times. This work should also take into account shift patterns of workers at the RIE. However there is likely to be a substantial number who continue to drive.

Finding 10: The lack of availability of affordable housing in Edinburgh is a barrier to recruitment in the NHS, as in many other employment areas.

Finding 11: The imaginative local recruitment strategy developed by the RIE, through working with local community partners, is to be commended and should be applied to a range of similar contexts across Edinburgh.

Finding 12: When the new RIE first opened, there were a number of issues raised concerning the catering. Action has been taken to address these, and the provision of food now appears to be well managed, with extensive involvement of both Dieticians and services staff from NHS Lothian, working alongside the catering company. Work at other Hospitals, notably Darlington, demonstrates, however, that it is possible to produce high quality meals using locally sourced ingredients.

Finding 13: NHS Lothian must fully embrace the opportunities presented by both the Edinburgh Partnership Group and the new Department of Health and Social Care. To do so will enable active involvement by all the Community Planning Partners – as envisaged by the Local Government, Scotland Act, 2003 – in future proposals that will affect health provision in the City.

Finding 14: NHS Lothian needs to be able reassure its stakeholders and partners that it sees consultation as a genuine two-way process.

10.2 Recommendations

Recommendation 1: That the Scottish Executive commissions an enquiry into the planning and development of the new RIE, both to learn lessons from the failure of the planning assumptions, and to make sure that future projects across the range are carried through more effectively. These measures would help to ensure public confidence in the planning of future health provision and other major public projects.

Recommendation 2: That the Chief Executive of the City of Edinburgh Council, through the Edinburgh Partnership Group, obtains details of the proposed programme for the building of "step down" facilities and reports to this Panel within three months.

Recommendation 3: Independent research, commissioned by the Scottish Executive, should be undertaken to establish whether patients are sometimes discharged too early from the RIE.

Recommendation 4: NHS Lothian, the City of Edinburgh Council, other local authorities and the transport companies look at alternative modes of transport for staff residing in outlying areas, that take into account both staff shift times and bus journey times.

Recommendation 5: A full review of car parking charges at the RIE should be undertaken, to take account of the needs of patients, visitors and staff. In particular, concessionary parking vouchers should be more readily available and the needs of lower paid staff working unsocial hours should be fully recognised.

Recommendation 6: The Panel recognises the pioneering work undertaken by the Director of Housing in the field of key worker accommodation, and calls on him to undertake further work in liaison with partner organisations, including neighbouring local authorities, to seek to overcome the shortage of affordable key worker housing, particularly in the context of "Better Homes for Edinburgh", and reports to the Panel in six months.

Recommendation 7: The key worker housing shortage is referred to the Planning Committee for consideration, in the context of future major housing development proposals.

Recommendation 8: NHS Lothian works with its Community Planning Partners to identify and allocate land holdings to be released to RSLs and other appropriate providers of affordable housing.

Recommendation 9: NHS Lothian seeks to promote good practice in catering at all its facilities, specifically the introduction of freshly prepared food, using local ingredients. In particular, the advantages to the reputations of NHS

Lothian, Consort and its sub-contractors of the RIE being at the forefront of the move away from pre-prepared meals should be exploited.

Recommendation 10: The Patients` Hotel should be retained in its present form as a valued facility, supporting the work of the RIE as a provider of specialist health care to a wide geographical area.

Recommendation 11: This Panel commends the Health Care Academy scheme and wishes to encourage the RIE and Local Community Planning Partners to build on this valuable work.

Recommendation 12: NHS Lothian, as a Community Planning Partner, seeks to work with the City of Edinburgh Council to develop an effective approach to consultation.

APPENDIX 1

The Remit of the Community Services Scrutiny Panel

In common with the other Scrutiny Panels, Community Services has a wide-ranging and cross-cutting remit. This includes "Community Care" and "Health".

Remits are illustrative - neither exhaustive nor mutually exclusive. Standing Orders confer powers on Panels to commission reviews, and to invite individuals and organisations with expertise or an interest to contribute to the review process.

The Scrutiny Panel Guidelines (paragraph 6) provide further guidance on the conduct of reviews. They indicate that while reviews will relate mainly to the organisation and delivery of services by the Council, they "may also address matters which are not the direct responsibility of the Council but which nevertheless affect the economic, environmental and social wellbeing of the City".

Further, the process for conducting approved reviews is to be determined by the Panel, on the advice of the officer allocated to the review.[xlix]

APPENDIX 2

Extracts of correspondence between NHS Trusts about Community Treatment Centres

Letter from RIE NHS Trust to Edinburgh Healthcare NHS Trust, August 1995:

"We described our approach to outreach, and I believe you were broadly supportive. You also indicated that you are developing your own strategy in this respect, and we agreed that we should share data and information and endeavour to develop complimentary services...

"I share your view that outreach facilities should be developed before the new hospital opens at Little France. However, the timeframe we are currently pursuing means that we will be going out to tender in September/October and therefore we have to be reasonably certain about what our requirements might be for the new hospital. It is likely therefore, that in terms of the design of the hospital, we will develop a modular approach...to allow outpatient services to be subsequently relocated to outreach centres as they are identified and agreed."[i]

Correspondence in May and June 1997 seems to illustrate further confusion, or lack of collaboration, between the various arms of the NHS in Lothian, regarding both the proposed Midlothian and Leith CTCs.

"I have discussed with David Bolton (Director of Primary Care, Lothian Health) your concerns about Trust involvement in the CTC developments.
He informs me that both David Small and Paul Milligan (Director of Planning and Contracts, RIE NHS Trust) were involved in the Midlothian Community Hospital development and that you do have all of the papers? [sic])

"You were not directly involved in the North East Edinburgh proposals so I would suggest that we meet as soon as possible so that you can be briefed on our current thinking."[ii]

"Please note the attached letter. (not attached) In November, action was agreed between ourselves and the RIE, regarding the need to examine the activity assumptions for out-patients at Midlothian on a speciality by speciality basis.

"The explanation I received (verbally) from the RIE about their lack of progress on this issue, was that they wished to consider Midlothian's activity along with activity assumptions for the other proposed CTCs, rather than in isolation. We have always been anxious to engage directly with the relevant RIE clinicians, but have been discouraged in doing so. I believe this failure to work together as agreed has brought us to the current position where heat is considerably more common than light...

"I am very exasperated that initial planning assumptions made on an open and sensible basis in order to begin discussions with individual speciality level clinicians, have not yet been able to be refined. As a result, clinicians naturally feel they are not being consulted or involved in the process. I have always been and will continue to be ready to engage with the RIE in guiding some of these planning assumptions to practical reality.

I would be grateful if you could make this longstanding offer known to members of your Committee."[lii]

The further levels of disagreement in this area are highlighted in the following letter:

"I understand that an outline Business Case has been prepared for the MCTC (Midlothian Community Treatment Centre) and presented to the Area Medical Committee at their last meeting. I hear that this gives proposed clinic attendances that are to be provided by specialists from the RIE.

"I am perplexed at the way in which you are undertaking this innovative piece of health care design. The last involvement of this Trust was a belated comment on the original proposal put to Lothian Health which claimed erroneously that these plans had been agreed by the Trusts involved. The Trust had some initial discussions with East and Midlothian Trust about the services that could be provided in the MCTC. This was presented as a wish list and later analysis here demonstrated that we could not justify the consultant resources required.

"I understand now that the Chairman of the Division of Medicine was asked by the Chairman of the AMC to contact the various specialties, whose services were required by the MCTC, and obtain their agreement to these proposals. I am not keen on this methodology. This Trust has already agreed a Business Plan with Lothian Health for the services to be provided in the Royal Infirmary and I cannot agree to proposals being put to my clinicians by this back door method...

"I have asked the Clinical Directors here to undertake no operational planning with representatives of the advisory structure and would look forward to arranging an appropriate forum with you in order to take the planning of the MCTC forward."[liii]

The following is the response to that letter:

"Major projects such as the Midlothian Community Hospital do require Lothian Health to seek views from the professional advisory structure and we are confident that this approach is both sound and necessary.

"Discussions during the latter part of 1996 on the outline specification for Midlothian Community Hospital did involve representatives from the Royal Infirmary NHS Trust and in November 1996, your Trust was approached by East and Midlothian NHS Trust to engage in clinical debate on the range of services to be provided. No response was received to this request, despite further reminders from east and Midlothian NHS Trust.

"A meeting to address this matter was held on Monday 26 May 1997. A representative from your Trust was asked to attend, agreed to attend but in fact did not attend.

"We both agree, however, that clinical dialogue is essential and I am grateful that you have arranged such meetings in June and July."[liv]

APPENDIX 3

The 2004 Royal Infirmary of Edinburgh Travel Survey Report (July 2004)

Annual travel surveys are undertaken at the RIE to monitor travel patterns of staff, patients and visitors, and to inform planning agreements for the development of public transport. A total of 2451 people participated in the 2004 RIE Travel Survey (July 2004): staff 52% of sample; patients 19%; visitors 26% and people on business 3%. The RIE staff structure is reasonably comparable with that of survey participants, though the biggest discrepancy was nurses where the sample proportion was only 34% compared to an actual staff proportion of 48%. A shortfall in the number of nurses participating may have skewed findings.

Endnotes

[i] Evidence to Scrutiny Panel, 17 February 2004
[ii] Evidence to Scrutiny Panel, J.Sansbury, NHS Lothian, 27 April 2004
[iii] Evidence to Scrutiny Panel, J.Sansbury, NHS Lothian, 27 April 2004
[iv] Evidence to Scrutiny Panel, 15 January 2004
[v] Comments from NHS Lothian, 9 May 2005
[vi] Evidence to Scrutiny Panel, NHS Lothian, 27 April 2004
[vii] Letter from Dr Galbraith to Donald Gorrie, MP, 24 February 1998
[viii] Letter from Mike Grieve to Lead Officer, 10 November, 2004
[ix] The New Royal Infirmary of Edinburgh: Full Business Case, July 1997, page 16
[x] Dr Dean Marshall – background briefing
[xi] RIE NHS Trust: 5 Year Plan – Report to Policy and Resources Committee, 30 January 1997
[xii] Evidence from Sue Brace, Social Work Department, to Scrutiny Panel, 25 May, 2004
[xiii] Email from Sue Brace to lead Officer, 25 January 2005
[xiv] Evidence from Sue Brace, Social Work Department, to Scrutiny Panel, 25 May, 2004
[xv] Presentation to Panel, 7 May 2004; letter from Mike Grieve to Lead Officer, 10 November 2004.
[xvi] Evidence to Scrutiny Panel, Dr Derek Bell, NHS Lothian, 27 April 2004
[xvii] Comments from NHS Lothian, 9 May 2005
[xviii] Evidence to Scrutiny Panel by Dr M. Dunnigan, 17 February 2004
[xix] Evidence to Scrutiny Panel, Dr Dean Marshall, 27 April 2004; BMA press release, 18 February 1999
[xx] Evidence to Scrutiny Panel, Dr George Venters, 17 February 2004
[xxi] Comments from NHS Lothian, 9 May 2005
[xxii] Dr Dean Marshall, background briefing
[xxiii] Report to Council Executive, 18 January 2005; Report to Council Executive, 7 June 2005
[xxiv] Evidence from Dr Brian Montgomery, Scrutiny Panel, 27 April 2004
[xxv] Presentation to Panel, 7 May 2004
[xxvi] Conversation with Dr Burns, confirmed in email, 1 April 2005
[xxvii] Figures supplied by Mike Grieve, letter to Lead Officer, 10 November, 2004
[xxviii] Scottish Ambulance Service, 2004
[xxix] Evidence to Scrutiny Panel, J.Sansbury, NHS Lothian, 27 April 2004
[xxx] RIE Travel Survey Report, 2004: presentation to Scrutiny Panel by City Development, 17 August 2004
[xxxi] Evidence to Scrutiny Panel, Mike Grieve, 17 February 2004
[xxxii] Scrutiny Panel Consultation on NHS Lothian's paper "Improving Care; Investing in Change"; comments from Barry Cross and MaxThompson of City Development, 12 October 2004; Comments from NHS Lothian, 9 May 2005
[xxxiii] Leaflet: "Car parking at the Royal Infirmary, Little France", NHS Lothian, June 2004
[xxxiv] RIE Travel Survey Report, 2004: presentation to Scrutiny Panel ,17 August 2004
[xxxv] Presentation to Panel, 7 May 2004
[xxxvi] Evidence from Dr Derek Bell, NHS Lothian, Scrutiny Panel, 27 April, 2004; Evidence from Dr Brian Montgomery, Scrutiny Panel, 27 April 2004

[xxxvii] Evidence to Scrutiny Panel, Mike Grieve, 17 February 2004
[xxxviii] Comments from NHS Lothian, 9 May 2005
[xxxix] Presentation to Scrutiny Panel 7 May 2004
[xl] Letter from Mike Grieve, to Lead Officer, 10 November, 2004
[xli] Presentation at catering Forum, RIE, 19 January 2005
[xlii] Evidence to Scrutiny Panel, 3 February 2005
[xliii] Edited email communication from David Bolton to Lead Officer, 23.3.05
[xliv] Presentation by Charles Swainson to Scrutiny Panel, 7 May, 2004
[xlv] RIE NHS Trust: 5 Year Plan – Report to Policy and Resources Committee, 30 January 1997
[xlvi] Comments from NHS Lothian, 9 May 2005
[xlvii] Scotsman, 16 November 2004
[xlviii] Scrutiny Panel Consultation on NHS Lothian's paper "Improving Care; Investing in Change"; comments from Barry Cross and MaxThompson of City Development, 12 October 2004;
[xlix] Guidelines for Scrutiny Panels, paragraph 6.5
[l] Letter from Paul Milligan, Director of Planning and Contracts, RIE NHS Trust to D.Piggott, Chief Executive, Edinburgh Healthcare NHS Trust, 3 August 1995
[li] Letter from Trevor Jones, General Manager, Lothian Health Board, to J.J.Owens, Chief Executive, RIE NHS Trust, 21 May 1997
[lii] Letter from David White, Locality Director, East and Midlothian NHS Trust to Dr R. Heading, Chairman Lothian Area Medical Committee, RIE NHS Trust, 22 May 1997
[liii] Letter from Dr C.P Swainson, Medical Director, RIE NHS Trust, to David Bolton, Director of Primary Care, Lothian Health
[liv] Letter from David Bolton (see above) to Dr C.P. Swainson (see above), 29 May 1997