CHIEF EXECUTIVE’S AND DIRECTORS’ REPORT
EMERGING ISSUES AND UPDATES

1 ANNUAL ACCOUNTS 2010/11

The 2010/11 Annual Accounts were considered by the Audit Committee on 29 June 2011 and subsequently approved by a special In Committee meeting of the Board on that day. Following this process, the Accounts were submitted by the External Auditor to the Scottish Government, for onward submission to the Scottish Parliament, where the NHS Highland Accounts, along with those of other NHS Boards have now been approved.

In 2010/11, NHS Highland achieved the statutory Financial Targets, and this was reported to the Audit Committee. It should be noted that performance against the revenue target was a minor undespend of £56,000 on the £555m Revenue Resource Limit, which is in line with Financial Reports submitted to the NHS Board during the year, and which has been carried forward into 2011/12. The capital position was that the Board operated within its limit of £28.8m. The confirmation of these results was included within the Auditors Final Report to Members, and the External Audit Certificate was unqualified.

This update concludes the formal process for the 2010/11 Annual Accounts. The full set of Accounts is available on the NHS Highland website. The delivery of an audited set of Accounts for the year is a statutory requirement for the NHS Board. As well as being a statutory requirement, the presentation, discussion and agreement of the Annual Accounts – with independent professional audit scrutiny – confirms the delivery of overall Financial Governance within NHS Highland.

2 CLINICAL ADVISORY GROUP – ANNUAL REPORT

The first Annual Report of NHS Highland’s Clinical Advisory Group (CAG) is circulated as Supplementary Paper 1 to this Chief Executive’s Report. CAG’s Annual Report describes the rationale, role and remit of the Group; highlights CAG’s activities and achievements to date; and proposes a future work programme relevant to the core business of NHS Highland. The Board is asked to Approve the Annual Report for 2011/2012 and Endorse the Future Work Programme.

3 OLDER PEOPLE IN ACUTE CARE AND DEMENTIA STANDARDS

In June 2011 the Cabinet Secretary announced that Healthcare Improvement Scotland would carry out a new programme of inspections to provide assurance that the care of older people in acute hospitals is of a high standard. The inspections will be undertaken by the Health Care Environment Inspectorate (HEI) and will look at the following:

- Treating older people with compassion, dignity and respect;
- Dementia and cognitive impairment;
- Falls prevention and management;
- Nutritional care and hydration;
- Preventing and managing pressure ulcers.
Raigmore will be the only hospital in Highland to receive a visit this year – this will be an announced visit.

The Older People in Acute Care and Dementia Standards Steering Group chaired by the Board Nurse Director has been set up and is taking the following work streams forward:

- Self assessment; a template has been provided by HEI and all hospitals in NHS Highland have completed this. Action plans are being developed locally to improve patient care and pan Highland work streams will be agreed where gaps in care are identified.
- Agreement has been reached with Alzheimer’s Scotland to fund a Dementia Nurse Consultant for 3 years. The job description is currently being banded.
- Building on excellent work lead by Argyll and Bute, Dementia Champions will be nominated by the Board across a wide range of areas including social care, care homes and health to support quality patient care.
- Building on the achievements of the new Migdale hospital, Dementia patient friendly standards are being developed in Highland for roll out across the Board to all hospital environments.
- The Butterfly Scheme is to be considered for implementation.
- 2 mock inspections have taken place on hospital wards led by the Board Nurse Director; learning from these is being rolled out across the Board.
- Education and training needs of staff are being mapped out.

This work is being aligned to the work of the Mental Health Strategy and Performance Monitoring Group, specifically the Redesign of Older Adult Mental Health Services in Highland.

4 PATIENT RIGHTS (SCOTLAND) ACT 2011

The Patient Rights (Scotland) Act 2011 supports the Scottish Government’s vision for a high-quality NHS that respects the rights of patients, their carers, and all the people who deliver health services.

The Act:
- Aims to improve patients’ experiences of using health services and to support them to become more involved in their health and health care
- Acknowledges the important role of carers
- Encourages responsible use of NHS services and resources
- Recognised that NHS staff and all providers of health services should be treated with dignity and supported to do their jobs well.

The Patient Rights Act reinforces and supports our commitment to patient centred services. Much of the Act reflects work streams that are already well developed in NHS Highland.

A full report will be presented to a future meeting of the Board. In the meanwhile, the Board may wish to note the following:

**Treatment Time Guarantee:**

The Act introduces a 12-week Treatment Time Guarantee (TTG) which stipulates that most patients will start their inpatient or day case treatment within 12 weeks of agreeing that treatment.
**Patient Advice and Support Service:**
The Act introduces a new independent Patient Advice and Support Service (PASS). This replaces the current Independent Advice and Support Service. A national arrangement is in place for this provision and the Citizens Advice Bureau are contracted to deliver this service from April 2012.

**Feedback, comments, concerns and complaints:**
The Act gives patients a legal right to provide feedback on their experience of healthcare and treatment and to provide comments, or raise concerns or complaints. This is very much in keeping with our agreed direction and we are eager to encourage patients to do this. This requirement also applies to independent contractors such as General Practitioners.

**Communication:**
Work to support the Act and raise awareness of its implications with patients and staff could usefully tie in with other pieces of work that as an organisation we are currently pursuing for example our Customer Care work and work on the values we seek to promote within the organisation.

5 REGIONAL PLANNING – NORTH OF SCOTLAND PLANNING GROUP AND WEST OF SCOTLAND PLANNING GROUP

A copy of the Briefing from the North of Scotland Planning Group for February 2012 is circulated as Supplementary Paper 2 to this update. There is no Briefing from the West of Scotland Planning Group this month.

6 WAITING LISTS – APPLICATION OF “UNAVAILABILITY” TO PATIENTS ON A WAITING LIST FOR CONSULTATION OF TREATMENT

There have been recent reports in the press regarding the inappropriate use of the unavailability status for patients waiting to be seen in hospital in an NHS Board in Scotland. NHS Highland can reassure our Board that we have always enforced a strict policy on the use of unavailability for patients and monitor the position on a weekly basis. We are well below the Scottish average with one of the lowest rates of the Scottish Boards.

On average 5% of total number of outpatients on the waiting list and 18% of total admissions waiting list are recorded as unavailable. The number of patients waiting for an admission is higher because we always seek to treat patients within the relevant target waiting time but if a patient chooses to wait longer (i.e. makes an informed decision based on the options available to them) to be seen closer to home even if we can see them within target at another hospital then it is appropriate to apply unavailability in these circumstances.

Our Internal Auditors will shortly be carrying out a review of waiting times management which will be reported to the Audit Committee in due course. We will be seeking assurance from the operational units regarding the management of “Unavailability” at the next meeting of the Improvement Committee.

Chief Executive’s Office  
Assynt House  
23 March 2012
1. INTRODUCTION

This is the first Annual Report of NHS Highland’s Clinical Advisory Group (CAG). This Report describes the rationale, role and remit of the Group; highlights CAG’s activities and achievements to date; and proposes a future work programme relevant to the core business of NHS Highland.

2. BACKGROUND

As part of NHS Highland’s Strategic Framework, and to ensure that resources are allocated as effectively as possible, NHS Highland aspires to provide services that are of high quality, integrated, equitable, needs and evidence-based, and cost-effective.

To meet this aspiration, the Clinical Advisory Group was established in March 2011 to provide clinical advice to the Board’s Senior Management Team (SMT) on health technologies, treatment and other healthcare developments. The composition and Terms of Reference (TOR) of CAG is shown in Appendix 1.

CAG’s founding principles recognised the importance of Quality i.e. to provide evidence-base, effective, efficient, timely, safe and person-centred care irrespective of healthcare specialty or setting. Its practice reflects the need to adopt a systematic, consistent, equitable, multi-professional, multi-disciplinary and transparent approach to NHS Highland service provision decision-making.

3. MEMBERSHIP

Two groups make up the overall CAG structure and function – the CAG and the Core CAG. The full CAG oversees, and is responsible for, the work of the supporting Core CAG. The full CAG reports, and is accountable, to NHS Highland’s Senior Management Team.

Both the Full and the Core CAGs are multi-professional and multi-disciplinary in composition with the Full CAG also including General Public representation. The membership and Terms of Reference of the Full CAG and Core Group are shown in Appendix 1. The Full CAG meets quarterly, the Core Group meets monthly.

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4. ROLE AND REMIT

The Clinical Advisory Group (CAG) was originally established to provide clinical advice and guidance on evidence-based and cost-effective best practice to the Board's Senior Management Team. However, during the passage of time, the role and remit of the Group has expanded to encompass two main areas of work: (1) the introduction of non-pharmacological health technologies; and (2) the appropriateness of requests to refer Highland residents to health care facilities out-with NHS Highland for assessment, investigation and/or treatment (commonly known as Out-of-Area Referral Requests).

5. PROCESS

With regard to requests for the introduction of health technologies, careful consideration is given by CAG of: (a) the evidence-base relating to the particular technology; (b) local and national policy relevance and importance in terms of the application of the technology; and (c) likely resource impact on NHS Highland by the introduction of the technology.

CAG processes and related documentation have been developed to support consistent consideration and decision-making relating to Out-of-Area Referral Requests. Documentation relating to this process is shown in Appendix 2. This information is also available at: http://intranet.nhsh.scot.nhs.uk/Org/CommNet/CAG/Pages/Default.aspx and/or http://intranet.nhsh.scot.nhs.uk/Org/CorpServ/PlanningandPerformance/ServicePlanning/Pages/Default.aspx

Decisions on requests for Out-of-Area referrals are made by the Core Clinical Advisory Group. The Full Clinical Advisory Group is provided with summaries of these decisions at its quarterly meetings to consider and approve. Where clinical urgency dictates, such requests are managed outside Core CAG meetings and considered by Core CAG members as necessary. The recommendations of the Full CAG are then submitted to the Board's Senior Management Team for their consideration and ratification if appropriate.

6. CORE CAG MEETINGS AND OUTPUTS

Through regular face-to-face and virtual Core CAG meetings and inter-meeting activity, several core elements of Core CAG work have been progressed during the past 12 months. Work outputs are routinely reviewed and revised, where appropriate, by the Core CAG to facilitate effective and efficient CAG reporting and decision-making. Examples include:

- CAG NHS Highland intranet web page (available at: http://intranet.nhsh.scot.nhs.uk/Org/CommNet/CAG/Pages/Default.aspx). This web page serves as the CAG information repository from which documents relevant to CAG business is available;

  Quarterly email reminders are sent to all NHS Highland Medical Hospital Consultants, GPs, Lead Nurses and AHPs, and members of the Area Clinical Forum to raise awareness of CAG in general and the availability of the web page in particular.

- Paper-based topic matrix – a list of topics considered by Core CAG with recommendations. Due to patient confidentiality information relating to this list of topics is available on request.

- Web-based (NHS Highland intranet) CAG database – developed to: (a) provide information on the activities and decision-making processes of CAG, and the topics considered by CAG; (b) facilitate CAG information-sharing across clinical and corporate settings within NHS Highland (available at: http://intranet.nhsh.scot.nhs.uk/Org/CommNet/CAG/Pages/Default.aspx).

The database illustrates the breadth and depth of topics considered by CAG and includes: information relating to the form and function of CAG along with a list of the topics considered by CAG; background information relating to each topic; each topic’s
current status in the Core CAG, Full CAG and NHS Highland Senior Management Team’s decision-making and recommendations process; and summaries of the evidence-base considered as part of the decision-making process.


7. CAG MEETINGS AND RECOMMENDATIONS

During the year 2011 / 2012, the full CAG met on four occasions as listed below:

- Thursday 5th May 2011
- Thursday 1st September 2011
- Thursday 8th December 2011
- Thursday 1st March 2012

The Group has considered several clinical issues and formulated recommendations for NHS Highland’s Senior Management Team. The recommendations produced to date are contained within Appendix 3.

At the time of writing, recommendations relating to the clinical issues discussed during the Group’s meeting on Thursday 1st March 2012 (specialist services for people with chronic fatigue syndrome / myalgic encephalopathy, and the management of drug-resistant hypertension) are still draft and awaiting approval by SMT.

8. SPECIFIC ITEMS / ACHIEVEMENTS

8.1 Tier 3 weight management pilot

CAG oversees the Weight Management Steering Group which is responsible for developing the proposals for a Highland-wide Tier 3 weight management service which involves specialist dietetic treatment. Without a third tier service in place we cannot refer for specialist surgery and it has been recognised that NHS Boards need to offer patients more robust weight management support. During 2012 a pilot tier 3 service is being implemented involving the treatment of some 60 patients in North Highland and just under 30 in Argyll & Bute. The first group of 30 patients from N Highland were seen in February 2012 for a 6 month period, and the remaining patients are planned to be seen from summer 2012. Progress will be reported on a quarterly basis to CAG with a mid-term report being submitted to Senior Management Team in summer 2012. Argyll & Bute patients will continue to be seen throughout this period. The Pilot work has also involved the repatriation of patients referred to the weight management service in Aberdeen where due to lengthy delays in treatment this cohort of patients are being transferred to the Highland weight management pilot. Appendix 3 provides more detail.

The Tier 3 Service is offering patients access to services that have previously been unavailable locally, with a new approach to weight management. Consultations will take place at a centre as near to patients as possible, also with the use of video conferencing facilities to ensure ease of access to the programme. As part of the discharge planning the pilot will offer a mentoring programme for staff in primary care to further support the patients to maintain the weight loss changes they have made.

8.2 OOA referral form and process

Some 80 individual Out of Area referrals have been considered by Core CAG between April 2011 and March 2012, where existing pathways and agreements for treatment are not in place. Within the year the Out of Area referral form and process have been developed and communicated with all Highland clinicians. The process is triaged through the Service
Planning team who also provide advice on national services and service agreements. In summary:

a) 32 out of area referrals have been authorised;

b) 25 referrals were not authorised but other services suggested utilising more appropriate clinical services;

c) 22 referral requests are either pending discussion in March or already in discussion where additional clinical information is being requested;

d) 1 referral was withdrawn.

8.3 Repatriation work

Service Planning on behalf of CAG, has been investigating a number of patients who have been electively receiving care in English Hospitals for a number of years, but where more local treatment might considered if clinically appropriate. This work is involving primary and secondary care clinicians throughout the UK to ensure that Highland patients can be appropriately given treatment as close to home as possible, and that the services offered to all Highland patients are equitable. Up to March 2012 there are 170 patients in the scope of this work. These patients might have been receiving care in England at the time of moving into Highland or where clinicians have referred Highland patients to English services prior to the implementation of the CAG out of area referral process. In summary:

a) 80 patient treatments have been reviewed, with the majority of Highland patients having been discharged from the English health services. A small number of patients continue with their treatments in England due to clinical complexity and it not being appropriate to receive care anywhere else at this time;

b) 90 patient treatments are currently under investigation.

In addition to alerting local Consultants and GPs to consider and constantly review where best their patients should go to receive care, many have found the topic stimulating when planning care for all their patients in the future.

8.4 Links to ADTC

The role of the CAG is to offer advice on non-pharmaceutical health technologies. The overall aim of the Area Drug and Therapeutic Committee (ADTC) is to ‘…ensure, patients receive safe and effective treatment with medicines, ensuring best use of resources.’

However, it is possible that issues considered by one Group may have implications for the other.

To help ensure that there is good communication between the CAG and the ADTC, the Chair of the ADTC and NHS Highland’s Director of Pharmacy are members of the CAG.

8.5 Links to NHS Highland Research & Development Office

Prior to December 2011, no formally-agreed links or systems were established between with the CAG and the NHS Highland R&D Office, other than the participation of the R&D Director as a member of the CAG. However, it was considered by both bodies that establishing links across the CAG and the R&D Office would offer a mutually beneficial exchange of intelligence with the perceived benefits being two-fold: (a) Identifying clinical trials and (b) Monitoring clinical trial activity.

In recognising such potential benefits, it was agreed that a formal link should be established. Regular liaison with the R&D Office would provide CAG with information, in a timely way, of the current status and potential future clinical and cost implications for NHS Highland of any clinical trials involving NHS Highland patients. Simultaneously, the R&D Office’s awareness of the various avenues by which clinical trial participation requests are submitted to the CAG would be raised, and the role of the R&D Office and its associated Research Governance processes would become embedded in CAG core business. Therefore, it was agreed that as of December 2011, the R&D Office would provide regular, quarterly reports to the CAG describing current research activity which involved NHS Highland patients.

An algorithm was developed which would serve as an aide memoir for both CAG and the R&D Office. This algorithm, outlining the exchange of intelligence across the CAG and the R&D office in relation to the participation of NHS Highland patients in clinical trials, is shown in Appendix 4.

### 8.6 Links to Pathways Development

When CAG was set up, it was recognised that most topics the Group might be asked to consider would form part of a clinical pathway. Implementing the Board’s Strategic Framework has led to proposals for the development and support of pathway groups which will be expected to work with CAG in formulating specific clinical advice for service use. These proposals are still being finalised and will come to the Board at a later date.

Increasing encouragement around the Quality agenda is evident to reduce NHS variation and harm. There is substantial magnitude of variation in many of our clinical processes. Pathway adherence is one way of ensuring some consistency in approach. This element is now part of 2011/12 GMS Contract (Quality and Outcomes Framework Quality and Productivity – QOF QP) whereby GPs are continually encouraged to help with the development of a range of clinical pathways.

### 8.7 Links to Clinical Thresholds Work

The CAG has considered the ‘Croydon list’ of low priority treatments, highlighted in a recent Audit Commission report. The list proposes a range of treatments, categorised under the following headings:

- Effective procedures where cost-effective alternatives should be tried first
- Effective interventions with a close benefit or risk balance in mild cases
- Potentially cosmetic interventions
- Relatively ineffective procedures
- Cancelled procedures

The Group has considered several treatments categorised as ‘relatively ineffective’ and sought to clarify, in discussion with clinical colleagues, the number of treatments undertaken within NHS Highland and the circumstances under which they are provided.

It is anticipated that the ‘Croydon list’ will be continue to referred to as the CAG seeks to engage with clinical colleagues to encourage the provision of clinically effective, evidence-based practice within NHS Highland.

9. FUTURE WORK PROGRAMME

In looking to the future, the Clinical Advisory will continue to progress with providing clinical advice and guidance on evidence-based and cost-effective best practice. It will also continue to consider the appropriateness of requests to refer Highland residents to health care facilities out-with NHS Highland for assessment, investigation and/or treatment. However, to facilitate the implementation of NHS Highland’s Strategic Framework, further work-streams will be developed namely:

- Clinical thresholds work
- Links to pathways
- Joint ADTC/CAG work
- Links to R&D
- Links to other Boards and regional and national work

10. CONCLUSIONS

Much has been achieved during the past year with regard to the establishment and development of NHS Highland’s Clinical Advisory Group.

The type of Out-of-Area requests and proposed new technologies received by CAG for consideration has been varied and wide-ranging. CAG-specific processes, protocols and systems have been developed to ensure that a transparent, consistent and evidence-based approach to decision-making has been adopted. Positive engagement has taken place across a wide range of local and national healthcare colleagues and organisations.

The future aims, aspirations and energies of CAG throughout the forthcoming year will focus on: (a) maintaining clarity and purpose in the CAG decision-making process; (b) informing core NHS Highland Quality business in an effective and efficient manner; and (c) continuing to engage and work collaboratively with primary, secondary and tertiary care colleagues to improve the quality of care provided for the Highland population.

11. CONTRIBUTION TO CORPORATE OBJECTIVES

The principles and practice of the Clinical Advisory Group contribute to NHS Highland’s Corporate Objectives by recognising the importance of providing evidence-base, effective, efficient, timely, safe and person-centred care as proposed within the NHS Highland Strategic Framework 2011/12: Highland Quality Approach.

12. GOVERNANCE IMPLICATIONS

CAG work is expected to provide more transparent and explicit assurance to the Board that it is providing evidence-based care in a consistent and systematic manner.

13. IMPACT ASSESSMENT

Providing clear guidance on issues of specific clinical care to all services within NHS Highland is expected to reduce clinical variation and inequalities both in health outcome and access to health care. Audit and monitoring tools still require development and implementation to establish whether this reduction in inequality actually occurs.
APPENDIX 1: CAG MEMBERSHIP AND TERMS OF REFERENCE (TOR)

FULL CLINICAL ADVISORY GROUP

Membership
Director of Public Health
Medical Director
Nursing Director
R&D Director
Chair of Ethics Committee
Chair of ADTC
Director of Pharmacy
Associate Medical Director (Primary Care)
Consultant in Public Health Medicine
Five clinical representatives
   1 Consultant
   1 Healthcare Scientist
   1 GP
   1 Nurse/midwife
   1 AHP
2 Lay Members

Terms of Reference

- Meets quarterly
- Quorum: Two Board directors, three clinical representatives from three CHPs/Raigmore; three health professions represented, one lay member.
- Remit
  - To provide expert clinical advice, based on evidence with local service interpretation and impact, to the Board’s planning and management group on health technologies and other healthcare developments.
  - To ratify decisions of core support team on tertiary referrals outwith current SLAs.
- Recommendations on individual topics will be drafted during meetings and approved after circulation of final wording.
- Approved recommendations will be sent to the original requesting group for action, reported to Senior Management Team and copied for information to relevant operational units/service departments, clinical governance and clinicians.
- Submits a summary report detailing topics referred, topics/questions prioritised for detailed work, resulting recommendations and action by group to the Senior Management Team on an annual basis.
CORE CLINICAL ADVISORY GROUP

Membership
Director of Public Health (Chair)
Medical Director
Associate Medical Director (Primary Care)
Nursing Director
Head of Service Planning
Service Planning Manager
Consultant in Public Health Medicine
Public Health Scientist
APPENDIX 2

NHS Highland Out-of-Area (OOA) Referral Process

This process should be followed by clinicians who wish to refer an NHS Highland patient to a health care provider out-with NHS Highland for assessment or treatment that is not provided within NHS Highland and where there is no existing service agreement with another Health Board for that speciality.

Details of the current services covered by Service Level Agreements (SLAs) which NHS Highland has entered into with other NHS Boards, specific exclusions to these agreements and nationally funded services are available on the NHS Highland internet / intranet: http://intranet.nhsh.scot.nhs.uk/Org/CorpServ/PlanningandPerformance/ServicePlanning/Pages/Default.aspx

If the proposed OOA referral is to a service covered by one of NHS Highland’s existing SLAs, and is not listed within the exclusions to these and does not relate to a nationally funded service, then the referring clinician can make the referral in the normal way.

If, however, the proposed OOA referral is not covered by one of NHS Highland’s existing SLAs, or is specifically excluded from these SLAs or relates to a nationally funded service, then the referring clinician must contact the NHS Highland Service Planning Team before making the referral.

There may be instances where a clinician wishes to refer a patient out-with NHS Highland for a second opinion – i.e. the patient has been assessed by an appropriate NHS Highland clinician, but review by another clinician is sought. In this situation, any second opinion requests should only be made via this process after a second opinion from another appropriate local consultant (if available) has been sought.

IN SUMMARY:

Clinicians wishing to refer a patient out-with NHS Highland should consult the list of non NHS Highland services that are covered by Service Level Agreements which NHS Highland has entered into, exclusions and nationally funded services. (See Note 1)

*If the proposed OOA referral is not covered by the services included on this list or is an exclusion or a nationally funded Service*, the referring clinician should contact NHS Highland’s Service Planning Team for advice:

- **Paul Nairn**, Service Planning Manager  
  o Tel: 01463 706768  
  o e-mail: paul.nairn@nhs.net
- **Lynne Roe**, Service Agreement Manager  
  o Tel: 01463 706770  
  o e-mail: lynne.roe@nhs.net

Service Planning colleagues may advise that an NHS Highland OOA Referral Request Form should be completed and submitted. (See Notes 2 - 4)

Fully completed OOA Referral Request Forms should be sent to the Service Planning Team. (See Note 5)

Fully completed OOA Referral Request Forms will be discussed at Clinical Advisory Group (Core Group) meetings and decisions taken. (See Note 6)

A letter informing clinicians of the outcome of their request will be sent from the Executive Director chairing the Core Group meeting at which the decision was taken. (See Note 7)

This letter will be copied to the Service Planning Team in order that the necessary contractual arrangements can be made if the referral request is approved.
**Note 1:** A list of services covered by NHS Highland Service Level Agreements and nationally funded services is available on the NHS Highland Intranet http://intranet.nhsh.scot.nhs.uk/Org/CorpServ/Plannin{g|andPerformance/Servi}{cePlanning/Pages/Default.aspx

**Note 2:** Out-of-Area (OOA) Referral Request Forms should be completed collaboratively by colleagues in primary and secondary care. For example:

- A GP may submit a request on behalf of one of their patients, following discussion with an appropriate NHS Highland secondary care consultant.
- An NHS Highland secondary care specialist may submit a request on behalf of a patient, following discussion with the patient’s GP.

**Note 3:** Clinicians advised by the Service Planning Team to complete and submit an OOA Referral Request Form should not make the OOA referral unless they have been formally notified by the NHS Highland Clinical Advisory Group that the referral request has been approved.

**Note 4:** It is anticipated that clinicians will be informed of the outcome of their OOA referral request within two months of fully completed OOA Referral Request Forms being submitted. It is recognised, however, that a minority of OOA referral requests will need to be dealt with more urgently.

In such circumstances, requesting clinicians should contact the Service Planning Team, using the contact details within the flowchart, to discuss the referral and the timeframe within which a decision is required. If appropriate, consideration of some referral requests will be fast-tracked.

In such circumstances, the Service Planning Team will discuss with the requesting clinician the action that the clinician should take.

**Note 5:** Only fully completed OOA Referral Request Forms will be accepted. Following submission, forms will be returned to the submitting clinician if they are not fully completed.

**Note 6:** Fully completed OOA Referral Request Forms will be considered at Clinical Advisory Group (Core Group) meetings.

For decisions to be taken, a minimum of four Clinical Advisory Group (Core Group) colleagues should be present, two of whom must be Executive Directors of NHS Highland.

**Note 7:** The requesting clinician will be informed of the outcome of their request within two months of a fully completed OOA Referral Request form being submitted.
APPENDIX 3
RECOMMENDATIONS FORMULATED FOLLOWING CAG MEETINGS

Development of a weight management service
(Discussed on 1st September 2011)
The Clinical Advisory Group accepted that there is more evidence supporting the short-term effectiveness and cost-effectiveness of bariatric surgery for selected groups of obese people than exists for other treatment options for obesity. Nevertheless, the CAG supported the national guidance, as set out in SIGN 115 and the Obesity Route Map, that there should be a tiered approach to weight management, which applies to the whole population. Tier 3 services should consist of intensive dietary and physical activity interventions with psychological interventions available for some individuals with complex needs. NHS Highland should work towards providing such a service for those individuals for whom less intensive interventions, as set out in the Highland Healthy Weight Strategy, have failed to reduce weight over an agreed period of time.
The CAG recognised that there is national work in progress to agree new criteria for bariatric surgery. Until these new criteria are accepted and available, the CAG advises that NHS Highland should not be referring new patients for surgery and instead should develop a pilot Tier 3 service as outlined in the paper. More work is required to establish the detail of this service and its cost; the steering group should continue with revised membership to develop the service as a matter of urgency and offer it to those patients for whom bariatric surgery has been considered.
The pilot Tier 3 service requires careful evaluation at the end of its agreed time with subsequent discussion of what form of service can then be made routinely available as part of a full weight management pathway.
Access to bariatric surgery will need to be reviewed when the new criteria are available.

Photoepilation for hirsutism
(Discussed on 1st September 2011)
The Clinical Advisory Group recognised that photoepilation for hirsutism is an effective and cost effective method of hair removal, but does not support its provision by the NHS on the grounds of low clinical priority for the following reasons:
- Effective alternatives are available, including options for self management
- The condition is not life-limiting

Dabigatran
(Discussed on 1st September 2011)
No recommendation can be made on the implementation of dabigatran for the prevention of thrombo-embolic events in those with atrial fibrillation until criteria for treatment in Scotland are agreed nationally. It is anticipated that these criteria will be agreed in the next few weeks and that the Area Drug and Therapeutics Committee will then consider the implications for NHS Highland and make a recommendation to the Senior Management Team.
Chronic Fatigue Syndrome/Myalgic Encephalopathy (CFS/ME)
(Discussed on 1st September 2011)

The Clinical Advisory Group noted that people with CFS/ME in NHS Highland are managed almost exclusively within primary care, with access to those specific treatments recommended by current evidence-based guidance as required. The CAG did not therefore consider that developing a more detailed clinical pathway was required at the moment.

Specialist services for people with CFS / ME were discussed further during the Group's meeting on 1st March 2012.

At the time of writing, the recommendations agreed during this meeting have still to be formulated.

Tonsillectomy
(Discussed on 8th December 2011)

The Clinical Advisory Group noted that tonsillectomy rates in Highland were the lowest in Scotland in 2010 – 11. While there is no agreed ideal tonsillectomy rate, the limited data available on complications of untreated tonsillitis (quinsy and acute tonsillitis) did not permit any conclusions to be made on whether the current rate is too low. The ENT surgeons in Highland follow the criteria set out in SIGN guideline 117, but the CAG noted that careful interpretation is needed in individual cases, requiring skilled and experienced senior clinical expertise. The CAG wishes to commend the ENT surgeons’ good practice in seeking evidence to support the frequency of tonsillitis through diary keeping.

The CAG recommended that such good practice should be actively promoted throughout Highland. There should be continued monitoring of both complications of tonsillitis and tonsillectomy to: (a) ensure that maintaining the current low intervention rates in Highland is providing optimum care for patients; and (b) provide patients with accurate balanced information on the risks and benefits of tonsillectomy.

Knee arthroscopy
(Discussed on 8th December 2011)

The Clinical Advisory Group noted that rates for elective knee arthroscopy were the second lowest in Scotland in 2010-11. Most of these procedures are likely to be carried out on older adults with degenerative knee joints requiring emergency arthroscopies and interventions. It was unclear what was the best way of determining whether an arthroscopy rate was too high or too low. However, the CAG noted that arthroscopy should be seen as one aspect of investigating and managing a range of knee conditions, rather than in isolation. Good use of other investigations, such as MRI scans and skilled, experienced clinical assessment ensured that arthroscopy was seldom undertaken for purely diagnostic purposes. Such clinical assessment is now undertaken by the physiotherapy triage service as part of the musculo-skeletal pathway, as well as by orthopaedic consultants. While the conversion rate of arthroscopy to subsequent procedure was reported as relatively high in Highland, the data were not available for the CAG to consider.

The CAG commended the current good practice in managing arthroscopy in Highland and recommended that the physiotherapy triage service should be routine practice across Highland to ensure that all patients have equitable and appropriate access to arthroscopy and further procedures. The conversion rate of arthroscopy to procedure should be monitored occasionally. The CAG recommends that the Board should carefully consider participation in future national audit to help establish evidence-based best practice in this area.
Dilatation & Curettage
(Discussed on 8th December 2011)

The Clinical Advisory group noted the excellent work undertaken by the Obstetric and Gynaecology Department, in conjunction with GPs, in developing and distributing guidelines for the management of heavy menstrual bleeding across Highland and the further work on advice and support to primary care. The CAG highly recommends the continued adherence to the NICE Guidelines for the Management of Heavy Periods before referral to secondary care.
APPENDIX 4
LINKS BETWEEN NHS HIGHLAND CLINICAL ADVISORY GROUP AND THE R&D OFFICE

Exchanging Clinical Trial Intelligence between the NHS Highland CAG and the R&D Office

**Identifying Clinical Trials**

1. Aid CAG decision-making with respect to individual clinical trial participation requests
   And
2. Raise R&D Office awareness of clinical trial requests submitted to CAG

**Monitoring Clinical Trial Activity**

1. Raise CAG awareness of clinical trials that may have clinical and cost implications in the short-, medium and long-term for NHS Highland
   And
2. Embed the R&D Office role and Research Governance processes in CAG core business.

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Request for NHS Highland patient participation in a clinical trial received by CAG

Clinical trial details sent to NHS Highland R&D Office to check legitimacy, appropriateness, status and design (methodology and duration) of the clinical trial.

Is NHS Highland patient involvement in Clinical Trial appropriate? (Taking account of Research Governance)

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Information on current NHS Highland clinical trial activity requested from the R&D Office by the CAG on a quarterly basis for presentation at the Full CAG meeting.

NHS Highland clinical trial activity presented to Full CAG meeting on a quarterly basis.

Are there any clinical trials which may have clinical and cost implications for NHS Highland in the short-, medium- and/or long-term?

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Yes
No

NHS Highland R&D Office provides clinical trial information to CAG

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Yes
No

CAG to take note and consider implications
A meeting of the NoSPG Executive was held on 29th February 2012. The following briefing has been prepared to update the North NHS Boards on the outcome of the meeting.

**NoSPG Projects**

**NoS Weight Management Implementation Group**

The timescale in place for the implementation of the new criteria is dependant on the national discussions and a further meeting is taking place on 29 February 2012, following which it is hoped that the timescale will be clearer before a report to the National Planning Forum in April. In the north a draft report has been prepared on the re-costing work of bariatric surgery and it is expected that a revised pricing structure will be in place from 1 April 2012.

**Virtual Finance Team Workshop 23 January 2012**

In summer 2011, NoSPG approved a proposal to investigate the potential to develop a virtual finance team to support the development of a hub approach to capital developments. A workshop was held on 23 January 2012, which had identified the gaps to be addressed and identified what actions could be addressed internally or where there needed to be wider discussion. During the workshop the potential for a regional approach was supported but there was concern that the bundling of smaller projects to make them more attractive to external partners sometimes did not make sense and clarity was needed on who made these decisions. It was agreed Governance needed to be streamlined and a better understanding of what can and cannot be done, NHS Grampian to be approached to take this forward.

**CAMHS**

The CAMHS OBC has been approved by the Boards of NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland and NHS Tayside, before being considered at Scottish Government Capital Investment Group (CIG). CIG approved the OBC subject to clarification of a number of issues. Also, as part of the approvals process NoS Boards also approved the establishment of the network model and associated network roles, for implementation in financial year 2012/13, on the understanding that the FBC would then become focussed on the construction aspect of the project.

NHS Tayside has appointed the design team, funded through capital enablement funding, approved by the East Central hubco. A meeting was held between the Scottish Futures Trust (SFT), East Central Territory (ECT) and representatives of NoS partners to discuss bundling with another project in Fife. It has also been agreed that this bundled project should be constituted as a single project, with a single project director and NHS Fife have agreed to second their current project director to this wider role. This will require a further Project Board structure and Ms Selkirk, as Project Board chair and Mr Strachan, as Regional manager will represent the NoS project on this group.
**Paediatric Secondary Care Sustainability Review**

The NoS Paediatric Secondary Care Sustainability Review report, which had been carried out by Dr Zoe Dunhill, Independent Child Health Consultant and its recommendations were approved. Boards will be asked to confirm their support to this work.

**NoS Neonatal Network – Implications of draft Quality Framework for NoS**

Members noted the findings of the gap analysis and agreed that the NMCN can move forward with the implementation plan and acknowledged the need for collaborative working with paediatric services.

**National Work Streams**

**National Update**

A paper regarding the NPF review of National Services Advisory Group (NSAG) and efficiency of specialised services was noted.

**NoSPG Business Management**

**NoS Director of Regional Planning & Workforce Development**

Members agreed to the appointment of an interim Director with the caveat that a reasonable timescale should be established.

**Chair of NoSPG Executive**

It was agreed with the current situation in respect of the Director of Regional Planning role, Mr Carey would remain as chair until the review had concluded.

**Workplan 2011/12**

Progress against the NoSPG workplan was noted.

**Workplan 2012/13**

The 2012/13 workplan was noted and members advised that this was still subject to amendments.

**Clinical Lead – Child Protection**

It was reported that the NoS Clinical Lead for Child Protection had tendered her resignation and it was agreed to have a further discussion on this matter at the NoS Chairs and Chief Executives meeting on 7 March 2012.

**Date and time of next meeting**

The next meeting will be a virtual meeting to be held on 18th April 2012 at 10:30 am.

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Dr Annie Ingram  
Director of Regional Planning & Workforce Development  
North of Scotland Planning Group  

19 March 2012