NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 28 NOVEMBER 2012

TIME: 9:30 A.M. - 12:30 P.M.

VENUE: BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG

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

AGENDA

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Lead Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Members of the Public and the Press</td>
<td></td>
</tr>
<tr>
<td>Apologies for Absence</td>
<td></td>
</tr>
</tbody>
</table>

1. Minutes of the Previous Meeting of Lothian NHS Board held on 24 October 2012

   1.1. Standards of Care for Older People

2. Matters Arising (9.35am - 9.50am)

2.1. Standards of Care for Older People

3. Committee Minutes for Adoption (9.50am - 10.00am)

   3.1. Audit & Risk Committee - Minutes of the Meeting held on 9 October 2012

   3.2. Finance & Performance Review Committee - Minutes of the Meeting held on 10 October 2012

   3.3. Service Redesign Committee - Minutes of the Meeting held on 8 October 2012

   3.4. West Lothian Community Health & Care Partnership Sub-Committee - Minutes of the Meeting held on 18 October 2012

4. Chairman’s Report to Lothian NHS Board (10.00am - 10.10am)

5. Governance (10:10am - 10:45am)

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

For further information please contact Peter Reith, ☎ 35672, 📧 peter.reith@nhslothian.scot.nhs.uk
5.1. Quality Report  DF *
5.2. Healthcare Associated Infection Update  AKM *
5.3. Management Culture Work Programme Progress Update  CJW *
5.4. Update on Paediatric and Neonatal Medical Workforce  DF *

6. Performance Management (10.45am - 11.45am)
6.1. Performance Management  AMcM *
6.2. Unscheduled Care  MH/PG *
6.3. Waiting Times Progress and Performance  DF *
6.4. Financial Position  SG *

7. Policy & Strategy (11.45am - 12.15pm)
7.1. The Human Resources and Organisational Development Strategy – Update and Revisions  AB *
7.2. Integration – Hosted Services  AMcM/PG/ DAS/JF *
7.3. Acute Services Unscheduled Care Capacity  MH *

8. Other Items (12:15pm - 12:30pm)
8.1. Standing Financial Instructions and Scheme of Delegation  SG *
8.2. Committee Memberships  CJW *
8.3. Shadow Health & Social Care Partnership Board Memberships  CJW *
8.4. Scottish Patient Safety Programme - 5-Year Update  DF *

9. Date, Time and Venue of Next Meeting: Wednesday 23 January 2013 at 1:00 p.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh. (Development Session 9:30 a.m. - 12:30 p.m.)

10. Resolution to take items in closed session

LUNCH 12:30 p.m.

Dates of Meetings in 2013:
2013:
27 February 2913
27 March 2013
24 April 2013
22 May 2013
26 June 2013
24 July 2013
No August Meeting
25 September 2013
23 October 2013
27 November 2013
No December Meeting
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 24 October 2012 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

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

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

In Attendance: Mrs M Christie (Deputising for Mr J Forrest, Director, West Lothian Community Health and Care Partnership); Mr P Gabbitas (Director of Health and Social Care, City of Edinburgh Council); Mr A Jackson (Deputising for Professor A McMahon, Director of Strategic Planning and Primary Care); Ms S Westwick (Deputising for Mr D A Small (General Manager, East and Midlothian Community Health Partnership); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications and Public Affairs).

Apologies for absence were received from Dr M Bryce, Mr J Forrest; Mrs J McDowell; Professor A McMahon and Mr D A Small.

Declaration of Financial and Non-Financial Interest

The Chair reminded members they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Mr Johnston declared an interest under agenda item 7.1 “Improving Care for Older People in Acute Hospitals Healthcare Improvement Scotland Inspections” advising he was a Non-Executive Board member of NHS Healthcare Improvement Scotland. It was agreed Mr Johnston would remain in the room but not participate in the debate around this item.

77. Chair’s Opening Comments

77.1 Welcome to Members of the Public and Press – The Chair welcomed members of the public and press to the meeting.
78. Minutes of the Previous Meeting of Lothian NHS Board held on 26 September 2012

78.1 The Minutes were approved as a correct record, subject to Mrs Goldsmith providing Mr Weir with clarification around the wording in Minute 59.4.

79. Matters Arising

79.1 Royal Hospital for Sick Children/ Department of Clinical Neurosciences Reprovision – Little France – Mrs Goldsmith advised the final agreement on enabling works had been submitted to Consort with a positive report from technical and financial advisers. The plan was to submit the contract to the Official Journal of the European Union (OJEU) on 12 November 2012. She undertook to provide Board members with a copy of the advertisement at the appropriate time.

79.1.1 It was reported that a “bidder’s day” had been arranged to allow interested parties to meet with the Chief Executive and the Director of Finance along with project leads to allow them to ask questions of the Board. Mrs Goldsmith would circulate details to the Board and confirm whether Board members could attend the session.

80. Committee Minutes

80.1. Healthcare Governance Committee – Minutes of the Meeting held on 2 October 2012 – the Board adopted the Minutes. A positive presentation had been received from Professor Martin Dennis, Professor of Stroke Medicine on compliance with stroke standards.

80.2 East Lothian Community Health Partnership (CHP) Sub-Committee – Minutes of the Meeting held on 27 June 2012 – The Board adopted the Minutes. Mr Whyte advised he wished his successor well, commenting a new management team was in place. He suggested capital projects should be an area of focus in the coming months and years. The Chair commented he would mark Mr Whyte’s departure from the Board later in the meeting.

80.3 Edinburgh Community Health Partnership (CHP) Sub-Committee – Minutes of the Meeting held on 1 August 2012 – The Board adopted the Minutes. Mrs Allan advised a performance management review was underway within the CHP. In addition, five capital projects were underway with the Communications Team being fully engaged. She commented the members of the Public Patient Forum were important to the overall structure.

80.4 Midlothian Community Health Partnership (CHP) Sub-Committee – Minutes of the Meetings held on 31 May and 26 July 2012 – The Board adopted the Minutes.

80.5 West Lothian Community Health and Care Partnership (CHCP) Sub-Committee – Minutes of the Meeting held on 30 August 2012 – The Board adopted the Minutes. Councillor Toner advised the Public Patient Forum now reported on a 3-monthly cycle, although there was an ability to report more frequently if necessary. Mrs Christie advised a process of integrated performance and risk management had
been developed in conjunction with West Lothian Council and reported to the Sub-
Committee and Partnership Board. Councillor Toner advised this process was
working well with web links established to reduce the amount of paper generated.

80.6 West Lothian Community Health and Care Partnership Board – Minutes of the
Meeting held on 13 August 2012 – The Board adopted the Minutes.

81. Chairman’s Report

81.1 The Chair reminded the Board expressions of interest had been invited for the post
of Board Vice-Chair. At the indicated closing date one expression of interest had
been received from Mrs S Allan. The Board endorsed Mrs Allan’s appointment to
the role, which would be effective until the end of her term on the Board.

81.2 The Board noted the Chair had met with the Leaders of Midlothian and East
Lothian Councils with both colleagues having been supportive of the ambition to
have integrated Health and Social Care Partnerships in place by 1 April 2013. This
meant there was a reasonable prospect that all four Partnerships would be
established within Lothian to that timeframe.

82. Quality Report

82.1 Dr Farquharson advised the current report was presented in dashboard indicator
style with background trends provided. The hospital score card would feature in
the report to the next meeting when re-admission rates and length of stay would be
the focus.

82.2 The Board noted the clinical effectiveness measures for diabetes, which was a
disease affecting 34,000 patients in Lothian representing 4% of the population and
with a medicines spend of £10m-£12m annually. It was anticipated in 25 years
time that 10% of the Lothian population would suffer from diabetes if factors
associated with current behaviours were not addressed. Successful treatment was
best achieved through a co-ordinated treatment plan between primary care and the
hospital service. Dr Farquharson commented the figures in the paper were
disappointing in a Scotland and Lothian context around blood pressure monitoring
and there was a need to work on the balance between primary and secondary care
in the management of diabetes.

82.3 Dr Farquharson commented education was important in the management of
diabetes with Lothian having access to structured educational resources, which
supported better understanding of the condition and hence improved control. The
tight control of blood sugar was also important with there being a need to consider
the introduction of diabetic nurses in Lothian, as had happened elsewhere in
Scotland. It was noted work was in progress to improve the pathway management
for diabetes and the introduction of the integrated health and social care agenda
would support this work. It was reported a “think glucose” project was in place to
improve staff confidence in the management of diabetes with the results to date
having demonstrated a reduction in the level of medical errors, as well as hopefully
reduced lengths of stays in hospital.
82.4 Dr McCallum commented it was important to recognise socio-economic and ethnic variations and the role local authorities would play in the integration agenda to reduce the percentage of people who were over-weight, particularly in respect of the regulation of food and the better understanding of nutritional standards. She advised consideration was being given to NHS Lothian’s own services to set good examples. She commented 82% of people with diabetes were over-weight or obese compared to 65-66% of the remainder of the population.

82.5 Dr Williams noted there had been no mention of cardio-vascular data in the report and he felt this was an important area of consideration. Dr McCallum would investigate whether that data was available across the rest of Scotland. Dr Farquharson, Mrs Goldsmith and Dr McCallum would look in more detail at measures of resource consumption linking with tools such as the integrated resource framework.

82.6 The Chief Executive commented when the Committee structure paper was discussed in Private session, it would be important to consider the triangulation of indicators and how these linked with issues like managing delayed discharges and the 24-hour target across Accident and Emergency services. He commented on the relationship between length of stay and re-admissions advising as the performance reporting system developed, it would be important to be more aware of inter-dependency. It was noted that in terms of hospital standardised mortality rates, he suggested the three main hospitals in Lothian were performing better than the Scottish average and the target to reduce levels by 20% would, therefore, be a particular challenge in a system already bettering the Scottish average. This would need to be an area of focus for the Healthcare Governance and Risk Management Committee.

82.7 The Board noted the Quality report.

83. Healthcare Associated Infection Update

83.1 Dr McCallum commented the circulated paper represented her regular update on progress and actions to manage and reduce healthcare associated infection across NHS Lothian.

83.2 The Board noted good progress continued to be made, although this would be challenging moving forward as people presented with multiple morbidity and the number of complex cases made up a higher proportion of the total. Dr McCallum advised it was important to be aware of the balance between community and truly hospital associated infection. The importance of the work looking at antimicrobial resistance optimising prescribing in primary care was explained and Dr McCallum advised she was aware a number of workshops had been undertaken with primary care teams to address some of the issues. An important issue moving forward would be to reduce the risk of resistant organisms emerging.

83.3 Dr McCallum commented she was concerned that with the publication of a new European Antimicrobiological Action Plan, NHS Lothian did not have all its resources quite in the correct place nor in as sustainable a way as possible and
this would be worked on over the coming months. She advised it was possible to demonstrate over the years the unnecessary harm and resource expended in treating hospital associated infection and this had reduced, although there was still a significant way to go.

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

84. **Waiting Times Progress and Performance**

84.1 The Chief Executive explained the background to the late issuing of the waiting times paper advising it had been felt to be beneficial to issue the bulk of the available Board agenda as early as possible to provide adequate reading time, whilst holding back on the waiting times and Finance papers in order to provide the most up-to-date and relevant data possible. The Board agreed it was content for this approach to be continued in future.

84.2 Dr Farquharson commented in respect of inpatients and day cases in April 2012 there had been 2,000 patients waiting more than 12 weeks with the September 2012 position reporting at 1,029. He stressed in most specialties very significant in-roads into the waiting list backlog had been made. He advised, however, as the inpatient backlog reduced this left a core of patients with complex needs who were more difficult to manage and treat. Dr Farquharson stressed despite the introduction of the 12 week treatment time guarantee (TTG) patients requiring urgent surgery would be seen as quickly as possible.

84.3 The Board was advised even with the level of patients identified for treatment in the independent sector, approximately 400-500 patients in four areas were at risk of waiting over 12 weeks at the end of the year. These included highly complex patients in plastic surgery, urology, colorectal surgery, as well as some paediatric patients.

84.4 Dr Farquharson reminded the Board the reported outpatient backlog in August had been around 5,000 and this had reduced to 3,600 in September with good progress again being demonstrated in a number of specialties. This progress was expected to continue with further significant reductions expected over the coming months. The end of August position of 5,000 patients waiting more than 12 weeks was likely to have halved by the end of the calendar year.

84.5 The Board was advised at the end of September 2012, 609 patients had been waiting longer than 6 weeks for diagnostic endoscopy, a rise from 372 the previous month, as a result of a reclassification of cases. It was anticipated the demand would continue to rise as outpatients were identified as requiring an endoscopy procedure. It was currently estimated it would take between 18-24 months to address this issue, although a shorter timescale was being sought and options were being considered by the Clinical Director.

84.6 Dr Farquharson reported additional endoscopic capacity in private hospitals in Glasgow was available to Lothian patients but the extent to which this could materially assist in reducing the time taken to clear the backlog of patients would be determined by the willingness of patients to travel and the requirement to
identify significant additional clinically appropriate patients to compensate. In addition, agreement was also being brokered for independent sector capacity within Edinburgh and patients were being identified to make use of this additional capacity.

84.7 Mr Jackson provided the Board with a detailed presentation addressing progress around the continuing reduction of the backlog, preparations for the treatment time guarantee, national comparisons, historical comparisons, standardised operating procedures, training and reporting to the Board. In addition, an explanation was provided on the reasons for periods of unavailability being applied, with it being pointed out that Lothian applied less of these periods than most other parts of Scotland.

84.8 In response to a question from Mr Brettell, it was reported the endoscopy patients delayed since 2008 and 2009 had, wherever possible, been given appointment dates although, in some instances, further information had been sought from their General Practitioners in respect of their current health status. It was confirmed that all of the 2008 patients had been provided with dates, and all except 39 of the 2009 cases, and more than 50% of the 2010 patients.

84.9 The Chief Executive reported over recent times demand for endoscopy had trebled, partly due to an ageing population with multiple health complexities. He commented the increase in current figures for diagnostic endoscopy was in direct correlation to the success in reducing the outpatient waiting list backlog and the large number of patients being referred for an endoscopic investigation. The Chief Executive stressed the importance of recognising that individual patients within the waiting list backlog were a constantly changing cohort.

84.10 Mr Ash commented he was encouraged to see Lothian’s application of unavailability status was lower than elsewhere in Scotland and suggested this would have a positive impact on inequalities, advising he had been involved in producing a Scottish Government Health Directorates’ report in this area. He sought assurance a firm trajectory and milestones for mitigating the overall position was in place.

84.11 The Chief Executive reminded the Board at previous meetings it had been reported the inpatient backlog would be at zero or close to zero by the end of December with the outpatient waiting list being in a similar position by the end of March 2013. He commented, however, as the backlog reduced, the case mix was becoming more complex and involving super-tertiary specialties. He commented under the direction of the Patients Right Act the system was considering following a procurement process looking at specialist cases for treatment in the UK and, in special cases, in Europe. He advised following the introduction of the Act on 1 October 2012, the first date for a patient breaching the 12-week guarantee period would be 24 December. He stressed he and colleagues were focussed on producing hard actions to ensure there were no breaches, as it was not possible for the Board to plan to break the law. The Chief Executive commented any patient listed as an inpatient or day case since 1 October 2012 onwards had a legal guarantee to be treated either locally, elsewhere in Scotland, the UK or Europe.
84.12 The Board was advised by the Chief Executive that the legacy patients on the waiting list pre-1 October 2012 were not strictly covered by TTG, although their clinical priority would determine that they were treated appropriately. Whilst this might put the Board in a difficult position in respect of the guarantee every effort would be made to get to a zero position. The Chief Executive in response to Mrs Allan confirmed that no patients would be disadvantaged by their pre-October status.

84.13 Mr Jackson advised future reports to the Board would show a trend on how long patients had been waiting. He commented the Act required Health Boards to communicate with patients, with letters to be sent to those covered by the guarantee. In the event their availability status changed, this also required to be notified to them by letter. The Act was specific about the need for communication to be in writing unless patients specifically agreed to receive electronic communications. Mrs Hornett commented this process would be augmented by the provision of nationally produced leaflets.

84.14 Mrs Mitchell questioned the position in respect of patients on the waiting list pre-1 October, who were not high pressure cases and sought assurance they would not be disadvantaged. The Chief Executive advised priority would be given to any patient waiting more than 12 weeks and they would be treated as quickly as possible. He stressed patients with minor ailments were not the problem with the issue being around highly complex cases as previously reported.

84.15 Councillor Toner welcomed the reduction in the overall waiting list and questioned what steps were being put in place to increase internal capacity to reduce reliance on the private sector. The Chief Executive reminded colleagues the Board reports over the previous 4-5 months had signalled a need to invest in core capacity on this part of the programme, as well as additional investment in unscheduled care. He advised recruitment had been increased in a number of areas such as plastic surgery and neurosurgery. The Chief Executive referred to previous Board meetings where he had reported it might take up to 2-3 years to get the Lothian system into equilibrium with this timescale reflecting timeframes to recruit to specialist staff aligned with the increasing demand for services across Lothian. It was noted as the system moved towards equilibrium there would be less reliance on the private sector.

84.16 Mr Wilson welcomed the circulated paper, although he commented Non-Executives would have benefitted from it having included the detail of the Chief Executive’s verbal summary. He stressed the need for the Board to have a forward looking projection of risks. The Chief Executive felt everything he had reported verbally had been included in the paper, albeit perhaps less succinctly than the verbal report. He agreed with the need in future for the paper to flag the risk element clearly.

84.17 Mr Walker welcomed the level of progress being made and commented he would be keen not to see reference to capacity building dropping out of the paper. He also requested future iterations of the paper should include the impact on activity for the £20m spend as he felt total activity and capacity planning was inextricably linked. Mr Jackson agreed to re-instate this feature in future papers and to include progress on recruitment as an appendix to the paper.
84.18 The Board agreed the recommendations made in the circulated paper.

85. Unscheduled Care

85.1 Mrs Hornett advised she and Mr Gabbitas would jointly present on this paper and commented the key challenge was to work effectively in partnership with Community Health Partnerships and other agencies. It was noted Lothian’s year to date performance against the 4 hour access target was 92% against the 98% compliance requirement. There had been 12 x 12 hours patients breaching this target, although there had been a welcome reduction in the trend in the number of patients boarding. It was noted in terms of performance recording that work was underway with the Scottish Government Health Directorates to develop a system-wide approach looking at high-level data and this would include health and social care aspects. Mrs Hornett hoped to be able to share some of this information with the Board at a forthcoming meeting.

85.2 Mrs Hornett advised at the previous Board meeting a set of workstreams had been agreed and work was in progress in respect of these around health and social care focussed on Edinburgh because this was the area of greatest challenge. The Board noted there continued to be an increase in demand for domiciliary care and demand continued to outstrip capacity. In addition, the delayed discharge position was deteriorating with this representing a particular problem in Edinburgh especially around the availability of nursing homes with there being fifty patients currently awaiting placement.

85.3 The Board noted from Mrs Hornett that significant multi-agency work was underway in respect of winter planning. Additional beds were being made available in the event there was a need to increase admissions, although it was important to recognise this quantum was less than in the previous year. Work was in progress in this regard, particularly around the festive period and the beginning of January where the management of discharge rates would be key. Consideration was also being given to managing risks around the elective programme.

85.4 Mr Gabbitas commented in respect of the delayed discharge, it was important to consider this within the context of a historical position where there had been 450 delays. Over the previous 18 month period, the delayed position had been around 45 patients. He commented in the current year, there had been significant increases in the number of delays despite the fact there had been an increase in the resource being put into facilitating patient discharges from the NHS with social care support. Mr Gabbitas commented if demand had remained constant throughout the year, the delayed discharge position would have been at zero after 6 months but the number of delayed discharges had increased. He advised in the previous week, 92 people had received support packages and, despite this, the delayed discharge position had increased. He advised money had been set aside to increase capacity, although this depended on how quickly external providers could provide additional resources.

85.5 Mr Gabbitas commented the care home market size in Edinburgh had been largely constant over the previous 3 years. He advised in 2013 between February and
October, there would be an increase of 161 places in the care home market, the first such increase in 3 years. He commented, however, in overall terms it was not the strategic desire to see an increase in the number of people going into care homes. It would be his intention to explore the use of these facilities to support people at home. The Board noted there had been a 7.5% increase in the first 6 months of the year in the number of people supported at home and it was the intention to continue that trend rather than to expand the care home market. Mr Gabbitas advised in most local authority areas, the local authority purchased the majority of care home places and, in that regard, they had a significant impact and influence on the market. He advised, however, in Edinburgh 50% of care home places were taken by self-funding patients, who were prepared to pay more than the nationally agreed rate available to local authorities.

85.6 Mrs Hornett commented in respect to a comment made by Mr Johnston that significant work was underway around the unscheduled programme to ensure patients were only admitted to hospital when clinically necessary.

85.7 Mr Whyte commented at a previous meeting Mr Gabbitas had commented about the desire to shift the trend to home care provision and questioned when it was anticipated that demand would level off through preventative spend to stop the requirement for hospital admission. Mr Gabbitas commented strategically this would occur through the Older People’s Capacity Plan, which was a national requirement and which looked at all elements of demand and supply, as well as taking into account demographic aspects to assist in shaping the market. The Edinburgh plan was currently out for consultation and would be finalised by the end of March 2013.

85.8 The Chief Executive commented the key issue was to attempt to mitigate the growth in demand commenting people in the 65-75 years age group did not use specialist services significantly more than those under 65. He commented, however, there was a dramatic increase in this position for patients aged over 75 and 85 years respectively. The key issue moving forward would be how to best utilise health and social care, particularly as it was anticipated the older population would grow by 20%. In future, therefore, it would be important initiatives were developed which allowed the system to do more for less. It was noted although steps were being taken to mitigate demand, these were currently not impacting at the necessary levels. Mr Gabbitas commented there was evidence in CHPs of some success in mitigating demand, although further effort was still required.

85.9 Mr Boyter commented it was important financial, service capacity and work plans were all linked. He advised the Service Redesign Committee had looked at the 75+ age group and had noted between 2006-2035 this would grow significantly. The Scottish Government Health Directorates 20-20 quality strategy vision had highlighted the need for more care to be provided at home and in the community. Mr Boyter commented in order for this to progress there were issues to be addressed around supervision and individual client judgement and work was underway with the Scottish Government Health Directorates about how to move from the current acute sector model to one more aligned to community care. Mrs Hornett commented in respect of the investments agreed at the previous Board meeting, these had been split 50:50 between community and acute sector. The focus was about addressing investment in health and social care and dealing with
current problems with a view to shifting the balance into the community. She undertook to provide a further progress report to a future meeting.

85.10 Mrs Allan commented most people aged 75 years and over had not been disproportionate users of the health service previously and it would be important to recognise at the time they needed to use the service they needed to be assisted to obtain optimal benefit. She questioned in respect of the 161 care home places due to come onto the market whether these were private or local authority provided places. Mr Gabbitas advised the places would be privately provided, although discussions were underway about the potential for using some proportion for “step up, step down” provision. In particular, discussions were underway about the provision of a specialist dementia wing.

85.11 Mr Brettell commented in terms of accident and emergency services that his own recent experience with a relative had been extremely positive after using the NHS 24 telephone line. He commented, however, there had been people who had waited over 3 hours who had not utilised the same service. He questioned whether it would be possible to encourage people to use NHS 24 in order to obtain a better scheduling experience. Mrs Hornett commented the number of A&E attendances had increased and she would reflect this in a future report to the Board. She commented in most cases the two areas where patients waited longest were for their first assessment and the second was waiting for a bed. She commented information was available on the 4 hour performance by hospital site. Mrs Hornett commented the point raised about NHS 24 engagement was valid and did help with managing the flow of patients. She commented, however, the accident and emergency service was very available and people tended to turn up expecting to obtain immediate access to care and treatment. Mr Brettell commented whilst he understood the points raised, he was aware the publicity around the availability and impact NHS 24 could make tended to only issue around the festive and holiday periods.

85.12 Mr Walker commented he greatly welcomed the report which provided a complete picture around the reasons why the 98% was not being achieved. He commented unlike other papers before the Board, he welcomed the absolute detail around levels of activity and was encouraged to see this. He questioned whether through the Unscheduled Care Group consideration was being given to investing in “step up, step down” facilities, as this had previously been alluded to at the Finance and Performance Review Committee.

85.13 Mr Gabbitas commented the Unscheduled Care Group was indeed looking at “step up, step down” facilities and the City of Edinburgh Council had commissioned such facilities using the change fund, although there was a need to increase capacity and this would form part of the Older People’s Capacity Plan.

85.14 Dr Williams questioned in respect of reducing admissions and delayed discharges whether this should not be a key focus for the emerging Health and Social Care Partnerships. Mr Gabbitas commented this would indeed be a key performance area through the development of a more joined up approach between acute, social and community care.
The Board received the update report and welcomed the joint presentation between Mrs Hornett and Mr Gabbitas.

Performance Management

Mr Jackson provided the Board with an update on the most recently available NHS performance data as reported through local and national systems. He advised the bulk of the paper had been discussed earlier in the meeting with the remainder of the report largely being similar to that received by the Board in the previous month. He highlighted to the Board the position in respect of early access to antenatal care for the least affluent in the population.

The Board noted the performance management paper.

Financial Position to 30 September 2012

Mrs Goldsmith provided the Board with an overview of the financial position of NHS Lothian to the end of September 2012 advising this was an extremely challenging year, particularly in respect of the need to create additional capacity to address activity and waiting times issues.

Mrs Goldsmith advised NHS Lothian was reporting an overspend of £1.3m for the first 6 months of the financial year. This comprised a small operational benefit of £0.2m off-set by an under-delivery of £1.5m against the efficiency savings target.

The Board noted the outcome of the mid-year review process, which was key to the performance in the forthcoming year would be incorporated into the Board report for November, as well as being discussed at the Finance and Performance Review Committee in December.

Mrs Goldsmith commented the biggest issue of concern was in respect of the delivery of the Local Reinvestment Plan (LRP), which continued to rely on non-recurrent solutions. Whilst she understood the challenge of delivering LRP at the same time as building capacity, there was a need for a focus to be retained. She advised a workshop had been held to look at the impact of capacity planning against LRP to identify areas needing additional funding and also where performance could be improved. She commented in the current year, the level of LRP being delivered non-recurrently would have an impact on financial plans moving forward.

The Chief Executive reminded colleagues at his first Board meeting he had advised the three over-arching systemic issues facing NHS Lothian were around elective waiting times, unscheduled care and financial issues. He commented the first two issues had been significantly and thoroughly exposed to the Board, although the financial position had been less so. He commented the intention was to keep a firm focus on delivering the current year’s financial out-turns, although the target was to re-direct focus to addressing the financial plan for the forthcoming financial year. He felt there was a need for a substantial proportion of protected Board time to have debate about what the financial position looked like moving forward, linked
to income. In addition to ordinary pressures, £20m had been committed to address capacity and waiting time issues. He felt there would be benefit in Mrs Goldsmith organising a half day session for the Board to look at financial issues in 2013/14. Mrs Goldsmith commented she would make the appropriate arrangements advising a similar process was being put in place for budget managers.

87.6 Councillor Toner questioned why there was a need for efficiencies to be made when the Scottish Government Health Directorates was increasing resources to NHS Lothian. Mrs Goldsmith explained the efficiency target was a product of income and demand and commented while NHS Lothian had received an increase in income, the system was still £50m short of parity in respect of the National Resource Allocation Committee (NRAC) formula. She commented it was anticipated, however, progress against the NRAC formula would be evidenced over the forthcoming 2 years.

87.7 Mrs Goldsmith commented in respect of waiting times that £12m had been expended to the end of September, which had been expected because of the increase in activity. She commented, however, there had been evidence of an increase in the average cost of cases partly explained by the consequence of complex cases and partly because estimates had been based on unknowns. She commented it was her view more than the £20m identified for waiting times would be required, although not significantly more because of the use of Medinet.

87.8 Mrs Goldsmith advised she would incorporate issues around activity and the outcomes of the mid-year review in her financial report to the November Board.

87.9 Mrs Goldsmith commented within the capital budget there was evidence of some slippage, particularly around the Royal Hospital for Sick Children and other schemes. She commented this was part of a national trend. Councillor Toner questioned the position in respect of progress around the provision of the MRI scanner and maternity unit at St John’s Hospital. It was noted both these areas were progressing.

87.10 Mr Wilson commented the efficiency target appeared to be heavily back-end weighted and questioned whether this was deliberate. Mrs Goldsmith commented there had been a number of identified workstreams prepared in advance of the beginning of the year but the reality was it took some time for schemes to start delivering. She advised programme managers were in place, although it was important to recognise it did take time to redesign services and many schemes were dependent upon staff turnover. Mrs Goldsmith confirmed any expenditure on waiting times in excess of the Scottish Government Health Directorates’ allocation would require to be addressed by NHS Lothian, although after the mid-year review process had been concluded there might be a desire to discuss with the Scottish Government Health Directorates the profile of repayment.

87.11 Mr Ash commented in his experience NHS Lothian was not the first NHS body experiencing challenges in meeting financial targets. He commented, however, if the system was serious about taking out non-recurrent reliance, there was a need to re-engineer and redesign services and this position was not unique to the NHS. He currently did not see any link to service redesign contained within the paper. He also questioned what the process was for differentiating between immediate
and medium schemes that could be provided at less cost. Mrs Goldsmith advised work continued through various workstreams to link work and this would be expanded further at the half-day workshop session previously agreed. Mr Ash welcomed this and commented by the end of the financial year, it would be useful to have assurances the service redesign links were in place. Dr McCallum commented previous clinical presentations to the Board had detailed how service redesign had taken place and appropriate linkages with other workstreams.

87.12 Mr Whyte commented the capital slippage position looked considerable. He commented this was evident in areas other than just the Royal Hospital for Sick Children and it was his understanding that previously the Board had agreed to include phasing in the capital reports. In his view, future capital reports to the Board needed to be more comprehensive. Mrs Goldsmith undertook to address the issues raised.

87.13 The Board noted the overspend of £1.3m for the 6 months to the end of September 2012 and that a detailed mid-year review was now being undertaken to ensure year-end financial balance was delivered.

88. **NHS Lothian Estate: Backlog Maintenance Issues**

88.1 Mrs Goldsmith commented the circulated paper provided the Board with an overview of the backlog maintenance issues in relation to the estate of NHS Lothian and the proposed approach to the management of this in the short-term. She commented a similar paper had been discussed at the Finance and Performance Review Committee.

88.2 The Board noted backlog maintenance issues was a national challenge and not one specific to NHS Lothian. Mrs Goldsmith advised backlog maintenance had become a recent focus largely as a consequence of the reduction of capital availability, which had resulted in a reduction in new build facilities. She advised the NHS Lothian backlog was £142m, which was again not out of line with the rest of Scotland. She provided a summary of the areas affected by backlog maintenance.

88.3 The Board noted the Finance and Performance Review Committee had been keen to understand better the backlog maintenance issue in terms of how best to manage the risk. Mrs Goldsmith commented the Property Strategy would require to come to the Board at the appropriate point. She advised property disposals would assist the overall backlog maintenance position, although it was difficult to dispose of assets in the current economic climate and, in general, the system did not receive the benefits of disposal. She advised in order to retain disposal receipts, a business case would require to be made to the Scottish Government Health Directorates based on enhancing particular investments.

88.4 Mrs Goldsmith commented, in addition, specific reprovision projects would reduce the backlog maintenance costs by around £43.2m. She advised this was primarily due to investments through the capital programme. The current capital programme set aside £4m for statutory compliance and this was insufficient and, in that regard, there was a need to look at how to prioritise capital planning.
88.5 The Board noted the Finance and Performance Review Committee was proposing to spend £10m on backlog maintenance over the next 18 months with issues around primary care premises still being worked through. The Finance and Performance Review Committee had agreed to establish a Project Board, chaired by Mrs Goldsmith with Non-Executive Director input, as well as input from health and safety, infection control, estates and capital. It was noted a Project Manager was being appointed.

88.6 Professor Iredale joined the meeting.

88.7 The Chair advised following the Finance and Performance Review Committee he had discussed issues around property disposals with colleagues from the Scottish Government Health Directorates and had proposed that Boards should retain the disposal proceeds if these could be linked to a programme schedule. The Chief Executive suggested there was a need to move to using fewer sites concentrating on moving out of old dilapidated stock. He commented Lothian had advantages over other parts of Scotland in that property tended to attract higher prices. The Chief Executive was of the view there were a number of sites in Lothian that could be disposed of to mitigate the backlog maintenance position. Mrs Goldsmith agreed there was a need to think differently about the use of assets.

88.8 Mr Walker commented he had not been at the Finance and Performance Review Committee meeting when backlog maintenance had been discussed. He was of the view statutory compliance issues needed to be addressed and, where the system was not in compliance, there was a need for this to be addressed on a site-by-site prioritised basis. He felt the suggestion made by the Chair around recycling disposal monies was reasonable but he still felt there was a need to progress to dispose of sites as quickly as possible. He advised the paper before the Board was useful and he had welcomed the co-operation between the Service Redesign Committee and the Finance and Performance Review Committee in this important area.

88.9 Professor Iredale advised collaborative work between the University and NHS Lothian was also important.

88.10 The Board agreed the recommendations in the circulated paper and, in particular, the establishment of a programme of up to £10m over the next 2 years utilising in-year slippage of £4m and the statutory budget this year and next.

89. **Improving Care for Older People in Acute Hospitals Healthcare Improvement Scotland Inspection**

89.1 Mr Johnston advised he had previously declared an interest in this agenda item and would take no part in the debate.

89.2 Mrs Hornett provided the Board with an update report and action plan following an unannounced visit to the Royal Infirmary of Edinburgh on 27-29 August by Healthcare Improvement Scotland (HIS). She advised the visit to the Royal Infirmary of Edinburgh had been the first of the unannounced visits to all Health
Boards from HIS and the second formal visit to NHS Lothian. The inspection team visited seven wards, the combined assessment area, discharge lounge and also paid a brief visit to the emergency department over the three days. They examined 37 healthcare records, spoke to 27 patients and conducted a telephone interview with one carer. They also distributed questionnaires to patients, carers and relatives within a return of 37.

89.3 Mrs Hornett commented the Board had previously received a number of papers and supporting documents around improving the care of older people in Lothian hospitals. She stressed as Nurse Director she found any example of sub-standard patient care as one too many.

89.4 Mrs Hornett commented she fully supported the concept of unannounced inspections as they could drive improvements as had been evidenced by the environment inspections. She advised if the intention of the inspectors was to produce improvements, there needed to be more of a balance and formal reports should include areas for continued improvement, as had been the case in the Western General Hospital report but not with the Royal Infirmary of Edinburgh report. Mrs Hornett was concerned about the impact the Royal Infirmary of Edinburgh report would have on the public and reported she had already received letters of concerns, as well as correspondence supporting the standards of care received. The Board was advised the deficiencies raised in the report were of a Scotland-wide nature and not specific to Lothian and it was worth noting the national work in progress to improve standards of care.

89.5 Mrs Hornett reminded the Board it had approved the vulnerable people’s action plan at its meeting in July, which had deliberately not focussed solely on older people. She advised the action plan had already captured the issues raised in the inspection report and work was underway to accelerate its rate of delivery. The Joint Management Team had also considered the inspection report in detail with a view to addressing organisational issues to improve service across the system. Mrs Hornett advised she expected a follow-up visit to the Royal Infirmary of Edinburgh. She undertook to submit progress reports to the Board and the Healthcare Governance and Risk Management Committee to provide assurance that improvements were being achieved.

89.6 Mr Ash commented it was not clear whether it had been unfortunate the inspectors had seen less than best practice or whether they had projected more negatively the issues around continuous improvement. Mrs Hornett stressed one example of poor care was more than enough. She agreed inspections were partly down to what was seen on the day but it had to be recognised some of the issues the inspectors had raised were unacceptable and should not need inspections and visits to address, as this should happen through internal process particularly in respect of ensuring people were assisted at meal times. The Board noted the work of the Vulnerable People’s action plan was Lothian-wide whilst the inspection process focussed on acute services. The inspection process also demanded an action plan for each site and these individual plans, as well as being addressed on a site basis were woven into the over-arching plan.

89.7 Mr Wilson questioned whether the issues raised were cultural and systemic. Mrs Hornett suggested there were some cultural issues in some wards, although she
did not feel the issue was systemic as good practice could be demonstrated with data available which could support this view through an increasing depth and range of quality indicators.

89.8 The Chief Executive commented the themes in the report warranted further discussion. He advised small specialist hospitals had a slower pace and the ward environment tended to be calm. He reminded the Board the Royal Infirmary of Edinburgh was operating under huge pressure as evidenced by the delayed discharge and medical re-admission rates. He advised the Royal Infirmary of Edinburgh had been built as an acute adult hospital but was now having to treat frail elderly people with multiple needs, as well as increasing issues around dementia. He was of the opinion that currently Lothian’s acute hospitals were not organised to deal with patients with the time and care people needed and he felt this was the key systemic issue for Lothian. The Chief Executive suggested the report demonstrated why there was a need for alternatives to hospital provision.

89.9 Dr Williams commented it was disappointing to see less than ideal practice. He advised policies and procedures were in place and the problem was not systemic with there being issues about some people perhaps needing re-training. He was aware of very high satisfaction rates around the Royal Infirmary of Edinburgh and felt some of the comments in the report were slightly unrealistic. Mrs Allan endorsed this view and commented she had visited facilities for older people recently and had seen wonderful age-related attention being delivered and this should be shared with the rest of Lothian.

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

90. Committee Membership

90.1 The Board agreed to confirm the appointment of Councillor D Grant and Councillor R Henderson to the Audit and Risk Committee.

91. Committee Terms of Reference

91.1 The Board agreed the amended terms of reference of the Audit and Risk Committee. The Chair commented he welcomed the change of title which brought the Audit and Risk Committee function for NHS Lothian into line with other public bodies.

91.2 Mr Brettell commented the intention was to address systemic organisational risk with other Board Committees bringing risk elements to the table. The Chair and Mr Brettell would discuss the timing and length of appointments to the Audit and Risk Committee outwith the meeting.

91.3 Mr Walker felt the proposed way forward was the correct approach and commented the Board had never received details of the Corporate Risk Register. He felt it would be useful for the Board to receive a regular risk review. The Chair agreed with this proposal advising he had discussed this with Mr Brettell as the
Board needed to understand its own risk. He advised he would like to see more
detailed reference to risk contained in the Board paper.

91.4 Mr Brettell advised the Risk Register had been received by the Audit and Risk
Committee, which had not been fit for purpose and would be re-considered at the
next Committee meeting.

92. NHS Lothian: Report on the 2011/12 Audit

92.1 Mrs Goldsmith provided the Board with the External Auditors report on NHS
Lothian for 2011/12 as completed by Audit Scotland. She commented the report
had been reviewed by the Audit Committee and would now be incorporated into the
wider overview report for Scotland produced by Audit Scotland.

92.2 The Board noted the report on the 2011/12 Audit.

93.1 Communications Received

93.1 The Board noted the list of communications received from the Scottish
Government.

94. Any Other Competent Business

94.1 Mr Iain Whyte – the Chair advised this would be Mr Whyte’s last Board meeting
and commented that during his term on the Board he had carried out a full portfolio,
including as Chair of the East Lothian CHP. The Chair, on behalf of the Board,
thanked Mr Whyte for his contribution to the Board and wished him well for the
future.

95. Date and Time of Next Meeting

95.1 The next meeting of the Lothian NHS Board would be held at 9.30am on
Wednesday, 28 November 2012 in the Boardroom, Waverley Gate, 2-4 Waterloo
Place, Edinburgh.

96. Invoking Standing Order 16b

96.1 The Chair sought permission to invoke Standing Order 16b to allow a meeting of
NHS Lothian to be held in private. The Board agreed to invoke Standing Order
16b. The requirement arose from the need to discuss items of commercial
confidentiality that would not be appropriate at a meeting in public.
Minutes of the NHS Lothian Audit & Risk Committee Meeting held at 9.00am on Monday, 9 October 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr J Brettell (in the Chair); Mr M Ash.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager); Mr T Davison (Chief Executive); Mrs S Goldsmith (Director of Finance); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr D McConnell (Audit Scotland); Mr D Woods (Chief Internal Auditor); Dr C J Winstanley (Chairman); Mr A Payne (Corporate Governance & Value-for-Money Manager); Mr A Perston (Audit Scotland); Dr N Uren (Consultant, Cardiology) and Miss L Baird (Committee Administrator).

Apologies for absence were received from Councillor Henderson, Councillor Grant, Councillor Johnstone and Mr Peacock.

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Mr Ash declared that he was a member of the Accounts Commission which has close links with the external auditors, Audit Scotland.

20. Minutes of the Previous Meeting

20.1 Minutes of the Previous Meeting held on 26 June 2012 – previously circulated minutes of the meeting of the NHS Lothian Audit Committee held on 26 June 2012 were approved as a correct record.

21. Matters Arising

21.1 Matters Arising from the Meeting of 26 June – the Committee noted the previously circulated paper detailing the matters arising from the Audit Committee meeting held on 26 June 2012, together with the action taken and the outcomes.

21.1.1 It was noted that a further debate to determine the value of continuing private patient treatments in those areas which were not currently under constraint was required. As those constraints evolved systems in place would adapt through a process of annual review. Mrs Goldsmith agreed to bring forward a report on private patients following the completion of the speciality by speciality work.
21.1.2 The Committee agreed to note the action taken in respect of the Matters Arising.

Mr Martin entered the meeting.

22. Cardiology Services: Audit Scotland – February 2012

22.1 The previously circulated report to inform the Committee of the Audit Scotland summary and full reports on Cardiology Services in February 2012 and how the recommendations would be progressed within NHS Lothian was received.

22.2 The Committee discussed the report in detail noting the positive outcomes and the efficient and effective management of Cardiology Services in NHS Lothian. It was noted that the main challenge would be continuity of high quality care with budgetary constraints.

22.3 Members received assurance that the findings and subsequent actions would be taken forward by the Healthcare Governance Committee and the Audit and Risk Committee would receive a report in due course.

22.4 The Committee agreed to note the recommendations detailed within the report.

Dr Uren left the meeting.

23. Introduction to Audit and Risk Committee

23.1 Proposed Terms of Reference of the Audit and Risk Committee – The Committee reviewed the previously circulated proposed terms of reference of the Audit and Risk Committee and the changes detailed therein.

23.1.1 There was some discussion surrounding the ownership of the corporate risk register. It was agreed that the corporate risk register would be considered by the Audit and Risk Committee on a six monthly basis. A further layer of assurance would be taken forward through the Risk Management Steering Group, which will have its first meeting on 29 October 2012.

23.1.2 It was agreed that the members of the Audit and Risk Committee would hold pre and post Committee meetings to tease out issues and confirm that all areas of concern identified prior to the meeting

23.1.3 The Committee agreed to recommend that the Board approve the proposed terms of reference for the Audit and Risk Committee subject to changes discussed.

23.2 Mapping of Activities to the Terms of Reference for the Audit and Risk Committee – the Committee agreed to defer consideration of this item until the November 2012 meeting.
24. **Linkages with Other Board Committees**

24.1 **Finance & Performance Review Committee - Minutes of the Meetings held on 6 June and 15 August 2012** - the previously circulated minutes of the Finance & Performance Review Committee meetings held on the 6 June and 15 August 2012 were received.

24.1.1 The Committee noted the Finance and Performance Review Committee minutes of 6 June and 15 August 2012 and the information therein.

24.2 **Healthcare Governance & Risk Management Committee - Minutes of the Meeting held 12 June and 7 August 2012** - the previously circulated Minutes of the Healthcare Governance & Risk Management Committee meetings held on the 12 June and 7 August 2012 were received.

24.2.1 The Committee noted the Healthcare Governance and Risk Management Committee minutes of 12 June and 7 August 2012 and the information therein.

24.3 **Staff Governance Committee – Minutes of the Meeting held on 30 May and 29 August 2012** – the previously circulated minutes of the Staff Governance Committee meetings held on 30 May and 29 August 2012 were received.

24.3.1 The Committee noted the Staff Governance Committee minutes of 30 May and 29 August 2012 and the information therein.

24.4 Following a brief debate on linkages between Board Committees it was agreed that any matters from other Committees that required to be discussed would be consider by exception. The minutes would be removed from the agenda as a standing item.

25. **Risk Management**

25.1 **NHS Lothian Revised Risk Register**

25.1.2 The Committee noted the previously circulated report on the NHS Lothian Risk Register and the detail therein.

25.1.2 The Committee discussed the mitigation of risk and the level of assurance the Audit and Risk Committee required to effectively discharge their duties on behalf of the Board.

25.1.3 The Committee agreed that the key points for the Risk Steering Group’s consideration were:

- Symptoms and causes of risk
- Understanding gross risk/ awareness
- control
- Identifying the gaps in the register
25.1.4 Ms Bennett agreed to bring forward a report on a view of risk, the impact of risk and areas that don't have the necessary systems of control for consideration at the February meeting. A report on developments in the risk management system would be brought forward for consideration at the November meeting.

26. Internal Audit Reports

26.1 Internal Audit – Progress Report September 2012

26.1.1 Mr Woods gave a brief overview of the report and highlighted progress made with the 2012 plan. He reiterated the 4 pieces of extra work which might impact on the 2012 plan: NHS Waiting Times Arrangements, which has been added to the plan following a direction from the Scottish Government; Review of Information Received by the Board, which represents follow-up work requested by the Chair of the Board; payments to consultants for waiting list initiatives, which follows on from a Critical Incident Review; and questions raised during a recent internal audit regarding a contract for supplementary staffing.

26.1.2 The Committee noted that:
- the NHS Waiting Time Arrangements audit was ongoing, with a target date of 17 December 2012 for providing the report to the Scottish Government;
- the Review of Information Received by the Board will be taken forward by Internal Audit in early 2013;
- payments to consultants for waiting list initiatives will be discussed between the Chief Internal Auditor and Director of Finance; and
- the contract for supplementary staffing was considered lower priority as the position has since moved on.

26.1.3 Following a brief debate it was determined that a special meeting would be convened in November for the Audit & Risk Committee to receive the report on NHS Waiting Times Arrangements.

26.1.4 The Committee noted the previously circulated Internal Audit Progress Report September 2012.

26.2 Internal Audit – Reports with Fully Satisfactory & Satisfactory Ratings - The Committee noted the previously circulated Internal Audit - Reports with Fully Satisfactory & Satisfactory Ratings and the issues and assurances therein regarding the audits of Supplementary Staffing, Bank & Cash, Health & Safety – Manual Handling, and Accounts Receivable.

26.2 Property Transactions June 2012 – Mr Woods gave a brief overview of the mandatory audit of property transactions, highlighting that the process for signing off the property certificates required strengthening. Members noted that the Land & Property Manager is clarifying with the Scottish Government particular aspects regarding what is required by the Property Transactions Handbook.
26.2.1 The Committee noted the previously circulated report on Property Transactions.

26.3 Ascribe System September 2012 – The Committee noted the previously circulated report on the Ascribe System and the information therein.

26.3.1 There was some general discussion surrounding the timely implementation of Management Actions by service managers. It was proposed that in future relevant service managers should attend the Audit & Risk Committee to respond to internal audit reports. Further consideration of this matter was required.

27. External Audit Reports

27.1 NHS Lothian Annual Report on the 2011/12 Audit - the previously circulated report on NHS Lothian: Annual Report on the 2011/12 Audit from Mr McConnell was received.

27.1.1 Mr McConnell presented the report, highlighting the key findings of the 2011/12 Audit. It was noted that the equal pay claims could not be quantified and unions had been unable to produce a benchmark; this matter would be taken forward nationally.

27.1.2 The Committee agreed to accept the report.

27.2 Using Locum Doctors in Hospitals – Follow up – the previously circulated report on using locum doctors in hospitals from Mr Perston was received.

27.2.1 Mr Perston presented the report highlighting the progress to date, systems in place, areas improvements and the impact of Waiting Times.

27.2.2 There was some discussion surrounding the continuity of care and the use of locums in respect of waiting times.

27.2.3 Members agreed that all audit reports should include a covering paper in the Board template prior to coming to the Committee for consideration.

27.2.4 The Committee agreed to accept the report.

28. General Corporate Governance

28.1 Review of the Standing Financial Instructions - the previously circulated report to advise the Committee of the outcome of the scheduled periodic review of the standing financial instructions and the proposed revisions was received.

28.1.1 The Committee agreed to recommend that the Board support the proposed revisions to the Standing financial instructions subject to the minor amendments discussed.
28.2 Revising the Scheme of Delegation – the previously circulated report to propose revisions to the Board’s Scheme of Delegation to clarify how it was to be applied was received.

28.2.1 Following a detailed review of the scheme of delegation and the proposed revisions the Committee agreed to recommend that the Board approve the revision to the scheme of delegation, subject to the amendments as discussed.

28.3 Nugatory Payment: Harvard Business School – the Committee noted the previously circulated report on the nugatory payment above the Board delegated limit to Harvard Business School.

28.3.1 There were some discussions surrounding the lack of enthusiasm surrounding uptake of the course from colleagues out with NHS Lothian and the lessons that would be learnt in respect of future training.

28.3.2 The Committee agreed to accept the report and support the recommendations therein.

28.4 Edinburgh and Lothian Health Foundation: 2011/12 Annual Accounts - the previously circulated report to brief the Committee on the form and content of the financial statements of the Edinburgh and Lothian Foundation, in view of the likely consolidation of the endowment funds into the NHS Board accounts was received.

28.4.1 The Committee noted the progress to date. Members agreed to await a further report as the consolidation process moves forward.

28.4.2 The Committee agreed to accept the report.

28.5 Technical Brief – the Committee noted the previously circulated technical brief for information. It was agreed that in future this item would be picked up any other business.

29. Any Other Competent Business

29.1 Integration – There was some discussion on the plans for integration and the establishment of Health and social Care Partnerships. It was agreed that integration would be picked up through the risk register. A report on integration would be brought forward for consideration in the near future.

29.2 Volume of Paperwork – the Committee agreed that given the substantial amount if paperwork received by Board members, there is a risk that key issues are missed and governance is compromised. It was agreed that this should be considered for inclusion in the Corporate Risk Register.

29.3 Feedback on Committee meetings - the Chair requested that feedback on the structure and effectiveness of each Committee meeting be a standing item on the agenda.
30. Date of Next Meeting

30.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 15 November 2012 at 9.00am in Waverley Gate, Edinburgh.
Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 10 October 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:** Mr P Johnston (In the Chair); Mr J Brettell; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson and Dr C J Winstanley.

**In Attendance:** Mr R Aitken; Mr B Currie; Mr P Gabbitas; Mr I Graham; Mr A Jackson; Mrs L Khindria; Dr G Mackenzie; Ms A Mitchell; Ms C Potter; Mr P Reith and Ms J Thwaites.

Apologies for absence were received from Mr A Boyter, Mr T Davison, Mrs M Hornett, Professor J Iredale, Dr A K McCallum, Mr G Walker and Mr I Whyte.

**Declaration of Financial and Non-Financial Interest**

The Chair reminded members they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Councillor Henderson declared a non-financial interest in item 4.4 Ratho Surgery Initial Agreement (Revised) as he was the local Councillor. There were no other declarations of interest.

**29. Royal Hospital for Sick Children/ Department of Clinical Neurosciences Capital Project Presentation**

29.1 Mrs Goldsmith gave a presentation outlining the background to the reprovision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France.

29.2 Dr Winstanley asked about the proportion of parking spaces for patients and visitors compared to staff and Mr Currie advised that this was still to be determined but when the information was available he would advise the Committee.

29.3 Mrs Goldsmith explained the background to Supplementary Agreement 6 dealing with access and the exchange of land.

29.4 Mr Currie advised that a reference design for the project had been produced and a full non-profit distribution procurement process was being undertaken. He outlined the pre-qualification phase and the steps necessary to ensure compliance with all relevant legislation. It was noted that three pre-qualification steps would require to be passed before three bidders with the highest scores would be proposed for shortlisting for the competitive dialogue stage. Following this stage, a preferred bidder would be selected on the basis of a detailed
evaluation of the final tender, which would identify the most economically advantageous tender using a combination of scores for price and quality.

29.5 Dr Winstanley sought information on the securing of funding sources and Mrs Goldsmith advised that these would be included in the Final Business Case. Mr Graham confirmed that a funding letter would be received from Scottish Government in response to the Outline Business Case.

29.6 Mrs Goldsmith advised that Mrs Sansbury was currently working on tying down the clinical enabling work in advance of the project.

29.7 Mr Brettell asked about the possibility of linkage with the Royal Infirmary of Edinburgh public finance initiatives, as both facilities would be located at Little France, and Mr Currie confirmed that this would not be possible as each scheme had to be as autonomous as possible.

29.8 Mr Brettell commented that whilst he understood the process and reasons for the delays in the project the public might not. Mr Currie confirmed that there would be appropriate public relations input to explain the reason for the delays.

29.9 Mr Currie also confirmed that other sources of funding for certain aspects of the project were also being explored.

29.10 In response to a question from Dr Winstanley, Mr Currie confirmed that accommodation for the Sick Kids Friends Foundation was included in the reference design and Dr Winstanley commented that the Board would need to take a view on the overall arrangements.

29.11 The Chair thanked Mrs Goldsmith and Mr Currie for a comprehensive presentation.

30. Minutes of the Previous Meeting

30.1 The previously circulated Minutes of the meeting held on 15 August 2012 were approved.

31. Matters Arising

31.1 Endoscopy Suite Royal Infirmary of Edinburgh: Upgrade of Decontamination Facilities – Dr Mackenzie advised the Committee that the Director of Public Health and Health Policy was working on the Business Case for the upgrade of decontamination facilities for submission to the Corporate Management Team. Mrs Goldsmith advised that the design budget for the project had been upgraded.
32. **Business Case Update**

32.1 The Committee received a previously circulated report giving an update of approved Business Cases. Dr Winstanley questioned how the cost of replacing current services and the net benefits from that replacement was shown.

32.2 Mrs Goldsmith advised that these details could be extracted from the data.

32.3 Dr Winstanley suggested that the Committee should allocate some time to discuss this information when it was available and the Chair suggested that the future-proofing of buildings and the process for agreeing Business Cases should also be considered.

32.4 Mr Brettell suggested that it was necessary to know the current cost of services versus the new costs and if the new costs were greater where the funding was coming from. He also commented that the Committee did not have any context about competing priorities.

32.5 Mrs Goldsmith explained that there was a management process to look at incremental growth and whilst this had previously come from the uplift to Board funding, it now mostly came from efficiency savings. Much of the capital work carried out was driven by key priorities and demand.

32.6 Mr Brettell suggested that the Committee should be involved in prioritising competing capital projects and not simply agreeing Business Cases.

32.7 Mrs Goldsmith commented that the changes proposed at the Board to the Committee terms of reference envisaged a greater emphasis on property strategy and this should create opportunities to take a more strategic view.

32.8 Mr Gabbitas commented that the top five or six priorities in capital projects did not necessarily happen, particularly if the required land was not available. The City of Edinburgh Council was looking at revenue gains achieved by using its asset base more effectively.

32.9 The Committee agreed to note the report.

33. **Royal Hospital for Sick Children and Department of Clinical Neurosciences Project Update**

33.1 A previously circulated confidential report detailing progress on the Royal Hospital for Sick Children and Department of Clinical Neurosciences project since the previous meeting on 15 August 2012 was received.

33.2 Mrs Goldsmith advised the Committee that a considerable amount of the governance for the project would go through the Project Board and involvement of Non-Executive Board members was essential to this process.

33.3 Dr Winstanley asked any Non-Executive Board members interested in participating in the Project Board to contact him as soon as possible.
34. **NHS Lothian Estate: Backlog Maintenance Issues**

34.1 The Committee received a previously circulated report giving an overview of the backlog maintenance issues in relation to the Estate of NHS Lothian and the proposed approach to the management of associated risk in the short-term.

34.2 Mrs Goldsmith introduced the paper and explained that there had been concerns about the amount of backlog maintenance when the Capital Plan was discussed. Whilst there was an overall challenge of £142m, when disposals and reprovision was taken into consideration this amounted to £43m and NHS Lothian was looking to prioritise slippage to invest in backlog maintenance. A robust programme management approach would be adopted for the delivery of an investment programme to address these risks over the next five years and plans were underway to scope the priority packages of work which could be delivered over the next two years.

34.3 Mr Graham confirmed that the Scottish Government carried out surveys on the condition of the NHS Estate and to ensure that appropriate operational management procedures were in place.

34.4 Dr Winstanley commented that it had been made clear at the Audit & Risk Committee that a risk-based approach required to be taken and he felt that the Audit & Risk Committee should see the details of the backlog maintenance requirements.

34.5 Mrs Goldsmith confirmed that there was a need to work out the most appropriate way to manage the backlog maintenance and to address how best to mitigate the risk.

34.6 Mrs Khindria commented that the Head of Health and Safety should also be involved and this was agreed.

34.7 The Committee agreed to note the current level of backlog maintenance risks identified through the Property and Asset Management Strategy for 2012-17 and that a major planning exercise was underway to scope the longer term investment required. The Committee noted that a robust programme management approach would be adopted for the delivery of an investment programme to address these risks over the next five years and that plans were underway to scope the priority packages of work which could be delivered over the next two years.

34.8 The Committee agreed to approve a programme of up to £10m over the next two years utilising in-year slippage of £4m and the statutory standard budget for this year and the next year.
35. **Creation of Teenage and Young Adult Cancer Unit, Western General Hospital**

35.1 A previously circulated report giving an update on the proposals to create a dedicated unit for older teenagers and young adults (aged 16-24 years) with cancer at the Western General Hospital was received.

35.2 Dr Farquharson spoke to the report and advised the Committee that the Business Case was revenue neutral and the unit would be embedded within the cancer unit at the Western General Hospital. There would be an overall loss of four beds and a full option appraisal had been carried out, as well as a risk assessment.

35.3 The Committee agreed to approve the Standard Business Case for the creation of a dedicated unit for young people with cancer to allow the project to start on site from November 2012.

35.4 The Committee agreed to support the signing of a formal Development Agreement between NHS Lothian and the Teenage Cancer Trust, who had made a commitment to fund the capital costs associated with the creation of the unit up to the sum of £3.5m. The Committee noted that the capital costs certainty for the project was achieved on 24 September 2012 when the target price agreement was reached with the main contractor.

36. **Replacement of an MRI Scanner at the Western General Hospital**

36.1 The Committee received a previously circulated report and Business Case for the replacement of an MRI scanner for the Western General Hospital.

36.2 Mrs Goldsmith introduced the report and advised that the capital cost of £1,170,000 would come from the existing approved Lothian Medical Equipment Review Group budget.

36.3 Mr Brettell asked if flexibility around the way in which existing scanners were used had been examined, along with the possibility of extending the working day.

36.4 Mrs Goldsmith advised that the national terms and conditions of service did not presently allow for such an extension without significant additional funding consequences. Mrs Khindria advised that work was underway to examine ways of making the best use of resources and new contracts were being issued but discussions on this were still ongoing.

36.5 The Committee agreed to note that the proposal had been approved by the Lothian Medical Equipment Review Group and the Lothian Capital Investment Group and to approve the capital expenditure of £1,170,000 for the MRI scanner from the existing approved Lothian Medical Equipment Review Group budget to replace this essential equipment. The Committee also agreed to approve the non-recurring revenue expenditure of £131,750 for the double running costs and return of the current MRI scanner to the lessor.
37. **Update on the St John’s Hospital Labour Suite Modernisation Project Accompanied by the Standard Business Case Submission for the Associated St John’s Hospital Burns Unit Re-Location**

37.1 The Committee noted a previously circulated report giving an update on the St John’s Hospital labour suite modernisation project decant proposals, together with the Burns Unit Standard Business Case.

37.2 Mrs Goldsmith introduced the report and explained the background to the birthing centre.

37.3 Dr Farquharson commented that these proposals would be an important part of delivering services at St John’s Hospital.

37.4 The Chair asked what the arrangements would be for the Burns Unit to move and Mrs Goldsmith advised that the process required to be agreed before further dialogue could be held to discuss this.

37.5 Dr Winstanley asked for details of how many beds would be involved and Dr Farquharson undertook to obtain this information.

37.6 The Committee agreed to note the background to the St John’s labour suite modernisation plans and confirmed its support. It was agreed to approve the Standard Business Case for the St John’s Burns Unit re-location and to approve the funds outlined in the report to allow the award of the contract for both parts of the project. The Committee agreed to note the latest revised timelines for the two-stage project, which would see the estimated construction completion by December 2013.

38. **Ratho Surgery Initial Agreement (Revised)**

38.1 Mr Gabbitas introduced the previously circulated report and outlined the history to the provision of premises for Ratho surgery.

38.2 Councillor Henderson declared a non-financial interest in this subject as he was the local Councillor. He commented that the owner of the land was leasing rather than selling it and sought confirmation that the lease would be an appropriate length.

38.3 Mr Gabbitas assured the Committee that a long lease was being obtained.

38.4 Mrs Goldsmith reminded the Committee that the process was bound by the Property Transaction Handbook issued by the Scottish Government.

38.5 The Committee agreed to note that the original Initial Agreement entitled ‘ Provision of Premises for Ratho Surgery’ had been approved by the Lothian Capital Steering Group in February 2012 as the capital amount was within their delegated limit.
38.6 The Committee noted that this revised Initial Agreement entitled provision of Premises for Ratho Surgery proposed a re-assigned reference project with an increased capital value. It was noted that the Initial Agreement had been supported by Edinburgh Community Health Partnership Performance Management Sub-Committee, Lothian Capital Investment Group and the Corporate Management Team.

38.7 The Committee agreed to approve the revised Initial Agreement.

39. Performance Management

39.1 The Committee received a previously circulated report providing an update on the most recently available NHS Lothian performance data as reported through local and national systems.

39.2 The Committee noted that the Scottish Government had reported in mid-August that NHS Lothian was up-to-date in the submission performance of the main SMR record types. In addition, there had been an increase in attendance to early trimester screening and scanning from women who knew they were pregnant, although further work was needed to plan for the most hard to reach women.

39.3 Work was continuing on previously agreed actions to support the HEAT standards target and associated work and the delayed discharge figures were consistent with the previous month’s position.

39.4 The Committee agreed to note the report and the further remedial actions being taken where performance was currently off trajectory. It was also noted that in order to inform the Committee of the current position across the range of targets and standards set out in the paper, the source of the data provided was from local management systems within NHS Lothian. This meant that some information was only available quarterly or annually. Where local systems were reporting potential difficulties with any of these targets, exception reports would be provided as part of these reports.

40. Financial Position to 31 August 2012

40.1 The Committee received a previously circulated report providing an overview of the financial position of NHS Lothian to the end of August 2012.

40.2 Mrs Goldsmith advised the Committee that the content of this was the same as the report to the September Board meeting and that the September results were broadly in line with the August figures.

40.3 The Committee agreed to note the report and the overspend of £1.8m for the five months to the end of August 2012. It was noted that the formal mid-year financial review would commence during October following the analysis of the
month 6 results and the Corporate Management Team would receive a report on the outcome of this work during November.

41. Workforce Efficiencies within NHS Lothian

41.1 A previously circulated report giving an update on the position of workforce efficiencies, delivery against workforce design and highlighting any concerns in regard to workforce costs was received.

41.2 Mrs Khindria introduced the report and advised that whilst efficiency and productivity plans required a reduction of workforce costs by £15.69m in 2012/13, this would be achieved by reducing posts through service redesign, by reducing workforce costs by changes in skill mix and further reducing management costs. At the same time, however, approximately £20m would be invested to develop the capacities required to achieve waiting times targets. With the balance of workforce redesign reductions against the need to increase capacity for waiting times, the workforce would remain level for 2012/13.

41.3 The Committee noted that plans were in place to further address sickness absence. It was also noted that there was no voluntary severance scheme.

41.4 Dr Winstanley asked if it would be possible to have a breakdown of the number of staff who saw patients and whether clinical roles could be identified.

41.5 Mrs Khindria explained that this would be difficult for generic posts of which there were a great many in NHS Lothian. It would, however, be possible to provide more detail behind each job family.

41.6 In response to a question from Councillor Henderson, Mrs Khindria confirmed that a detailed drilling down into information about types of sickness absence was carried out and there were panels investigating sickness absence rates, which reported to the Staff Governance Committee.

41.7 Mr Brettell commented that he was proud to be part of a Board with such a low sickness absence rate.

41.8 The Committee agreed to note the position in NHS Lothian’s in-post hours for the period 1 April 2012-August 2012, which evidenced an increase of 54.76 whole time equivalents. The Committee noted the sickness absence position which was 4.17% in July, the lowest of the five largest Scotland Boards and a reduction from the May position of 4.3%.

41.9 It was agreed to note the position in regard to overtime expenditure which continued to show a significant increase since March 2012 and the £559,000 increase in the first five months when compared with the same period in the previous year, which would result in an estimated increase of £1.149m for 2012/13 if it continued at this level.
42. Shared Services Position Update

42.1 The Committee received a previously circulated report giving an update on the emerging strategic and operational workstreams and partnership within the umbrella of “shared services”, looking particularly to achieve gains during fiscal year 2012/13 within facilities management.

42.2 Mr Aitken introduced the report and explained that Shared Services Project Boards were now established in three local authority areas and the final one would have an initial meeting in October/November 2012. Each Project Board had its own evolving workstreams and were progressing work with gains in the current financial year.

42.3 Councillor Henderson asked about shared services involving catering and Mr Aitken explained that there was some involvement with schools, however, the NHS had a catering requiring requirement which continued even through weekends and school holidays.

42.4 Dr Winstanley commented that the Transport Users Group was exploring the possibility of using local authority vans which could use a queue planning strategy to assist in non-urgent patient transfers. The possibility of taking up the issue of top-slicing funding for the Ambulance Service on a national basis was being considered.

42.5 Mr Aitken commented that local authority colleagues could link into the transport hub.

42.6 The Chair advised that the next meeting of the Transport Access Committee would be focussing on shared services.

42.7 The Committee agreed to note and support the evolving work with local partners and identified efficiencies and timescale and that the developing local workstreams complimented the broader facilities agenda currently underway within the Efficiency and Productivity Steering Group work programme and also with regard to national NHS Scotland efficiency and productivity priorities.

42.8 It was noted that the local work programme would identify quick wins to be delivered during 2012/13, as well as longer term more significant gains in efficiency.

43. Date of Next Meeting

43.1 It was noted that the next meeting of the Committee would be held at 9.00am on Wednesday, 12 December 2012, in meeting room 5.4, Waverley Gate, Edinburgh.

43.2 The meeting closed at 11.22am.
Minutes of the Meeting of the Service Redesign Committee held at 2.00pm on Monday, 8 October 2012 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Professor J Iredale; Dr B Agrawal; Mrs L D'Arcy; Mr D Forbes; Dr D Farquharson; Mr J Forrest; Mrs M Hornett; Dr J Steyn; Ms L Tait; Mr S Wilson and Dr C J Winstanley.

In Attendance: Miss L Baird; Mr A Boyter; Dr C Evans; Miss T Gillies; Dr R Hardie; Mr S Harvey; Ms L Lawson and Mr R Samson.

Apologies for absence were received from Ms J Anderson; Mrs S Egan; Dr A K McCallum; Dr B McKinstry and Professor A McMahon.

Declaration of Financial and Non-Financial Interest

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

Welcomes and Introductions

The Chair welcomed the members present to the October meeting of the Service Redesign Committee. He went on to advise the Committee of the development of the Committee Structure and decisions taken at the September Board meeting. Further consideration of the structure had been scheduled for the October Board meeting. Members agreed to await a formal decision regarding the future of the Service Redesign Committee.

9. Minutes of the Previous Meeting

9.1 The Minutes of the Service Redesign Committee meeting held on 11 June were approved as a correct record.

9.2 The Committee Administrator agreed to re-circulate Dr McCallum’s presentation to the group for information.

Mr Boyter entered the meeting.

10. Workforce Plan 2012/13

10.1 Mr Boyter gave a concise presentation on the workforce plan 201/13 highlighting concerns in respect of the aging population and impact of the feminisation of the workforce.
10.2 Members were assured that Human Resources were tracking the workforce by speciality to ensure that the Board has an accurate picture of staffing levels and impending retirements to enable the succession planning process.

10.3 There was some discussion surrounding the development of the Health and Social Care Partnerships. Members noted that there were a number of issues that still required to be addressed as the Health and Social Care Partnerships moved forward.

Mr Boyter left the meeting.

11. Waiting Times Capacity and Demand Planning

11.1 The Committee received a report previously prepared for the Joint Management team in August and Dr Farquharson gave a verbal update on the progress made to address waiting times and capacity issues within NHS Lothian. Efforts made to maximise internal capacity and use external providers were highlighted. There was some discussion surrounding the Board’s capacity to sustain the 18 week target following the elimination of the backlog. It was anticipated that sufficient internal capacity to achieve the 18 week referral to treatment target would not be achievable until 2014.

11.2 Following a brief discussion in respect of the figures detailed within the report Dr Farquharson agreed to take forward amending any inaccuracies with Miss Gillies and Mr Bone out with the meeting.

11.3 The Committee considered whether a variation order on staffing would be to the Board’s advantage. Dr Farquharson agreed to explore the possibility of obtaining a variation order from Scottish Government colleagues as the Board moves forward with address Waiting Times.

12. Lesson from Legionella Outbreak

12.1 The Committee received a detailed presentation on the lessons learnt during the management of the Legionella outbreak, both good practice and areas requiring improvement were noted.

Dr Farquharson and Dr Agrawal left the meeting.
Mr Samson entered the meeting.

12.2 Members received assurance that the capacity within NHS Lothian for management of incidents was tested on a regular basis, and that as services develop under integration the necessary links would be identified and established. Contacts were updated on a regular basis and a range of exercises were carried out on a regular basis to ensure that the structure remained appropriate. Recent exercises included CBRN and counter terrorism.

12.3 The Committee acknowledged that the final report would be available in December 2012. Members agreed to await the table top exercise to re-run processes from the incident and the subsequent outcomes.
Ms Hornett, Dr Evans and Mr Harvey left the meeting.

13. Digital Engagement

13.1 The Committee noted the detailed presentation and the previously circulated report on digital engagement within NHS Lothian.

13.2 There was some discussion surrounding rolling out WiFi to other areas of the organisation and the associated cost implications, use of social media and the associated risks around confidentiality and misuse of NHS Lothian time. Members agreed that the use of social media in the workplace should be managed through the appropriate channels where the use of it could be deemed beneficial to the organisation.

13.3 The Committee proposed that the consultation process be broadened to gauge the likely engagement of the older population with digital media and assess reluctance towards digital engagement. Members felt that a greater understanding of issues surrounding patient confidentiality, disinvestment versus investment, the demographics of NHS Lothian and where it was appropriate to use digital engagement was required.

13.4 The Committee agreed to support the recommendations detailed within the report subject to the issues discussed at the meeting being addressed.

14. Spreading Good Practice in Service Redesign

14.1 The Committee agreed to defer the presentation on spreading good practice in service redesign to a future meeting.

15. Items for Information

15.1 Hepatitis MCN Annual Report – The Committee noted the previously circulated hepatitis MCN Annual report and the information detailed therein.

15.2 Minutes of the Transport Meetings held on 17 May, 19 July and 20 September 2012 – The Committee noted the previously circulated minutes of the Transport meetings held on 17 May, 19 July and 20 September 2012 and the information detailed therein.

16. Date of Next Meeting

16.1 The date of the next meeting was to be confirmed following the consideration of the Board Committees structure on 24 October 2012.
Minutes of the West Lothian Sub Committee held on 18 October 2012 at 2 – 4 pm in Strathbrock Partnership Centre.

Present
Frank Toner (FT)   Chair, West Lothian CHCP
John Richardson (JRi)  Public Involvement Representative
Julie Cassidy (JC)   Public Involvement Co-ordinator
Annabel Ross (AR)   GP Rep
Jane Houston (JH)  Partnership Rep
John Reid (JRe) Housing Policy and Development Manager
Pat Donald (PD)   Acting AHP Manager, West Lothian CHCP
Lindsay Seywright (LS)  Assistant Principal, West Lothian College (part)
Jane Kellock (JK)   Senior Manager, Children & Early Intervention
Alan Bell (AB) Senior Manager, Community Care Support & Services
Jim Forrest (JF) CHCP Director
Gill Cottrell (GC)  Chief Nurse
Claire Kenwood (CK) Assoc. Clinical Director
Alison Mitchell (AM) Non-Executive Member, NHS Lothian
Nick Clater (NC) Multi Agency Adult Protection Service Development Officer

Apologies
Lorraine Gillies (LG) Community Planning & Development Manager
Moira Niven (MN) Depute Chief Executive
Marion Christie (MC) Head of Health / General Manager, WLCHCP
James McCallum (JMc) Clinical Director
Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
Jennifer Scott (JS) Head of Social Policy, WLC
Michaela Kerr (MK) Lothian & Borders Police
Jim Gallacher (JG) Chief Executive Officer, Voluntary Sector Gateway
Tim Ward (TW) Senior Manager, Young People & Public Protection
Dr Morag Bryce (MB) Non-Executive Member, NHS Lothian

In Attendance
Rhona Anderson (RA) CHCP Development Manager

1. **APOLOGIES**
As above.

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

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

4. **DECLARATION OF INTEREST**
There were no declarations of interest made at this point that were relevant.

5. **DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE**
The minutes of the meeting held on 30 August 2012 were approved as being an accurate record.
6. **MATTERS ARISING FROM PREVIOUS MINUTE**
   There were no matters arising from the previous minutes.

7. **CONFIRMATION OF ACTION POINTS**
   All actions completed.

8. **MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING**
   No minutes available.

9. **MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP**
   No matters arising.

10. **MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT**
    No matters arising.

11. **SINGLE OUTCOME AGREEMENT 8 (SOA8)**
    We have improved the life chances for people at risk
    AB presented slides on the SOA8 CHCP workplan themes and described the format of the report. AB stated that a web link would be sent out with the draft minutes for the next meeting so members would be able to consider the detail further.

    NC described each of the performance indicators (PIs) which were all within target.

    NC explained that there were four strands to public protection – MAPPA (Multi Agency Public Protection Arrangements, but now more accurately described as the Management of Violent & Sexual Offenders within the Community), Adult Protection, Child Protection and Violence against Women.

    NC also explained that the indicators do not tell the whole story and that they are in need of revision, particularly so that the views and experiences of service users can be reflected.

    JRi raised concern regarding the use of jargon and acronyms and queried the 100% achievement levels.

    NC explained the acronyms and reported that, in future, areas for improvement would be included particularly around the experience of people and how safe they felt etc.

    It was agreed that AB should provide a brief cover note explaining acronyms, traffic light system etc.

12. **OUTCOMES FOR LOOKED AFTER CHILDREN**
    JK spoke to the report which informed the Sub-Committee of outcomes for looked after children (LAC) across three key performance indicators. The report highlighted the inequity between the destination types for looked after children compared to all school leavers (46% looked after children in positive destinations as opposed to 83% of all school leavers).

    JK outlined the local response to improve outcomes for looked after children. Key themes being addressed include attainment and achievement, placement choice and stability, workforce development, the role of the corporate parent and sustaining positive destinations.
A recruitment campaign is underway to address the low number of foster carers and the number of residential houses is being increased with two additional properties in Newton and Dedridge which will be used more flexibly. The ‘Sweet Sixteen’ approach is being adopted to support young carers and the LAC attainment fund will be used more flexibly (eg driving/music lessons etc).

JH asked if there was an upper age limit for foster carers. JK replied that foster carers are reviewed annually, including medical reports, but will check regarding age limit.

AM asked how the Early Years Early Intervention funding will be targeted and monitored.

JK explained that disbursement decisions are made by three strategic groups and that proposals were based on gap analysis. JK explained that the two main ways of achieving these outcomes are through allocation of resources and redesigning existing services eg residential accommodation.

JRe queried if LAC young people were being discriminated positively within Housing and whether this was something the LAC strategy group could consider, particularly regarding allocations.

Concern was expressed regarding the implication of impending welfare reforms and the position of under 25s generally, particularly those relying on benefits.

JC asked if any voluntary groups were involved in the LAC strategy group. JK confirmed that there were, plus the Children’s Rights Officer.

The recommendations of the report were agreed.

13. PROJECT FUNDED BY SCOTTISH GOVERNMENT’S VIOLENCE AGAINST WOMEN FUND

AB passed on apologies from Miranda Pio who was the author of the report and who had intended to speak to the report. AB spoke to the report and slides on Miranda’s behalf.

Information was tabled regarding the launch of the new service LISA (Living in Safe Accommodation) on 28 November at 2.00 pm in the Civic Centre, Livingston.

AB reported that West Lothian Council had been successful in its application to the Scottish Government for a 3 year grant of £245,000 to support an innovative system redesign.

The new model prioritises prevention rather than crisis intervention with the key components being preventing homelessness, early intervention, reducing trauma and supporting independence.

JC queried whether men would also be included. AB confirmed that, although the numbers of women and children affected were greater, men would also be supported.

AM queried the allocation of the funding. AB agreed to provide the detail and append this to the minute when circulated.

JRe reported that AnnMarie Carr would be attending a future Sub-Committee meeting to cover homelessness.

The Sub-Committee noted the recommendations of the report.
14. WEST LOTHIAN SUICIDE STATISTICS 2011

JK spoke to the report and explained that suicide statistics are published 6 months after the calendar year they are reporting on, therefore the most recent published statistics covered 2011.

JK explained that a new system of coding deaths was introduced from 2011 which means that some additional types of death are classified as suicide. However in the statistics for 2011, Public Health has estimated what the suicide figures for 2011 would have been if the old coding was used to allow for trends to be analysed.

JK stressed that caution needed to be exercised in relation to the statistics as they can be misleading and that if more detail was needed on how the statistics are calculated Jim Sherval could be invited to a future meeting.

JK explained that considerable work was underway to put preventative measures in place as far as this was possible and that this was a very difficult area to predict or prevent.

The recommendations of the report were agreed.

15. SCHEDULE OF DATES FOR FUTURE MEETINGS OF THE CHCP SUB-COMMITTEE

The report proposed meeting dates for the Sub-Committee for 2013.

It was agreed to remove the July date from the list.

With the proviso that the July date was removed, the dates outlined in the report were agreed.

16. ANY OTHER COMPETENT BUSINESS

West Lothian Buttle UK Award – Support Children Leaving Care

LS reported that the college had been successful in being awarded the Buttle UK Award which is a quality mark to support success in education for care leavers.

17. DATE, TIME OF NEXT MEETINGS 2012

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

06.12.2012
31.01.2013
28.03.2013
23.05.2013
29.08.2013
17.10.2013
05.12.2013

Meeting closed at 3.50pm
CHAIRMAN’S REPORT TO LOTHIAN NHS BOARD

1. Internal

1.1 Mid-Year Reviews

I commenced the autumn round of mid-term performance reviews for Board members in this period, and saw three Non-Executive Board members and the Chief Executive.

2. External

2.1 Annual Review

Alex Neil MSP hosted NHS Lothian’s annual review on 5 November, held at Murrayfield. The Cabinet Secretary expressed satisfaction with the event, which featured detailed comments and questions from members of the public.

2.2 Awards: Celebrating Success

On 25 October we staged the third ‘Celebrating Success’. I hosted one of the sponsor tables. Congratulations to the following:

- Innovation in Healthcare
  Dr John Steyn, General Practitioner and Clinical eHealth Adviser

- Lean in Lothian
  Orthotics Team, Smart Centre

- Best Service Redesign
  Obstetrics Triage and Assessment Team, Royal Infirmary of Edinburgh

- Improving Patient Access
  East Lothian Psychological Therapies Team

- Partnership in Practice
  Gateway to Recovery, Midlothian and East Lothian Drug and Alcohol Services

- Equality in Lothian
  The Willow Service

- Volunteer of the Year
  Pamela Duffy, Patient Representative, Teenage and Young Adult Cancer Unit
• Staff Member of the Year
   Ronald Fraser, Gardening Supervisor, Western General Hospital

• Team of the Year
   Legionella Outbreak Incident Management Team

• Health Hero
   Maxwell Reay and Lynne MacMurchie, Community Mental Health Chaplains

2.3 Awards: Daily Record Health Awards

On 8 November I attended the Daily Record health awards, for which I was also one of the judges. Congratulations to the following NHS staff:

• Doctor Award: Dr Paul Eunson, Consultant Paediatric Neurologist at the Royal Hospital for Sick Children

• Nurse Award: Jennifer Neilson, Community Psychiatric Nurse at South West Community Mental Health Team

• Healthier Lifestyle Award: Val Alexander, Family Nurse and Partnership Supervisor at Edinburgh Community Health Partnership

• Leading for Quality Award: Shena Brown, Respiratory Facilitator at West Lothian Community Health Care Partnership

2.4 Health and Social Care Integration

With colleagues I met Midlothian Council on 8 November to discuss the integration of health and social care. Later the same day I chaired a meeting of East Lothian and Midlothian Councils to discuss the same subject. In a very positive session it was agreed that:

- East Lothian and Midlothian Councils would each join with NHS Lothian to form Health and Social Care Partnerships for each Council area, with as much joint operational working across their boundaries as feasible.

- The Partnership Boards will have a start date of 1 April 2013 and (as in Edinburgh) initially have oversight of adult health and social care. Both Councils have the ambition to incorporate children’s’ services at a future date.

- Shadow Boards will meet as soon as possible, initially chaired by NHS Lothian in a rotating arrangement.

Charles Winstanley
Chairman
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the updated Quality Report for November 2012.

2 Recommendations

The Board is asked to:

2.1 Review the quality measures.

3 Discussion of Key Issues

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

3.2 Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 5. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard measures at every other Board meeting. The next report will focus on Cancer Clinical Effectiveness Measures.

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

3.4 The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.
3.5 Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

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

3.6.1 Hospital Scorecard data continues to show that NHS Lothian has a higher rate of medical and surgical readmissions and length of stay than the Scottish rate. Further work is being undertaken to analyse this data and integrate into work already being progressed through medical profiles.
Quality Dashboard October 2012 (dates for each data item stated in background charts)

This table shows a monthly summary of process and outcome quality measures. The trend arrow shows the change from the previous month’s/quarter’s data.¹ Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focusing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.

### Quality Ambition: Person-centred

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

**Outcome Measures**
- Number of complaints

### Quality Ambition: Safe

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

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

### Quality Ambition: Effective

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

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

### Additional Quality Measures

**Hospital Scorecard: April 2011-March 2012 (Next release December 2012)** *

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian Rate (Per 1000 admissions)</th>
<th>Scottish Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>21.12</td>
<td>20.24</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>41.88</td>
<td>38.75</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>50.03</td>
<td>45.72</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>111.56</td>
<td>102.10</td>
</tr>
</tbody>
</table>

**Average Surgical Length of Stay – Adjusted**
- Lothian: 0.90
- Scotland: 1.00

**Average Medical Length of Stay – Adjusted**
- Lothian: 0.97
- Scotland: 1.00

¹Note that these arrows have not been assigned following a formal set of rules; they are more of a general indication of the last period’s data. For example HSMR is shown to be remaining stable across Lothian, although the actual ratios for the last quarter show slight reductions (2 sites) or a slight increase (1 site).
Quality Ambition: Person-Centred

“Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.”

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

Goal: Reduction in number of complaints

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

Data Source: Datix

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

Data Source: Datix

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

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

Data Source: Datix
Quality Ambition: Safe

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

**Safe: Reduction in mortality**

<table>
<thead>
<tr>
<th>Title</th>
<th>Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Total number of in-hospital deaths and deaths within 30 days of discharge from hospital</td>
</tr>
<tr>
<td>Denominator</td>
<td>Predicted total number of deaths</td>
</tr>
<tr>
<td>Goal</td>
<td>National goal 15% reduction against 2006/07 baseline by 2012.</td>
</tr>
</tbody>
</table>

**Outcome Measure**

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – June 2012

Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – June 2012

Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – June 2012

Data Source: ISD (Quarterly)

**Safe: Reduction in Incidents with Harm and improved Incident Management**
Title: Incident Management Key Performance Indicators (KPIs)

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

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

Goal: Compliance target – 100%

Title: Incidents with harm

Numerator: Number of incidents associated with serious harm reported per month in NHS Lothian (Apr 2010-Mar 2012)

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

Title: Adverse Event Rate (NHS Lothian Acute Hospitals)

Numerator: The number of adverse events (AE) in a monthly random sample of closed case notes (deaths and live discharges)

Denominator: The total number of patient days (PD) in the month for the randomly drawn patients in the sample.

Goal: 30% reduction in Adverse Events from a 2007 baseline by 2012
**Safe: Reduction in Healthcare Associated Infections**

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

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

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

**Goal:** 95% Compliance

---

**Title:** C.Difficile associated disease rate against HEAT Target 2011-12

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

**Goal:** Further reduce healthcare associated infections so that by March 2013 NHS Boards’ rate of Clostridium Difficile infections in patients aged 65 and over is 0.39 cases or less. **Rate at October 2012 – 0.34**

---

**Process Measure**

Data Source: Local Audits (QIDS)

**Outcome Measure**

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

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

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

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

**Goal:** 95% Compliance

---

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

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

**Goal:** Further reduce healthcare associated infections so that by March 2013 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less. **Rate at October 2012 – 0.30**

---

**Process Measure**

Peripheral Vascular Cannula Bundle

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

---

**Outcome Measure**

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

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

| Title: | Percent compliance with the EWS Bundle (NHS Lothian Acute Hospitals) |
| Numerator: | The total number of SEWS observations completed correctly |
| Denominator: | The total number of observations reviewed per month. n=11,265 |
| Goal: | 95% Compliance |

Cardiac/Respiratory Arrests

| Title: | Number of Cardiac & Respiratory Arrest Calls |
| Numerator: | Arrest – Number of 2222 calls which were for a cardiac or respiratory arrest. Medical Emergency – calls which were not for a cardiac or respiratory arrest |
| Denominator: | Number of calls where an event type is recorded excluding staff, visitors, False Alarms, Cancelled Calls and Out of Hospital Arrests |
| Goal: | 30% reduction in Cardiac/Respiratory Arrests from February 2012 baseline within 2 years from baseline |

Process Measure

- Compliance with Standardised Early Warning Score (SEWS)
- Source Data: Local Audits (QIDS)

Outcome Measure

- Breakdown of 2222 Calls
- Source Data: Local Audits (Resuscitation Officer Database)
Safe: Improvement in Medicines Reconciliation

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

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

Source Data: Local Audits (QIDS)

Outcome Measure

OUTCOME MEASURE TO BE DETERMINED
Quality Ambition: Effective

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

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

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

### Process Measure

Compliance with Clinical Quality Indicator: Falls

Data Source: QiDS

### Outcome Measure

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

Data Source: Datix

Title: Patient Falls with Harm

Numerator: Number of falls reported with harm, moderate, major/ death

Goal: 20% reduction in inpatients falls and associated harm by March 2013.
### Effective: Reduction in Pressure Ulcers in patients

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

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

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

**n=546**

**Goal:** 95% Compliance

---

### Number of Pressure Ulcers per month across NHS Lothian

**Title:** Number of Pressure Ulcers per month across NHS Lothian

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

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

---

**Process Measure**

- **Data Source:** QiDS

**Outcome Measure**

- **Data Source:** Datix

**Count of avoidable pressure ulcers (Grade 2 and above) developed in NHS Lothian hospitals reported on Datix**

- **Target = Zero (avoidable pressure ulcers)**
Effective: Delivering Better Care - Reduction in Nursing Medication Administration Incidents

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

Outcome Measure

All NHS Lothian
Number of Nursing Administration of Medication Incidents: All incidents

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

**Title:** Admission to Stroke Unit within 1 day of admission

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

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

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

**Process Measure**

- **HEAT target**
- **Percentage of stroke patients admitted to acute stroke unit within one day of admission**

**Data Source:** ISD

---

**Title:** Stroke Treatment Measures

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

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

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

**Process Measure**

- **Percentage of stroke patients with swallow screen on day of admission**

**Data Source:** ISD

---

**Title:** Stroke Treatment Measures

**Numerator:** Number of admitted patients with initial diagnosis stroke that have a brain scan on the day of admission

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

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

**Process Measure**

- **Percentage of stroke patients with brain scan on day of admission**

**Data Source:** ISD
4 Key Risks

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

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

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

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

7 Involving People

7.1 Not applicable.

8 Resource Implications

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

Jo Bennett
Clinical Governance & Risk Manager
6 November 2012
jo.bennett@nhslothian.scot.nhs.uk

Dr Elizabeth Bream
Consultant in Public Health
6 November 2012
Elizabeth.bream@nhslothian.scot.nhs.uk

List of Appendices
Appendix 1: Supporting Technical Appendix
Appendix 1

Technical Appendix

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

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

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

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

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

Surgical readmissions within 7 days
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011. This measure has been standardised by age, sex and deprivation (SIMD 2009).

Surgical re-admissions within 28 days
As for 7 day readmissions.

Medical Re-admissions within 7 Days
This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty. The data are presented for calendar year 2011. This measure has been standardised by age, sex and deprivation (SIMD 2009).

Medical Re-admissions within 28 Days
As for 7 day readmissions.
**Average Length of Surgical Stay (Adjusted)**
Ratio of 'observed' length of stay over 'expected' length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

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

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

1 Purpose of the Report

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

2 Recommendations

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

- Maintain enhanced weekly surveillance of Meticillin Resistant *Staphylococcus aureus* and Meticillin Sensitive *Staphylococcus aureus* Bacteraemia to target resources for a sustained reduction.
- Support the reduction of healthcare associated *Clostridium difficile* Infection by promoting compliance with the antimicrobial stewardship, as recommended by Antimicrobial Management Team.
- Support the ongoing work with Meticillin Resistant *Staphylococcus aureus* screening programme by promoting compliance with Clinical Risk Assessment and swabbing.
- Support the ongoing work with mandatory surveillance.
- Recognise the need for ongoing work to maintain standards in anticipation of announced and unannounced Healthcare Environment Inspectorate visits.
- Support work ongoing regarding decontamination within NHS Lothian.
- Support Domestics Services with the enhancement of cleaning provided at Liberton Hospital.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 22 episodes of *Staphylococcus aureus* Bacteraemia in October 2012 (7 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*), compared to 24 in September 2012 (2 Meticillin Resistant *Staphylococcus aureus*, 22 Meticillin Sensitive *Staphylococcus aureus*). NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.26 cases or fewer per 1000 acute occupied bed days by March 2013, with a current rate of 0.31 (updated to October 2012). In order to achieve the target, NHS Lothian has to average no more than 17 episodes per month for the twelve month period, with a current average of 20 episodes per month.
3.2 *Clostridium difficile* Infection: there were 23 episodes of *Clostridium difficile* Infection in patients aged 65 or over in October 2012, compared to 25 in September 2012. NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.39 cases or fewer per 1000 total occupied bed days by March 2013, with a current rate of 0.34 (updated to October 2012). In order to achieve the target, NHS Lothian has to average no more than 27 episodes per month for the twelve month period, with a current average of 23 episodes per month.

3.3 Norovirus outbreaks: Health Protection Scotland has announced that the norovirus season has begun. NHS Lothian has noticed an increase in outbreaks at all acute sites. Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to service. Since August 2012 there have been 28 incidents of gastro-enteritis investigated in NHS Lothian. Of these, norovirus has been confirmed in 17 (61%) of the incidents by the Virology laboratory. In the remaining 11 (39%) the cause was not identified. This was due to norovirus not being detected, no samples having been received from affected patients or samples not yet tested by the laboratory. Since November 2012 there have been 47 patients identified as norovirus positive in all acute sites.

3.4 The Meticillin Resistant *Staphylococcus aureus* screening Key Performance Indicators have been reviewed by Health Protection Scotland in conjunction with Health Boards. A pilot of data collection is running 5-26/11/2012 with a view to roll-out in January 2013. The compliance levels have been set at a minimum of 90% for Clinical Risk Assessment and swabbing.

3.5 Mandatory Surgical Site Infection Surveillance: monthly and quarterly reports are compiled and distributed to the clinical areas and any actions required are discussed. These reports/figures are placed in the information display boards for staff, patients and visitors to peruse. For August 2012, there were 395 procedures performed within the mandatory surveillance scope: Abdominal hysterectomy, Caesarean Section, Hip Arthropscopy, Reapiprof Neck of Femur. One Surgical Site Infection was detected, a rate of 0.3%.

3.6 The Healthcare Environment Inspectorate:
3.6.1 NHS Lothian was asked to provide information on bed numbers/specialities for all acute sites plus community sites. In addition, the Healthcare Environment Inspectorate requested a breakdown of Healthcare Associated Infections including *Staphylococcus aureus* Bacteraemia, *Clostridium difficile* Infection and Surgical Site Infection data for the last four quarters. This information was returned to the Healthcare Environment Inspectorate by their deadline of 31/10/3012.
3.6.2 The Healthcare Environment Inspectorate asked NHS Lothian to provide an update on all sixteen week action plans to date for announced and unannounced inspections. This was returned to the Healthcare Environment Inspectorate by the required deadline of 9/11/2012.

3.6.3 The Healthcare Environment Inspectorate requested NHS Lothian provide a sixteen week action plan update for the unannounced inspection to the Royal Hospital for Sick Children in July 2012. This was returned to the Healthcare Environment Inspectorate by the required deadline of 14/11/2012.

3.6.4 NHS Lothian has been asked to update their Healthcare Associated Infection Self Assessment and return the information by 14/12/2012.

3.6.5 The Healthcare Environment Inspectorate have advised for a trial period, November 2012 - March 2013, they will be extending their inspection reporting timescale from six weeks to eight weeks. This means the final report will be published on the Healthcare Improvement Scotland website eight weeks after the inspection date. The main changes from this will be that the draft inspection report will be sent to Health Boards one week later than the previous time frame. There is no change to the Health Board response time frame on issues of any factual accuracy; this deadline remains five working days.

3.7 Incident updates for November 2012: the Infection Prevention and Control Team have been involved in investigating several incidents, including: *Mycobacterium tuberculosis* at the Royal Infirmary Edinburgh; colonisation with a sentinel resistant organism at the Royal Infirmary Edinburgh; an increased number of patients with *Clostridium difficile* Infection; norovirus outbreaks.

3.8 Antimicrobial Management Team:

3.8.1 Alert antibiotic policy pilot-study: this policy supports the appropriate use of selected broad-spectrum antibiotic agents (termed ‘alert antibiotics’) in order that development of antibacterial resistance is reduced. The pilot study has been running at the Royal Infirmary Edinburgh site since the beginning of February, is currently being implemented at St John’s Hospital and will be extended to the Western General Hospital in the next few months.

3.8.2 Antibiotic Prescribing indicators: the target level for compliance with the guidelines and documentation of indication is 95%. In clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines is above the target level for the Western General Hospital and the Royal Infirmary Edinburgh (with 100% compliance) and below the target level for St John’s Hospital (with 70% compliance). All the sites are above the target level for documentation of indication for antibiotic treatment (with 100% compliance). For surgical prophylaxis, the data collection focuses on colorectal surgery. Compliance with the Surgical Prophylaxis Policy has remained above target at 100% compliance in the last month and administration of single dose antibiotic prophylaxis has also remained above the target level at 100% compliance. The target level for both prescribing indicators is 95% compliance with Surgical Prophylaxis Guidelines and administration of a single dose of surgical prophylaxis.

3.9 Domestic Services are continuing to work with Infection Prevention and Control and nursing colleagues and have secured resources to increase support to Liberton Hospital to reflect the changing needs of the hospital population. This will be implemented during November 2012.
3.10 Decontamination:
3.10.1 Following restructuring, the responsibility for decontamination now comes under the Healthcare Associate Infection Executive Lead, the Director of Public Health and Health Policy. The strategic direction and priorities were agreed in October 2012.
3.10.2 Podiatry decontamination remains on the risk register. This will be addressed through the inclusion of capacity for the decontamination of podiatry instruments within the Initial Agreement Document for the Decontamination of Community Dental instruments. This is to be presented to the Finance and Performance Review Committee 12/12/2012 for their endorsement. In the interim it is planned that disposable podiatry equipment will be purchased to minimise risk until the specialist community based dental decontamination facility is operational.
3.10.4 Endoscopy: two steering groups have been set up to take forward the Central Endoscopy Decontamination Units at both the Royal Infirmary Edinburgh and Western General Hospital sites.
3.10.5 A Standard Operating Procedure for Rigid Sigmoidoscopes has been drafted and approved by the Decontamination Strategy Group, both University Hospital Division and Community Health (Care) Partnership Infection Control Committees. It has now been circulated to the Lothian Infection Control Advisory Committee for comment and approval at its meeting in November 2012.
3.10.6 New Building/refurbishment/upgrades: Lauriston Building Ear Nose and Throat Department’s new endoscopy decontamination unit has been completed, awaiting confirmation of installation and validation of decontamination equipment. The new Decontamination Unit at Sighthill Health Centre has been completed and the decontamination equipment delivered; again, confirmation of installation and validation of decontamination equipment is required.
3.10.7 Scottish Prison Services: the responsibility for Scottish Prison Services moved to the NHS domain in November 2011. A meeting was held in September with representatives from Her Majesty’s Service Edinburgh, Addiewell, the Clinical Director of Community Dental and the General Managers of Edinburgh Midlothian and East Lothian Community Health Partnerships to investigate developing further capacity for decontamination.

4 Key Risks

4.1 The key risks associated with the recommendations are:
- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Funding for Meticillin Resistant *Staphylococcus aureus* screening and monitoring of Key Performance Indicators set by Health Protection Scotland is non-recurring.
- Increased numbers of Healthcare Associated Infections leads to adverse patient harm, as well as failure to comply with Health Efficiency Access Treatment targets.
- There is the potential for the Healthcare Environment Inspectorate to find adverse areas of cleanliness or standards of practice. This would undermine the organisation’s commitment to a healthier, safer healthcare environment and
could lead to adverse publicity for NHS Lothian and loss of public/patient confidence.

- Financial and capacity plans for infection prevention and control for 2013/14 do not yet include costs associated with addressing issues associated with unscheduled care and waiting times.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

Fiona Cameron
Head of Infection Prevention and Control Services
15/11/2012
fiona.cameron@nhslothian.scot.nhs.uk

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
There were 22 SAB recorded during October 2012 (7 MRSA & 15 MSSA). The lowest number recorded in the last 12 month period is 15 (August 2012).

There were 31 CDI recorded in October 2012, 23 were in aged 65 & over. February 2012 recorded the lowest number in the last 12 month period with 20 cases.

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

Currently, NHS Lothian is on trajectory to achieve the set target of 0.39 or less cases per 1000 OBDS. The challenge going forward is to maintain this or reduce even further.

Hand Hygiene Monitoring Compliance

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td></td>
</tr>
</tbody>
</table>

Cleaning Compliance

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

Estates Monitoring Compliance

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>94%</td>
<td>97%</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>35</td>
<td>24</td>
<td>45</td>
<td>20</td>
<td>23</td>
<td>28</td>
<td>22</td>
<td>46</td>
<td>25</td>
<td>40</td>
<td>33</td>
</tr>
</tbody>
</table>

MRSA Bacteraemia Cases

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>25</td>
<td>21</td>
<td>19</td>
<td>16</td>
<td>22</td>
<td>23</td>
<td>16</td>
<td>18</td>
<td>21</td>
<td>15</td>
<td>24</td>
</tr>
</tbody>
</table>

MSSA Bacteraemia Cases

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>35</td>
<td>24</td>
<td>45</td>
<td>20</td>
<td>23</td>
<td>28</td>
<td>22</td>
<td>46</td>
<td>25</td>
<td>40</td>
<td>33</td>
</tr>
</tbody>
</table>

This is the new Report Card Format introduced by Scottish Government July 2011.
**Royal Infirmary of Edinburgh**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 3 SAB recorded during October 2012.

**Clostridium difficile Infection (CDI)**
There were 9 CDI recorded during October 2012.

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

**Hand Hygiene Monitoring Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95%</td>
<td>94%</td>
<td>96%</td>
<td>94%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td>94%</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Cleaning Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>99%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>

**Estates Monitoring Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**MRSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**MSSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
**Western General Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 3 SAB recorded during October 2012.

**Clostridium difficile Infection (CDI)**
There were 9 CDI recorded during October 2012.

---

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

### Hand Hygiene Monitoring Compliance

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>97%</td>
<td>94%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>94%</td>
<td></td>
</tr>
</tbody>
</table>

### Cleaning Compliance

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

### Estates Monitoring Compliance

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

---

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

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>12</td>
<td>3</td>
<td>13</td>
<td>7</td>
<td>7</td>
<td>10</td>
<td>9</td>
<td>12</td>
<td>6</td>
<td>10</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

---

### Total Staphylococcus aureus Bacteraemia (SAB) Cases

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### MRSA Bacteraemia Cases

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

### MSSA Bacteraemia Cases

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
**St Johns Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB with the onset greater than 48 hours after admission recorded during October 2012.

**Clostridium difficile Infection (CDI)**
There were 3 CDI recorded during October 2012.

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

**Hand Hygiene Monitoring Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>

**Cleaning Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Estates Monitoring Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>94%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

**MRSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

**MSSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
**Liberton Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during October 2012.

**Clostridium difficile Infection (CDI)**
There were 2 CDI recorded during October 2012.

---

**Hand Hygiene Monitoring Compliance**

<table>
<thead>
<tr>
<th>Month</th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
</tr>
</tbody>
</table>

**Cleaning Compliance**

<table>
<thead>
<tr>
<th>Month</th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>94%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>97%</td>
<td>93%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>94%</td>
<td>81%</td>
</tr>
</tbody>
</table>

**Estates Monitoring Compliance**

<table>
<thead>
<tr>
<th>Month</th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>93%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
<td>97%</td>
<td>98%</td>
<td>69%</td>
<td>96%</td>
<td>87%</td>
</tr>
</tbody>
</table>

---

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

<table>
<thead>
<tr>
<th>Month</th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**MRSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th>Month</th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

**MSSA Bacteraemia Cases**

<table>
<thead>
<tr>
<th>Month</th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Staphylococcus aureus Bacteraemia (SAB)
There were no SAB with the onset greater than 48 hours after admission recorded during October 2012.

Clostridium difficile Infection (CDI)
There were no CDI recorded during October 2012.

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

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

<table>
<thead>
<tr>
<th>Hand Hygiene Monitoring Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-11</td>
</tr>
<tr>
<td>96%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cleaning Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-11</td>
</tr>
<tr>
<td>94%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estates Monitoring Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-11</td>
</tr>
<tr>
<td>99%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Total Staphylococcus aureus Bacteraemia (SAB) Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-11</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MRSA Bacteraemia Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-11</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MSSA Bacteraemia Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-11</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>
**Royal Victoria Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were no SAB recorded during October 2012.

**Clostridium difficile Infection (CDI)**
There were no CDI recorded during October 2012.

---

**Hand Hygiene Monitoring Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>97%</td>
<td>98%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>100%</td>
<td>97%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Cleaning Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>96%</td>
<td>93%</td>
<td>94%</td>
<td>94%</td>
<td>95%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Estates Monitoring Compliance**

<table>
<thead>
<tr>
<th></th>
<th>N-11</th>
<th>D-11</th>
<th>J-12</th>
<th>F-12</th>
<th>M-12</th>
<th>A-12</th>
<th>M-12</th>
<th>J-12</th>
<th>J-12</th>
<th>A-12</th>
<th>S-12</th>
<th>O-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
<td>97%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

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

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
Community Hospitals

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

*Clostridium difficile* Infection (CDI)
There were no CDI recorded during October 2012.

This is the new Report Card Format introduced by Scottish Government July 2011.
**Staphylococcus aureus Bacteraemia (SAB)**
Patients who are identified with a SAB within 48 hours of admission to Hospital are included in this report card. During October 2012 there were 15 SAB recorded.

**Clostridium difficile Infection (CDI)**
This report card shows the number of CDI Episodes identified from specimens submitted from General Practice's. During September 2012 there were 8 CDI recorded.

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

1.1 The purpose of this report is to update the NHS Lothian Board on the progress we have made in taking forward the work programme which addresses the concerns raised in the D J Bowles report.

Any member wishing additional information should contact the Programme Lead, Lynne Khindria, Associate Director of Workforce Development, in advance of the meeting.

2 Progress

The Board is asked to note the following progress:

2.1 The Steering Group has been established, has agreed terms and reference and has met on four occasions. There is now an agreed work programme and the group will now meet every two months to ensure the work programme is prioritised and progressed. The Steering Group is accountable to the Scottish Government Health Department and provides regular reports to them. The programme lead is Lynne Khindria, Associate Director of Workforce Development who reports jointly to the Chairman and the Chief Executive for this work.

Resources

2.2 Resources have been identified and agreed by the Steering Group. To minimise costs, staff have been deployed from other duties to concentrate on the work programme. Following a competitive process an external facilitation company has been appointed to provide external leadership development, expertise and support.

Work Programme

2.3 A comprehensive work programme has been developed and agreed which takes forward the key concerns raised with the D J Bowles report. In addition, the work programme integrates with other current and planned programmes of work that will enhance our workforce, the employee experience and our staff governance standards.

Progress to date

2.4 The key areas within the work programme and progress to date: -
Development Programmes for NHS Lothian

The D J Bowles report made a number of recommendations in regard to the Corporate Management Team and in order to progress these the following actions have taken place:

- We have realigned the portfolios of the Corporate Management Team, thus ensuring equity of workload and to provide additional support to the management of Acute services. Full details of these changes were presented to the Remuneration Committee, the Lothian Partnership Forum, the Area Clinical Forum and Senior Teams.

- A development programme has been determined for the Corporate Management Team which addresses how they improve their team working, it includes assessing their individual development needs and to agree the development needs of the team. Each member of the Corporate Management Team has been interviewed on an individual basis, with an external Consultant to ensure the programme meets their individual and collective development needs. A team building workshop with external facilitation is scheduled for 20th and 21st November 2012.

- When the final arrangements for the management of the sub structures of Acute services is agreed, a similar development programme will be established for the Acute Senior Team. A programme will also be developed to provide support to the Senior Teams, who will be taking forward the establishment and the integration of Health and Social Care Partnership.

- It is also proposed that we have a collective leadership session with the NHS Board, the Area Partnership Forum, Area Clinical Forum, the Corporate Management Team and Senior Teams in order to discuss, engage and agree on how we work together to take forward our key challenges and priorities. This event will probably be scheduled for February 2013 and will be formatted as a one-day conference.

2.5 In order to ensure better engagement and linkage between the Corporate Management Team, Area Partnership Forum, Area Clinical Forum, the Employee Director and the Chair of the Area Clinical Forum will become members of the Joint Management Team. This meets monthly to discuss priorities and to monitor performance and includes the Corporate Management Team and the Acute Senior Management Team. It is chaired by the Chief Executive.

Values and Culture

2.6 To ensure that our staff are fully engaged in determining our values and behaviours, we have organised a large number of inter-active workshops throughout our sites and hospitals. Sessions with staff last for no longer than one hour. Arrangements have also been made to engage with medical staff and we have integrated this work into our corporate induction programme, which now includes a session on “Putting Values and Behaviours into Action”. These workshops started in September 2012.
and will run until the end of November 2012 and the feedback will inform the
determination of our values and behaviours. The outcomes from this work will be
presented to the Steering Group.

Management Development

2.7 A programme to improve our management capability and competency is essential if
we are able to take forward our challenging agenda. The process to do this will be to:-

- Determine the core managerial posts within NHS Lothian, clarifying the roles,
accountabilities and responsibilities, this needs to be based on proposed new
structures if planned changes are anticipated. Work has commenced in Acute
services and will be taken forward in Health and Social Care Partnerships,
thereafter.

- Determine and agree the essential skills that an individual requires to undertake
these roles.

- Assess the skills and competence of individuals and where there is a skill or
competence gap we need to address this by development, coaching, mentoring
or redeployment.

To support this work we have asked a number of the Harvard / Napier participants,
Management and Partnership, to assist in the developmental stage of this
programme. We may also require some assistance from external development and
leadership providers to undertake assessment and the provision of appropriate
programmes. This work is critical as we implement new structures and ways of
working for Acute services and the development of Health and Social Care
Partnerships. It is anticipated that this will be a two year programme.

Dignity at Work

2.8 Meetings have been held with Partnership representatives to determine what action
requires to be taken forward in regard to Dignity at Work. The position is that they
are content with the policy; however there are some implementation issues which
need to be resolved. To progress this work, a small group has been formed to
review these issues and develop solutions including monitoring arrangements. The
group has met twice and the main areas of discussion are:-

- Policy changes
- Access to confidential contacts
- Medication and Facilitation services

Performance Management

2.9 Performance management was raised as an issue in the D J Bowles report and was
also highlighted in the refreshed HR/OD strategy. This will be taken forward with
the implementation of the HR/OD strategy and we will also take the opportunity to
consider team based performance.
Embedding Policies and Procedures

2.10 Work to streamline HR policies and procedures has already commenced as part of HR and OD service review, which involves maximising the use of internal intranet and portal. This work is due to be completed by the end of December 2012.

Evaluating and Monitoring

2.11 The Steering Group intends to discuss at a later meeting, how we will measure success of this programme and also what arrangements we need to establish to ensure we prevent the situation described in the D J Bowles report happening again. Those who contributed to the original feedback have been asked if they wish to continue.

Staff Engagement and Communication

2.12 Staff are being involved as part of the values work described in 2.6 above. The Communications Team have developed a Communications Plan.

Mapping the Future

2.13 A new vision statement is being considered to replace the aspiration to achieve the “Top 25”. This work is being led by Alex McMahon, Director of Strategic Planning, Performance Reporting and Information. Any vision statement must be aligned to the Clinical Strategy and our work on values and culture.

Information Governance

2.14 The Steering Group are also responsible for ensuring that the recommendations are in regard to Information Assurance and Governance are taken forward. The first priority for this work was to review and agree the appropriate effective and efficient Board Committee structure that ensures we discharge our statutory responsibilities. The Board agreed these at the meeting on the 24th October 2012. Committees are now required to undertake the following: -

- Agree the statutory information assurance requirements for the Board and its sub-committees.

- To establish and agree the content and supply of information to the Board and its Sub-Committees.

- To ensure that all information is validated and provided from a single source.

The Manager for Corporate Governance and Associate Director of Information are providing assistance to take these actions forward.

3 Key Risks

3.1 The purpose of this report is to update on progress, any risks will be presented to the Steering Group.
4 Risk Register

4.1 Any risks will be incorporated into the Register and managed as the programme progresses.

5 Impact on Inequality, Including Health Inequalities

5.1 Impact assessment will be carried out for individual elements of the work programme, the work on values has been impact assessed and the results were very positive.

6 Involving People

6.1 Management teams and Partnership representatives have been briefed and engaged on the work to date. Regular reports are provided to the Lothian Partnership Forum.

7 Resource Implications

7.1 The resource implications are agreed and managed by the Steering Group.

Dr Charles Winstanley
Chairman, NHS Lothian
15th November 2012
Elaine.Watters@nhslothian.scot.nhs.uk
PAEDIATRIC & NEONATAL MEDICAL WORKFORCE UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on paediatric and neonatal medical workforce issues across the SEAT region, the potential implications and on the urgent action being taken to try to ameliorate the situation in the short term.

1.2 The paper also requests the Board’s approval to undertake an engagement process with stakeholders between December 2012 and February 2013 on the following:

- An explanation of the developments in the paediatric and neonatal workforce;
- The challenges that this presents in continuing the current service model to provide a safe and sustainable service for women and children across South East Scotland;
- An outline of the extensive range of actions that have been taken to mitigate the problems;
- An exploration of the full range of options for maintaining patient safety across the region in both the medium and longer term.

2 Recommendations

Members of the Board are asked to:

2.1 Note the forecast position regarding gaps in the paediatric middle grade rotas in the South East of Scotland from February 2013 and the service and patient safety risks that this presents for all of the services in the region.

2.2 Endorse the Board’s absolute commitment to working with its partners to ensure the continued provision of safe services for babies and children in all acute facilities across the South East Region.

2.3 Approve the immediate actions to be taken with the intention of ameliorating the pressures in short term, including a further international recruitment initiative using external agency support to attempt to fill rota gaps left by trainee vacancies.

2.4 Confirm the need to identify and implement a long term sustainable solution for paediatrics and neonatal services across Lothian and the rest of the South East.

2.5 Approve the immediate development and implementation of a comprehensive engagement process with stakeholders between December 2012 and February 2013 to explore all the options for achieving that outcome.
3 Discussion of Key Issues

3.1 The South East and Tayside Planning Group (SEAT) has reviewed the current position and challenges involved in workforce planning and service delivery for paediatric and neonatal services in Fife, Lothian and Borders and looked at options for the redesign of the paediatric and neonatal workforce and/or existing services across the region. This review has been carried out jointly by the SEAT Boards’ Chief Executives and Medical Directors, the Post Graduate Dean and SEAT over a period of months. However, the position has continued to evolve over this period and this paper sets out the most up to date position.

3.2 The SEAT review has identified that the current workforce models employed, in particular the reliance on paediatric medical trainees to deliver existing paediatric and neonatal services out of hours across the region, are unsustainable in the short term. There is a high risk that the circumstances that led to the temporary closure of the inpatient paediatric services at St John’s Hospital will recur.

3.3 The SEAT review has taken account of the growing problems in medical paediatric staffing across Scotland and the UK since 2008, as a result of:

- A reduction in the number of hours trainee doctors can work (European Working Time Directive)
- The increasingly high percentage of paediatric trainees who are female, which has resulted in unprecedented levels of maternity leave and an increase in trainees working less than full time
- The loss of very experienced trainees going ‘Out of Programme’ to gain further specialist experience

3.4 In order to address the number of gaps, SEAT Boards have worked together to try to address the situation. The actions taken over the last four years in Lothian include:

- Repeated unsuccessful attempts to recruit specialty doctors (and also GPs) i.e. doctors who are trained and become permanent members of staff, as opposed to trainees
- Changes to consultant job plans to provide extended out of hours cover into the evenings at St John’s Hospital and RHSC
- Repeated attempts to recruit Advanced Neonatal Nurse Practitioners (ANNPs) and Advanced Paediatric Nurse Practitioners (APNPs) to provide support to the services at St John’s Hospital and to reduce reliance on trainee doctors out of hours
- Recruitment of additional consultants with a job plan which involves a commitment to providing resident out of hours cover for the middle grade doctor rota, instead of trainees

3.5 Attempts to recruit more staff have been ongoing, with limited success, for almost four years. In the meantime, the burden of ‘shoring up’ the middle grade trainee rota has fallen primarily on a small group of the existing consultant paediatricians at St John’s Hospital.

3.6 The SEAT review has also reflected on the report from the Royal College of Paediatrics and Child Health. As a result of the review of training in the South East it recommends that out of hours training opportunities do not justify the presence out
of hours of trainees at St John’s Hospital or possibly Borders General Hospital. The Post Graduate Dean is obliged to follow the recommendations of the College and has informed SEAT Boards that trainees will be not be available to work out of hours on either of these sites from August 2013.

3.7 Prioritisation of services on the grounds of clinical risk and safety is paramount. SEAT Boards’ Medical Directors and the Post Graduate Dean have agreed that, where possible given training requirements, paediatric trainees should be deployed to sustain services on this basis. On this basis the priority for SEAT is to sustain the paediatric and neonatal intensive care units in Edinburgh and the general and specialist paediatric services based at the Royal Hospital for Sick Children (RHSC) in Edinburgh. These highly specialist services support Lothian, the East of Scotland and, at times, all of Scotland. It is therefore essential that these services be maintained to support very ill babies and children from across Scotland.

3.8 The next priority for SEAT is sustaining the paediatric and neonatal services at the Victoria Hospital; NHS Fife given it also has a neonatal intensive care unit and a wide range of paediatric services. Borders General Hospital and St John’s Hospital with relatively low levels of inpatient activity are therefore the sites where the loss of paediatric trainees for out of hours working would have the least impact on the delivery of safe services. Given its more rural location and the longer travel time to services based in Edinburgh the SEAT Boards’ Medical Directors agreed the next priority should be the Borders General Hospital.

3.9 At St John’s Hospital, given its proximity to services in Edinburgh and that an alternative paediatric service model can be implemented quickly and safely if required (as demonstrated by the temporary closure of the paediatric inpatient unit for a three week period over July/August 2012), the least clinical risk is presented if trainee gaps were to lead to closure of the paediatric inpatient service.

3.10 Boards continue to use a range of options for filling the gaps including asking trained medical staff to ‘work down’ and the employment of locums to cover overnight or weekend rota gaps. These options are expensive. For example existing consultants are currently paid ‘triple time’ to provide resident overnight cover at St John’s Hospital, costing c£1,800 per twelve and a half hour shift. The cost of providing additional staffing to maintain services at St John’s Hospital reached c£65k per month between April and July 2012.

NHS Lothian, in response to a similar level of gaps in paediatric trainee numbers in late 2011, advertised for an additional four consultants in both paediatrics and neonatology for St John’s Hospital. Recruitment proved difficult and adverts were placed on a number of occasions from December 2011 onwards. Five additional consultants have been appointed, two paediatricians and three neonatologists, all of whom have been contracted to work a resident overnight shift on a 1 in 9 basis. All of the five consultants are now in post. However, even with the additional consultant appointments, there is still insufficient medical staffing to cover out of hours requirements on a sustainable basis with the level of trainee input that will be available from February. Current medical and advanced nurse staffing would be able to sustain cover for around seven out of nine neonatal shifts and around four out of nine paediatric shifts, based on a 1 in 9 shift pattern.
3.11 The option of asking existing consultants based in paediatric and neonatal services in Edinburgh to work resident OOH shifts to cover middle grade gaps at St John’s Hospital has been considered. However, because of their specialist roles, only a small minority of the paediatricians at RHSC could cover the neonatal service at St John’s and none of the current neonatologists could cover paediatric services there. It would therefore require two consultants to cover the middle grade trainee gap out of hours. Transferring consultant input from the RHSC and Simpsons to provide this would seriously deplete the level of cover at the busiest units within the region and create a patient safety risk for them.

3.12 Finally the Terms and Conditions of Service for consultants mean that any such change in consultants working patterns would have to be negotiated and agreed with existing consultants and they have indicated that they would not agree.

3.13 The SEAT review has examined a number of options for longer term workforce and service redesign and is likely to result in a recommendation that SEAT commissions a working group to develop a more detailed option appraisal for paediatric, neonatal and the interlinked maternity services on each site.

3.14 Because of the hierarchy of clinical priorities set out above, the key focus of the option appraisal is likely to be St John’s Hospital which is at greatest risk and requires a sustainable workforce and service model. The aim is, if at all possible, to retain safe and sustainable 24/7 paediatric services at St John’s Hospital. The proposal is that the options outlined through the SEAT review will form the basis of detailed engagement with a wide range of stakeholders in the next few months.

3.15 Since the SEAT review was initiated there has been a further deterioration in the paediatric medical trainee middle grade numbers forecast for February 2013. The Post Graduate Dean notified the Medical Directors in NHS Borders, Fife and Lothian in October that he had been informed by the Paediatric Training Programme Directors (TPDs) of further maternity leave and resignations from the programme. As a result the TPDs are unable to staff all existing middle grade rotas to meet the minimum safe staffing levels. This is detailed in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Borders General</th>
<th>Victoria Kirkcaldy</th>
<th>RHSC Edinburgh</th>
<th>PICU Edinburgh</th>
<th>Simpson’s Neonatal Edinburgh</th>
<th>St John’s Edinburgh</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainees required for a viable OOH rota</td>
<td>5.0</td>
<td>10.0</td>
<td>13.0</td>
<td>5.0</td>
<td>8.0</td>
<td>6.0</td>
<td>47.0</td>
</tr>
<tr>
<td>Anticipated trainee numbers for OOH from February 2013</td>
<td>3.0</td>
<td>8.1</td>
<td>11.6</td>
<td>3.6</td>
<td>5.0</td>
<td>3.1</td>
<td>34.4</td>
</tr>
<tr>
<td>Anticipated gaps from February 2013</td>
<td>2.0</td>
<td>1.9</td>
<td>1.4</td>
<td>1.4</td>
<td>3.0</td>
<td>2.9</td>
<td>12.6</td>
</tr>
</tbody>
</table>

3.16 The above is a ‘best case’ scenario; it is highly likely that further gaps will emerge between now and February 2013. In addition to the above, gaps are also emerging in the advanced nursing workforce with two ANNPs having planned maternity leave during the same period. The position in February differs from previous occasions. Due to the training requirements of trainees, there are gaps emerging in the middle grade rotas in both the paediatric and neonatal Intensive Care Units in Edinburgh as well as in the District General Hospitals. These intensive care units support the region, the East of Scotland and on occasions the West with provision of neonatal and paediatric intensive care on a Scotland-wide basis. Both units run at 100%
occupancy. In addition, St John’s Hospital will once again have at least 2.9 wte gaps in a rota of six.

3.17 Strenuous efforts are being made to try and address the above rota gaps, for example adverts have been placed for locum registrars and a substantive consultant in paediatrics at St John’s Hospital. A national and international recruitment campaign using external agency support is also being launched. In light of the predicted position in February the Paediatric Staffing Group, jointly chaired by Dr Edward Doyle, Associate Medical Director and Fiona Mitchell, Director of Operations, Women and Children’s Services will be re-established in order to lead the detailed work required to sustain services and maintain patient safety. Whilst every effort will be made to sustain existing services it is likely that the 24/7 inpatient service at St John’s Hospital will once again come under pressure.

3.18 A key priority for the Paediatric Staffing Group will be sustaining the neonatal and therefore maternity services at St John’s Hospital. Middle grade paediatric trainees currently provide out of hours cover for both paediatric and the neonatal services in the hospital. There are currently over 2,700 births per annum at St John’s Hospital and the neonatal service is essential for sustaining this activity and ensuring patient safety. There is insufficient capacity within Edinburgh or across the region to safely absorb this number of births and it is therefore essential that the neonatal service at St John’s Hospital is sustained.

3.19 In conclusion, SEAT has carried out a review of the ongoing issues within the paediatric medical workforce across the region and indicated that these are likely to necessitate change in both the current paediatric workforce and paediatric services. St John’s Hospital will not have paediatric medical trainees working out of hours from August 2013 and is therefore at highest risk.

3.20 More detailed work and consultation with a wide range of stakeholders on the options for ensuring the delivery of a safe and sustainable service is now required. This work will need to be prioritised given the gaps forecast in the paediatric trainee numbers from February 2013 and the need to ensure safe, sustainable and affordable paediatric and neonatal services at St John’s Hospital.

4 Key Risks

The key risks are:

4.1 Immediate actions do not result in sufficient additional resource being identified to compensate for increasing level of gaps in trainee rotas from February 2013 at all sites across the region.

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

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

4.4 Short notice of unplanned absences or changes to the availability of staff leading to an inability to fill a paediatric inpatient rota and the consequent clinical risk posed by an unmanaged and rapid change in the service provided on that site.
4.5 Inability to recruit to any short term measures to improve staffing particularly in the paediatric intensive care unit and Simpson’s neonatal intensive care unit given the relatively short time scale.

5 Risk Register

5.1 The risks associated with the paediatric and neonatal medical workforce is already on the risk register. The register will be updated to reflect the high risk associated with the forecasted shortfall in medical trainee numbers in February 2013.

6 Impact on Inequality, Including Health Inequalities

6.1 An equality and impact assessment has not yet been undertaken. As full assessment will, however, be undertaken as part of the detailed option appraisal process.

7 Involving People

7.1 There will need to be comprehensive public engagement, which may require involving all three SEAT Health Board areas, on the options for a long term, sustainable solution for paediatric and neonatal services. This is in line with guidance from the Scottish Health Council and will require involving patients, carers and the public in the option appraisal process.

7.2 Should a temporary and more urgent change to services at St John’s Hospital be required to maintain patient safety, NHS Lothian will require to undertake an immediate and extensive interim process of informing those directly affected by this temporary reduction in service. This would include media coverage, Public Partnership Forum networks, the St John’s Stakeholder Group, information for frontline staff to pass on to parents and families, linking into West Lothian Council’s public networks and contact systems as well as informing key service providers such as GPs, NHS 24, Scottish Ambulance Service and related clinical teams. The PFPI engagement process in relation to the longer term options will need to start as soon as possible in early January with a draft plan currently being developed.

8 Resource Implications

8.1 Sustaining 24/7 paediatric inpatient and neonatal services at St Johns Hospital required additional funding of £65K over budget per month when trainees were withdrawn between April and July 2012.

Dr Edward Doyle
Associate Divisional Medical Director, Women, Childrens and DCN Services
edoyle2@nhs.net

Derek Phillips
SEAT Regional Workforce Planning Director
Derek.phillips@nhslothian.scot.nhs.uk

On behalf of SEAT Regional Planning Group
16th November 2012
PERFORMANCE MANAGEMENT

1 Purpose of the Report

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

2 Recommendations

The Board is recommended to:

2.1 Receive this update on the current performance against each of the current HEAT targets, standards and a number of other local and national targets, as outlined in Appendix 1. Where performance is currently off trajectory, further remedial actions being taken are outlined in the ‘Risks’ section of this report as appropriate.

2.2 Note that in order to inform the Board of the current position across the range of targets and standards as set out in this paper, the source of the data provided is from local management systems within NHS Lothian. This means that some information is only available quarterly or annually. Where local systems are reporting potential difficulties with any of these targets, exception reports will be provided as part of this paper.

2.3 Note that work is underway to strengthen the process for collecting and reporting performance information through the Health Intelligence Unit and Strategic Planning. This will involve information being collected at a fixed point in each month (the first day of each month) and in turn the same suite of information being reported consistently to the Joint Management Team (JMT) and the Board.

2.4 Work on the ‘deep dive’ exercise across all clinical and managerial lines is also almost complete and will be feedback in terms of issues and any actions at the December JMT.

3 Discussion of Key Issues

3.1 Of the 44 items monitored within Appendix 1, the most recent data indicates NHS Lothian:
<table>
<thead>
<tr>
<th>Performance</th>
<th>Table Key</th>
<th>This Month</th>
<th>Last Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Items Monitored</td>
<td></td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td>Meets the overall target</td>
<td>✔ ✔</td>
<td>8 occasions</td>
<td>6 occasions</td>
</tr>
<tr>
<td>Is on trajectory to meet, but has not yet met the final target</td>
<td>✔</td>
<td>9 occasions</td>
<td>10 occasions</td>
</tr>
<tr>
<td>Is off trajectory</td>
<td>✗</td>
<td>8 occasion</td>
<td>7 occasions</td>
</tr>
<tr>
<td>Does not meet the overall target</td>
<td>☒ ☒</td>
<td>15 occasions</td>
<td>14 occasions</td>
</tr>
<tr>
<td>No data available yet (new or revised target)</td>
<td>blank</td>
<td>4 occasions</td>
<td>4 occasions</td>
</tr>
</tbody>
</table>

3.2 Further information is available in the key risks section for those areas currently off trajectory or where no performance data is included in the table.

4 Key Risks

4.1 The following performance measures are those where NHS Lothian are currently off trajectory and therefore are considered risks to the organisation. We are in the process of reviewing the corporate risk register to ensure that each target has been reviewed by responsible Directors actions are being taken to mitigate these risks.

4.1 HEAT Targets

4.1.1 Detecting Cancer Early (Responsible Director: Director of Public Health and Health Policy)

The aim of the NHS Lothian Detect Cancer Early Programme is to increase the population of people diagnosed and treated in the first stage of Breast, Colorectal and Lung cancer by 25%, by 2014/2015. Work in developing the baseline for the lung cancer target has been agreed, and work is now commencing in relation to agreeing the baselines for breast and colorectal cancer.

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

A quarterly steering group has been established to drive forward early access to antenatal care. The steering group has allocated funding for this financial year, and is regularly reviewing progress against the agreed Action Plan. NHS Lothian is currently meeting the target of early access to antenatal care for 80% for each quintile of the population.

4.1.3 Provision of insulin pumps for those under and those over 18 years of age (Responsible Director: Director of Strategic Planning, Performance Reporting and Information)
A report on the current waiting times position for the adult and paediatric service was presented at the CMT in early November. The Nurse Director and the Medical Director will progress the actions that resulted from the discussion.

Information on performance in this area will be reported every three months in line with requests from Scottish Government.

4.1.4 A&E Attendances (Responsible Director: Director of Strategic Planning & Primary Care)

Based on the most recently available (September 2012) data NHS Lothian T10 performance has made a slight improvement on the August position with a reduction in the increase in attendances compared with the same period last year.

<table>
<thead>
<tr>
<th>T10 sites</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>17,133</td>
<td>17,946</td>
<td>17,090</td>
<td>17,084</td>
<td>17,216</td>
<td>17,271</td>
</tr>
<tr>
<td>2012/13</td>
<td>17,164</td>
<td>18,269</td>
<td>17,629</td>
<td>16,789</td>
<td>17,916</td>
<td>17,555</td>
</tr>
<tr>
<td>Change</td>
<td>31</td>
<td>323</td>
<td>539</td>
<td>-295</td>
<td>700</td>
<td>284</td>
</tr>
<tr>
<td>% Change</td>
<td>+0.2</td>
<td>+1.8</td>
<td>+3.2</td>
<td>-1.7</td>
<td>+4.1</td>
<td>+1.6</td>
</tr>
</tbody>
</table>

Looking at emergency department attendance rates for Lothian, this is still deviating from the target trajectory, with a fluctuating course. Work to address this is now being taken into the Unscheduled Care Group chaired by the Nurse Director and the Joint Director, Edinburgh. Dr Andrew Coull the clinical lead for this work will now support the Unscheduled Care Group in reviewing and agreeing any further actions.
4.1.5 **Child Fluoride Varnishing** (Responsible Director: Director of Public Health and Health Policy)

The target is that 60% of three and four year old children will have two fluoride varnish applications in a year. It is the Scottish Government’s expectation is that children in the least deprived SIMD quintile will receive fluoride varnish application from their general dental practitioner.

A new system of payment and recording of fluoride varnish application for general dental practitioners has been established. As the system has just completed its first year, it will take until publication of the next set of data before it is possible for general dental practitioners to have completed two fluoride varnish applications in a year.

2011/12 data for the whole of Scotland shows that 5.1% of three and four year olds in the least deprived SIMD quintile received two fluoride varnish applications in a year. NHS Lothian is not unique in being a long way from meeting the HEAT target.

4.2 **HEAT Standards**

4.2.1 **4-hour Emergency Access** (Responsible Director: Nurse Director)

Work is continuing on previously agree actions to support this target and the work associated with it. Performance for September was 93.07%, and 92.9% for October.

4.2.2 **12hr Breaches – October 2012** (Responsible Director: Nurse Director)

The number of reported 12 hour breaches for October was 7 in total.

4.2.3 **Cancer Waiting Times** (Responsible Director: Medical Director)

Overall, cancer waiting times are:

- 62 days – 93.0%
- 31 days – 99.4%

These headline results are based on the September 2012 monthly management report, which is the most recently reported period.

Due to the recent scrutiny in cancer waiting times performance, monthly cancer waiting times will now be included in the performance reports. Monthly performance is submitted to ISD on the 20th of each month detailing the previous month treatments for 62 and 31 day targets. Whilst the monthly reports give a good indication of performance, the quarterly data submission may change following discussion at the quarterly service sign off meetings, for example exclusions due to complexity, and potentially as a result of the data validation and sign-off process undertaken with ISD Scotland.
Endometrial cancer performance is submitted to ISD on a monthly basis for developmental reporting only, this data is not published. Endometrial performance will be included in Appendix 1 of future performance reports. In August 2012 endometrial cancer performance was 100% for 62 days and 42.9% for 31 days (4 breaches of 7 cases).

It should also be noted that the Scottish Government has written to Health Boards on 31st October 2012 outlining a requirement to collect and report information on neurological cancers, effective from 1 January 2013. As per the treatment of endometrial cancer developmental data, neurological cancers will be reported as management information only, and will not be included in performance reporting or public reporting against cancer waiting times standards. This information will be reported through this paper as information feeds through the monthly management reports in 2103. The necessary development work in the neurological service, e-health, tracking, information services and cancer audit is being actioned now.

There will be a weekly review of all cancer patients to minimise any future breaches.

We are also in the process of setting up a meeting with Scottish Government Improvement team in relation to reviewing our current performance and information on the agreed actions from that group with be feedback to JMT in due course.

4.2.4 Stroke (Responsible Director: Nurse Director)

Data for September shows 69% adherence to this target across Lothian. Whilst the current capacity and occupancy rates within RIE, WGH and St John’s acute stroke wards remains very high it is difficult to predict large scale improvements.

On-going improvements to achieve a reduction in the number of patients with delayed discharges are another key area of focus which will support improved patient flow and therefore access. These measures should allow patients to access the appropriate acute beds and are the most important to ensure compliance with the HEAT standard for stroke.

4.2.5 Improving access to psychological therapies (Responsible Director: Joint Director, West Lothian CHCP)

We are currently undertaking redesign, demand and capacity work using a phased approach to ensure equity and sustainable delivery of this target.

The recently allocated QUEST funding will be used increase capacity in terms of data analysis, process redesign and specific project work on clinical services and client groups. We are taking a planned and measured approach to meeting this target:

- A model for sustainable delivery of psychological therapies has been developed in East Lothian.
- The recently appointed Head of Adult Mental Health Psychology, who took up post on 1 November, led the development of this in East Lothian and Dr Graham will now roll this model out across Edinburgh, Mid and West Lothian.
• We have reconfigured our data processes and IT system to enable capture of patient’s presenting problem / diagnosis, the psychological therapy they receive, which in line with the evidence base for the patient’s condition and their CORE (Clinical Rating Scale) score on first assessment and discharge.

• We have mapped the training and supervision capacity of our current staff through a staff survey and are developing a training plan to meet identified needs to deliver evidence based psychological therapies and ensure that there is equity of access across Lothian.

4.3 Other National/local Targets

4.3.1 In relation to cataract and hip as well as diagnostic performance, which now includes surveillance scopes further information on our performance in these areas will be available and presented in the November Board paper and will be routinely reported in the waiting times paper.

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

The table gives a summary of headline figures from the October census

<table>
<thead>
<tr>
<th>Total ISD Delays (incl. x-codes)</th>
<th>Total Delays (Excel. x-codes) NHSL target 66</th>
<th>Complex Codes</th>
<th>6 Weeks+ (National standard - 0)</th>
<th>Short Stay (Target - 0)</th>
<th>Average length of stay as a delayed discharge Days (non-x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>164</td>
<td>120</td>
<td>44</td>
<td>21</td>
<td>8</td>
</tr>
</tbody>
</table>

- 120 delays after X codes removed (143 Sept, 130 Aug, 106 July)
- 164 overall including X codes (187 Sept, 181 Aug, 152 July)
- 21 patients (20 Edin- 1 non Lothian) delayed >6wks (21 Sept, 17 Aug, 12 July)
- 26 days is the average length of stay (26 Sept, 22 Aug, 21 July)
- 1 Non-Lothian delay (5 Sept, 4 Aug, 2 July)
- UHD running at 160, unavailable beds per day with delayed discharges/awaiting transfer
- October does show a 15% improvement on August/September for over all delays, but as a delayed discharge partnership we continue to fail to met the national standard of having Zero delays over 6 weeks.
The table below set out the delay code by council area.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>City of Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Scottish Borders</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>11A</td>
<td>Awaiting commencement of post-hospital social care assessment</td>
<td>9</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>11B</td>
<td>Awaiting completion of post hospital social care assessment</td>
<td>22</td>
<td>11</td>
<td>2</td>
<td></td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>24A</td>
<td>Awaiting place in Local Authority Residential Home</td>
<td>13</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>24C</td>
<td>Awaiting place in Nursing Home (not NHS funded)</td>
<td>21</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>24D</td>
<td>Awaiting place in Specialist Residential Facility for under 65 age groups</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>24F</td>
<td>Awaiting place availability in care home (EM/Dementia bed required)</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>25D</td>
<td>Awaiting completion of social care arrangements - in order to live in own home</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>25DDT</td>
<td>Health GT assessed POC under 16 hours</td>
<td>11</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>25F</td>
<td>Specialist Housing Provision (including homeless patients)</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>73</td>
<td>Family/relatives arranging care</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Grand Total</td>
<td>93</td>
<td>20</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>120</td>
</tr>
</tbody>
</table>

49 of the 75 assessed patients are waiting for care homes. On top of this we have another 15 coded in the X’s as ‘not suitable for interim’ who are all awaiting dementia beds in nursing homes.

Patients/clients, who are self-funding, are increasingly not willing to go to interim care placement. Which to them means increased costs, that are avoidable if they stay in hospital beds, until their choice of home becomes available. The cost of most Edinburgh care homes are now more than double the agreed national contract rate, and coming to terms with this, from the carers or relatives perceptive, causes us many extra days delays.

Package of Care delays, in the City of Edinburgh, whilst generally there is still a big improvement from last Autumn, have risen in October. Edinburgh is going ‘off contract’ to increase and purchase additional capacity, to meet demand.

East, West and Midlothian, continue to have no delays over six weeks, although East’s overall numbers are rising, now at 20, having been around 10 across last autumn/winter. A meeting with East Lothian colleagues is taking place to discuss this issue.

West and Midlothian are forecasting to achieve the impending 4 weeks standard due in April 2013.

The table below shows both the overall delays and the ISD reportable. Even allowing for changes in what is reported to ISD we have 20% more delays in the system than we did, this time last year.
The number of patients who are coded as complex is the same as September at 44. This is a slight improvement from 50 we were running at over the summer. The biggest group remains the number of complex delays under 65 years within the Royal Edinburgh Hospital who require supported accommodation in the community, 17 currently.

The following table details the type of complex delay and where within the hospital system they are.

<table>
<thead>
<tr>
<th>Count of Chrmns</th>
<th>Descriptiv</th>
<th>24Ex - Awaiting place availability in specialist facility for younger age groups (&lt;65) where the facility is not.</th>
<th>24Ex - Awaiting place availability in specialist facility for younger age groups (&gt;65) where the facility is not</th>
<th>42Ex - Awaiting bed availability in other NHS Hospital when no facilities exist in NHS Board area</th>
<th>46X - Patient well but can't be discharged</th>
<th>51X - Adults With Incapacity</th>
<th>71X - Patient exercising statutory right of choice - internal placement is not possible or reasonable</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Edinburgh</td>
<td>Arley Ainslie Hospital</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ellen's Glen House</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liberton Hospital</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Royal Edinburgh Hospital</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Royal Infirmary of Edinburgh at Little France</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Western General Hospital</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City of Edinburgh Total</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Lothian</td>
<td>Midlothian Community Hospital</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roadlands General Hospital</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Lothian Total</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian</td>
<td>Learning Disabilities Service Hosp</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian Total</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Lothian</td>
<td>Arley Ainslie Hospital</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning Disabilities Service Hosp</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>St Michael's Hospital</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tippethill Hospital</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>William Fraser Centre</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Lothian Total</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasgow City</td>
<td>Royal Edinburgh Hospital</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasgow City Total</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highland</td>
<td>Royal Edinburgh Hospital</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highland Total</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>17</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>15</td>
<td>8</td>
<td>64</td>
<td></td>
</tr>
</tbody>
</table>

The annual Scottish Government round of talks with each Board areas Delayed Discharge Partnerships meeting was held on 18th October. Following the meeting,
Brian Slater from the Scottish Government has added the following to be included in briefing for NHS Lothian’s Annual Review for the Scottish Government with the Minister on 5th November.

4.3.3 **Monthly Hospital Inpatient Boarding**

Scottish Government has asked Boards to report monthly (broken down by each week) on the number of Borders in their respective acute hospitals. This is an extension to ‘all year round’ on what boards have been doing for the last three years as part of the ‘winter reporting’ suit of data.

Boarding is classified as: “the total number of bed days occupied by patients during the reporting week, who are managed by an individual consultant or team and are out with the main allocated inpatient area for that consultant/team or specialty for their treatment”.

This should include patients who become boarders upon admission or transfer and patients who are boarding in non-inpatient bedded areas. This should include boarders in both medical and acute specialties.

The figures for September are show in the table below

<table>
<thead>
<tr>
<th>Location</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIE</td>
<td>64</td>
<td>145</td>
<td>189</td>
<td>170</td>
<td>70</td>
<td>66</td>
<td>102</td>
<td>110</td>
</tr>
<tr>
<td>WGH</td>
<td>126</td>
<td>120</td>
<td>75</td>
<td>117</td>
<td>64</td>
<td>60</td>
<td>39</td>
<td>60</td>
</tr>
<tr>
<td>SJH</td>
<td>76</td>
<td>121</td>
<td>165</td>
<td>159</td>
<td>21</td>
<td>48</td>
<td>72</td>
<td>68</td>
</tr>
<tr>
<td>NHS Board Total</td>
<td>263</td>
<td>396</td>
<td>398</td>
<td>445</td>
<td>155</td>
<td>202</td>
<td>213</td>
<td>244</td>
</tr>
</tbody>
</table>

4.3.4 **Vasectomy**

The Vasectomy Service achieved 67.3% compliance against the 18 week RTT, and there were 8 breaches of the 12 week outpatient waiting time guarantee in September. The service is working to reduce a backlog of patients that was built up when capacity was removed from the service in the previous financial year. Extra outpatient waiting list clinics and additional Day Case procedures are being held to reduce the number of patients breaching the 12 week OP and 18 week RTT waiting times. The service has recently modelled its activity and is confident that each patient entering the service now will receive an OP appointment within 12 weeks and treatment within 18 weeks. In addition to this, the service will be moving to TRAK within the next month which should aid the management of waiting times data and ensure more effective monitoring of patient waits.
In addition the Director of Edinburgh CHP has identified that there are waiting times issues in a number of other services such as sexual problems and gender reassignment clinic. These will be addressed as required.

4.3.5 Wheelchair

94.6% of patients entering the mobility service received their wheelchair within 18 weeks. The non-compliant episodes have been reviewed and a number of the cases will have been progressed since the writing of this report. As previously reported, the service is experiencing a significant reduction in the level of recurring funding available since the completion of the Wheelchair and Seating Services Modernisation Programme.

The service currently meets the 18RTT standard in well over 90% of patients, but is in the process of clarifying whether this should apply to the service. This does not, of course, change the aspiration to continue with this high standard.

The service is conscious that there have been changes in the level of funding provided centrally and is examining, with Fife and Borders, the impact this will have over the coming months.

4.3.6 Palliative & End of Life Care

Progress against the NHS Lothian strategic targets of reducing the proportion of acute hospital deaths, and increasing the proportion of residential deaths needs to be accelerated to avoid slipping away from trajectory. The current position was discussed by the Palliative Care Managed Clinical Network on 30th October 2012. As assessment of how to more systematically apply proven service improvement work with care homes will now be undertaken with a view to actioning these in 2013. Lothian hospices will further strengthen the recording of preferred place of care for their in-patient and community case-loads. Additionally the Managed Clinical Network will review a more detailed analysis of place of death and pathway data, produced by Strategic Planning with Lothian Information Services, and will ensure that findings from this are related back to all current schemes targeting and supporting palliative care pathway improvement.

The NHS Lothian and Marie Curie Delivering Choice redesign programme, which is currently in the formation stages, will be central to taking forward the required improvements. This work is also being linked to Lothian Local Authority social care planning through the strategic programmes and through approaches to councils directly. As such we expect future delivery of service redesign to fit as part of integrated care.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities
6.1 As a report on progress, this paper does not require impact assessment in its own right. The HEAT performance framework has been subjected to impact assessment, with programmes assessed individually for impact on health inequalities in the wider population since April 2010 rather than overall. These assessments focus on underlying content of targets, e.g. both smoking cessation and cardiovascular health checks are examples of specific targets related to health inequalities.

7 Involving People

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

8 Resource Implications

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

Moray Paterson
Business Manager
15th November 2012
moray.paterson@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning, Performance Reporting and Information
15th November 2012
alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices
Appendix 1: Performance Management Scorecard
### Health Improvement

#### Child Healthy Weight - number of children aged 2-15 years completing approved healthy weight intervention programmes over the period 2011/12 to 2013/14 (adt. requirement that at least 40% of child healthy weight interventions are delivered to children/families in the two most deprived SIMD quintiles by local SIMD datazone-to be reported annually)

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-14</td>
<td>2,268</td>
<td>Apr 11 - Mar 12</td>
<td>682</td>
<td>Apr 12-Jun 12</td>
<td>119</td>
<td>265</td>
<td>AKM</td>
</tr>
</tbody>
</table>

The figures for Apr 11-Mar 12 have now been validated. While we reported previously that we had missed the trajectory by one intervention (679 vs 680) the final figures exceeded this trajectory. This was because 574 interventions were recorded on the national Child Health Surveillance Programme. School system rather than the 571 initially anticipated from locally held data. A relatively small number of school-based interventions were completed between April - June in one of the attached nursery schools will be reported in the next quarter.

#### Suicide Reduction - % of suicides per yr per 100,000 plan

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>20%</td>
<td>2008-10</td>
<td>14.1%</td>
<td>2009-11</td>
<td>13.7%</td>
<td>✓</td>
<td>AMcM</td>
</tr>
</tbody>
</table>

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

#### Smoking Cessation - to deliver universal smoking cessation services to achieve at least 11,686 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within-Board SIMD areas over the period 2011/12 to 2013/14

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-14</td>
<td>11,686</td>
<td>Jul-12</td>
<td>3,905</td>
<td>Aug-12</td>
<td>4,488</td>
<td>3,381</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### Child Fluoride Varnishing Aged 3 - achieve at least 60 per cent of 3 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-14</td>
<td></td>
<td>01/04/2011</td>
<td>22.02%</td>
<td>Aug-12</td>
<td>1.24%</td>
<td>✓</td>
<td>AMcM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31/03/2012</td>
<td>25.41%</td>
<td></td>
<td>✓</td>
<td>AKM</td>
<td></td>
</tr>
</tbody>
</table>

#### Child Fluoride Varnishing Aged 4 - achieve at least 60 per cent of 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-14</td>
<td></td>
<td>01/04/2011</td>
<td>11.65%</td>
<td>Aug-12</td>
<td>2.81%</td>
<td>✓</td>
<td>AKM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31/03/2012</td>
<td>7.41%</td>
<td></td>
<td>✓</td>
<td>AMcM</td>
<td></td>
</tr>
</tbody>
</table>

#### Detecting Cancer Early - of all those diagnosed with breast, colorectal and lung cancer, 50% are to be diagnosed while in the first stage of the disease

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td></td>
<td>Aug-12</td>
<td>85.14%</td>
<td>Sep-12</td>
<td>73.21%</td>
<td>✓ ✓</td>
<td>AMcM</td>
</tr>
</tbody>
</table>

#### Early Access to Antenatal Care - at least 80% of pregnant woman in each SIMD quintile to have booked for antenatal care by the 12th week of gestation by March 2015

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td></td>
<td>Aug-12</td>
<td>88.17%</td>
<td>Sep-12</td>
<td>73.21%</td>
<td>✓ ✓</td>
<td>AMcM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aug-12</td>
<td>88.35%</td>
<td>Sep-12</td>
<td>73.21%</td>
<td>✓ ✓</td>
<td>AMcM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aug-12</td>
<td>92.09%</td>
<td>Sep-12</td>
<td>73.21%</td>
<td>✓ ✓</td>
<td>AMcM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aug-12</td>
<td>68.01%</td>
<td>Sep-12</td>
<td>73.21%</td>
<td>✓ ✓</td>
<td>AMcM</td>
</tr>
</tbody>
</table>

#### Efficiency

##### Reduce Carbon Emissions - % reduction year-on-year (Tonnes of CO2)

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qrt 1, 12/13</td>
<td>1.89%</td>
<td>Qrt 2, 12/13</td>
<td>6.36%</td>
<td>5.91%</td>
<td>X</td>
</tr>
</tbody>
</table>

#### Reduce Energy Consumption - % reduction year-on-year (Energy GJ)

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>-2.97%</td>
<td>Qrt 1, 12/13</td>
<td>1.19%</td>
<td>Qrt 2, 12/13</td>
<td>0.94%</td>
<td>1.99%</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### Access to Services

##### Drug and Alcohol waiting times - 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>90%</td>
<td>Qrt 1, 12/13</td>
<td>76.30%</td>
<td>Qrt 2, 12/13</td>
<td>84.50%</td>
<td>81%</td>
<td>X</td>
</tr>
</tbody>
</table>

SG have advised that New Ways is not to be applied in the interim, which has contributed to the level of variation against target. A bid has been made for SG QUEST monies to fund staff time to undertake robust Demand, Capacity, Activity and Queue analysis.

##### Faster access to CAMHS - deliver 26 wks Referral to Treatment

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>0</td>
<td>Aug-12</td>
<td>6</td>
<td>Sep-12</td>
<td>7</td>
<td>47</td>
<td>✓</td>
</tr>
</tbody>
</table>

##### Faster access to Psychological Therapies - deliver 18 wks Referral to Treatment

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-14</td>
<td></td>
<td>Aug-12</td>
<td>2.111</td>
<td>Sep-12</td>
<td>1.951</td>
<td>X</td>
<td>AMcM</td>
</tr>
</tbody>
</table>

#### Treatment Appropriate for Patient

##### A&E Attendances - rate of A&E attendances per 100,000 population

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-14</td>
<td>1.911</td>
<td>Aug-12</td>
<td>2.111</td>
<td>Sep-12</td>
<td>2.068</td>
<td>1.951</td>
<td>X</td>
</tr>
</tbody>
</table>

#### MRSA / MSSA Reductions - achieve a reduction in the infection rate of staphylococcus aureus bacteraemia (including MRSA) cases to 0.26 or less per 1,000 acute occupied bed days

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Milestone</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-13</td>
<td>0.26</td>
<td>Aug-12</td>
<td>0.29</td>
<td>Sep-12</td>
<td>0.30</td>
<td>0.28</td>
<td>X</td>
</tr>
</tbody>
</table>
Summary of NHS Lothian Performance Measures - HEAT Targets, Standards and other Local / National Targets

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target Details</th>
<th>Data available from</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.diff infections - achieve a reduction of the rate of C. difficile infections in patients aged 65 and over to 0.39 cases or less per 1,000 total occupied bed days</td>
<td>Mar-13: 0.39  Aug-12: 0.33  Sep-12: 0.34  Oct-12: 0.39  Nov-12: 0.39</td>
<td>AKM</td>
<td>✓ ✓ Meets the overall target</td>
</tr>
<tr>
<td>Reduction in emergency bed day rates for patients aged 75+</td>
<td>Mar-15: 5,143  Mar-12: 5,177  Oct-12: 5,149  Nov-12: 5,368</td>
<td>AM &amp; WM</td>
<td>✓ ✓ Achieves the overall target</td>
</tr>
<tr>
<td>Delayed Discharges - no people to wait more than 28 days to be discharged from hospital into a more appropriate care setting from April 2013</td>
<td>Apr-13: 0  Sep-12: 49  Oct-12: 46  Nov-12: 24  Dec-12: 22</td>
<td>AM &amp; WM</td>
<td>✓ ✓ Achieves the overall target</td>
</tr>
<tr>
<td>Delayed Discharges - no people to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015</td>
<td>Apr-15: 0  Sep-12: 83  Oct-12: 72  Nov-12: 6  Dec-12: 22</td>
<td>AM &amp; WM</td>
<td>✓ ✓ Achieves the overall target</td>
</tr>
<tr>
<td>Stroke Unit - 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>Mar-13: 90%  Aug-12: 78%  Sep-12: 69%  Oct-12: 85%  Nov-12: 85%</td>
<td>MH</td>
<td>✓ ✓ Achieves the overall target</td>
</tr>
</tbody>
</table>

Assessment:

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

Data available monthly (from SBCA at ISD), one month in arrears. Non validated & may be incomplete data till following month.
<table>
<thead>
<tr>
<th>HEAT Standard</th>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Brief Interventions - maintain the same total level of delivery of ABIs as under the HEAT H4 target for 2011-12 - at least 90% of delivery to be in priority settings.</td>
<td>Standard</td>
<td>9,938</td>
<td>2011-12 17,093</td>
<td>April to July 2012 4,932</td>
<td>3,313</td>
<td>✓</td>
<td>AKM</td>
</tr>
<tr>
<td>Cancer Waiting Times - 62 day referral to treatment - achieve 95% per cent of patients diagnosed with cancer starting treatment within 62 days if urgently referred with a suspicion of cancer, referred through A&amp;E, or referred from one of the national cancer screening programmes.</td>
<td>Standard</td>
<td>Breast 100.00%</td>
<td>Q4 2012 100.00%</td>
<td>Sep-12 95%</td>
<td>✓</td>
<td>DF</td>
<td>Due to the recent downward trend in cancer waiting times performance, details of the monthly performance will be included in future performance reports.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carcinical 90.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colorectal 86.30%</td>
<td>90.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung 90.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lymphoma 100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Melanoma 100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ovarian 100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upper GI 93.60%</td>
<td>90.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urological 94.20%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Waiting Times - 31-day decision to treat to first treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 31 days of their decision to treat, irrespective of the source or urgency of the referral.</td>
<td>Standard</td>
<td>Breast 100.00%</td>
<td>Q4 2012 100.00%</td>
<td>Sep-12 95%</td>
<td>✓</td>
<td>DF</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carcinical 91.10%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colorectal 91.10%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head &amp; Neck 96.60%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung 100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lymphoma 100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Melanoma 100.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ovarian 90.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upper GI 99.10%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urological 96.30%</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>95% 96.60%</td>
<td>93.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 weeks Referral To Treatment - 90 per cent of patients to wait no longer than 18 weeks from referral to treatment</td>
<td>Standard</td>
<td>90%</td>
<td>Jul-12 87.00%</td>
<td>Aug-12 87.60%</td>
<td>90%</td>
<td>XX</td>
<td>DF</td>
</tr>
<tr>
<td>12 week Outpatients - no patient to wait longer than 12 weeks from referral to a first outpatient appointment</td>
<td>Standard</td>
<td>0%</td>
<td>Aug-12 4962</td>
<td>Sep-12 3672</td>
<td>0</td>
<td>XX</td>
<td>DF</td>
</tr>
<tr>
<td>4-hour A&amp;E - % of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&amp;E treatment</td>
<td>Standard</td>
<td>98%</td>
<td>Sep-12 RIE - 89.3%</td>
<td>Oct-12 RIE - 94.6%</td>
<td>98%</td>
<td>X</td>
<td>MH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WGH - 93.5%</td>
<td>WGH - 94.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>JSH - 96.29%</td>
<td>JSH - 96.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>RSADG - 96.0%</td>
<td>RSADG - 95.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia - number of people on QOF dementia register - improvements in the early diagnosis and management of patients with Dementia</td>
<td>Standard</td>
<td>5,795</td>
<td>Mar-11 6,198</td>
<td>Mar-12 6,455</td>
<td>5,795</td>
<td>✓</td>
<td>AMcM</td>
</tr>
<tr>
<td>GP Access - patients reporting they had GP access within 48 hours</td>
<td>Standard</td>
<td>90%</td>
<td>10/11 94.3%</td>
<td>11/12 91.8%</td>
<td>90%</td>
<td>✓</td>
<td>AMcM</td>
</tr>
<tr>
<td>GP Access - advance booking more than 2 days in advance</td>
<td>Standard</td>
<td>90%</td>
<td>n/a</td>
<td>n/a</td>
<td>90.0%</td>
<td>90%</td>
<td>× ×</td>
</tr>
</tbody>
</table>

**Assessment**

- ✓ ✓ Meets the overall target
- ✓ is on trajectory to meet, but has not yet met, the final target
- X is off trajectory
- × × Does not meet the overall target
<table>
<thead>
<tr>
<th>Other Local / National Target</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Date</th>
<th>Lead Drtr</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Delayed Discharges over 6 weeks (monitor nationally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Sep-12</td>
<td>22</td>
<td>Oct-12</td>
<td>21</td>
</tr>
<tr>
<td>Total number of Delayed Discharge in Short-Stay setting (monitor locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Sep-12</td>
<td>8</td>
<td>Oct-12</td>
<td>8</td>
</tr>
<tr>
<td>Inpatient/Day Case Max 12 wks</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12</td>
<td>1432</td>
<td>Sep-12</td>
<td>1029</td>
</tr>
<tr>
<td>Inpatient/Day Case Max 9 wks</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12</td>
<td>1969</td>
<td>Sep-12</td>
<td>1477</td>
</tr>
<tr>
<td>Wait for key diagnostic tests &gt; 4 weeks (Monitor Nationally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12</td>
<td>9</td>
<td>Sep-12</td>
<td>4</td>
</tr>
<tr>
<td>Cataract Waiting Times - max wait 18 wks outpatient and inpatient combined (Monitor locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12</td>
<td>219 day cases and 246 outpatients</td>
<td>Sep-12</td>
<td>146 day cases and 165 outpatients</td>
</tr>
<tr>
<td>Hip Surgery - waiting times % of Hip Fracture operations within 24 safe operating hours (Monitor Locally)</td>
<td>Ongoing</td>
<td>98%</td>
<td>Aug-12</td>
<td>85.7%</td>
<td>Sep-12</td>
<td>98.3%</td>
</tr>
<tr>
<td>Wait for cardiac intervention to be &lt; 15wks (angiography, angioplasty and CABG) (Monitor Locally)</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12</td>
<td>0</td>
<td>Sep-12</td>
<td>0</td>
</tr>
<tr>
<td>Audiology (Adults) - number of patients waiting over 9 weeks</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12</td>
<td>0</td>
<td>Sep-12</td>
<td>0</td>
</tr>
<tr>
<td>Audiology (Paediatrics) - number of patients waiting over 12 weeks</td>
<td>Ongoing</td>
<td>0</td>
<td>Aug-12</td>
<td>0</td>
<td>Sep-12</td>
<td>0</td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in acute hospital</td>
<td>Dec-15</td>
<td>38%</td>
<td>Qrt 4 2011/12</td>
<td>Qrt 1 2012/13</td>
<td>40.2%</td>
<td>X</td>
</tr>
<tr>
<td>Palliative Care strategy - proportion of deaths occurring in community residential settings</td>
<td>Dec-15</td>
<td>39%</td>
<td>Qrt 4 2011/12</td>
<td>Qrt 1 2012/13</td>
<td>37.3%</td>
<td>✔</td>
</tr>
<tr>
<td>Vasectomy - 12 Week OP Breaches</td>
<td>Ongoing</td>
<td>0</td>
<td>Not available</td>
<td>Not available</td>
<td>Sep-12</td>
<td>8</td>
</tr>
<tr>
<td>Vasectomy - 18 Week RTT Compliance</td>
<td>Ongoing</td>
<td>90%</td>
<td>Not available</td>
<td>Not available</td>
<td>Sep-12</td>
<td>67.3%</td>
</tr>
<tr>
<td>Wheelchair - referral to fitting - Patients still waiting 18 weeks+</td>
<td>Ongoing</td>
<td>100%</td>
<td>Aug-12</td>
<td>90.00%</td>
<td>Sep-12</td>
<td>94.56%</td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>Mar-13</td>
<td>4%</td>
<td>Jul-12</td>
<td>4.17%</td>
<td>Aug-12</td>
<td>4.32%</td>
</tr>
</tbody>
</table>

### Assessment

- ✔✔ Meets the overall target
- ✔ On trajectory to meet, but has not yet met, the final target
- ✗ Is off trajectory
- XX Does not meet the overall target
UNSchEDULED CARE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on plans and actions to safely meet the unscheduled care needs of patients and achieve sustained improvement against the national 4 hour access standard.

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

2 Recommendations

The Board is recommended to:

2.1 Note the current performance against the 4 hour emergency access standard.

2.2 Recognise the variables and risks around unscheduled care.

2.3 Note the progress with the Improvement Plan.

3 Discussion of Key Issues

3.1 Performance for NHS Lothian against the 4 hour standard in October was 92.9%. The performance for Lothian (YTD) is 93.1%. There were 7 12-hour breaches during October. Graph 1 shows NHS Lothian trend performance against the 4 hour standard on a weekly basis since January 2012, along with the number of attendances at emergency departments and the number of 12 hour breaches.

Graph 1- NHS Lothian Emergency Department attendances, 4hr emergency care standard compliance, 12hr breaches (weekly)
3.2 To address current potential risks to patients and associated performance issues, system and process improvement work is progressing concurrently. Projects of note are the implementation of the Acute Medicine model of care at the three adult acute sites; increase in community capacity.

3.3 The one month trial of the new Acute Medicine model of care at the RIE, which extended consultant working to 22.00hrs, and increased input at weekends, was completed successfully. The key positive outcomes from the trial were:
• More rapid assessment of patients transferred from Emergency Dept. to Acute Medical Unit
• Reduction in the number of patient transfers overnight
• Reduction in the % of 4 hour breaches relating to bed waits
• Primary Assessment Area (PAA) did not close and resulted in an increase in the % of GP referred patients seen by Acute Medicine compared to Emergency Medicine
• Reduced delays associated with clerk in
• Positive junior medical and nursing staff feedback (increased support from consultants)

3.4 At the Western General Hospital (WGH), work on the implementation of a WGH ‘mobile MoE (Medicine of the Elderly) team’, and the planned new general medicine model of embedded consultants in specialty (non general medicine) wards, continues. This will result in a reclassification of the significant facility of wards, to include general medicine and/or MoE where boarding has typically been occurring. This reclassification is required to address boarding and respond to the capacity deficit for general medicine/MoE, on the site identified by recent bed modelling/analysis. As no physical additional capacity was identifiable to close the capacity gap, other than ward 25 (12 beds), some specialty wards will have some beds reclassified.

3.5 The Emergency Medicine medical staffing, within NHS Lothian, is integrated across all three Emergency Departments. In August 2012 the Joint Management Team (JMT) supported the latest version of the Emergency Department Workforce Plan (EMWP), to safely manage the national reduction in the number of Emergency Medicine trainees since 2011. The Scottish Government has announced that it is pausing to consult on this policy for further reductions in other specialties. However in Emergency Medicine the full impact of the planned reduction will be reached in August 2013, regardless of the policy review.

3.6 NHS Lothian has already committed £1.3m in additional resources as part of a total programme of almost £3m, to support the EMWP, with the balance coming from disestablished trainee posts. The plan is currently in year two of three. The plan is reviewed regularly and was revised in August, to reflect changing recruitment market conditions relating to the lack of availability of specialty grade doctors. As a result of this latest adjustment, fewer specialty doctor posts will be pursued, and offset by additional provision of “shop-floor” nursing and consultant staff. This decision was supported by JMT equating to £855k.

3.7 A further opportunity exists to develop the current integration between primary, secondary and social care, with closer working between the Emergency Department, the Lothian Unscheduled Care Service, and the West Lothian Health and Social Care Partnership.

3.8 GPs are already employed within all NHS Lothian Emergency Departments and fulfil daytime and out of hours roles within them, either as Specialty doctors or as part of their GP training.

3.9 In addition to the planned recruitment of an additional two consultants in Emergency Medicine in 2013/14, it is proposed to include trained GP’s in the regular staffing
within the Emergency Department, overnight at St John’s, instead of trainee medical staff. This group will be supplemented by a dedicated Emergency Nurse Practitioner. The remaining nursing and consultant staffing will remain the same.

3.10 The GP’s who will work within the Emergency Department will be part of a tailored Emergency Medicine training programme, to further enhance their existing skills within the specialty, and ensure their continuous professional development. The GP’s who are employed in this role will be employed through LUCCS and subject to an agreed governance framework.

3.11 The pathway for patients arriving at the Emergency Department, with the planned developments in staffing, will remain unchanged for patients.

3.12 The main services provided by Social Care to support hospital discharge include, care home places, home care reablement and mainstream home care, intermediate care and step up-step down (within housing).

3.13 In Edinburgh between January and March 2012, the baseline figure of supported hospital discharges was 63 per week. Additional investment in reablement, home care and intermediate care has increased the overall capacity in the system. Between weeks ended 29th April 2012 to week ended 11th November 2012 (29 weeks), there were 2,103 supported discharges from hospital. This compares to a previous baseline of 1,764 for a similar period. There has been an increase of 276 discharges over the 29 week period i.e. and additional average of 9.5 discharges per week. The number of home care hours has increased by 4,068 hours (12.5%), compared to 1,429 hours in a similar period last year.

3.14 The total waiting list for home care (community and hospital) has reduced from 1,540 hours to 1,094 hours in the last six weeks. Previous projections estimated that we would clear the waiting list, by the time 36,304 hours was exceeded. This occurred in the first week of November, however, the volume required to clear the
waiting list is now only projected to be met by the middle of December. This would indicate that demand is considerably in excess of previous years.

3.15 A number of new sources of domiciliary care provision are due to come on stream in the coming months. All new provision will be for older people aged 65+.

- **Home Care:**
  - 255 hours (12.75 FTE) in December
  - 190 hours (7.5 FTE) in January
  - 350 hours (17.5 FTE) in February
  - 350 hours (17.5 FTE) in March
- **Short term agency provision:**
  - Assumption based on 21 FTE coming into service during December
- **Care at Home:**
  - Continued small weekly increase of 43 hours per week
  - New provider, M Care, 500 hours in January
  - Mini-tender
  - An additional 500 hours coming into service during December

3.16 The number of hours is projected to increase by a further 2,764 (7.5%) hours, by the end of March 2013. Under the assumptions that 40% of this new provision will be for hospital discharges, and that each hospital package is 13.8 hours, an additional 80 people should be discharged from hospital between now and the end of March.

3.17 The total number of people waiting for home care/care at home as at 4th November 2012 is 120 (September: 161).

3.18 As reported previously, there will be an additional 186 care home beds coming on line between February 2013 and autumn 2013. The projected numbers are as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative</td>
<td>38</td>
<td>62</td>
<td>87</td>
<td>106</td>
<td>125</td>
<td>144</td>
<td>165</td>
<td>186</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A tender has been placed for a combination of 40 beds for people with challenging behaviour (respite and long term care), and 20 Step Up Step Down beds.

4 **Key Risks**

4.1 The risks associated with achieving the 4 hour standard, and the management of the surge activity expected throughout the winter period, include not meeting the demand for unscheduled care and older people. In particular, older people being adversely affected by long waits, boarding and extended stay in hospitals and the growing evidence which demonstrates the associated increase in mortality and morbidity. This relates to being unable to finance the proposals for unscheduled care and surge activity plans, and being able to implement the proposals, including having timely recruitment to required posts, and finally to the proposals meeting the level of demand required.
4.2 There are also risks to elective activity if capacity for unscheduled care patients is exceeded at times of surge activity, and boarding into surgical specialties is required. This could result in elective cancellations, and non compliance with the new treatment time guarantees.

4.3 There are many variables which can affect performance outside the control of the Health Board, such as seasonal variation, incidents, and infection outbreaks.

5 Risk Register

5.1 The clinical risk to patients and the corporate risks of non delivery, associated with unscheduled care, are noted on local and corporate risk registers. Mitigation of these risks has been outlined above.

6 Impact on Inequality, Including Health Inequalities

There is no impact assessment needed for this report. The overarching Improvement Plan will require to have work streams impact assessed, and this work is in progress.

7 Involving People

As this is a performance report, the involvement of people is not appropriate.

8 Resource Implications

8.1 Financial implications of the priority investments for unscheduled care were outlined in the Board paper for September. Further change to the NHS resource implications are noted in a separate paper, focused on Acute Services Capacity Plans.

8.2 Financial Implications for CEC are the cost of the additional Home Care and Care at Home activity is £2.9m in 2012/13, with a full year cost of £5.8m in 2013/14. The 2012/13 costs have been funded, £1.5m from the Change Fund and £1.4m from the Council’s demography funds. The shortfall in funding for 2013/14 is £2.3m.

The cost of the 60 beds currently being tendered for is estimated to be £1.4 in 2012/13 and £2.8m in a full year. Funding needs to be urgently identified, in order to proceed with the tender.

The cost of the remaining 122 beds is estimated to be £1.041m in 2012/13 and £2.082m in 2013/14.

Melanie Hornett
Nurse Director
19th November 2012
Melanie.hornett@nhslothian.scot.nhs.uk

Peter Gabbitas
Director of Health & Social Care
City of Edinburgh Council
WAITING TIMES PROGRESS AND PERFORMANCE

1 Purpose of the Report

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

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

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

2 Recommendations

The Board is recommended to:

2.1 Receive the report outlining progress with provisional information showing ongoing reductions in inpatient waits and outpatient numbers;

2.2 Recognise both the possibility of inpatients over 12 weeks at the end of December and the steps being taken to address that risk;

2.3 Note the work ongoing to reduce the long delays experienced by patients waiting for surveillance and other “repeat” endoscopies and that the timescale expected to resolve this difficulty has reduced from 18-24 months to 12;

2.4 Record that through the provision of additional internal and external provision, inpatient and daycase activity is up just under 10% on April-October last year, with outpatients up 3% overall;

2.5 To consider whether it would be benefit of to include waiting times as a theme within a board development session for members; and

2.6 Recognise the variables, risks and areas of uncertainty around these actions.
3 Background

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

3.2 To address the long waits facing some patients, NHS Lothian has developed and is implementing detailed plans to improve performance.

4 Current Position – Inpatients and Daycases

4.1 The table below shows the numbers waiting more than 12 and 9 weeks as well as availability levels and overall list size since April 2012.

<table>
<thead>
<tr>
<th>Table 1 - Inpatient and Daycase Waiting List Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Over 12 Weeks</td>
</tr>
<tr>
<td>Over 9 Weeks</td>
</tr>
<tr>
<td>Available</td>
</tr>
<tr>
<td>Unavailable</td>
</tr>
<tr>
<td>Total List Size</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
</tr>
</tbody>
</table>

Source: MMI returns; Performance Review

4.2 At the end of October, the fall in the number of inpatients and daycases continued. The trend since April 2011 is shown in Figure 1 alongside changes in overall list size and unavailability. These latter two aspects of the overall waiting list have been relatively stable in recent months.

4.3 Figure 2, using operational information, shows that the overall reduction of waits continuing into November, despite increasing pressure within women and children’s services from waits experienced by paediatric ENT and spinal patients in neurosurgery. The challenges in the prompt treatment of these spinal patients is also reflected in Figure 3, where the recent rise in the overall list size in specialties within Women and Children’s CMT is contrasted with ongoing reductions in both General Surgery and Head and Neck’s management teams.

4.4 The trend in reported patients over 12 weeks by specialty in shown in appendix 1.

\(^1\) For more information see [http://www.scotland.gov.uk/Resource/0039/00390166.pdf](http://www.scotland.gov.uk/Resource/0039/00390166.pdf)
Figure 1 – Inpatient and Daycase Waiting List

INPATIENT/DAY CASE WAITING LIST - MONTH END

Source: Management MMI; ISD Data Warehouse

Figure 2 – Inpatient and Daycases over 12 weeks

INPATIENTS/DAY CASES OVER 12 WEEKS - WEEKLY MONITORING

Source: Performance Review (report issued for operational management), 16th November

2 The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
4.5 In recent reports to the board the total time patients have been waiting, with no account taken for adjustments to the waiting time clock for either non-attendance or unavailability, have been provided. The report for the end of October is shown in appendix two. At the last board meeting, it has asked how this position had changed over time. This is shown in Figure 4, with those over 6 months, falling to 397 at the end of October from 638 in August. In common the position once clock adjustments are incorporated, the predominant specialties throughout have been urology and plastic surgery.

4.6 Discussion at last month’s board meeting also focussed on the importance of understanding the change in activity levels as the waiting list position has changed. Elective admissions on Lothian sites was up 6.1% (3140) in the period between April and October against the equivalent period in 2011. As board members know this additional activity internally is coupled with activity which has occurred outside of NHS Lothian, which provisional figures - excluding Golden Jubilee where activity is broadly on a par with last year - place at 1928 over the same period. This is equivalent to a further 3.75% increase, making the overall movement 9.85%.

4.7 Board members will note this level of additional activity outstrips the drop in the total elective waiting list over the same period by some margin, over 5000 admissions against a drop in the waiting list size of 1200. While this could be seen to substantiate the belief outlined in board papers in June’s board paper that three

---

3 Board members will recall from the June board paper that ophthalmology was excluded from the figure due to inconsistent recording of “second eye” cataract patients. The reported position for the specialty is also effected by premature and duplicate listing of patients. Support is being given to staff to address these data quality issues.
quarters of additional activity sought would be necessary to halt the rise in waiting times, proper account needs to be taken of spread of the additional activity across specialties and of definitional consistencies as not all elective activity is featured in headline waiting list numbers (for example, transplant and repeat patients are excluded).

4.8 Elective activity by specialty is detailed in appendix 4.

4.9 Figure 5 shows the most recent month’s theatre utilisation. The drop in Plastic Surgery and ENT use of sessions reported last month has been reversed but these areas, with gynaecology and orthopaedics, remain below the level sought in DCAQ and efficiency discussions.
5 Current Position - Outpatients

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

<table>
<thead>
<tr>
<th></th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 12 Weeks</td>
<td>4418</td>
<td>4601</td>
<td>5177</td>
<td>5069</td>
<td>4962</td>
<td>3627</td>
<td>3176</td>
</tr>
<tr>
<td>Available</td>
<td>39418</td>
<td>38541</td>
<td>38887</td>
<td>39346</td>
<td>39145</td>
<td>38226</td>
<td>38480</td>
</tr>
<tr>
<td>Unavailable</td>
<td>963</td>
<td>1044</td>
<td>1060</td>
<td>1204</td>
<td>921</td>
<td>796</td>
<td>750</td>
</tr>
<tr>
<td>Total List Size</td>
<td>40381</td>
<td>39585</td>
<td>39947</td>
<td>40550</td>
<td>40066</td>
<td>39022</td>
<td>39230</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
<td>2.4%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>3.0%</td>
<td>2.3%</td>
<td>2.0%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Source: MMI returns; Performance Review

5.2 As the breakdown of those over 12 weeks shows (Appendix 2), the reductions last month continue in those specialties targeted for see and treat activity, particularly ophthalmology and gastroenterology. Reductions in those specialties are mirrored in declining overall sizes of waiting lists shown in Figure 7.

5.3 As with inpatients, the reduction in patient waits is also impacting on the length of time patients wait when no account is taken of adjustments to the waiting time clock, for instance periods of unavailability (Figure 8). Those waiting more than 6 months have more than halved since August from 1117 to 522, with the majority of those waiting seeking an appointment in Urology

4 The PricewaterhouseCoopers Report of March 2012 highlighted that historical figures relating to attainment of targets and levels of unavailability are inaccurate.
5.4 Appendix 5 shows the change in outpatient activity on last year by specialty. Overall it is up by over 3% with 4353 additional attendances. Board members will note that the outpatient activity in Urology overall is reduced on last year, resulting predominately from the long term sickness of a Consultant, who is now back at work.

**Figure 7 - Outpatient Waiting List in specialties with largest variances**

- **Ophthalmology**
- **Gastroenterology**
- **General Surgery**
- **Urology**

<table>
<thead>
<tr>
<th>Date</th>
<th>Ophthalmology</th>
<th>Gastroenterology</th>
<th>General Surgery</th>
<th>Urology</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/04/2012</td>
<td>1500</td>
<td>2000</td>
<td>2500</td>
<td>3000</td>
</tr>
<tr>
<td>13/04/2012</td>
<td>2000</td>
<td>2500</td>
<td>3000</td>
<td>3500</td>
</tr>
<tr>
<td>20/04/2012</td>
<td>2500</td>
<td>3000</td>
<td>3500</td>
<td>4000</td>
</tr>
</tbody>
</table>

Source: Performance Review (report issued for operational management), 16th November

**Figure 8 – Trend in Long Outpatient Waits**

<table>
<thead>
<tr>
<th>Time (months)</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;6m</td>
<td>1200</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>&gt;9m</td>
<td>800</td>
<td>400</td>
<td>0</td>
</tr>
<tr>
<td>&gt;12m</td>
<td>600</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td>&gt;15m</td>
<td>400</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>&gt;18m</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Performance Review, 21st November
**6 Timescales and Routes to Recovery of Inpatient and Outpatient Waits**

6.1 Clinical Management Teams continue to reduce the number of inpatients and daycases waiting longer than 12 weeks. At the time of writing, 515 patients are likely to be over 12 weeks internally at the end of November with up to a further 191 externally, suggesting that the history of reduction will continue.

6.2 Board members will recall from discussions last month that between 400-500 inpatients and daycases were at risk of being over 12 weeks at the end of the calendar year. This remains a risk, however work continues to minimise it though the deployment of additional operating internally and suitable external provision. Capacity before the end of the year has not been identified for a small proportion of patients. Dates for these individuals are being found in the new year, while the alternative locations continue to sought, to ensure that these patients are not further disadvantaged if other options cannot be found in the next few weeks.

6.3 Discussions are also continuing on some patients for whom it is not clinically appropriate to seek treatment elsewhere. This could be, for example, because it is one episode in an ongoing pathway of treatment for the patient. In addition to the clinical considerations, legal advice is being taken on the expectations of the Patient Rights Act in such circumstances.

6.4 Last month, it was suggested that it was likely that the half of the outpatient backlog faced in June will have been addressed by the turn of the year. This now looks more than likely, with it being close to achieved at the end of the current month. At the time of writing it is anticipated that the position at the end of the month will see close to 2500 waiting over 12 weeks. As has been the case to date, the majority of the reduction will be in those areas where the “see and treat” model is applicable. Indeed, gastroenterology which saw over 900 patients over 12 weeks earlier this year is liable to have effectively eliminated any backlog by the end of next month through a combination of see and treat provision and internal clinics.

6.5 However “see and treat” is not suitable in all situations and a number of areas where patients are currently waiting beyond 12 weeks are likely to require redesign to resolve the delay currently being experienced by some patients and thus take longer to overcome. Potential solutions in these areas are currently being examined.

**7 Current Position – Diagnostics**

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

7.2 At the end of October – and as anticipated at last month’s board meeting, the number of diagnostic patients waiting longer than 6 weeks rose. The trend in endoscopy numbers over the 6 week standard is shown in Figure 9 with 1124 waiting over six weeks, rising from 609 the previous month. A further 5 patients were waiting beyond 4 weeks for cystoscopy with one patient exceeding 4 weeks while waiting for a MRI.
7.3 The provision of additional capacity to address these waits is dealt with in the next section.

7.4 Work undertaken by the Clinical Management Team has identified that a series of actions to support the provision of additional diagnostic endoscopy capacity. This projects that the pressure on diagnostic capacity will peak in January as a result of the additional outpatient activity, returning within six weeks by August/September 2013.

7.5 The additional capacity will be generated through the provision of CT colonography, planned from February and maximising the potential for additional sessions both at the weekend and at Roodlands hospital. Use of the independent sector will also be kept under consideration and reviewed in light of the progress made to reduce the number of surveillance patients waiting, which is discussed in the next section.

8 Current Position – Surveillance and Review Waits

8.1 In recent months, the number of patients overdue a repeat endoscopic examination have been reported to the Board. In the last paper considered, the position at the 19th October was related with 2278 patients overdue a colonoscopy with a further 787 another endoscopic examination.

8.2 As the 16th November, this remains stable with 2127 and 706 overdue respectively.

8.3 Previously the timescale to recovery in this area was anticipated to 18-24 months. It is now expected to have been addressed by next December through the use of both existing internal sessions and that agreed to be in place with the independent sector from January.
8.4 Earlier this month the Government’s Health Department asked that a monthly return on the status of these patients be returned to them. The contents of that return will form the basis of future reports on this issue to the board.

9 Recording and Management of Patient Waiting Times

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

9.2 Earlier this month, the Audit Committee considered a report on these arrangements. The Chair of the Committee welcomed the report, detailing both the history in this area as well as the actions in train, and asked that progress against these actions be fed back to that committee in February. The Board will be updated on progress after that meeting.

9.3 A recommendation was made at the meeting that, given the importance of the issue, that Board members should be asked whether time should be put aside within a board development session to focus on detail of waiting times management processes. The Board is asked to consider this opportunity.

10 Investment in Sustainable Capacity

10.1 Board members will recall from previous papers and discussions that a number of additional posts have been approved. These were the first steps towards providing sustainable capacity for the prompt treatment of patients and the initial element, alongside unscheduled care investment, into the additional 250 posts highlighted at the Annual Review.

<table>
<thead>
<tr>
<th>Table 3 – Current Position on Appointments Agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Upper Limb Surgeon Consultant 1 X</td>
</tr>
<tr>
<td>Back Surgeon Consultant 1 X</td>
</tr>
<tr>
<td>Admin Support Band 3 1 X</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>Urologist Consultant 2 X</td>
</tr>
<tr>
<td>Speciality Doctor 1 X</td>
</tr>
<tr>
<td>Admin Support Band 3 0.5 X</td>
</tr>
<tr>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Plastic Surgeon Consultant 1 X</td>
</tr>
<tr>
<td>Physiotherapist Band 6 1 X</td>
</tr>
<tr>
<td>Admin Support Band 2 0.81 X</td>
</tr>
<tr>
<td>Endoscopy</td>
</tr>
<tr>
<td>Colorectal Surgeon Consultant 1 X</td>
</tr>
<tr>
<td>Gastroenterologist Specialty Doctor 1 X</td>
</tr>
<tr>
<td>Nursing Band 5 10.9 X</td>
</tr>
<tr>
<td>Nursing Band 2 4.97 X</td>
</tr>
<tr>
<td>Admin Band 3 2 X</td>
</tr>
<tr>
<td>Anaesthetics &amp; Theatres</td>
</tr>
<tr>
<td>Anaesthetist Consultant 6 X</td>
</tr>
<tr>
<td>Theatre Nursing/ODP Band 6 4.8 X</td>
</tr>
<tr>
<td>Theatre Nursing/ODP Band 5 29.85 X</td>
</tr>
<tr>
<td>Theatre Nursing/ODP Band 2 11.34 X</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
<tr>
<td>Consultant Neurologist Consultant 1 X</td>
</tr>
</tbody>
</table>

10.2 The earlier discussion on the imbalance between additional activity and waiting list movement in Section 4.7 highlights the importance of such investments.
10.3 Table 3 summarises the position at the time of writing of those posts previously highlighted and including others – such as the consultant neurologist, more recently agreed.

11 Financial Performance against Plan

11.1 Cumulative expenditure to the end of October is £15,287k against the planned expenditure outlined in the June Board paper. Planned and actual expenditure are reported in Table 1, below. The plan (previously reported as £20M) has been restated to include £1.3M of expenditure supporting core capacity for which funds were committed recurringly in 2011-12. This expenditure remains non-recurrent pending finalisation of capacity plans and agreement of the 2013-14 Financial Plan.

Table 1: Expenditure for 7 months to 31st October

<table>
<thead>
<tr>
<th></th>
<th>Plan (Apr-Mar) £000s</th>
<th>YTD 7 Months £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>6,106</td>
<td>3,900</td>
</tr>
<tr>
<td>Medinet</td>
<td>1,719</td>
<td>2,634</td>
</tr>
<tr>
<td>GJNH</td>
<td>2,995</td>
<td>1,596</td>
</tr>
<tr>
<td>Spire Murrayfield</td>
<td>3,954</td>
<td>5,562</td>
</tr>
<tr>
<td>Nuffield Health</td>
<td>1,090</td>
<td>167</td>
</tr>
<tr>
<td>BMI Ross Hall</td>
<td>4,479</td>
<td>869</td>
</tr>
<tr>
<td>The Edinburgh Clinic</td>
<td>1,031</td>
<td>561</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21,374</strong></td>
<td><strong>15,287</strong></td>
</tr>
</tbody>
</table>

11.2 Internal NHS expenditure has increased from plan largely related to greater variable staffing costs as efforts are made to maximise in house capacity as well as recruitment of additional substantive posts to support the development of increased baseline capacity.

11.3 Medinet usage was originally focussed on supporting core capacity in diagnostic endoscopy in advance of recurring investment; the agreement of See & Treat pathways for a number of surgical services has resulted in an increase in use of Medinet against plan. This represents a further shift towards the use of NHS Lothian facilities and offsets a reduction in independent sector throughput in West of Scotland providers.

11.4 Overall expenditure against independent sector has remained in line with plan, despite lower levels of takeup against West of Scotland capacity. An increase in the use of Spire Murrayfield has negated any potential reduction in overall spend. This increase in Spire costs reflects variation in the specialty and casemix requirements against original projections.

11.5 A revised forecast will be reported as part of the NHS Lothian Mid Year Review. Expenditure is expected to be higher than the plan outlined in June, reflecting the issues outlined above and incorporating in year set up costs related to the implementation of additional capacity requirements identified through DCAQ analysis as well as further recovery actions identified against Diagnostic and Surveillance Endoscopy.
12  **Key Risks**

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

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

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

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

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

12.6 Sustained progress will also be dependent upon the willingness of staff to undertake additional hours above contractual levels for a prolonged period. To reduce the level of risk this presents it will be necessary to continue to invest in core capacity and also to seek alternative capacity to see those patients potentially affected.

12.7 Seasonality will also have an effect as staff will wish to arrange leave over the winter holiday periods. To counter this external agencies are being used to maximise the level of core capacity retained. This is also being factored into the Boards winter/resilience planning.

12.8 Seasonality will also affect patient availability as an unwillingness for patients to be treated for routine conditions was seen during the holiday period. Future plans will take better account of this through phasing. Core capacity could also be affected by further industrial action in light of the ongoing discussions over public sector pensions.
12.9 If the risks above are not managed successfully, the Board could be in breach of the Patients Rights Act.

Andrew Jackson  
Associate Director, Strategic Planning  
21 November 2012  
Andrew.C.Jackson@nhslothian.scot.nhs.uk

List of Appendices  
Appendix 1 – Trend in Patients reported over 12 weeks since April 2011  
Appendix 2 - Time since added to the Inpatient List for those Currently Waiting.  
Appendix 3 - Time since added to the Outpatient List for those Currently Waiting.  
Appendix 4 - Elective Inpatient and Daycase Activity  
Appendix 5 - Outpatient Activity
Appendix 1 – Trend in Patients reported over 12 weeks since April 2011

**BREACHES OF WAITING TIME STANDARDS REPORTED ON MONTHLY MMI RETURNS**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>3</td>
<td>4</td>
<td>184</td>
<td>159</td>
<td>459</td>
<td>470</td>
<td>573</td>
<td>625</td>
<td>696</td>
<td>561</td>
<td>524</td>
<td>361</td>
</tr>
<tr>
<td>Urology</td>
<td>2</td>
<td>2</td>
<td>191</td>
<td>210</td>
<td>195</td>
<td>178</td>
<td>192</td>
<td>201</td>
<td>170</td>
<td>141</td>
<td>134</td>
<td>85</td>
</tr>
<tr>
<td>ENT</td>
<td>21</td>
<td>108</td>
<td>134</td>
<td>172</td>
<td>229</td>
<td>305</td>
<td>324</td>
<td>343</td>
<td>311</td>
<td>276</td>
<td>269</td>
<td>231</td>
</tr>
<tr>
<td>General Surgery</td>
<td>31</td>
<td>148</td>
<td>343</td>
<td>411</td>
<td>326</td>
<td>259</td>
<td>218</td>
<td>196</td>
<td>177</td>
<td>131</td>
<td>99</td>
<td>58</td>
</tr>
<tr>
<td>Maxillofacial/Oral</td>
<td>10</td>
<td>33</td>
<td>61</td>
<td>105</td>
<td>131</td>
<td>110</td>
<td>120</td>
<td>140</td>
<td>117</td>
<td>107</td>
<td>54</td>
<td>39</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>63</td>
<td>60</td>
<td>68</td>
<td>70</td>
<td>62</td>
<td>70</td>
<td>67</td>
<td>65</td>
<td>62</td>
<td>58</td>
<td>56</td>
<td>52</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>4</td>
<td>14</td>
<td>22</td>
<td>29</td>
<td>28</td>
<td>30</td>
<td>34</td>
<td>31</td>
<td>35</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5</td>
<td>6</td>
<td>18</td>
<td>26</td>
<td>49</td>
<td>46</td>
<td>38</td>
<td>23</td>
<td>19</td>
<td>17</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>5</td>
<td>34</td>
<td>39</td>
<td>10</td>
<td>11</td>
<td>14</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>17</td>
<td>86</td>
<td>134</td>
<td>106</td>
<td>29</td>
<td>29</td>
<td>23</td>
<td>29</td>
<td>25</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>53</td>
<td>132</td>
<td>134</td>
<td>136</td>
<td>52</td>
<td>63</td>
<td>34</td>
<td>15</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>6</td>
<td>19</td>
<td>22</td>
<td>20</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory</td>
<td>27</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>13</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total &gt; 12 weeks</strong></td>
<td><strong>63</strong></td>
<td><strong>81</strong></td>
<td><strong>177</strong></td>
<td><strong>204</strong></td>
<td><strong>234</strong></td>
<td><strong>299</strong></td>
<td><strong>500</strong></td>
<td><strong>590</strong></td>
<td><strong>658</strong></td>
<td><strong>2160</strong></td>
<td><strong>2246</strong></td>
<td><strong>1979</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>5</td>
<td>4</td>
<td>23</td>
<td>25</td>
<td>33</td>
<td>28</td>
<td>29</td>
<td>29</td>
<td>30</td>
<td>22</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>Urology</td>
<td>3</td>
<td>2</td>
<td>11</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>ENT</td>
<td>21</td>
<td>108</td>
<td>134</td>
<td>172</td>
<td>229</td>
<td>305</td>
<td>324</td>
<td>343</td>
<td>311</td>
<td>276</td>
<td>269</td>
<td>231</td>
</tr>
<tr>
<td>General Surgery</td>
<td>31</td>
<td>148</td>
<td>343</td>
<td>411</td>
<td>326</td>
<td>259</td>
<td>218</td>
<td>196</td>
<td>177</td>
<td>131</td>
<td>99</td>
<td>58</td>
</tr>
<tr>
<td>Maxillofacial/Oral</td>
<td>10</td>
<td>33</td>
<td>61</td>
<td>105</td>
<td>131</td>
<td>110</td>
<td>120</td>
<td>140</td>
<td>117</td>
<td>107</td>
<td>54</td>
<td>39</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>63</td>
<td>60</td>
<td>68</td>
<td>70</td>
<td>62</td>
<td>70</td>
<td>67</td>
<td>65</td>
<td>62</td>
<td>58</td>
<td>56</td>
<td>52</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>4</td>
<td>14</td>
<td>22</td>
<td>29</td>
<td>28</td>
<td>30</td>
<td>34</td>
<td>31</td>
<td>35</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5</td>
<td>6</td>
<td>18</td>
<td>26</td>
<td>49</td>
<td>46</td>
<td>38</td>
<td>23</td>
<td>19</td>
<td>17</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>5</td>
<td>34</td>
<td>39</td>
<td>10</td>
<td>11</td>
<td>14</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>17</td>
<td>86</td>
<td>134</td>
<td>106</td>
<td>29</td>
<td>29</td>
<td>23</td>
<td>29</td>
<td>25</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>53</td>
<td>132</td>
<td>134</td>
<td>136</td>
<td>52</td>
<td>63</td>
<td>34</td>
<td>15</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>6</td>
<td>19</td>
<td>22</td>
<td>20</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory</td>
<td>27</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>13</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total &gt; 12 weeks</strong></td>
<td><strong>63</strong></td>
<td><strong>81</strong></td>
<td><strong>177</strong></td>
<td><strong>204</strong></td>
<td><strong>234</strong></td>
<td><strong>299</strong></td>
<td><strong>500</strong></td>
<td><strong>590</strong></td>
<td><strong>658</strong></td>
<td><strong>2160</strong></td>
<td><strong>2246</strong></td>
<td><strong>1979</strong></td>
</tr>
</tbody>
</table>

Historical figures relating to levels of attainment of the waiting times standard and levels of patient unavailability are known to be inaccurate.


Source: MMI returns
## Appendix 2 - Time since added to the Inpatient List for those Currently Waiting

### October 2012 Extract

Takes no account of periods of unavailability nor clock resets

Figures should not be added – eg 397 patients were waiting longer than 6 months, of whom 205 were waiting longer than 9 months

Source: Performance Review 21<sup>st</sup> November 2012

<table>
<thead>
<tr>
<th>Specialty Description</th>
<th>&gt;6m</th>
<th>&gt;9m</th>
<th>&gt;12m</th>
<th>&gt;15m</th>
<th>&gt;18m</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLASTIC SURGERY</td>
<td>167</td>
<td>89</td>
<td>12</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>148</td>
<td>80</td>
<td>42</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>TRAUMA AND ORTHOPAEDIC SURGERY</td>
<td>14</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>EAR, NOSE &amp; THROAT (ENT)</td>
<td>15</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RESPIRATORY MEDICINE</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GENERAL SURGERY (EXCL VASCULAR)</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GYNAECOLOGY</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ORAL AND MAXILLOFACIAL SURGERY</td>
<td>18</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLINICAL ONCOLOGY</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NEUROSURGERY</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VASCULAR SURGERY</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>397</strong></td>
<td><strong>205</strong></td>
<td><strong>72</strong></td>
<td><strong>14</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>
Appendix 3 - Time since added to the Outpatient List for those Currently Waiting.

<table>
<thead>
<tr>
<th>Specialty Description</th>
<th>&gt;6m</th>
<th>&gt;9m</th>
<th>&gt;12m</th>
<th>&gt;15m</th>
<th>&gt;18m</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAR, NOSE &amp; THROAT (ENT)</td>
<td>16</td>
<td>12</td>
<td>11</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>374</td>
<td>176</td>
<td>29</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>DERMATOLOGY</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TRAUMA AND ORTHOPAEDIC SURGERY</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>GENERAL SURGERY (EXCL VASCULAR)</td>
<td>34</td>
<td>9</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>14</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>ORAL AND MAXILLOFACIAL SURGERY</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>REHABILITATION MEDICINE</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>RESTORATIVE DENTISTRY</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>13</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PAEDIATRIC DENTISTRY</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ORAL SURGERY</td>
<td>13</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GP OTHER THAN OBSTETRICS</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PLASTIC SURGERY</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GYNAECOLOGY</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GERIATRIC MEDICINE</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DIABETES</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NEUROLOGY</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RESPIRATORY MEDICINE</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ORTHODONTICS</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ENDOCRINOLOGY</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PAEDIATRICS</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>522</td>
<td>243</td>
<td>68</td>
<td>15</td>
<td>3</td>
</tr>
</tbody>
</table>

October 2012 Extract
Takes no account of periods of unavailability nor clock resets
Figures should not be added – eg 522 patients were waiting longer than 6 months, of whom 243 were waiting longer than 9 months

Source: Performance Review 21st November 2012
### Appendix 4 - Elective Inpatient and Daycase Activity

#### Activity by CMT - Months of April to October 2011 and 2012

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Apr - Oct 11</th>
<th>Apr - Oct 12</th>
<th>Variance</th>
<th>%age Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>36</td>
<td>7</td>
<td>-29</td>
<td>-80.5%</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>197</td>
<td>125</td>
<td>-72</td>
<td>-36.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>46</td>
<td>53</td>
<td>7</td>
<td>16.2%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>122</td>
<td>114</td>
<td>-8</td>
<td>-6.6%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>378</td>
<td>262</td>
<td>-116</td>
<td>-30.7%</td>
</tr>
<tr>
<td>Medical CMT</td>
<td>779</td>
<td>561</td>
<td>-218</td>
<td>-28.0%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>448</td>
<td>394</td>
<td>-54</td>
<td>-12.1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2328</td>
<td>2287</td>
<td>-41</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>1517</td>
<td>1536</td>
<td>19</td>
<td>1.3%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>458</td>
<td>483</td>
<td>25</td>
<td>5.5%</td>
</tr>
<tr>
<td>CTR CMT</td>
<td>4751</td>
<td>4700</td>
<td>-51</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>154</td>
<td>158</td>
<td>4</td>
<td>2.6%</td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>5</td>
<td>9</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td>12</td>
<td>4</td>
<td>-8</td>
<td></td>
</tr>
<tr>
<td>REAS CMT</td>
<td>171</td>
<td>171</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>996</td>
<td>953</td>
<td>-43</td>
<td>-4.3%</td>
</tr>
<tr>
<td>General Surgery (excl Vascular)</td>
<td>4078</td>
<td>4273</td>
<td>195</td>
<td>4.8%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>183</td>
<td>184</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>2654</td>
<td>3060</td>
<td>426</td>
<td>16.1%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>775</td>
<td>949</td>
<td>174</td>
<td>22.5%</td>
</tr>
<tr>
<td>General Surgery CMT</td>
<td>8686</td>
<td>9439</td>
<td>753</td>
<td>8.7%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>3706</td>
<td>3724</td>
<td>18</td>
<td>0.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>48</td>
<td>90</td>
<td>42</td>
<td>87.5%</td>
</tr>
<tr>
<td>MSK CMT</td>
<td>3754</td>
<td>3814</td>
<td>60</td>
<td>1.6%</td>
</tr>
<tr>
<td>Ear Nose &amp; Throat</td>
<td>1627</td>
<td>1693</td>
<td>66</td>
<td>4.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>3290</td>
<td>3381</td>
<td>101</td>
<td>3.1%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>2305</td>
<td>2554</td>
<td>279</td>
<td>12.1%</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>680</td>
<td>774</td>
<td>94</td>
<td>13.8%</td>
</tr>
<tr>
<td>Head &amp; Neck CMT</td>
<td>7892</td>
<td>8432</td>
<td>540</td>
<td>6.8%</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>2970</td>
<td>3128</td>
<td>158</td>
<td>5.3%</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>879</td>
<td>973</td>
<td>94</td>
<td>10.7%</td>
</tr>
<tr>
<td>Haematology</td>
<td>5753</td>
<td>6524</td>
<td>771</td>
<td>13.4%</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>4713</td>
<td>5222</td>
<td>509</td>
<td>10.8%</td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>36</td>
<td>43</td>
<td>7</td>
<td>19.4%</td>
</tr>
<tr>
<td>Oncology CMT</td>
<td>14351</td>
<td>15890</td>
<td>1539</td>
<td>10.7%</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>3</td>
<td>0</td>
<td>-3</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>3</td>
<td>0</td>
<td>-3</td>
<td></td>
</tr>
<tr>
<td>Critical Care CMT</td>
<td>26</td>
<td>35</td>
<td>9</td>
<td>34.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>4112</td>
<td>3979</td>
<td>-133</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>81</td>
<td>66</td>
<td>-15</td>
<td>-18.5%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>1341</td>
<td>1499</td>
<td>158</td>
<td>11.0%</td>
</tr>
<tr>
<td>Paediatric specialties</td>
<td>6896</td>
<td>6399</td>
<td>501</td>
<td>8.5%</td>
</tr>
<tr>
<td>Women &amp; Children CMT</td>
<td>11432</td>
<td>11943</td>
<td>511</td>
<td>4.5%</td>
</tr>
<tr>
<td>Total Elective Admissions</td>
<td>51845</td>
<td>54985</td>
<td>3140</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Source: Performance Review, 21st November
## Appendix 5 - Outpatient Activity

**ACTIVITY BY CMT - MONTHS OF APRIL-OKTBER 2011 AND 2012**

<table>
<thead>
<tr>
<th>CMT, Specialty</th>
<th>Apr-Oct 11</th>
<th>Apr-Oct 12</th>
<th>Variance</th>
<th>Percentage variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>10</td>
<td>1</td>
<td>-9</td>
<td>-50.0%</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>1533</td>
<td>1655</td>
<td>122</td>
<td>8.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>12029</td>
<td>11568</td>
<td>-461</td>
<td>-3.6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1009</td>
<td>873</td>
<td>-136</td>
<td>-13.5%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>1050</td>
<td>1167</td>
<td>117</td>
<td>11.1%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>1867</td>
<td>2132</td>
<td>265</td>
<td>14.2%</td>
</tr>
<tr>
<td>Medical CMT</td>
<td>17498</td>
<td>17397</td>
<td>-101</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>206</td>
<td>192</td>
<td>-13</td>
<td>6.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3567</td>
<td>3739</td>
<td>172</td>
<td>4.8%</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>3735</td>
<td>4089</td>
<td>354</td>
<td>9.8%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>427</td>
<td>431</td>
<td>4</td>
<td>0.9%</td>
</tr>
<tr>
<td>CTR CMT</td>
<td>7834</td>
<td>8451</td>
<td>517</td>
<td>6.8%</td>
</tr>
<tr>
<td>Genetrie Medicine</td>
<td>1558</td>
<td>1631</td>
<td>73</td>
<td>4.7%</td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td>817</td>
<td>776</td>
<td>-42</td>
<td>-5.1%</td>
</tr>
<tr>
<td>REAS CMT</td>
<td>2375</td>
<td>2406</td>
<td>31</td>
<td>1.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>4131</td>
<td>4406</td>
<td>275</td>
<td>6.7%</td>
</tr>
<tr>
<td>General Surgery (excl Vascular)</td>
<td>7635</td>
<td>7920</td>
<td>285</td>
<td>3.7%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>299</td>
<td>345</td>
<td>46</td>
<td>15.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>4394</td>
<td>4133</td>
<td>-261</td>
<td>-5.9%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1377</td>
<td>1604</td>
<td>227</td>
<td>16.5%</td>
</tr>
<tr>
<td>General Surgery CMT</td>
<td>17836</td>
<td>18408</td>
<td>572</td>
<td>3.2%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>14974</td>
<td>16457</td>
<td>1483</td>
<td>9.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>2085</td>
<td>2251</td>
<td>166</td>
<td>8.0%</td>
</tr>
<tr>
<td>MSK CMT</td>
<td>17059</td>
<td>18708</td>
<td>1649</td>
<td>9.7%</td>
</tr>
<tr>
<td>Ear Nose &amp; Throat</td>
<td>8930</td>
<td>9308</td>
<td>378</td>
<td>4.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>16170</td>
<td>16425</td>
<td>255</td>
<td>1.6%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>4471</td>
<td>4839</td>
<td>368</td>
<td>8.8%</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1675</td>
<td>1420</td>
<td>-255</td>
<td>-15.3%</td>
</tr>
<tr>
<td>Head &amp; Neck CMT</td>
<td>31247</td>
<td>31792</td>
<td>545</td>
<td>1.7%</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>1777</td>
<td>1815</td>
<td>38</td>
<td>2.1%</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>4834</td>
<td>4754</td>
<td>-80</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Haematology</td>
<td>1755</td>
<td>1989</td>
<td>234</td>
<td>13.3%</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>608</td>
<td>703</td>
<td>95</td>
<td>16.6%</td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>39</td>
<td>53</td>
<td>14</td>
<td>35.9%</td>
</tr>
<tr>
<td>Oncology CMT</td>
<td>9013</td>
<td>9314</td>
<td>301</td>
<td>3.3%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>785</td>
<td>762</td>
<td>-23</td>
<td>-2.9%</td>
</tr>
<tr>
<td>LATCC</td>
<td>785</td>
<td>762</td>
<td>-23</td>
<td>-2.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>10531</td>
<td>10776</td>
<td>244</td>
<td>2.3%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>4346</td>
<td>4741</td>
<td>395</td>
<td>9.1%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>4888</td>
<td>4993</td>
<td>105</td>
<td>2.1%</td>
</tr>
<tr>
<td>Paediatric specialties</td>
<td>9737</td>
<td>9855</td>
<td>118</td>
<td>1.2%</td>
</tr>
<tr>
<td>Women &amp; Childhood CMT</td>
<td>29502</td>
<td>30564</td>
<td>862</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total New Outpatients</strong></td>
<td><strong>133249</strong></td>
<td><strong>137602</strong></td>
<td><strong>4353</strong></td>
<td><strong>3.3%</strong></td>
</tr>
</tbody>
</table>

Source: Performance Review, 21st November
MID YEAR REVIEW AND FINANCIAL POSITION TO 31ST OCTOBER 2012

1 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the Mid Year Review, linking this to the financial position to the end of October 2012, and confirming that NHS Lothian remains on track to deliver financial balance in 2012/13.

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

2 Recommendation

2.1 Members of the Board are asked to note the:

- Financial position for the seven months to the end of October 2012;
- Forecast year end position of financial balance and the key associated risks;

3 Discussion of Key Issues

Financial Position to October

3.1 As highlighted in the routine monthly finance reports, NHS Lothian has reported an overspend each month of this financial year. The position at the end of October was a net overspend of £1.6m, incorporating a baseline budget overspend of £0.4m and a shortfall against the efficiency savings target of £1.2m.

3.2 This is a slight (£0.1m) deterioration from the position reported in September. There were two significant adjustments during October:

- The efficiency target has been formally reduced from £37.5m to £32.3m for the year, reflecting the impact of the projected prescribing benefit of £5.2m. This benefit has arisen through a reduction in the actual price of drugs, when compared to those used in the budget setting model at the time of financial planning for this year.
A favourable movement in balance sheet provisions, including clinical negligence, was identified and quantified as part of the Mid Year Review process and is now reflected in the reported financial position. This benefit is projected at £4.8m for the year, £2.6m of which is supporting the year to date position.

3.3 These 2 adjustments largely offset and, whilst there have been some other minor movements, there are no other major changes to the underlying position to report at this time. The results are summarised in Table 1 below with details of the financial position by operational unit included in Appendix 1.

Table 1: Financial Position to 31st October 2012

<table>
<thead>
<tr>
<th>Total</th>
<th>Baseline</th>
<th>Outstanding Efficiency Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>University Hospital Division</td>
<td>(1,496)</td>
<td>(638)</td>
</tr>
<tr>
<td>CHPs/CHCP/PCCO</td>
<td>(186)</td>
<td>(110)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>(1,173)</td>
<td>(902)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(1,371)</td>
<td>(1,354)</td>
</tr>
<tr>
<td><strong>Operational Under/(Over) Spend</strong></td>
<td>(4,227)</td>
<td>(3,004)</td>
</tr>
<tr>
<td>Offset by release of provisions</td>
<td>2,642</td>
<td>2,642</td>
</tr>
<tr>
<td><strong>Total Under/(Over) Spend</strong></td>
<td>(1,585)</td>
<td>(362)</td>
</tr>
</tbody>
</table>

**Mid Year Review**

3.4 The Mid Year Review was undertaken following publication of the financial results for September. The Quarter 1 review concluded that in year financial balance was achievable and this was reconfirmed by the Mid Year Review. It also highlighted the imbalance between the recurring and non-recurring position, wholly related to the delivery of recurring efficiency savings. This will be reflected in the emerging financial plan for 2013/14 onwards.

3.5 Appendix 2 provides a high level overview of the movements from the financial plan target of breakeven and a summary is given in Table 2 on the following page.

3.6 In line with the revised approach to monthly financial performance reporting, the Mid Year Review focuses specifically on the key areas of financial pressure and risk across the system. This includes slippage on the planned savings programme. Board Members should note therefore, that not all issues are specifically highlighted below, and there are areas of both overspend and underspend which are netted off within the Forecast Baseline Outturn Position of £0.2m reported within this schedule.
Table 2: Summary of the Mid Year Review 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1 Review £m</th>
<th>Mid Year Review £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-recurring Resources</td>
<td>13.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Forecasted Baseline Outturn</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Forecast LRP Outturn</td>
<td>(11.8)</td>
<td>(3.9)</td>
</tr>
</tbody>
</table>

**Movements from Financial Plan:**
Changes agreed following the Quarter 1 review (7.4) (7.6)

**Movements to be tracked**
- Waiting Times (21.9) (26.8)
- Energy (1.0) (1.0)
- UNPACs (2.6) (2.5)
- Provisions 1.4 5.9
- Research & Development (1.8) (1.3)
- Income from other health systems (1.0) (2.4)
- Prescribing 5.2 0.0

**Offsetting Benefits**
- Slippage on Financial Plan Investments, 20.4 16.1
- SGHD Waiting Times Brokerage 10.0 10.0

**Forecasted Year End Position** 2.9 0

3.7 The issues highlighted in previous months and the Quarter 1 review remain evident in both the October financial position and the Mid Year Review. Waiting times and provisions are discussed elsewhere in this report; other key factors include:

- **Energy costs** - a cost pressure has emerged due to increased energy prices under the terms of the national contract (£0.2 ytd, increasing to £1.0m for the year following the more expensive winter months);
- **UNPACs** – the ongoing impact of high cost learning disability patients with independent sector providers, some of which have recently transferred to the care of NHS Lothian. A capital solution is being pursued to provide an alternative facility for this patient group. Whilst work is underway on this development, costs remain within the system as patients remain in these independent facilities. Public Health colleagues continue to closely scrutinise these cases. The total pressure is £1.7m to October and £2.4m in the full year;
- **Research and development** – changes to the Scottish Government allocation have given rise to a cost pressure in the region of £1.2m. The allocation has been reduced, whilst costs remain embedded within the organisation with limited potential to reduce. Discussions are ongoing with University of Edinburgh and the Chief Scientist’s Office and, on this basis, the projected shortfall is not reflected in the October financial position but provision has been made in the Mid Year Review forecast;
- **Income from other health systems** – this reflects the likely impact on income caused by a fall in non Lothian activity. Discussions with other Health Boards
are ongoing but provision has been made within the Mid Year Review for a shortfall in income of £2.4m; and

- **Other operational pressures** – includes benefits from a range of medical workforce vacancies and unused reserves for SMC drugs offset by increases in nursing, equipment, clinical and other supplies costs £2.2m.

3.8 All of these costs highlighted above are offset by a range of benefits including slippage on allocations and financial plan investments; unutilised reserves and the brokerage from the SGHSCD to support the additional cost of waiting times. The forecast position for the year, therefore, remains one of breakeven.

**Efficiency & Productivity**

3.9 As reported above, the efficiency and productivity target has been formally reduced by £5.2m to give a revised target of £32.3m.

3.10 For the seven month period to October, efficiencies of £13.0m have been delivered against a plan of £14.3m, an under delivery of £1.2m. This is a slight improvement on delivery as at September.

3.11 Against the £32.3m target it is anticipated that £28.4m of savings will be delivered in year giving a forecast under delivery of £3.9m. There have been a number of non-recurring benefits assumed in arriving at the year end forecast whilst work on recurring plans is implemented. The forecast recurring shortfall carried into 2013/14, therefore, is estimated at £12.2m. Work is underway to ensure the workstream targets are met on a recurring basis during 2013/14 to address this. For the purposes of financial planning, this has been recognised as the opening shortfall for the organisation going into 2013/14.

**Table 3: Efficiency & Productivity 2012/13**

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Current Year Target</th>
<th>Slippage to October</th>
<th>Forecast Slippage MYR</th>
<th>Forecast carry forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in Interventions Low Clinical Value</td>
<td>537</td>
<td>(208)</td>
<td>(495)</td>
<td>(369)</td>
</tr>
<tr>
<td>Primary &amp; Community Care Bed Reduction</td>
<td>650</td>
<td>(99)</td>
<td>(346)</td>
<td>198</td>
</tr>
<tr>
<td>Acute Flow &amp; Capacity Management</td>
<td>3,233</td>
<td>(38)</td>
<td>(542)</td>
<td>(611)</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,894</td>
<td>(746)</td>
<td>(1,546)</td>
<td>(1,430)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>6,211</td>
<td>(463)</td>
<td>(836)</td>
<td>(534)</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,631</td>
<td>(8)</td>
<td>(1,410)</td>
<td>(615)</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,758</td>
<td>(64)</td>
<td>(643)</td>
<td>(1,237)</td>
</tr>
<tr>
<td>Corporate/Strategic Services</td>
<td>1,945</td>
<td>(127)</td>
<td>(152)</td>
<td>(1,279)</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1,779</td>
<td>(159)</td>
<td>(599)</td>
<td>(696)</td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td>5,171</td>
<td>22</td>
<td>346</td>
<td>(1,046)</td>
</tr>
<tr>
<td>UHD Local</td>
<td>3,893</td>
<td>683</td>
<td>2,071</td>
<td>(2,129)</td>
</tr>
<tr>
<td>LAMS</td>
<td>2,000</td>
<td>(17)</td>
<td>(113)</td>
<td>(100)</td>
</tr>
<tr>
<td>Other</td>
<td>(362)</td>
<td></td>
<td>361</td>
<td></td>
</tr>
<tr>
<td><strong>Total Planned Savings</strong></td>
<td><strong>32,340</strong></td>
<td><strong>(1,224)</strong></td>
<td><strong>(3,904)</strong></td>
<td><strong>(9,848)</strong></td>
</tr>
<tr>
<td><strong>Residual Gap</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>(2,365)</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32,340</strong></td>
<td><strong>(1,224)</strong></td>
<td><strong>(3,904)</strong></td>
<td><strong>(12,213)</strong></td>
</tr>
</tbody>
</table>
3.12 Whilst there has been an improvement in the position since the Quarter 1 review (which forecast a shortfall of £11.8m), the level of overall slippage continues to give cause for concern. Non delivery of the efficiency target remains one of the key risks for the organisation.

Waiting times

3.13 The total cost of delivering additional waiting times activity was £15.3m to the end of September, an increase of £3.1m in the month and in line with the agreed plans. This includes £1.9m for activity undertaken at independent sector hospitals, and reflects a more complex casemix than originally envisaged.

3.14 The Mid Year Review has identified a significant increase to forecast costs, based on indicative activity and casemix, against the waiting times recovery plan agreed in June, resulting in a projected shortfall of £4.9m. Overall expenditure is now forecast at £26.8m. The main areas of change relate to an increase in internal and Medinet costs, the addition of a separate recovery plan for endoscopy surveillance, start up costs for developing internal capacity, and locum costs for a significant number of vacancies in anaesthetics. Increased use of Medinet had been intended to offset reduced throughput in the independent sector, however the impact of variation in specialty and casemix requirements from original projections has negated any potential reduction in costs.

Capital

3.15 The Quarter 1 review of capital identified significant slippage in the programme and the Corporate Management Team (CMT) and the Finance and Performance Review Committee (F&PR) have since approved a programme of up to £10m over the next 2 years utilising a combination of in-year slippage and the statutory standards budget this year and next, to support investment in backlog maintenance. Further slippage has been identified in the Mid Year Review and the options to manage this are being considered by the Lothian Capital Investment Group (LCIG) in the first instance, with a proposal to be discussed at the meeting of the Joint Management Team on 5 December.

3.16 Expenditure of £11.6m was incurred for the first 7 months of the financial year. Appendix 3 includes details of the programme on a scheme by scheme basis.

4 Key Risks

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

- Delivery of the agreed recurrent efficiency schemes and the need to identify further plans to address the shortfall;
- Continued management of the financial exposure on waiting times' related additional activity delivery;
- The solution(s) agreed to address the system wide bed capacity pressures across the system, including any double running costs associated with any continued use of the Royal Victoria Hospital;
• The potential cost of changes to pay terms & conditions (including revised on call arrangements); and
• The increasing trend of expenditure on clinical supplies, hotel and equipment costs.

5 Risk Register

5.1 There is nothing to add to the Risk Register at this stage.

6 Health and Other Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 Involving People

7.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith
Director of Finance
16 November 2012
Susan.goldsmith@nhlothian.scot.nhs.uk

List of Appendices

Appendix 1; NHS Lothian Expenditure Summary October 2012
Appendix 2; NHS Lothian Income Summary October 2012
Appendix 3; NHS Lothian Capital Expenditure Programme October 2012
## NHS Lothian Expenditure Summary to October 2012

### UNIVERSITY HOSPITALS DIVISION

<table>
<thead>
<tr>
<th>Section</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical &amp; Associated Services</strong></td>
<td>122,666</td>
<td>70,128</td>
<td>71,306</td>
<td>(1,177)</td>
<td>(652)</td>
<td>(525)</td>
</tr>
<tr>
<td><strong>REAS &amp; MOE</strong></td>
<td>66,976</td>
<td>37,334</td>
<td>37,717</td>
<td>(382)</td>
<td>(302)</td>
<td>(80)</td>
</tr>
<tr>
<td><strong>Surgical Directorate</strong></td>
<td>81,729</td>
<td>50,732</td>
<td>50,728</td>
<td>79</td>
<td>(483)</td>
<td>(266)</td>
</tr>
<tr>
<td><strong>Labs, A&amp;T, Critical Care &amp; HSDU</strong></td>
<td>120,542</td>
<td>71,469</td>
<td>71,023</td>
<td>447</td>
<td>578</td>
<td>(131)</td>
</tr>
<tr>
<td><strong>Women, Children &amp; Neuroscience</strong></td>
<td>91,522</td>
<td>51,978</td>
<td>52,728</td>
<td>(749)</td>
<td>(483)</td>
<td>(266)</td>
</tr>
<tr>
<td><strong>Radiology, Cancer, Head &amp; Neck</strong></td>
<td>101,236</td>
<td>58,535</td>
<td>58,274</td>
<td>261</td>
<td>(154)</td>
<td>415</td>
</tr>
<tr>
<td><strong>Corporate</strong></td>
<td>(4,362)</td>
<td>(13,943)</td>
<td>(14,386)</td>
<td>443</td>
<td>411</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>580,310</td>
<td>326,235</td>
<td>327,732</td>
<td>(1,496)</td>
<td>(638)</td>
<td>(859)</td>
</tr>
</tbody>
</table>

### CHPs/CHCP/PCCO

<table>
<thead>
<tr>
<th>Section</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>East Lothian CHP</strong></td>
<td>67,945</td>
<td>40,173</td>
<td>40,275</td>
<td>(101)</td>
<td>(55)</td>
<td>(46)</td>
</tr>
<tr>
<td><strong>Edinburgh CHP</strong></td>
<td>237,364</td>
<td>141,738</td>
<td>141,667</td>
<td>70</td>
<td>69</td>
<td>1</td>
</tr>
<tr>
<td><strong>Midlothian CHP</strong></td>
<td>69,346</td>
<td>41,544</td>
<td>41,534</td>
<td>11</td>
<td>42</td>
<td>(32)</td>
</tr>
<tr>
<td><strong>West Lothian CHCP</strong></td>
<td>98,218</td>
<td>55,937</td>
<td>55,905</td>
<td>32</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td><strong>Primary Care Contractor Organisation</strong></td>
<td>12,805</td>
<td>54,451</td>
<td>54,464</td>
<td>(195)</td>
<td>(195)</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Corporate</strong></td>
<td>11,998</td>
<td>(7,782)</td>
<td>(7,779)</td>
<td>(3)</td>
<td>(3)</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>497,675</td>
<td>326,061</td>
<td>326,248</td>
<td>(186)</td>
<td>(110)</td>
<td>(76)</td>
</tr>
</tbody>
</table>

### CORPORATE BUDGETS

<table>
<thead>
<tr>
<th>Section</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Executive</strong></td>
<td>652</td>
<td>435</td>
<td>440</td>
<td>(5)</td>
<td>(4)</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Consort</strong></td>
<td>45,703</td>
<td>26,028</td>
<td>26,028</td>
<td>0</td>
<td>(0)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Communications</strong></td>
<td>1,142</td>
<td>565</td>
<td>549</td>
<td>16</td>
<td>21</td>
<td>(5)</td>
</tr>
<tr>
<td><strong>Ehealth</strong></td>
<td>26,716</td>
<td>13,868</td>
<td>13,914</td>
<td>(46)</td>
<td>(46)</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Facilities Management</strong></td>
<td>80,079</td>
<td>45,100</td>
<td>46,741</td>
<td>(1,641)</td>
<td>(1,498)</td>
<td>(143)</td>
</tr>
<tr>
<td><strong>Finance &amp; Capital Planning</strong></td>
<td>10,528</td>
<td>5,945</td>
<td>5,826</td>
<td>118</td>
<td>170</td>
<td>(52)</td>
</tr>
<tr>
<td><strong>Human Resources</strong></td>
<td>11,170</td>
<td>5,744</td>
<td>5,831</td>
<td>(87)</td>
<td>(14)</td>
<td>(73)</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td>976</td>
<td>228</td>
<td>183</td>
<td>45</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>3,189</td>
<td>(399)</td>
<td>(509)</td>
<td>110</td>
<td>111</td>
<td>0</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>12,129</td>
<td>6,871</td>
<td>6,685</td>
<td>186</td>
<td>136</td>
<td>50</td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td>3,747</td>
<td>1,290</td>
<td>1,069</td>
<td>221</td>
<td>221</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Public Health</strong></td>
<td>3,277</td>
<td>1,683</td>
<td>1,773</td>
<td>(90)</td>
<td>(44)</td>
<td>(47)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>133</td>
<td>(13)</td>
<td>(13)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>199,441</td>
<td>107,347</td>
<td>108,519</td>
<td>(1,173)</td>
<td>(902)</td>
<td>(271)</td>
</tr>
</tbody>
</table>

### STRATEGIC BUDGETS

<table>
<thead>
<tr>
<th>Section</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SLAs/UNPACs/NCA</strong></td>
<td>10,051</td>
<td>5,863</td>
<td>7,552</td>
<td>(1,689)</td>
<td>(1,689)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Depreciation, Capital Grants &amp; Asset Impairment</strong></td>
<td>50,546</td>
<td>35,038</td>
<td>35,069</td>
<td>(31)</td>
<td>(15)</td>
<td>(17)</td>
</tr>
<tr>
<td><strong>Provisions for Pension Costs &amp; Claims</strong></td>
<td>15,049</td>
<td>1,593</td>
<td>1,593</td>
<td>0</td>
<td>(1)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Commissing from 3rd Sector</strong></td>
<td>8,829</td>
<td>9,814</td>
<td>9,840</td>
<td>(25)</td>
<td>(25)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Reserves &amp; Uncommitted Allocations</strong></td>
<td>3,982</td>
<td>(838)</td>
<td>(1,213)</td>
<td>375</td>
<td>375</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>88,458</td>
<td>51,470</td>
<td>52,842</td>
<td>(1,371)</td>
<td>(1,356)</td>
<td>(17)</td>
</tr>
</tbody>
</table>

### TOTAL

<table>
<thead>
<tr>
<th>Section</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>Actuals £k</th>
<th>Variance £k</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Release of Provisions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,643</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,365,884</td>
<td>811,114</td>
<td>815,340</td>
<td>(4,227)</td>
<td>(3,005)</td>
<td>(1,223)</td>
</tr>
</tbody>
</table>

**Release of Provisions**

- Amount: 2,642
- Variance: 0

**Total**

- Amount: 1,365,884
- Variance: (1,585)
<table>
<thead>
<tr>
<th>Income Category</th>
<th>Annual Budget £k</th>
<th>YTD Budget £k</th>
<th>YTD Actuals £k</th>
<th>Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from other health systems</td>
<td>(114,841)</td>
<td>(58,392)</td>
<td>(58,590)</td>
<td>197</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(58,006)</td>
<td>(34,218)</td>
<td>(34,382)</td>
<td>164</td>
</tr>
<tr>
<td>National services</td>
<td>(31,323)</td>
<td>(27,055)</td>
<td>(27,114)</td>
<td>59</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,801)</td>
<td>(1,677)</td>
<td>(1,438)</td>
<td>(238)</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(2,401)</td>
<td>(1,401)</td>
<td>(1,397)</td>
<td>(4)</td>
</tr>
<tr>
<td>Other income</td>
<td>(39,882)</td>
<td>(28,459)</td>
<td>(29,429)</td>
<td>970</td>
</tr>
<tr>
<td><strong>Sub Total Income</strong></td>
<td><strong>(249,254)</strong></td>
<td><strong>(151,202)</strong></td>
<td><strong>(152,349)</strong></td>
<td><strong>1,147</strong></td>
</tr>
<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,268,423)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>(1,517,678)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The difference in the total annual income above and the annual expenditure budget in Appendix 1 relates to income budgets which are held within CMTs/CHPs/CHCP and corporate departments. At this local level £0.15bn of income budgets are offset against expenditure.
## NHS Lothian Capital Expenditure Programme 2012/13

### Overall Programme 2012/13

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Agreed Programme £k</th>
<th>Revised Forecast £k</th>
<th>Increase/ (Reduction) in Forecast £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td>2,234</td>
<td>3,353</td>
<td>(2,171) (63)</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children and DCN Enabling</td>
<td>2,000</td>
<td>110</td>
<td>2,541 541</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>269 (16)</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>GDP Dental Premises</td>
<td>2,000</td>
<td>420</td>
<td>500 (1,500)</td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>3,917</td>
<td>1,293</td>
<td>4,261 344</td>
</tr>
<tr>
<td>RIE Lifecycle Costs</td>
<td>4,663</td>
<td>2,637</td>
<td>4,520 (143)</td>
</tr>
<tr>
<td>Gullane Medical Centre</td>
<td>459</td>
<td>0</td>
<td>459 0</td>
</tr>
<tr>
<td>Radiotherapy - Phase 7</td>
<td>11 (12)</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>2,245</td>
<td>206</td>
<td>2,245 0</td>
</tr>
<tr>
<td>Radiotherapy - Other</td>
<td>226</td>
<td>15</td>
<td>226 0</td>
</tr>
<tr>
<td><strong>Total - SCHEMES WITH SPECIFIC FUNDING</strong></td>
<td><strong>18,025</strong></td>
<td><strong>8,006</strong></td>
<td><strong>16,960 (1,064)</strong></td>
</tr>
<tr>
<td>Approved, not committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West End Medical Practice</td>
<td>1,467</td>
<td>182</td>
<td>571 (896)</td>
</tr>
<tr>
<td><strong>Total - SCHEMES WITH SPECIFIC FUNDING</strong></td>
<td><strong>19,879</strong></td>
<td><strong>8,187</strong></td>
<td><strong>17,919 (1,960)</strong></td>
</tr>
<tr>
<td>Over/ (Under) Commitment on Specific Funding</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>NHS Lothian Formula and Other Funding Programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rolling Programmes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory Compliance</td>
<td>1,331</td>
<td>429</td>
<td>1,529 198</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>10,266</td>
<td>791</td>
<td>10,270 4</td>
</tr>
<tr>
<td>E-Health Strategic Priorities</td>
<td>2,000</td>
<td>214</td>
<td>2,000 0</td>
</tr>
<tr>
<td>Backlog maintenance</td>
<td>5,000</td>
<td>0</td>
<td>5,000 0</td>
</tr>
<tr>
<td>Traffic Management</td>
<td>115</td>
<td>49</td>
<td>115 0</td>
</tr>
<tr>
<td>Invest to Save</td>
<td>269</td>
<td>30</td>
<td>105 (164)</td>
</tr>
<tr>
<td>National PACS Refresh 2007-17</td>
<td>85</td>
<td>85</td>
<td>85 0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,066</strong></td>
<td><strong>1,598</strong></td>
<td><strong>19,104 38</strong></td>
</tr>
<tr>
<td>Committed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expansion of renal capacity RIE</td>
<td>(297)</td>
<td>7</td>
<td>0 297</td>
</tr>
<tr>
<td>Laboratory Equipment</td>
<td>746 (5)</td>
<td>214</td>
<td>(5310)</td>
</tr>
<tr>
<td>Radiotherapy - Phase 8</td>
<td>130</td>
<td>0</td>
<td>130 0</td>
</tr>
<tr>
<td>Observation Ward A&amp;E Rie</td>
<td>(160)</td>
<td>0</td>
<td>0 16</td>
</tr>
<tr>
<td>Birthing suite RIE</td>
<td>(355)</td>
<td>13</td>
<td>13 367</td>
</tr>
<tr>
<td>Chalmers Hospital</td>
<td>39 (22)</td>
<td>(15)</td>
<td>(54)</td>
</tr>
<tr>
<td>LAMS</td>
<td>742</td>
<td>215</td>
<td>763 21</td>
</tr>
<tr>
<td>HEI</td>
<td>324</td>
<td>0</td>
<td>324 0</td>
</tr>
<tr>
<td>Other Donations</td>
<td>521</td>
<td>319</td>
<td>551 30</td>
</tr>
<tr>
<td>RVH Relocations</td>
<td>1,318</td>
<td>897</td>
<td>1,448 129</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,153</strong></td>
<td><strong>1,424</strong></td>
<td><strong>3,427 275</strong></td>
</tr>
</tbody>
</table>
## Appendix 4

### NHS Lothian Capital Expenditure Programme 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Agreed Programme</th>
<th>12/13 Expenditure as at Oct 2012</th>
<th>Revised Forecast</th>
<th>Increase/ (Reduction) in Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td><strong>Approved, not committed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography Upgrade WGH</td>
<td>1,387</td>
<td>146</td>
<td>1,399</td>
<td>12</td>
</tr>
<tr>
<td>Labour Ward/ Maternity Unit SJH</td>
<td>41</td>
<td>15</td>
<td>121</td>
<td>80</td>
</tr>
<tr>
<td>Burns Unit (SJH)</td>
<td>570</td>
<td>32</td>
<td>464</td>
<td>(106)</td>
</tr>
<tr>
<td>Teenage Cancer Trust, WGH</td>
<td>899</td>
<td>48</td>
<td>898</td>
<td>(1)</td>
</tr>
<tr>
<td>Tranent</td>
<td>389</td>
<td>5</td>
<td>293</td>
<td>(96)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,286</td>
<td>246</td>
<td>3,175</td>
<td>(110)</td>
</tr>
<tr>
<td><strong>Programmed, but unapproved</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of Items for Cancer Treatments</td>
<td>146</td>
<td>96</td>
<td>146</td>
<td>0</td>
</tr>
<tr>
<td>Other Equipment (Revenue Sweep)</td>
<td>132</td>
<td>0</td>
<td>180</td>
<td>48</td>
</tr>
<tr>
<td>Endoscopy RIE</td>
<td>153</td>
<td>0</td>
<td>169</td>
<td>17</td>
</tr>
<tr>
<td>Balfour Pavilion</td>
<td>650</td>
<td>0</td>
<td>500</td>
<td>(150)</td>
</tr>
<tr>
<td>Closure of Edenhall</td>
<td>284</td>
<td>128</td>
<td>295</td>
<td>11</td>
</tr>
<tr>
<td>Reconfiguration of Greenbank Unit (Royal Edinburgh Hospital)</td>
<td>350</td>
<td>9</td>
<td>10</td>
<td>(340)</td>
</tr>
<tr>
<td>Macmillan Centre SJH</td>
<td>430</td>
<td>31</td>
<td>223</td>
<td>(207)</td>
</tr>
<tr>
<td>Completed Schemes under Review</td>
<td>(152)</td>
<td>(162)</td>
<td>(131)</td>
<td>21</td>
</tr>
<tr>
<td>NSD Projects</td>
<td>17</td>
<td>0</td>
<td>42</td>
<td>25</td>
</tr>
<tr>
<td>Dental transfer to HSDU RIE</td>
<td>750</td>
<td>0</td>
<td>460</td>
<td>(290)</td>
</tr>
<tr>
<td>RIE Bed Capacity</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St John’s Hospital MRI</td>
<td>134</td>
<td>0</td>
<td>134</td>
<td>0</td>
</tr>
<tr>
<td>Malta House</td>
<td>329</td>
<td>0</td>
<td>329</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total - SCHEMES FUNDED BY FORMULA &amp; OTHER FUNDING</strong></td>
<td>3,222</td>
<td>102</td>
<td>2,357</td>
<td>(865)</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>28,727</td>
<td>3,370</td>
<td>28,063</td>
<td>(664)</td>
</tr>
<tr>
<td><strong>Total over/ (under) commitment</strong></td>
<td>48,605</td>
<td>11,557</td>
<td>45,982</td>
<td>(2,623)</td>
</tr>
<tr>
<td></td>
<td>1,861</td>
<td></td>
<td></td>
<td>(648)</td>
</tr>
</tbody>
</table>
THE HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT STRATEGY – UPDATE AND REVISIONS

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress against the agreed Human Resources and Organisational Development Strategy.

2 Recommendations

The Board is invited to

2.1 Note the position achieved in respect of the Human Resources Strategy. December 2011 to November 2012 and the key achievement and revision.

3 Discussion of Key Issues

3.1 The Board agreed the refreshed Human Resources and Organisational Development Strategy at its meeting on 23rd November 2011.

3.2 The strategy has now been revised to take into account the actions we require to take to support the resolution of our strategic challenges, specifically:-

- Delivering on waiting times and guarantees
- Improving our performance in the management of Unscheduled Care
- Developing and implementing Health and Social Care Partnerships
- Realigning Acute Services
- Managing our financial position
- The concerns raised in the D J Bowles report

3.3 The strategy still concentrates on six key areas from which specific work programmes have been developed and implemented, delivered and or refreshed. Each specific work programme is considered by the Lothian Partnership Forum and the Staff Governance Committee of the Board prior to implementation. Subsequent governance arrangements are considered by the Staff Governance Committee, Healthcare Governance Committee, Service Redesign Committee, Mutuality and Equality Governance Committee and of course twice a year by the full Board. These six key areas are as follows:
3.4.1 Employability and Social Responsibility

3.4.2 Promoting Organisational Values and An Aspirational Culture that Enhances Staff Engagement and Ensures that our people have the opportunity to reach their maximum potential to drive organisational performance.

3.4.3 Best Practice in Leadership, Staff Governance, Performance Management Compliance.

3.4.4 Managing Change, Organisational Design, Development, Implementation and Sustainability.

3.4.5 Workforce Planning, Redesign, Modernisation and Productivity.

3.4.6 Provision of Core and Expert Human Resources and Organisational Development Services and Systems.

3.5 Our HR/OD Framework continues to support the fundamental principles espoused in Living Values, Engaging Leadership and Delivering Quality. Doing what we say we will do, making explicit the standards we expect of our people, providing leadership based on an evidence base, ensuring training activity is aligned to helping people to do their jobs properly and provide highly competent, but just as critically, compassionate care, which is what our patients deserve and expect from us.

4 Summary of Progress

4.1 Appendix B details the significant progress which has been made during the course of last year. Key achievements are:-

- We have secured 243 employment and training opportunities for the 16-24 age group, against an agreed target of 190.

- We have commenced a review of the Lothian Healthcare Academy and we now include Social Care. We are working closely with Further Education providers to develop a curriculum that enables progression to an integrated Health and Social Care Employment approach.

- Modern Apprenticeships are available in Facilities and in Laboratories.

- A new role of Maternity Care Assistant is also being progressed working with NES and Scotland’s colleges.

- To address the key action within the strategy a review of HR/OD has commenced and the findings of this review will be completed by December 2012.

- Significant improvement in the performance of staff in taking forward the collection of ethnicity data through enhanced training and support.
- A clinical review of Occupational Health Service has been completed with a major move towards nurse-based clinical assessment.

- A range of leadership development programmes to be taken forward to address concerns raised in the D J Bowles report.

5 Key Risks

5.1 Approximately 50% of our annual revenue budget of £1.4bn is in staff costs. Failure to implement our people management strategies and policies will put a risk to our ability to deliver our Clinical Strategy in a manner that is patient centred, safe and effective and within the available resources.

6 Impact on Health Inequalities

6.1 Human Resources and Organisational Development matters appear on the NHS Lothian Risk Register and are subject to regular review.

7 Impact in Health Inequalities

7.1 The proposals in the attachment to this report have been subject to an Equality and Diversity Impact Assessment. The assessment revealed that the proposals could be expected to enhance equality and diversity through an enlightened approach to employability and social responsibility as part of a concerted effort to break the links between poverty and ill health. Promoting a system to enable all staff to reach their maximum potential would be likely to have a beneficial impact.

8. Impact on Inequalities

8.1 The provision of effective and expert human resources and organisational development services will enable best practice in the field of equality and diversity to be identified and implemented.

9. Involving People

9.1 The refreshed Human Resources and Organisational Development Strategy and work associated with implementing the management culture review and work programmes are all taken forward in Partnership with our staff.

10. Resource Implication

10.1 There are no resource implications as a direct consequence of the approved of this paper.

Failure to have appropriate people management arrangements in place in the labour intensive organisation where approximately 50% of our costs are staff related could compromise the Board's ability to meet its financial obligations.

All proposals which might have financial implications stemming from this paper, and the attached Human Resources and Organisational Development Strategy
Framework, will be considered as part of the Board’s financial planning processes and approved in line with the scheme of delegation and the Standing Financial Instructions by the Finance and Performance Review Committee.

Alan M Boyter
Director of Human Resources & Organisational Development
November 2012

List of Appendices

Appendix 1 – Revised Human Resources and Organisational Development Strategy 2011 - 2014

Appendix 2 – Summary of progress
NHS Lothian

Human Resources and Organisational Development Strategy
(Revised Version – November 2012)

November 2011 – March 2014
## Index

<table>
<thead>
<tr>
<th>Section</th>
<th>Headings</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Strategic Challenges and Fundamental Principles</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>Employability and Social Responsibility</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Promoting Organisational Values and An Aspirational Culture that Enhances Staff Engagement and Ensure that our People have the Opportunity to Reach their Maximum Potential to Drive Organisational Performance</td>
<td>7</td>
</tr>
<tr>
<td>4.</td>
<td>Best Practice in Leadership, Staff Governance, Performance Management and Compliance</td>
<td>9</td>
</tr>
<tr>
<td>6.</td>
<td>Workforce Planning, Redesign, Modernisation and Productivity</td>
<td>12</td>
</tr>
<tr>
<td>7.</td>
<td>Provision of Core and Expert Human Resources and Organisational Development Services and Systems</td>
<td>13</td>
</tr>
</tbody>
</table>
1. **Strategic Challenges and Fundamental Principles**

We have established 3 fundamental principles in developing this Human Resources and Organisational Development Strategy; however the strategy also takes into account the strategic challenges which must be addressed by NHS Lothian, namely:

- Delivering our waiting times targets and guarantees
- Improving our performance in the management of Unscheduled Care
- Developing and Implementing Health and Social Care Partnerships
- Realigning Acute Services
- Managing our financial position

The 3 fundamental principles are:-

**Living Values**

- Doing what we say we will do
- Making explicit the behaviours and attitudes expected from all staff
- Providing leadership which is visible, accessible and involved
- Enhanced Health and Safety and well being for our staff

**Engaging Leadership**

- Ensuring appropriate training is provided
- Growing internal capacity to modernise roles and ways of working to deliver 21st century services to patients and to the population of NHS Lothian
- Developing and delivering an integrated leadership and management development plan

**Delivering Quality**

- Improving our processes to deliver better health prevention, treatment and care
- Develop our workforce to deliver person centred and compassionate care
- Develop best value and equitable plans with key strategic partners in ‘Public Scotland’
Living Values

2. Employability and Social Responsibility

2.1 The single biggest determinant of ill health is poverty. The NHS exists for two reasons: to assist people who become ill and to help people not to become ill in the first place. NHS Lothian is the regions single largest employer. In partnership with the Scottish Government, City of Edinburgh Council, West Lothian Council, East Lothian Council, Midlothian Council we will develop pathways and entries to employment to succeed in 21st Century roles. We will further develop partnerships with Job Centre plus, the third sector, higher and further education.

2.2 The case for Socially Responsible Recruitment has never been stronger:-

The World Health Organisation describe ‘poverty is the single largest determinant of health, and ill health is an obstacle to social and economic development. Poorer people live shorter lives and have poorer health than affluent people. This disparity has drawn attention to the remarkable sensitivity of health to the social environment.

Destinations of School Leavers (Scottish Government, 2010) reflects the current difficult economic climate. The figures demonstrate that due to fewer labour market opportunities there is greater demand for places in Higher and Further Education, and increases numbers of pupils staying on at school, with correspondingly lower numbers entering employment.

The unemployment rate for 16- to 24-year-olds rose sharply in 2009, from 15% in 2008 to 19% in 2009. However, the rate had already been rising for a number of years before the recent recession, from 12% in 2004 to 15% in 2008.

Currently two-fifths of all those who are unemployed are now aged under 25. (Labour Force Survey, May 2010).

The unemployment rate for young people in the UK is around 20%. This is more than three times the unemployment rate among older workers. Young people without qualifications have an even lower chance of getting a job as more people compete for each vacancy. Long-term youth unemployment has hit a 16 year high (Princes Trust, 2010).

The profile of long-term youth unemployment is changing, the number of 16-24 year olds who have been out of work for six months or more in the UK is 388,000 this has increased almost 70 per cent since before the recession 2008.

There is a personal cost of not being in work, education or training, which goes beyond the immediate loss of earnings. Gregg and Wadsworth (2010) describe the justification for intervention to prevent long or frequent periods out of work or education among young people does not just rest on the current unemployment, but on the long term scars that these young people experience and potentially feed into the next generation. Although these scarring effects are not confined to young people, they are more common for this age group.
Educational underachievement has a substantial, and lasting, effect on individuals. Oreopoulos & Salvanes (2009) document evidence on the relationship between education and a long list of benefits, success in the labour market, better health, reduced probability of risky behaviours and premature death, trust and civic participation. At a macro-economic level, educational underachievement inevitably also affects the relative performance of the economy over time.

Increasing employment and opportunities of employment will directly promote better health and well-being assist in reducing child poverty and poverty in later life, and raise the growth in productivity of the economy.

The health impact of unemployment is well documented with individuals who find themselves unemployed more likely to suffer from mental, physical and emotional ill-health, in addition to the effects of social isolation and exclusion unemployment brings. People who are unemployed are more to be prescribed medication for depression, anxiety and emotional instability, as well as increased incidence of smoking alcohol and substance misuse. There is also the increased risk that unemployment becomes generational within workless households, this is due to reduced aspiration and access, lack if availability of a positive role models aligned social segregation and environmental issues.

2.3 In particular we will;

- Create employment and training opportunities for a minimum of 190 people per year in the 16 to 24 age group in need of a positive destination.

- Further develop the eleven projects currently in place to support individuals who are socially excluded into employment including a review of the contribution of the NHS Lothian Healthcare Academy, a review of the possible development of the relationship with the LEAP initiative, modern apprenticeships, volunteering, work experience and user employment.

- Review internal arrangements in training and development to enhance literacy and numeracy levels of staff.

- Create a sustainable job infrastructure across Agenda for Change bands 1 to 4 so that entry level staff have realistic promotion opportunities to advance their careers based on ability and ambition. This will be designed to provide staff on bands 1 and 2 with opportunities to progress to bands 3 and 4.

- Work with higher education and regulatory organisations to create an environment whereby a combination of the accreditation of experiential learning and study will give staff in bands 1 to 4 a route into the registered and professional workforce thereby opening up opportunities to work at band 5 and above, and opening up an additional source of recruitment that will enrich the diversity of the workforce. This will require new models for employment and employability.
Living Values

3. Promoting Organisational Values and An Aspirational Culture that Enhances Staff Engagement and Ensure that our People have the Opportunity to Reach their Maximum Potential to Drive Organisational Performance

3.1 NHS Lothian intends to refocus and redefine the culture it aspires to be in the future and what its underlying values should be. Staff at all levels within our organisation will be involved in determining our core values to ensure ownership and commitment.

The health and safety of our staff will be of vital importance to us in providing person centred, safe and effective care. Indeed we can only provide a quality service if our staff work in an improving health and safety environment.

We will continue to support and develop partnership working with the trades unions and professional organisations. Working in partnership with staff side colleagues improves the quality of our plans and greatly increases the likelihood of change being implemented in a manner that is implementable and sustainable.

We will continue to develop and promote equality and diversity in the workplace and in service provision via our employment policies and practice, systems, training and no tolerance approach to inappropriate behaviours and attitudes.

We will review all of our internal communications strategies to ensure that all staff are well informed, aware of all the key issues affecting the organisation and which impact on patient centred, safe and effective care provision.

We will review all training and development activity to ensure it is aligned in a way to help staff undertake their duties and responsibilities. This will include a Performance Development Plan within one year of joining the organisation, a meaningful annual conversation with an appropriate line manager about development needs/plans, and that all mandatory training is delivered to an appropriate standard on a timely basis.

3.2 In particular we will:

- Involve staff at all levels and in all job families in engagement events to be part of the process for agreeing a new set of values and behaviours for NHS Lothian.

- Review the development needs of Partnership representatives, shop stewards and employee relations practitioners to aid fair and consistent employee relations practice.

- Train staff in equality and diversity and ensure that we are aware of the ethnicity of a minimum of 90% of our patients to ensure services are designed in a culturally competent manner.

- Work with all relevant and appropriate interest groups to ensure all services are provided in an equitable and appropriate manner.
- Implement a new internal communication strategy and to improve mechanisms for maximising staff engagement.

- Review all training and development activity to ensure it is aligned to service delivery and that all mandatory training is delivered to an appropriate standard by the required timescale, in particular, provide tailored programmes to assist the delivery of waiting times and unscheduled care.

- Support and enable staff to maximise the services provided to patients and improve the health and safety environment at work by developing and improving the delivery of our Occupational Health and Safety service.

- Seek to improve the physical and mental health of our workforce, working with the Healthy Working Lives initiative.

**Engaging Leadership**

4. **Best Practice in Leadership, Staff Governance Standard, Performance Management and Compliance**

4.1 The Staff Governance Standard places a legal obligation on NHS Lothian (and all other NHS Boards in Scotland) to demonstrate that staff are:

   - Well informed
   - Appropriately trained
   - Involved in decisions which affect them
   - Treated fairly and consistently and
   - Provided with a healthier, safer working environment

These standards are the basic minimum required not to be aspirational. If NHS Lothian is to improve the services it provides to patients we will require to provide our people with the best possible education in leadership skills so that they have both an evidence base for the decisions they will be faced with implementing, and the confidence to put their leadership skills into practice.

NHS Lothian through our leadership and management of our current strategic challenges will set the tone and direction for our leadership ethos. This will involve developing our top leadership cohort which includes the NHS Board / Corporate Management Team / Lothian Partnership Forum and Senior Manager who report to the members of the Corporate Management Team. This cohort is responsible for developing, agreeing and implementing the culture that everyone who works in NHS Lothian, or used our services, requires of us. They need to embed a position and supportive culture throughout the organisation, leading by example.

All of our employees, all of the time, must act in concert with the stated values of the organisations. These values will need to be effectively communicated through our communications strategy.

4.2 In particular we will:
- Based on the new set of values and behaviours for NHS Lothian we will develop and implement an organisational development programme which will embed our values across the organisation

- Develop a leadership programme for our top cohort which will embed our values, leadership tone and ethos

- Review and realign the leadership and management arrangements for Acute Services

- Develop and implement change management programmes that take into account the implications of Health and Social Care Partnerships

- Develop a range of leadership and management skills development programmes appropriate to all supervisory, management and clinical director staff levels across the organisation

- To develop and implement a processed system to improve the performance competence and capability of managers within NHS Lothian. This will enable us to manage any skill gaps through development, coaching, mentoring or redeployment.

- Review recruitment and selection practice to ensure that capability, competency and a compassionate service ethos is demonstrated by individuals applying to join the organisation

- For supervisors and managers and shop stewards develop programmes of employee relations and core management skills in partnership with the trades unions

- Introduce across the organisation the Institute of Healthcare Managements competent manager programme

- Review and improve honest, consistent and fair performance management arrangements

- To develop a system of team based performance management

**Engaging Leadership**

5. Managing Change – Organisational Design, Development, Implementation and Sustainability

5.1 Given the nature of the purpose of the NHS, the single most important strategy is the Clinical Strategy. All other strategies and policies should be designed to support the Clinical Strategy and be affordable, implementable and sustainable. In addition, wherever possible, resources should be directed to delivering patient care. At one level descriptions of front line and back room or clinical and non-clinical services is not helpful. Modern healthcare is delivered by teams of professional dedicated people working together. Where a service can be shared within the public sector and where the quality of the service can be maintained or
improved, and where this releases resources that can provide additional or enhanced services, then this should be implemented wherever possible.

5.2 In particular we will:

- Support the development and implementation of the Clinical Strategy through organisational development and service redesign
- Bring forward both within the NHS and with other partners options to consider shared services, both local, national and international,
- Ensure within all leadership, employee relations, and people management skills training programmes that specific investment is made in the development of managers who have the responsibility for the design, implementation and sustainability of organisational change for improvement in national, regional and local programmes of work.
- Develop joint workforce and organisational change programmes and policies for the implementation and development of Health and Social Care Partnerships.

Delivering Quality

6. Workforce Planning and Redesign, Modernisation and Productivity

6.1 Workforce Planning is easy to describe and difficult to do well. At one level it is about ensuring you have the right staff in the right place at the right time. It might be appropriate to add, and motivated to do a good job. It is difficult because of the variables involved; demographics/demand for services; available resources; advances in modern medicine; advances in pharmaceutical science; rising patient expectations; changing government targets/policies; advances in information and other technology; changes in undergraduate and postgraduate training ; and legislative changes.

Given all of this, together with salary costs in the region of £635m, the contribution appropriate workforce planning can make cannot be underestimated. The maximising and utilisation of staff resources is key to the successful delivery of our Clinical Strategy. However, as an organisation we need to ensure that best value is evident within our workforce costs. To do this we need to maintain a 4% sickness rate, minimise overtime costs and ensure that supplementary staffing is used appropriately. The key will be getting the balance right between workforce numbers, skill mix and efficient/effective ways of working.

6.2 In particular we will:

- Investigate the extent to which the layers of management ensure clear lines of accountability, and consistent communications and support decision making
- Ensure working patterns are based on, and are supportive of, the achievement of delivering safe, sustainable services
- Design and recruit to new roles, especially in support workers roles (e.g. the healthcare technician pilot) based on 21st Century models to support person centred care
- Promote attendance and wellbeing at work and aim to achieve a sickness absence rate averaging 4.0%
- Develop a workforce plan that supports the emerging clinical strategy
- Develop a medical workforce plan that incorporates a risk assessment analysis

**Delivering Quality**

7. **Provision of Care and Expert Human Resources and Organisational Development Services and Systems**

7.1 In an organisation of some 24,000 people across 700 square miles, deployed 24/7, 365 days a year, core and expert human resources management and organisational development advice needs to be in place. This keeps the organisation safe and legal, and provides the platform from which to build our people development approach.

7.2 In particular we will:

- Support the implementation of the NHS Scotland new national HR IT system ensuring it meets the needs of NHS Lothian
- Apply LEAN business process re-engineering techniques to all transactional personnel support services to maximise efficiency and productivity
- Deliver and seek to improve the Occupational Health and Safety Service specification
- Ensure that the emerging Health and Social Care Partnerships and Acute Services have access to a designated Senior HR Practitioner bridging the hap between Corporate and Operational services.
- Develop a facilitation service to support dignity at work issues.
- Review HR policies to ensure they are fit for purpose and meet the demands of NHS Lothian’s strategic challenges.

Alan M Boyter  
Director of Human Resources & Organisational Development  
November 2012
<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications Yes/No and Plan?</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Create employment and training opportunities for a minimum of 190 people per year in the 16 to 24 age group.</td>
<td>RK</td>
<td>Yes, funding secured as per 14/2/12 EMT paper of £200k</td>
<td>Ongoing / Complete</td>
<td>243 placements achieved against the 190 target. However, the one area that has been slow has been the 12 placements for the Edinburgh Guarantee and these have still to be progressed. First cohort of Skills Development Scotland funded young people commenced joint preparation for employment programme with Edinburgh College and NHS Lothian inclusive of clinical and non clinical placements.</td>
</tr>
<tr>
<td>1.2 Further develop the projects currently in place to support individuals socially excluded into employment including a review of the contribution of the NHS Lothian Healthcare Academy and a review of the relationship with the LEAP initiative, modern apprenticeships, volunteering and work experience placements.</td>
<td>RK</td>
<td>Covered as part of 1.1. Above.</td>
<td>Ongoing</td>
<td>Academy review to include Social Care, now includes engagement with East Lothian and City of Edinburgh Education Department working in partnership with NHSL and Edinburgh College to develop and support a curriculum at S4 and S5/S6 that enables progression in to Health and Social Care employment/ Further Education/Higher Education Courses in Health and Social Care, Due to begin Autumn 2013 Modern Apprenticeships ongoing in facilities, labs and EXLORATION FOR CARE. Exploration of commissioned pre employment course for clinical HCSW underway jointly with City of Edinburgh Council and the Edinburgh College</td>
</tr>
<tr>
<td>1.3</td>
<td>To integrate literacy and numeracy training into the Learning Plan for NHS Lothian.</td>
<td>LK</td>
<td>No; refresh current investment priorities in 2012.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------------------</td>
<td>----</td>
<td>-----------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>1.4</td>
<td>Create a sustainable career infrastructure across Agenda for Change bands 1 to 4 so that entry level staff have realistic promotion opportunities to advance their careers based on ability and ambition. This will be designed to provide staff on bands 1 and 2 with opportunities to progress to bands 3 and 4</td>
<td>LK</td>
<td>To be clarified during Q1 of 2012/2013 in line with organisational requirements.</td>
<td>March 2013 Integrated programme to be ready</td>
</tr>
<tr>
<td></td>
<td>Work has commenced in developing a programme for enhancing careers for Bands 1-4 in clinical and non-clinical areas. This includes the development of Clinical Support workers in Band 2 and Band 3, tasks being undertaken through the Healthcare Technician pilot in three areas.</td>
<td></td>
<td>Work has commenced in developing a programme for enhancing careers for Bands 1-4 in clinical and non-clinical areas. This includes the development of Clinical Support workers in Band 2 and Band 3, tasks being undertaken through the Healthcare Technician pilot in three areas.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The introduction of a Laboratory Training School being progressed by Laboratories.</td>
<td></td>
<td>• The introduction of a Laboratory Training School being progressed by Laboratories.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The training of Maternity Care Assistants to commence in February 2013.</td>
<td></td>
<td>• The training of Maternity Care Assistants to commence in February 2013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• An integrated comprehensive programme which includes these initiatives and our future plans for Bands 1 to 4 to be developed by April 2013.</td>
<td></td>
<td>• An integrated comprehensive programme which includes these initiatives and our future plans for Bands 1 to 4 to be developed by April 2013.</td>
<td></td>
</tr>
</tbody>
</table>

1.5 Work with higher education and regulatory organisations to create an environment whereby a combination of the accreditation of experiential learning and study will give staff in bands 1 to 4 a route into the registered workforce thereby opening up

| 1.5 | Work with higher education and regulatory organisations to create an environment whereby a combination of the accreditation of experiential learning and study will give staff in bands 1 to 4 a route into the registered workforce thereby opening up | LK | Covered as part of 1.4 above. | Ongoing – discussed enhanced arrangements to commence during 2013 |

Academy model includes engagement currently with Edinburgh Napier University and QMU re articulation. Work experience placements and guaranteed access to employment is
opportunities to work at band 5 and above, and opening up an additional source of recruitment that will enrich the diversity of the workforce. This will require new models for employment and employability integrated into this programme.

2. Living Values—Promoting Organisational Values and an Aspirational Culture that Enhances Staff Engagement and Ensure that our People have the Opportunity to Reach their Maximum Potential to Drive Organisational Performance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Involve staff at all levels and in all job families in engagement events to be part of the process for agreeing a new set of values and behaviours.</td>
<td>LK</td>
<td>Still to be determined</td>
<td>Values work completed and agreed by 31/03/2013</td>
<td>Engagement events have been organised and will be completed by the end of November 2012, thereafter an agreed set of values will be established and an organisational development plan will be determined and implemented.</td>
</tr>
</tbody>
</table>
| 2.2 Review the employment relations practice and processes, including the development needs of shop stewards and employee relations practitioners, to aid fair and consistent employee relations practice. | JB   | No; refresh current priorities | Ongoing and continues monitoring to ensure performance improvement | Director of HR&OD and the Employee Director commissioned a review of Board Level Appeal cases in Spring 2012. A short sampling of views and experiences was sought from the cohort of Non-Executive Board Members, Staff representatives, line managers and HR staff who had direct involvement in Board level appeal cases during the calendar year 2011. There was also complimentary “desk top” review of the paperwork for this same period. The outcome of the review process was reported to and accepted by the Staff Governance Committee in August 2012. The recommendations from the review are due to be implemented by December 2012. It is important to note that the prevailing view from the majority of respondents is that correct decisions are taken in Board level appeal cases. A separate but complementary
The review of the suspension processes has also been taken place and consequently a revised risk assessment process has been implemented. The revised assessment process takes cognisance of emerging case law which calls into question suspension as a 'neutral act'. The underpinning message is that suspension ought to be a last resort and should only happen were there is a risk to patient or staff safety which cannot be mitigated, or there is a "commercial" risk to the organisation.

The employee relations case management pathway is also currently being reviewed (due to report December 2012) as part of the wider review of HR and OD, to identify opportunities for change which will improve efficiency, productivity and quality.

### 2.3 Train staff in equality and diversity and ensure that we are aware of the ethnicity of a minimum of 90% of our patients to ensure services are designed in a culturally competent manner.

| JG | No; refresh current priorities | March 2013 |

Performance continues to exceed the target in A&E and for inpatient services. For outpatients average performance is at around 86-88%. Training and support continues for these services. Tailored training on equality delivered to select staff groups including nurse managers and managers in Estates & Facilities. Ongoing mainstream training continues via LearnPro and Management in Practice Equality module.

Following paper to Lothian Partnership Forum in Sept 2011, a number of workstreams established. Currently work ongoing to continue and develop Bite Size literacy programme (see LPF paper Nov...
|   | 2012), broadening out to wider range of staff Work to support registered staff (mainly nurses) on literacy and numeracy via Mary Parkhouse’s team  
Work to develop effective in-house testing and support for staff reporting dyslexia/dyscalculia, jointly with OHS Awareness-raising and guidance for line managers to help them support staff with literacy and numeracy problems more effectively is continuing. |   |   |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4</td>
<td>Work with all relevant and appropriate interest groups to ensure all services are provided in an appropriate manner, taking account of the values expressed in “Delivering Better Care” and the Quality Strategy</td>
</tr>
<tr>
<td>2.5</td>
<td>Implement a new modern communication strategy including a particular emphasis on internal communication</td>
</tr>
</tbody>
</table>

Wide range of external stakeholders representing all protected characteristics have been involved in developing NHS Lothian’s next equality strategy, since June 2012. This strategy will support delivery of the Clinical Framework and Delivering Better Care.

The internal Communications strategy was agreed by the Executive Management Team and the Lothian Partnership Forum. A monthly electronic newsletter has replaced the quarterly Connections paper. The Communications Team is being realigned to create a separate internal communications Team.
2.6 Refresh NHS Lothian Learning Plan to ensure it is aligned to service delivery and that all mandatory training is delivered to an appropriate standard by the required timescale

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications Yes/No and Plan?</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refresh NHS Lothian Learning Plan to ensure it is aligned to service</td>
<td>LK</td>
<td>No; refresh of existing investment choices</td>
<td>May 2013</td>
<td>Realigning the learning and development team and their priorities. NHS Lothian learning plan to be ready by 31st May 2013.</td>
</tr>
<tr>
<td>delivery and that all mandatory training is delivered to an</td>
<td></td>
<td>and priorities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>appropriate standard by the required timescale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.7 Support and enable staff to maximise the services provided to patients and improve the health and safety environment at work by developing and improving the delivery of our Occupational Health and Safety service

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications Yes/No and Plan?</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support and enable staff to maximise the services provided to patients</td>
<td>CK</td>
<td>To be clarified during Q1 of 2012/2013 in line with statutory &amp; organisational requirements.</td>
<td>Complete</td>
<td>1. Clinical review complete endorsed by Partnership now for implementation in 2013. Major move towards nurse based clinical assessment as opposed to seasonal doctors. 2. First cycle of competence assessment based manual handling policy reported and endorsed by H&amp;S Committee. 3. Limited ‘trauma’ response capability introduced within the Counselling Service. 4. H&amp;S team relocation, H&amp;S manual review commenced. Many new policies introduced during the year. 5. Full adoption of triage of MSK based management referrals to staff Physio.</td>
</tr>
<tr>
<td>and improve the health and safety environment at work by developing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and improving the delivery of our Occupational Health and Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Engaging Leadership- Best Practice in Leadership, Staff Governance Standard, Performance Management and Compliance

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications Yes/No and Plan?</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a leadership programme for our top cohort which will</td>
<td>LK</td>
<td>Yes, finding to be agreed by management</td>
<td>Work commenced will</td>
<td>A development plan</td>
</tr>
<tr>
<td>embed our values, leadership and ethos.</td>
<td></td>
<td>culture steering group.</td>
<td>continue through 2013</td>
<td>for the CMT has</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>commenced which</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>incorporates their</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>development needs,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>the concerns raised</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>in the D J Bowles</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and to improve their</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>team working.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Further leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>development events</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and programmes are</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>proposed for early</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2013. Work overseen</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>by the Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Culture Steering</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Group.</td>
</tr>
<tr>
<td>3.2</td>
<td>Develop a suite of leadership skills development programmes appropriate to all supervisory, management and clinical director staff levels across the organisation</td>
<td>LK</td>
<td>Yes, priorities and options for funding to be advised during 2012 subsequent to confirmation of Integration and Capacity Planning priorities.</td>
<td>March 2014</td>
</tr>
<tr>
<td>3.3</td>
<td>Review the recruitment and selection practices to ensure that a capability, competency and a compassionate service ethos are demonstrated as part of the selection process by individuals applying for employment with NHS Lothian</td>
<td>JB</td>
<td>No; refocus and modernization as part of 6.2 below.</td>
<td>December 2013 for completion of recommendations</td>
</tr>
<tr>
<td>3.4</td>
<td>In partnership with the trades unions, review and refresh people management skills development programmes for supervisors, managers and shop stewards.</td>
<td>JB</td>
<td>No; rework of current priorities as part of 6.2.</td>
<td>Complete</td>
</tr>
<tr>
<td>3.5</td>
<td>To consider the introduction and pilot of the Institute of Healthcare Management’s competent manager programme</td>
<td>LK</td>
<td>Yes; to be considered against all priorities for ROI benefits during Q1&amp;2 of 2012.</td>
<td>March 2013</td>
</tr>
<tr>
<td>3.6</td>
<td>Review and ensure honest, consistent and fair performance management arrangements are in place for all levels within NHS Lothian providing further training and guidance as required.</td>
<td>RK</td>
<td>No; refocus and refresh of current system(s) during 2012 and enabled by outcomes of 6.2. during 2013 plus.</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
reviewed as part of the wider review of HR & OD services.

| 3.7 | To develop and consider a team based performance scheme to encourage team working whilst enhancing our capacity and capability. | RK | TBC | June 2013 | To be developed. |

### 4. Engaging Leadership: Managing Change – Organisational Design, Development, Implementation and Sustainability

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications Yes/No and Plan?</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>LK</td>
<td>Yes, priorities to be confirmed during 2012</td>
<td>Ongoing</td>
<td>Workforce planning working with strategic planning ensuring that workforce issues are incorporated and taken into account. The Workforce plan will be set within the context of the agreed Clinical Strategy.</td>
</tr>
<tr>
<td>4.2</td>
<td>AB</td>
<td>Yes, interim role funding secured for 2012/2013.</td>
<td>Ongoing</td>
<td>Progress being made reported to the Finance and Performance Review Group. A costed programme will be agreed November 2012.</td>
</tr>
<tr>
<td>4.3</td>
<td>LK</td>
<td>No; rework of existing investment choices.</td>
<td>Ongoing</td>
<td>This action is incorporated into actions in 2.2, 3.1, 3.2 and 3.4.</td>
</tr>
<tr>
<td>4.4</td>
<td>LK</td>
<td>TBC</td>
<td>April 2013</td>
<td>Scoping work has commenced, drafts will be prepared and developed for April 2013.</td>
</tr>
</tbody>
</table>

### 5. Delivering Quality- Workforce Planning and Redesign, Modernisation and Productivity

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications Yes/No and Plan?</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>LK</td>
<td>No; rework of existing investments.</td>
<td>Ongoing</td>
<td>Work has commenced on realigning the portfolios of CMT members,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Realign acute services and developing new structures for the development of Health and Social Care Partnerships, these ambitions and expectations are incorporated into this work.</td>
<td>RK</td>
<td>Yes, potentially NR if needed to buy out legacy arrangements. Scope cost options 2012.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5.2</td>
<td>Review the working patterns with services, to ensure they facilitate efficient and high quality patient pathways, and develop where required new ways of working.</td>
<td>RK</td>
<td>No; rework of existing investments subject to outcome from current pilot.</td>
<td>March 2013</td>
</tr>
<tr>
<td>5.3</td>
<td>Design and recruit to new roles (e.g. the healthcare technician pilot) based on 21st Century models to support person centred care</td>
<td>LK</td>
<td>Yes, additional costs as a consequence of waiting times incorporated into workforce projections for 2012/13</td>
<td>June 2012</td>
</tr>
<tr>
<td>5.4</td>
<td>Promote attendance and wellbeing at work to support delivery of the corporate objective of a sickness absence rate averaging 4.0%</td>
<td>JB</td>
<td>No; rework of existing investment choices and priorities.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5.5</td>
<td>Develop the annual workforce plan ensuring that it supports the emerging clinical strategy</td>
<td>LK</td>
<td>Yes, additional costs as a consequence of waiting times incorporated into workforce projections for 2012/13</td>
<td>June 2012</td>
</tr>
</tbody>
</table>
5.6 Develop a medical workforce plan that incorporated a risk assessment analysis by speciality and takes into account the national medical workforce position.  

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Any new cost implications Yes/No and Plan?</th>
<th>Completion Date / Status</th>
<th>Comments / Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Support the implementation of the new national HR system (eESS) as a one of the first Board implementers.</td>
<td>RK</td>
<td>To be clarified during Q1 of 2012/2013 in line with national project updates.</td>
<td>March 2012</td>
<td>During the early part of 2012, it was clear that the new eESS was not going to be able to deliver all of the solutions required by the agreed implementation date of June 2012. It was considered too big a risk for the organisation to move from our current provider to the new system until the system was fully developed and functioning. Although this has more or less been achieved at a national level and will be implemented in two Boards in November 2012, given all of the other work priorities within NHS Lothian the time is not right to implement the new HR system within NHS Lothian at this time. A revised implementation date of 1 March 2014 has now been agreed nationally and therefore this takes this action out with the timeframe of the current strategy.</td>
</tr>
<tr>
<td>6.2 Apply the LEAN business process re-engineering techniques to all transactional personnel support services to maximise efficiency and productivity.</td>
<td>JB</td>
<td>Yes, short term non-recurring secured via under spend.</td>
<td>March 2013</td>
<td>This action point has been incorporated into the wider review of HR and OD.</td>
</tr>
</tbody>
</table>
| 6.3 Deliver and seek to improve the Occupational Health and Safety Service specification | CK | To be clarified during Q1 of 2012/2013 in line with statutory and organisational requirements. | Complete | 1. Manual handling element of specification endorsed by Partnership forum and implemented.  
2. Full reporting against specification now in place.  
3. Specification review scheduled |
<table>
<thead>
<tr>
<th></th>
<th>Ensure that the emerging Health and Social Care Partnerships and Acute Services have access to designated Senior HR/OD advising bridging the gap between corporate and operational.</th>
<th>JB</th>
<th>No resource of existing provision</th>
<th>March 2013</th>
<th>This part of the HR/OD review and new structure will be available by March 2013.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4</td>
<td></td>
<td>AB</td>
<td>Yes, detail to be advised during 2012.</td>
<td>March 2013</td>
<td>This has been incorporated into the wider review of HR and OD. It is also a key element in supporting the implementation of Dignity and Work.</td>
</tr>
<tr>
<td>6.5</td>
<td>Develop a cadre of internal capability in relation to using mediation to resolve disputes before costly legal processes are necessary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INTEGRATION – HOSTED SERVICES

1 Purpose of the Report

The purpose of this report is to provide the Board with an update on the progress that is being made in respect of six pan Lothian services as part of our on going discussions in respect of integration between health and social care. This relates to:

- Learning Disabilities
- Community Complex Care
- Mental Health
- Substance Misuse
- Prisons
- Health Promotion

- An update on the event held on the 31st October to discuss these services
- Present an outline of the key recommendations for these services
- Describe the next steps to be taken

2 The NHS Lothian Leadership Group on behalf of the Corporate Management Team agreed to take a phased approach to focusing on the ‘hosted’ services across NHS Lothian. Therefore a pan Lothian event was held on 31st October 2012, to consider those hosted services as listed.

2.1 The purpose of the event was to provide an opportunity for key NHS stakeholders and council partners from across Lothian to be engaged, to inform the decision making process about how services can be more integrated within Health & Social Care Partnerships. 75 members of staff attended the event with representation from key clinical, management, partnership staff side from NHS Lothian, alongside a number of council partners.

2.3 It was recognised that a period of change is imminent but that this event and the opportunity to discuss and review services with the support of key leaders, clinicians and managers should be seen as an opportunity for colleagues to work better together to improve outcomes for the population of Lothian, through a more integrated pathway approach at community level whilst retaining (host) very specialist services as highlighted below at a pan Lothian level.

2.4 Any member wishing additional information should contact the Executive Lead in advance of the meeting.
3 **Recommendations**

The NHS Lothian Board is asked to note and support:

- Following on from the above pan Lothian event on the 31st October, the NHS Lothian Leadership Group reviewed the outputs from this session at their meeting on the 8th November and using the agreed principles, values and criteria around integration put forward key recommendations in relation to each of the six services areas as listed in section 4 of this paper.

- that other than mental health (Jim Forrest) and primary care (David Small) where the strategic leads have been identified, that the issue of which senior officer should take strategic leadership should be agreed by the corporate management team meeting on the 20th and 21st November. An update on the outcomes of this discussion will be provided to Board members as timing does not allow for this to be included in this report.

- At the same time a decision will be made as to whether or not any of the remaining pan Lothian services (paper attached under appendix 1) need to be reviewed or whether they can remain as they are currently as there is no benefit to patients or the system. This will be discussed at the next meeting of the Leadership Group on the 22nd November and again an update on these discussions will be provide to Board members on the day.

4 **Discussion of Key Issues and recommendations on those services reviewed on the 31st October:**

4.1 **Community Complex Care**

Direct provision of approximately 20 whole time equivalent specialist staff will remain as managed service.

Stronger links will be made with community and acute complex care for children as well as a review of the current funding arrangements.

The management of the service will continue to be provided through the General Manager in East & Midlothian but we recommend that this be reviewed in at the end of the financial year.

4.2 **Mental Health**

Royal Edinburgh and Associated Services will be part of the Edinburgh Health & Social Care Partnership, with distinct links with the specialist hospital based substance misuse services being made.

The strategic for mental health lead will be provided through the Director in West Lothian.
4.3 **Learning Disabilities**

The ‘very’ specialised service (predominantly acute beds and beds for those with profound and complex care), the scope of which to be agreed by the clinicians and managers should remain as a managed single system service and be managed by the Edinburgh Health and Social Care Partnership (H&SCP) as the majority fall within the REAS site and the move to Edinburgh H&SCP.

An integrated model at community level in each of the partnerships is to be considered, with more alignment across community mental health, social care, voluntary and private provision. This will also include designated health promotion and public health links to work within the partnership.

A proposal for the management arrangements for the ‘very’ specialist and community based services will be developed by the leadership group.

4.4 **Prisons**

This will continue to be a managed service across both prisons.

Stronger links with mental health, substance misuse, social care, health promotion and public health will be developed.

The management of the service and the strategic lead will be provided through the General Manager in East & Midlothian.

4.5 **Health Promotion**

The proposal is that this service should remain a single system service and the management should move from East and Mid to the Director of Public Health and Health Policy as discussed and agreed at the CMT development session on the 3rd September. In doing so a stoke take of current service provision should be undertaken to ensure that equity of access and provision of services is provided across the four partnerships.

4.6 **Substance Misuse**

Distinct links with the specialist hospital based substance misuse services will be made with the Royal Edinburgh and Associated Services, ensuring the very specialised service is maintained at a pan Lothian level through single management system under the Edinburgh Health and Social Care Partnership. The scope of which to be agreed by the clinicians and managers, and this will remain as a managed service.

An integrated model in each of the partnerships to be considered, with more alignment across community substance misuse, mental health, social care, voluntary and private provision, and criminal justice provision. This will also include designated health promotion and public health links to work within the partnership.

There are teams in SMD (ie Primary Care facilitation team) that work at a pan-Lothian level, and further work is required to consider how to best position those services within the integration process.
5 **Key Risks**

5.1 In undertaking the engagement session and then further discussion within the Leadership Group there is no perceived risk in the recommendations put forward as above. What will be required to be undertaken with clinical staff, partnership and managers is the need to ensure that a clear plan is developed that will ensure that patient safety and quality of care will be sustained or enhanced and that there is no inequity across the system. In addition where a ‘network’ model is required i.e. where one part of the system continues to host a services for the rest of the system that there are clear professional and managerial; lines of accountability and most importantly access to appropriate care and treatment for the totality of Lothian patients.

6 **Risk Register**

6.1 At this stage there is no identified risk in moving to the next stage of this work but as required any identified risks will be managed and where required escalated to be on local or the NHS Lothian Risk Register.

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

7.1 An impact assessment has not been carried out at this initial stage. If the recommendations above are supported an inequality and health inequalities impact assessment exercise will be undertake with each of the services and at a system wide level and issues addressed as appropriate.

8 **Involving People**

8.1 The event that was organised to undertake the initial engagement involved 75 members of staff from across the six services as well as council representatives. Going forward staff engagement and partnership/staff side in put will be sustained and as appropriate other staff groups and where appropriate and required patient groups will be involved to

9 **Resource Implications**

9.1 The resource implications are not clear as yet within this initial stage. There will be no additional funding required to support the recommendations but there will be a requirement to ensure that resource implications in relation to managing services as devolved to each partnership are clearly stated within the financial memorandum of understanding which are being developed as part of the partnership agreements.

Professor Alex McMahon  
Director, Strategic Planning, Performance Reporting and Information  
15th November 2012  
Alex.mcmahon@nhslothian.scot.nhs.uk

**List of Appendices**

Appendix 1: Hosted Pan Lothian Services
<table>
<thead>
<tr>
<th>Service Title</th>
<th>Service Description – e.g. purpose, delivery units/major client groups</th>
<th>Target Population</th>
<th>Budget</th>
<th>Staffing activity (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Service</td>
<td>In-patient services</td>
<td></td>
<td></td>
<td>Total 498wte</td>
</tr>
<tr>
<td></td>
<td>Stroke (22 beds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brain injury and neurorehabilitation (36 beds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amputee rehabilitation (13 beds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedic rehabilitation service (63 beds).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lanfine Unit – neuro-progressive disorders (26 beds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Robert Fergusson Unit – neurobehavioural service (19 beds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total in-patient beds: 179 beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-patient services</td>
<td>SMART (prosthetics, orthotics, wheelchair, driving assessment, bio-engineering, ‘blue badges’ and outreach spinal injury clinic planned)</td>
<td></td>
<td>£18,373</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiac rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant out-patient clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neuro-outpatients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Title</td>
<td>Service Description – e.g. purpose, delivery units/major client groups</td>
<td>Target Population</td>
<td>Budget</td>
<td>Staffing activity (WTE)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>---------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Sexual and Reproductive Health</td>
<td>Central specialist service in Chalmers plus peripheral clinics providing a mix of ‘walk in’ and booked appointments for the full range of sexual and reproductive health service including genitor-urinary medicine, HIV, contraception, menopause clinic, vasectomy service and sexual problems service.</td>
<td>Lothian</td>
<td>£4.359m</td>
<td>76.81wte</td>
</tr>
<tr>
<td>Community Continence Service</td>
<td>Provision of clinical advice to patients, carers and professional health, social care and care home staff regarding the full range of continence issues. Procurement and provision of continence care products (containment and urology products) to community patients and care homes. Laundry service for community patients.</td>
<td>Edinburgh, East Lothian and Midlothian</td>
<td>£3.178m</td>
<td>16.67wte (including drivers)</td>
</tr>
<tr>
<td>Community Equipment Service</td>
<td>Responsible for the health budget for equipment provided by CES. Health equipment includes walking aids, chair accessories, toileting aids, beds and accessories, hoists and slings, positioning equipment.</td>
<td>Edinburgh, East Lothian and Midlothian</td>
<td>£1.267m</td>
<td>1.81 wte NHS employees</td>
</tr>
<tr>
<td>Title</td>
<td>Service Description – purpose, delivery units and client groups</td>
<td>Target Population</td>
<td>Budget</td>
<td>Staffing activity (WTE)</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------</td>
<td>--------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>East &amp; Midlothian CHP, information provided by D Small and E Egan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LUCS</td>
<td>Currently across 5 locations in Lothian with key links with A &amp; E and NHS 24</td>
<td></td>
<td>7.4m</td>
<td>112</td>
</tr>
<tr>
<td>Learning disability service</td>
<td>Specialist inpatient units; RFU, Primrose Lodge, Camus Tigh, Murray Park RFU- national others Lothian</td>
<td></td>
<td>14m</td>
<td>366</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>Spittal Street service – close to Chalmers Hospital Ritson clinic for detox</td>
<td></td>
<td>8.4m</td>
<td>174</td>
</tr>
<tr>
<td>Complex care</td>
<td>predominantly ventilation team supporting people at home and in care homes end of life care at home Historically WL Trust invested their allocation within community nursing services to provide a mainstream service</td>
<td>East, Mid, Edinburgh</td>
<td>2.3m</td>
<td>13</td>
</tr>
<tr>
<td>Prison service</td>
<td>new service to NHS Lothian</td>
<td>Lothian</td>
<td>4.4m</td>
<td>71</td>
</tr>
<tr>
<td>Health Promotion</td>
<td></td>
<td>Lothian</td>
<td>1.8m</td>
<td>45</td>
</tr>
</tbody>
</table>

<p>| <strong>West Lothian CHCP, information provided by J Forrest</strong> | | | | |</p>
<table>
<thead>
<tr>
<th>Title</th>
<th>Service Description – purpose, delivery units and client groups</th>
<th>Target Population</th>
<th>Budget</th>
<th>Staffing activity (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Dental Service</td>
<td>The main role of the salaried service is to: • promote oral health; • monitor the oral health of the population; • inspect selected populations for oral disease; • provide general dental services, including specialist services, for those who cannot obtain this from general dental practice; and • provide emergency and urgent dental care as well as a short course of treatment and follow up care where appropriate.</td>
<td>Lothian</td>
<td>£9m</td>
<td>352 WTE</td>
</tr>
</tbody>
</table>

7
The groups of patients involved are:

- anyone with a physical or learning disability who has difficulty accessing care in general practice;
- anyone with a medically compromising condition who has difficulty accessing care in the general dental service;
- anyone with a drug or alcohol abuse problem whose condition makes it difficult for them to access the general dental service;
- any child whose family cannot or will not take them to a dentist;
- school children under the NDIP inspection programme;
- anyone with a mental illness accessing care in general practice;
- any patient in hospital;
- anyone in a care home who has difficulty accessing care in general practice;
- anyone whose fear of dentistry discourages them from seeking care;
- homeless people who have difficulty accessing care; and
- other special needs groups such as Haemophiliacs.

<table>
<thead>
<tr>
<th>Smoking Cessation</th>
<th>Provide service to deliver universal smoking cessation services with an emphasis on to stop smoking and achieve HEAT target of 7,011 quits in the most deprived Lothian SIMD areas by March 2014. HEAT Target beyond 2014 unknown at present. Deliver tobacco component of CEL01(2012).</th>
<th>Lothian</th>
<th>£1.46k</th>
<th>30.23wte</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>With a further 3.8 wte currently line managed by UHD/REAS, led by the Smoking cessation co-ordinator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NHS LOTHIAN

Board Meeting
28 November 2012

Nurse Director

ACUTE SERVICES UNSCHEDULED CARE CAPACITY

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board support the planned development of increased bed capacity. Plans for short-term and longer-term capacity increases are presented in this paper to support delivery of sustainable performance of Unscheduled and Scheduled Care programmes.

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

2 Recommendations

The Board is recommended to:

2.1 Support the immediate plan to reinstate capacity at the Royal Victoria Hospital in order to maintain patient safety, and support both unscheduled and scheduled care targets, over the immediate winter period.

2.2 Support the planned development of Business Cases for additional bed capacity on the Royal Infirmary of Edinburgh (RIE) site and delegate approval of these Business Cases to the Finance and Resource Committee.

2.3 Note ongoing work to reduce the demand for additional bed capacity through the development of alternative clinical models.

3 Discussion of Key Issues

3.1 NHS Lothian, and in particular the RIE, performs at an unsatisfactory level against the 4 hour Emergency Care Access standard. This “whole system” measure quantifies patients who wait longer than 4 hours to be treated within the emergency department, before being discharged or admitted. While some performance issues against the standard relate to pressures wholly within the Emergency Department, a major cause of breach is related to problems with effective patient flow through the hospital and onwards to discharge. The problems with flow are manifested in terms of breaches against the 4 hour standard, boarding and delays in transfers of care (to home, other hospitals or other care facilities).

3.2 Analysis of capacity requirements was undertaken using 2010/11 activity and repeated using 2011/2012 data. This work was originally commissioned with the goal of quantifying the capacity and clinical model required to eliminate boarding, which is also recognised to have adverse impact for patient outcomes.
The analysis examined current NHS Lothian case-mix and compared it to other hospitals, to identify opportunities for performance improvement. It also examined whether there would be continuing shortages in capacity if target clinical pathways for length of stay, occupancy, day case rates and ambulatory care rates were implemented.

3.3 The key findings of the analysis were that the “front door” capacity (unscheduled care assessment and admission areas) is too small to prevent boarding and delays for either the current clinical model or for the model preferred by clinicians. The analysis also identified that there were capacity gaps in some acute ward areas.

To assess the potential impact of demographic change, further analysis was undertaken, looking ahead at predicted capacity requirements by 2016. The numbers for surgical demand, however, do not reflect potential reductions in LOS or decisions to retain capacity being undertaken on other sites or outwith NHS Lothian.

3.4 Current Position

3.4.1 November, performance against the 4 hour standard has continued to deteriorate (87.9% month-to-date). Furthermore, across Lothian, 15 12-hour breaches have occurred.

3.4.2 Flow has been compounded by outbreaks of norovirus, which has limited available bed capacity and had the unfortunate effect of requiring the cancellation of a small number of elective admissions. In order to maintain patient safety at the ‘front door’, 26 additional beds, 18 at St John’s Hospital (SJH) and 8 at Liberton Hospital, have been opened. Nevertheless, unscheduled care flows remain under significant pressure, due to seasonal activity and continued incidence of norovirus.

3.5 Additional Capacity

Given the current situation as described above, acknowledgement that additional capacity within the system is required (as demonstrated by the modelling for unscheduled care, and the elective capacity planning programme) and recognition that significant process improvement work is being taken forward, the Unscheduled Care Group has recommended that additional short-term capacity be created at the Royal Victoria Hospital, with a further recommendation that plans for addition long-term capacity, at the RIE, be progressed as a priority.

3.6 The Board is recommended to support the following three phase approach to creating this additional capacity:

3.6.1 Re-open wards 1 and 2 at the RVH, providing between 34 beds. These wards were closed in August 2012 as the psychiatry of old age beds moved to the Royal Edinburgh Hospital (REH) and the medicine of elderly beds at the RVH moved to the new Royal Victoria Building (RVB) on the Western General Hospital (WGH) site. The upgrade works required to be done to these wards is minimal, due to previous estates work taking place in winter 11/12.

3.6.2 For wards 1 & 2, start-up costs of £20K per ward are expected, with an estimated revenue consequence of £850K for both wards, for 4 months ending 31 March 2012. These costs are in addition to the costs that are currently being incurred for the residual elements of the RVH site.
3.6.3 Re-commission wards 3 & 4 at the RVH, providing 44 beds; as additional ‘surge’ capacity at an approximate cost of £100,000. If opened, revenue costs would be approximately £160,000 per month. The decision to use this surge capacity will be made at executive level.

3.6.4 In parallel to the use of additional capacity at the RVH, it is proposed that the development of a business case for the conversion of support and office space at the RIE into ward areas, be progressed as a priority. Developments will realise the recommendations of the bed modelling, while also creating ‘head room’ for the additional capacity required to sustain elective waiting times (as well as minimising the volume of elective activity that is sent outside of NHS Lothian), and also provide ‘surge’ capacity and/or decant facilities to permit refurbishment or redecoration.

3.6.5 The suggested developments would create additional ward capacity of up to 54 beds at the RIE. In order to expedite progress of this work, the Board is recommended to delegate the approval of these Business Cases to the Finance and Resource Committee.

3.6.6 Further consideration will be given to what other reconfiguration of the site is required to maximise patient flow, to support both unscheduled and scheduled care. This will include reorganisation of the current ward configuration which currently physically splits some specialties minimising workforce efficiency.

3.6.7 In addition, a review of non clinical space (e.g. offices) and non clinical staff is underway to identify what space can be identified through relocating staff who do not require to be on the RIE site to another NHS Lothian facility (e.g. Waverly Gate, Pentland House, Astley Ainslie).

3.6.8 A review of capacity and potential developments on other sites is ongoing and will be reported as required to the Board in due course

4 Key Risks

4.1 The risks associated with achieving the 4 hour standard, and the management of the surge activity expected throughout the winter period include not meeting the demand for unscheduled care and older people. In particular, older people being adversely affected by long waits, boarding and extended stay in hospitals and the growing evidence which demonstrates the associated increase in mortality and morbidity.

4.2 All agreed works will need to be programmed alongside work to support the re-provision of RHSC/DCN to avoid unnecessary disruption to the RIE site.

4.3 There are also risks to elective activity, if capacity for unscheduled care patients is exceeded, at times of surge activity, and boarding into surgical specialties is required. This could result in elective cancellations, and non compliance with the new treatment time guarantees or additional spend in the private sector.
5 **Risk Register**

5.1 The clinical risk to patients and the corporate risks of non delivery associated with unscheduled care are noted on local and corporate risk registers. Mitigation of these risks has been outlined above.

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

There is no impact assessment needed for this report. The overarching improvement plan will require to have work streams impact assessed and this work is in progress.

7 **Involving People**

7.1 Involvement of people has not yet commenced but will be included in the development plans of additional capacity at the RIE if approved.

8 **Resource Implications**

8.1 The resource implications are in terms of capital costs and revenue consequences and are outlined above where known, for the RVH, and are under review for development plans at the RIE.

Melanie Hornett  
Nurse Director  
19th November 2012  
Melanie.hornett@nhslothian.scot.nhs.uk

Chris Stirling  
Associate Director of Operations  
Medicine & Associate Services

Lorna Seville  
Business Manager  
Directorate of Corporate Improvement

David King  
Head of Finance
STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

1 Purpose of the Report

The purpose of this report is to present to the Board revised Standing Financial Instructions and a revised Scheme of Delegation for its approval.

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

2 Recommendations

2.1 The Board is recommended to:

- Approve the Standing Financial Instructions (SFIs)
- Approve the Scheme of Delegation (Scheme)

3 Discussion of Key Issues

3.1 Every NHS Board is required to have SFIs and a Scheme of Delegation. The approval of these documents is a matter reserved for the Board, as set out in paragraph 7.1 of the Board’s Standing Orders. The Audit & Risk Committee reviewed the proposed documents on 9 October 2012 and agreed that they be recommended to the Board for approval.

3.2 The Board approved the current SFIs & Scheme on 24 May 2010, and their renewal date was set as May 2013. However given the changes in the organisation since 2010, it is appropriate to bring the reviews forward.

SFIs

3.3 The content of the SFIs is high level. Consequently the text is reasonably stable over a long period of time, in comparison to the more detailed Scheme. The proposed changes to the document are in many cases are simply updates to keep the document current. The Board’s attention is drawn to the following key changes:
• The introduction of the new Audit & Risk Committee (Sections 2 & 3)
• A more explicit statement on what is expected from all areas to support the control of assets (paragraph 2.13)
• Additional material relating to tendering & contracting, which has been mirrored in the revisions to the Scheme of Delegation. Further details have been added as to the requirements for market testing for expenditure below £25k. Furthermore explicit provisions on the waiver of tenders have been added to provide further clarity and control on this area (paragraphs 7.13 – 7.16).
• Section 22 (Funds Held on Trust) has been updated to reflect the content of the Edinburgh & Lothians Health Foundation Charter, which the Trustees agreed last year.

Scheme of Delegation

3.4 The Scheme of Delegation is a more detailed document, and is used on a daily basis by management. The review of the Scheme has been going on for a considerable time and has involved consultation and detailed review by management. The Scheme needs to reviewed in order to reflect the changes to the management structure, and the lessons learned from applying the Scheme in practice.

3.5 The review of the Scheme has brought it up to date. The changes do not fundamentally change the system of delegated authority, but rather try to make the Scheme easier to understand and apply. The former Audit Committee had previously reviewed an earlier draft in April 2012, and whilst supportive of the Scheme, it requested that further work be undertaken. This was to clarify the process of delegation, and to consider what further controls could be added to avoid poor practice in delegation. The following is a summary of the changes made since then:

1. The Executive Board members are listed in the Introduction. The Scheme now makes a distinction between these Executive Board members and other directors in the organisation. Furthermore on Page 4, there is a new requirement for a quorum of three Executive Board members to be achieved when the Joint Management Team is approving certain matters as set out in the Scheme. These measures have been introduced to clarify how the Scheme is to be applied – the current Scheme uses the phrase “executive directors”, which is open to interpretation.

2. For Sections 1-22, a Director has been identified as the lead, consistent with the content of the proposed interim management arrangements.

3. Sections 23-31 of the Scheme have been re-positioned, to make the sequence of events more obvious. The objective is to make it clear that expenditure should follow the processes of robust planning, market testing and contracting.
4. The effect of creating a single Joint Management Team, and removing the position of Chief Operating Officer is to allow this Scheme to be simplified. Therefore in Sections 1-22 there is now a box setting out the “Role of all operational areas”, whereas in the previous version there was a box for UHD and a box for CHP/CHCP. The content in both was broadly similar.

5. With regard to capital expenditure a number of measures have been introduced to clarify the process of delegating authority and acting on it.

- Section 27 – Award of Capital Tenders has been simplified. The award of tenders over £1m now must be approved by two executive Board members, rather than what was the Executive Management Team. This means that the processes are not held back waiting for a meeting to convene, but also reserves the decision to award tenders the minimum number of Board members required to form a Committee (per the Standing Orders).

- Section 27 cross refers to a new section (39), which explains who can sign contract documentation on the Board’s behalf. Again this improves clarity and supports the efficient conduct of business. This section has been reviewed by the Central Legal Office.

- Section 28 has been introduced to explain how a decision by an approving body to proceed with a capital project will lead to the delegation of a budget and authority to an officer.

- Section 29 (Revenue Expenditure) has been simplified. An additional paragraph has been added in bold to highlight that the ability to delegate authority further does not extend to certain areas of expenditure.

- Section 32 (Use of Management Consultants) has been added, restricting the authority to engage them to either the Chief Executive or Director of Finance.

- Section 36 (Asset Transactions) has been revised to restrict the authority to enter into land and property leases to the Chief Executive and Director of Finance. This consistent with amendments to Section 24 (Business Cases) and Section 39 (Signing of contractual documentation). The Board does need to follow the Property Transactions Handbook, and act within its delegated powers. Making these changes will allow a complex entry in the Standing Orders to be removed.

- Section 40 (Payroll) has been added to explain the process for delegating authority to compile and approve payroll information. This reflects current practice, and picks up the additional measures that have already been introduced to improve controls over waiting times initiative payments.

3.7 The Scheme of Delegation is only one of the tools available to the Board and management to control expenditure. Further work is already underway to revise
how the Board’s Committees discharge their roles, and improve the information they receive to satisfy their assurance needs. Effective monitoring of expenditure and assurance on key controls could detect any poor decisions that stemmed from inappropriate delegation, or an individual acting beyond the scope of their authority.

3.8 In summary the Scheme has been significantly revised to improve its clarity and the measures reduce the risk of inappropriate delegation.

4 Key Risks

4.1 The SFIs and the Scheme should be current in order to serve the Board well in meeting its responsibilities for financial governance. A failure to have SFIs and a Scheme of Delegation would mean that the Board would not be complying with well-established NHS Scotland requirements to have them.

5 Risk Register

5.1 This is pertinent to the controls required to manage the risk (ID: 2964) on the corporate risk register entitled “The Board does not achieve its financial targets each year on a sustainable basis”.

6 Impact on Inequality, Including Health Inequalities

6.1 A Rapid Impact Assessment was conducted on the whole Standing Orders package that the Board approved in May 2010. No significant impacts were identified. The documents set the framework for governance and should provide stability of working conditions and clarity about decision-making. Having this framework should bring overall improvements in healthcare quality, but this depends on the content of the policies coming forward. There are no changes to the SFIs or the Scheme that would require a further assessment to be done.

7 Involving People

7.1 Managers and staff throughout the organisation have been consulted throughout this review process. The SFIs and Scheme do not directly impact on the provision or form of any clinical service.

8 Resource Implications

8.1 There are no cost implications from the proposed changes. The changes have been suggested to improve the quality of the SFIs and the Scheme, and support good financial governance and internal control.

Alan Payne
Corporate Governance & VFM Manager
13 November 2012
alan.payne@luht.scot.nhs.uk
Appendices:

Appendix 1 – Standing Financial Instructions
Appendix 2 – Scheme of Delegation
CONTENTS

1 INTRODUCTION ............................................................................................................2

2 KEY RESPONSIBILITIES FOR FINANCIAL GOVERNANCE ........................................4

3 ROLE OF INTERNAL AUDIT ........................................................................................8

4 EXTERNAL AUDIT .......................................................................................................10

5 FINANCIAL MANAGEMENT ........................................................................................11

6 PAY EXPENDITURE ....................................................................................................14

7 NON-PAY EXPENDITURE ...........................................................................................17

8 ADDITIONAL MATTERS FOR CAPITAL EXPENDITURE ...........................................21

9 ASSET REGISTERS AND SECURITY OF ASSETS .......................................................24

10 BANKING AND CASH HANDLING ...........................................................................24

11 STORES ...................................................................................................................27

12 INCOME, FEES AND CHARGES .............................................................................28

13 SERVICE AGREEMENTS FOR PATIENT SERVICES .............................................29

14 RISK MANAGEMENT & INSURANCE .......................................................................31

15 INFORMATION TECHNOLOGY ................................................................................32

16 RETENTION OF DOCUMENTS ................................................................................34

17 PRIMARY CARE CONTRACTORS ..............................................................................35

18 LOSSES AND SPECIAL PAYMENTS ........................................................................36

19 THEFT, FRAUD OR ANY OTHER FINANCIAL OR LEGAL IRREGULARITIES ........37

20 ANNUAL ACCOUNTS AND REPORTS ......................................................................38

21 PATIENTS' PROPERTY ............................................................................................39

22 FUNDS HELD ON TRUST (Endowments) ................................................................40
1 INTRODUCTION

General

1.1 These Standing Financial Instructions (SFIs) form part of the NHS Lothian Standing Orders.

1.2 The SFIs explain the financial responsibilities to be observed by Lothian NHS Board and its employees. They cover all activities, including those entered into in partnership with other organisations. They should be used with the Standing Orders and the Scheme of Delegation (Annex 4 of the Standing Orders).

1.3 The principles underlying this document are:-

1.3.1 The Board shall discharge its responsibilities in accordance with the relevant legislative requirements of the European Parliament, and the United Kingdom and Scottish Parliaments. The organisation shall also comply with any Directions or guidance issued by the Scottish Ministers.

1.3.2 The Board shall conduct its activities in an open and accountable manner. Its activities and organisational performance will be auditable.

1.3.3 The Board shall perform its activities within the available financial resources at its disposal.

1.3.4 The Board shall conduct its activities in a manner that is cost effective and demonstrably secures value-for-money.

1.4 To achieve the above, all employees must observe these SFIs and the above principles.

1.5 For budget holders and their staff, this will mean:-

1.5.1 Agreeing their budget, and performing their duties strictly within that budget.

1.5.2 Following all of the Board’s approved policies and procedures.

1.5.3 Not acting beyond the authority that has been delegated to them.

1.6 Failure to comply with these SFIs is a disciplinary matter, which could result in dismissal.

1.7 The Director of Finance shall:-

1.7.1 Approve all financial procedures and working practices.

1.7.2 Provide advice and support where there is any difficulties regarding the interpretation or application of the SFIs.
Terminology

1.7.3 “NHS Lothian" means all elements of the NHS under the auspices of Lothian NHS Board.

1.7.4 "Board" and “Health Board” mean Lothian NHS Board, the common name of Lothian Health Board.

1.7.5 "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Health Board.

1.7.6 "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.7.7 "Chief Executive" means the chief officer of the Health Board.

1.7.8 "Director of Finance" means the chief financial officer of the Health Board.

1.7.9 "Legal Adviser" means the properly qualified person appointed by the Health Board to provide legal advice.

1.8 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include anyone who has been authorised to represent them.

1.9 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Health Board when acting on behalf of the Health Board, e.g. agency staff, locums, employees of service providers.

1.10 All budget holders shall be provided with a summary of these SFIs with instructions as to where the full version can be located. Budget holders are expected to comply with the SFIs whilst discharging their responsibilities and to ensure that employees in their area of responsibility are aware of the SFIs, and how the SFIs affect the conduct of their duties.

1.11 The Board shall review these SFIs no longer than 3 years after the date of their approval.
2 KEY RESPONSIBILITIES FOR FINANCIAL GOVERNANCE

The Board & The Audit & Risk Committee

2.1 The Board shall approve these SFIs and the Scheme of Delegation.

2.2 The Board shall ensure and be assured that the SFIs and Scheme of Delegation are complied with at all times.

2.3 The Board shall agree the terms of reference for the Audit & Risk Committee which, amongst other things, shall include:-

2.3.1 Overall assurance on corporate governance, internal control and risk management, including regularly reviewing these SFIs and the Scheme of Delegation, and make a recommendation to the Board for their adoption.

2.3.2 Financial reporting.

2.3.3 The internal audit and external audit functions.

2.4 The Audit & Risk Committee’s terms of reference shall conform with extant Scottish Government instructions and other guidance on good practice.

2.5 The Board shall perform its functions within the total funds allocated by the Cabinet Secretary.

The Chief Executive (Accountable Officer)

2.6 The Chief Executive is the Accountable Officer for the organisation. As such, the Chief Executive is responsible and accountable for funds entrusted to the Board.

2.7 The Chief Executive is accountable, through NHS Scotland’s Principal Accountable Officer, to the Scottish Parliament. This responsibility is detailed in the Accountable Officer memorandum.

2.8 The Chief Executive has overall executive responsibility for the Board’s activities, and shall ensure that the Board’s meets its financial targets.

2.9 The Chief Executive shall ensure that all directors and employees are notified of and understand their responsibilities within these SFIs.

The Director of Finance

2.10 The Director of Finance shall:-

2.10.1 implement the Board’s financial policies and co-ordinate any action necessary to further those policies;

2.10.2 maintain an adequate and effective system of internal financial control. This shall include developing and implementing financial procedures that are consistent with the principles of internal control;
2.10.3 ensure that sufficient records are kept to show and explain the Board's transactions, and carry out its statutory duties;

2.10.4 be able to present the financial position of the Board, with reasonable accuracy, at any time;

2.10.5 provide financial advice to the Board and its directors and employees; and

2.10.6 propose accounting policies consistent with Scottish Government and Treasury guidance, financial reporting standards, and generally accepted accounting practice.

2.11 On behalf of the Chief Executive, the Director of Finance is also responsible for:-

2.11.1 ensuring arrangements are adequate to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function (in accordance with the internal audit standards applicable to NHS bodies and the Scottish Government’s Audit Committee Handbook); and

2.11.2 designating an officer as the Fraud Liaison Officer to work with NHS Scotland Counter Fraud Services and co-ordinate the reporting of frauds and thefts.

2.12 The Director of Finance is entitled without necessarily giving prior notice to require and receive:-

2.12.1 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

2.12.2 access at all reasonable times to any land, premises or employee of the health board;

2.12.3 the production of any cash, stores or other property of the health board under an employee's control; and

2.12.4 explanations concerning any matter under investigation.

All Directors and Employees

2.13 All directors and employees, individually and working together, are responsible for:

2.13.1 Keeping the property of the Board secure, and to apply appropriate routine security practices as may be determined by the Board. This includes:-

a. ensuring that the assets within their area of responsibility are included within the appropriate asset register (see Section 9);

b. ensuring that asset records/registers are kept up-to-date;
2.13.2 avoiding loss;
2.13.3 securing Best Value in the use of resources; and
2.13.4 following these SFIs and any other policy or procedure that the Board may approve.

2.14 All budget holders shall ensure that:-
2.14.1 information is provided to the Director of Finance to enable budgets to be compiled;
2.14.2 budgets are only used for their stated purpose; and
2.14.3 budgets are never exceeded.

2.15 When a budget holder expects his expenditure will exceed his delegated budget, he must secure an increased budget, or seek explicit approval to overspend before doing so.

2.16 All NHS staff who commit NHS resources directly or indirectly must be impartial and honest in their conduct of business and all employees must remain beyond suspicion.

2.17 All employees shall observe the requirements of MEL (1994) 48, which sets out the Code of Conduct for all NHS staff. There are 3 crucial public service values which underpin the work of the health service:-

2.17.1 **Conduct**
There should be an absolute standard of honesty and integrity which should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers; in the use of information acquired in the course of NHS duties; in dealing with the assets of the NHS.

2.17.2 **Accountability**
Everything done by those who work in the NHS must be able to stand the test of parliamentary and public scrutiny, judgements on propriety and professional codes of conduct.

2.17.3 **Openness**
The Board should be open about its activities and plans so as to promote confidence between the component parts of NHS Lothian, other health organisations and its staff, patients and the public.
2.18 All employees shall:-

2.18.1 ensure that the interest of patients remain paramount at all times;
2.18.2 be impartial and honest in the conduct of their official business;
2.18.3 use the public funds entrusted to them to the best advantage of the service, always ensuring value for money; and
2.18.4 demonstrate appropriate ethical standards of personal conduct.

2.19 Furthermore all employees shall not:-

2.19.1 abuse their official position for the personal gain or to the benefit of their family or friends;
2.19.2 undertake outside employment that could compromise their NHS duties; and
2.19.3 seek to advantage or further their private business or interest in the course of their official duties.

2.20 The Director of Finance shall publish supplementary guidance and procedures to ensure that the above principles are understood and applied in practice.

2.21 The Board shall approve a Code of Conduct for Board members, in accordance with the Ethical Standards in Public Life Act (2000). Members of Community Health (and Care) Partnership Sub-Committees shall also be required to observe the Code.

2.22 The Chief Executive shall establish procedures for voicing complaints or concerns about misadministration, breaches of the standards of conduct, suspicions of criminal behaviour (e.g. theft, fraud, bribery) and other concerns of an ethical nature.

2.23 All employees must protect themselves and the Board from any allegations of impropriety by seeking advice from their line manager, or from the appropriate contact point, whenever there is any doubt as to the interpretation of these standards.
3 ROLE OF INTERNAL AUDIT

3.1 The purpose of Internal Audit is to provide an objective evaluation and opinion on the adequacy and effectiveness of governance, risk management and control. The role of Internal Audit and scope of activities are as set out in the internal audit standards applicable to NHS bodies, including Internal Audit’s assurance role and consulting services.

3.2 Internal Audit operates in accordance with the Definition of Internal Auditing, Code of Ethics and Standards set out in the internal audit standards applicable to NHS bodies. Any deviations from the standards will be reported to the Audit & Risk Committee, and significant deviations will be considered for inclusion in the Governance Statement.

3.3 The Chief Internal Auditor has direct access and freedom to report to the Audit & Risk Committee, Chief Executive, Chairman and the Board. Within this right, the Chief Internal Auditor has freedom to meet in private with the Chairperson of the Audit & Risk Committee or any sub-committee of the Audit & Risk Committee.

3.4 While maintaining independence, the Chief Internal Auditor’s management reporting line is to the Director of Finance, who will undertake the Chief Internal Auditor’s performance appraisal. Every year, the Chief Executive, Director of Finance and Chief Internal Auditor will review the management reporting line to confirm that Internal Audit’s independence remains intact. The results of the review will be reported to the Audit & Risk Committee. If necessary, the Chief Internal Auditor’s management reporting line will be revised to ensure independence is maintained.

3.5 Internal Audit has the right to determine audit scopes, perform work and issue reports free from interference. In particular, Internal Audit has the right to issue reports without necessarily obtaining agreement or approval from directors or operational managers.

3.6 Internal Audit is entitled without necessarily giving prior notice to require and receive:-

3.6.1 access to all records, documents, correspondence or information relating to any transactions or matters, including documents of a confidential nature;

3.6.2 access at all reasonable times to any land, premises or employee of the health board;

3.6.3 the production of any cash, stores or other property of the health board under an employee's control; and

3.6.4 explanations concerning any matter under investigation.

3.7 The Chief Internal Auditor will be selected and appointed by a panel chaired by a non-executive director, preferably the Chairperson of the Audit & Risk Committee. The composition of the panel will be approved by the Chairperson of the Audit & Risk Committee.
3.8 The Chief Internal Auditor is responsible for appointing members of the Internal Audit team. The Chief Internal Auditor will appoint candidates to maintain appropriate professionalism, skills and experience to deliver Internal Audit’s assurance and consulting services.

3.9 The Chief Internal Auditor will normally attend Audit & Risk Committee meetings and any sub-committees of the Audit & Risk Committee.

3.10 The Chief Internal Auditor shall prepare risk-based audit plans for approval by the Audit & Risk Committee. Unless otherwise agreed by the Audit & Risk Committee, audit plans will comprise:

3.10.1 a detailed annual audit plan for the forthcoming year; and

3.10.2 outline audit plans covering the 2 years thereafter.

3.11 In addition to standard audit reports, the Chief Internal Auditor shall prepare an annual report to be considered by the Audit & Risk Committee. The annual report will confirm whether:

3.11.1 adequate and effective internal controls were in place throughout the year;

3.11.2 the Chief Executive as Accountable Officer has implemented a governance framework sufficient to discharge the responsibilities of this role; and

3.11.3 the internal audit plan has been delivered in line with the internal audit standards applicable to NHS bodies.

3.12 Directors and operational managers are required to respond fully to draft audit reports within 2 weeks of the issue date. Responses should be presented either in writing or during a close-out meeting with Internal Audit. If an appropriate response is not received, Internal Audit can deem the draft audit report and management actions as being fully accepted.

3.13 Directors and operational managers must address issues raised in audit reports by the agreed target dates. Internal Audit will follow-up on the completion of management actions, and provide the Audit & Risk Committee with reports on completion. Failure by directors or managers to complete agreed actions on time shall be reported by Internal Audit to the Audit & Risk Committee and Chief Executive.

3.14 In addition to the appropriate directors and operational managers, Internal Audit will issue copies of final audit reports to the board’s external auditors.
4 EXTERNAL AUDIT

4.1 The appointment of external auditors for NHS Lothian will be made by Audit Scotland.

4.2 The external auditors will conduct their duties in accordance with Audit Scotland’s Code of Audit Practice.
5 FINANCIAL MANAGEMENT

This section applies to both revenue and capital budgets.

Planning

5.1 The Scottish Government has set the following financial targets for all boards:-

5.1.1 To operate within the revenue resource limit.
5.1.2 To operate within the capital resource limit.
5.1.3 To operate within the cash requirement.

5.2 The Chief Executive shall produce a Local Delivery Plan. The Chief Executive shall submit a Plan for approval by the Board that takes into account financial targets and forecast limits of available resources. The Local Delivery Plan shall contain:-

5.2.1 a statement of the significant assumptions within the Plan; and
5.2.2 details of major changes in workload, delivery of services or resources required to achieve the plan.

5.3 Before the financial year begins, the Director of Finance shall prepare a financial plan, for approval by the Board. The report shall:-

5.3.1 show the total allocations received from the Scottish Government and their proposed uses, including any sums to be held in reserve;
5.3.2 be consistent with the Local Delivery Plan;
5.3.3 be consistent with the Board’s financial targets;
5.3.4 identify potential risks;
5.3.5 identify funding and expenditure that is of a recurring nature; and
5.3.6 identify funding and expenditure that is of a non-recurring nature.

5.4 The Director of Finance shall continuously review the financial plan, to ensure that it meets the Board’s requirements and the delivery of financial targets.

5.5 The Director of Finance shall regularly update the Board on significant changes to the allocations and their uses.

5.6 The Director of Finance shall establish the systems for identifying and approving how the Board’s capital allocation will be used. The approval of business cases shall be as described in the Scheme of Delegation.

5.7 The Director of Finance shall release capital funds allowing for project start dates and phasing.
Budgetary Control

5.8 The Board shall approve the opening budgets for each financial year on an annual basis.

5.9 The Chief Executive shall delegate the responsibility for budgetary control to designated budget holders. The Scheme of Delegation sets out the delegated authorities to take decisions and approve expenditure for certain posts.

5.10 Employees shall only act on their delegated authority when there is an approved budget in place to fund the decisions they make.

5.11 Delegation of budgetary responsibility shall be in writing and be accompanied by a clear definition of:-

5.11.1 the amount of the budget;

5.11.2 the purpose(s) of each budget heading;

5.11.3 what is expected to be delivered with the budget in terms of organisational performance; and

5.11.4 how the budget holder will report and account for his or her budgetary performance.

5.12 The Chief Executive may agree a virement procedure that would allow budget holders to transfer resources from one budget heading to another.

5.13 If the budget holder does not require the full amount of the budget delegated to him for the stated purpose(s), and virement is not exercised, then the amount not required shall revert back to the Chief Executive.

5.14 The Director of Finance shall devise and maintain systems of budgetary control. These will include:-

5.14.1 monthly financial reports to the Board in a form approved by the Board containing:-

a. net expenditure of the Board during the previous month and for the financial year-to-date; and
on a quarterly basis, a forecast of the Board’s expected net expenditure for the remainder of the year.

b. movements in working capital;

c. capital project spend and projected outturn against plan;

d. explanations of any material variances from plan;
e. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

5.14.2 the issue of timely, accurate and comprehensible advice and financial reports to each holder of a budget, including those responsible for capital schemes, covering the areas for which they are responsible;

5.14.3 investigation and reporting of variances from agreed budgets;

5.14.4 monitoring of management action to correct variances; and

5.14.5 ensuring that adequate training is delivered on an on-going basis to budget holders.

**Monitoring**

5.15 The Chief Executive shall submit any required monitoring forms to the Scottish Government.

5.16 The Director of Finance shall provide monthly reports in the form requested by the Cabinet Secretary showing the charge against the Board's resource limit on the last day of each month.
6 PAY EXPENDITURE

Remuneration Committee

6.1 The Board shall approve the terms of reference for the Remuneration Committee, in line with any extant guidance or requirements.

6.2 The Board shall remunerate the Chairman and other non-executive directors in accordance with instructions issued by the Cabinet Secretary.

Funded Establishment

6.3 The manpower plans incorporated within the annual budget will form the funded establishment.

6.4 The funded establishment of any department may not be varied without the approval of the Chief Executive, or without the application of any control procedure that the Board may put in place.

6.5 Only the Remuneration Committee can vary the establishment for posts directly accountable to the Chief Executive.

6.6 The Board shall follow national policy, procedures and guidance for the determination of commencing pay rates, conditions of service, etc, for employees.

Staff Appointments

6.7 The term staff appointment can mean to engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or agree to changes in any aspect of remuneration. The engagement of agency staff shall only occur in accordance with procedures established by the Board.

6.8 A director or employee may make a staff appointment if:-

6.8.1 the organisation’s approved procedures permits the person to do so; or

6.8.2 the Remuneration Committee has approved the appointment (for posts directly accountable to the Chief Executive)

and

6.8.3 the appointment is within the limit of his approved budget and funded establishment.

Processing of Payroll

6.9 The Director of Finance is responsible for:-

6.9.1 specifying timetables for submission of properly authorised time records and other notifications;
6.9.2 the final determination of pay;
6.9.3 making payment on agreed dates; and
6.9.4 agreeing method of payment.

6.10 The Director of Finance shall issue instructions regarding:-
6.10.1 verification and documentation of data;
6.10.2 the timetable for receipt and preparation of payroll data and the payment of employees;
6.10.3 maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
6.10.4 security and confidentiality of payroll information;
6.10.5 checks to be applied to completed payroll before and after payment;
6.10.6 authority to release payroll data under the provisions of the Data Protection Act;
6.10.7 methods of payment available to various categories of employee;
6.10.8 procedures for payment by cheque, bank credit, or cash to employees;
6.10.9 procedures for the recall of cheques and bank credits;
6.10.10 pay advances and their recovery;
6.10.11 verification, authorisation and payment of expenses;
6.10.12 maintenance of regular and independent reconciliation of pay control accounts; and
6.10.13 a system to ensure the recovery from leavers of sums of money and property due by them to the Health Board.

6.11 Nominated managers shall have delegated responsibility for:-
6.11.1 completing and submitting payroll documentation, and other notifications in accordance with agreed timetables and any instructions from the Director of Finance; and
6.11.2 completing and submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee’s resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.
6.12 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

Contracts of Employment

6.13 The Board shall delegate responsibility to the Director of Human Resources and Organisational Development for:-

6.13.1 ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation and any extant national NHS policies; and

6.13.2 dealing with variations to, or termination of, contracts of employment.
7 NON-PAY EXPENDITURE

7.1 This section shall apply to both revenue and capital expenditure.

Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

7.2 The Chief Executive shall designate a senior officer as the lead senior officer for procurement, and this person shall oversee the procurement of goods and services, to ensure there is an adequate approval of suppliers and their supplies based on cost and quality.

7.3 NSS National Procurement shall undertake procurement activity on a national basis on behalf of boards (including NHS Lothian), and the Board shall implement these nationally negotiated contracts.

7.4 The Board shall operate within the processes established for the procurement of publicly funded construction work, Frameworks Scotland.

7.5 The Board shall comply with Public Contracts (Scotland) Regulations 2012 (and any subsequent relevant legislation) for any procurement it undertakes directly.

7.6 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

7.7 All other aspects of procurement activity must follow the requirements of these Standing Orders and SFIs. Any decision to depart from the requirements of this section must have the approval of NHS Lothian Board.

7.8 The lead senior officer for procurement shall:

7.8.1 Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained in accordance with the Public Contracts (Scotland) Regulations, as issued annually through Scottish Statutory Instrument.

7.8.2 Prepare comprehensive procedures for all aspects of procurement activity.

7.9 The following basic principles shall be generally applied:

7.9.1 Procurement activity satisfies all legal requirements;

7.9.2 Adequate contracts are in place with approved suppliers for the supply of approved products and services;

7.9.3 Segregation of duties is applied throughout the process;

7.9.4 Adequate approval mechanisms are in place before orders are raised;

7.9.5 All deliveries are checked for completeness and accuracy, and confirmed before approval to pay is made; and
7.9.6 All payments made are in accordance with previously agreed terms, and what the Board has actually received.

7.10 All procurement on behalf of the Board must be made on an official order. Official Orders must:-

7.10.1 be consecutively numbered;

7.10.2 be in a form approved by the lead senior officer for procurement;

7.10.3 state the Board’s terms and conditions of trade; and

7.10.4 only be issued following the authorisation of the relevant officer or officers described in the Scheme of Delegation, or officers with the necessary delegated authority on the Authorised Signatory Database.

7.11 The Board shall not make payments in advance of need. However payment in advance of the receipt of goods or services is permitted in circumstances approved by the lead senior officer for procurement. Examples of such instances are:-

7.11.1 Items such as conferences, courses and travel, foreign currency transactions, where payment is to be made at the time of booking, or where the use of the corporate purchasing card is deemed necessary by the Head of Procurement.

7.11.2 Where payment in advance of complete delivery is a legal or contractual requirement, e.g. maintenance contracts, utilities, rates.

7.11.3 Where payment of in advance is necessary to support the provision of services/delivery of a project by external providers (e.g. grants to local authorities or voluntary bodies.)

7.12 Purchases from petty cash shall be undertaken in accordance with procedures stipulated by the Director of Finance.

**Tendering and Contracting**

7.13 Competitive tenders for the supply and disposal of all goods and services shall be invited unless:-


7.13.2 The supply or disposal has been arranged by the National Services Scotland – National Procurement, Procurement Scotland, Office of Government Commerce, Hubco, or any other agreed collaborative procurement.

7.13.3 The supply has been arranged under a framework agreement such as Frameworks Scotland.
7.13.4 The supply has been arranged under the local framework arrangements (for smaller capital/construction schemes) that have been established by the Estates function.

7.13.5 The method of supply or disposal is subject to existing contractual obligations, and the Board is not free to put the matter out to tender.

7.13.6 The supply value (including VAT) is not greater than £25,000, and paragraph 7.15 below applies.

7.13.7 The supply value (including VAT) is greater than £25,000, and the Director of Finance has approved a decision to waive the requirement to tender (see paragraphs 7.16-7.20 below).

7.14 Tenders shall be issued in accordance with the Scheme of Delegation. The evaluation criteria and basis of scoring will be established prior to the issue of the tender. If it is proposed to accept a tender other than the lowest (or for disposals the highest) in the interests of Best Value, a formal record shall be retained of the reasons for doing so.

**Supply of Value up to £25,000**

7.15 Where the estimated expenditure is not greater than £25,000 (including VAT), then the following alternative arrangements should be followed by the budget holder:

<table>
<thead>
<tr>
<th>Value of Supply</th>
<th>Process to Follow</th>
</tr>
</thead>
<tbody>
<tr>
<td>£10,001 - £25,000</td>
<td>Competitive Quotation – at least 2 written quotations should be received and considered.</td>
</tr>
<tr>
<td>£2,501 - £10,000</td>
<td>One written quotation is should be considered.</td>
</tr>
<tr>
<td>Under £2,501</td>
<td>There are no requirements to get quotations.</td>
</tr>
</tbody>
</table>

**Supply of Value greater than £25,000 - Waiver of Tender Requirements**

This section must be read in conjunction with the Board’s Scheme of Delegation, in particular Section 26 – Requirements for Market Testing and Tendering (Capital and Revenue).

7.16 Budget holders are expected to anticipate their procurement requirements in advance of when the supply is to be delivered, and routinely work with the Procurement Department to undertake the appropriate tendering and contracting as is required by the law and 7.13 above. However, the Director of Finance may waive the requirement to undertake tendering in the following circumstances:-

7.16.1 The timescale (from identification of need to the time of required delivery) genuinely precludes the appropriate form of market testing. This provision cannot be used if the limited timescale is due to a failure to anticipate the need for the supply.
7.16.2 The supply or disposal is for goods and services of a special nature or character in respect of which it is not possible or desirable to obtain competitive tenders.

7.16.3 Specialist expertise is required and is available from only one source.

7.16.4 The supply concerns a task that is essential to complete a piece of work, and arises as a consequence of a recently completed assignment, and engaging different suppliers for the new task would be inappropriate.

7.16.5 There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

7.17 The lead senior officer for procurement shall prepare standard form to be used on every occasion to set out the reasons for a proposal to waive formal tendering procedures, and which of the above clauses at 7.16 is being used.

7.18 The lead senior officer for procurement must confirm within that form whether the proposed waiver taken together with other associated procurement actions will breach the Public Contracts (Scotland) Regulations 2012 (and any subsequent relevant legislation). If the waiver would constitute a breach, then the waiver cannot proceed. (N.B. Para 1.3 of these SFIs requires the Board to follow the law.)

7.19 The Director of Finance must review the completed form before approving the waiver. The Director of Finance shall forward all waiver approvals to the lead senior officer for procurement. The lead senior officer for procurement shall maintain a waiver of tender register.
8 ADDITIONAL MATTERS FOR CAPITAL EXPENDITURE

Overall Arrangements for the Approval of the Capital Plan

8.1 The Board shall follow any extant national instructions on the approval of capital expenditure, such as the Scottish Capital Investment Manual. The authorisation process shall be described in the Scheme of Delegation.

8.2 The Chief Executive shall ensure that:

   8.2.1 there is an adequate appraisal and approval process in place for determining capital expenditure priorities within the Property Strategy and the effect of each proposal upon business plans;

   8.2.2 all stages of capital schemes are managed, and are delivered on time and to cost;

   8.2.3 capital investment is not undertaken without confirmation that the necessary capital funding and approvals are in place; and

   8.2.4 all revenue consequences from the scheme, including capital charges, are recognised, and the source of funding is identified in financial plans.

Implementing the Capital Programme

8.3 For every capital expenditure proposal the Chief Executive shall ensure:

   8.3.1 that a business case as required by the Scottish Capital Investment Manual (SCIM) is produced setting out:

       a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

       b. appropriate project management and control arrangements; and

   8.3.2 that the Director of Finance has assessed the costs and revenue consequences detailed in the business case.

8.4 The approval of a business case and inclusion in the Board’s capital plan shall not constitute approval of the individual elements of expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

   8.4.1 specific authority to commit expenditure; and

   8.4.2 following the required approval of the business case, authority to proceed to tender.

8.5 The Scheme of Delegation shall stipulate where delegated authority lies for:

   8.5.1 approval to accept a successful tender; and
8.5.2 where Frameworks Scotland applies, authority to agree risks and timelines associated with a project in order to arrive at a target price.

8.6 The Director of Finance shall issue procedures governing the financial management of capital investment projects (e.g. including variations to contract, application of Frameworks Scotland) and valuation for accounting purposes.

Public Private Partnerships and other Non-Exchequer Funding

8.7 When the Board proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:-

8.7.1 The Director of Finance shall demonstrate that the use of public private partnerships represents value for money and genuinely transfers significant risk to the private sector.

8.7.2 Where the sum involved exceeds the Board’s delegated limits, the business case must be referred to the Scottish Government for approval or treated as per current guidelines.

8.7.3 The Board must specifically agree the proposal.

8.7.4 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Disposals of Assets

8.8 The Director of Finance shall issue procedures for the disposal of assets including condemnations. All disposals shall be in accordance with MEL(1996)7: Sale of surplus and obsolete goods and equipment.

8.9 There is a requirement to achieve Best Value for money when disposing of assets belonging to the Health Board. Competitive tendering should normally be undertaken.

8.10 When it is decided to dispose of a Health Board asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

8.11 All unserviceable articles shall be:-

8.11.1 Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

8.11.2 Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.
Capital Accounting

8.12 The Director of Finance shall be notified when capital assets are sold, scrapped, lost or otherwise disposed of, and what the disposal proceeds were. The value of the assets shall be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

8.13 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

8.14 The value of each asset shall be indexed and depreciated in accordance with methods specified by the Scottish Government.

8.15 The Director of Finance shall calculate capital charges, which will contributed to the total net expenditure that shall be debited against the general fund.
9 ASSET REGISTERS AND SECURITY OF ASSETS

9.1 The Chief Executive is responsible for the control of all assets. The Chief Executive shall establish a fixed asset register. The register shall hold the minimum data set required by the Scottish Government.

9.2 The Director of Finance shall:-

9.2.1 devise the format of the fixed asset register and the methods for maintaining it; and

9.2.2 arrange for a physical check of assets against the asset register to be conducted at least once a year, and ensure that any discrepancies are reported.

9.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:-

9.3.1 authorised agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

9.3.2 stores, requisitions and wages records for own materials and labour including appropriate overheads; and

9.3.3 lease agreements in respect of assets held under a finance lease and capitalised.

9.4 The Director of Finance shall approve the systems of control and procedures for the general security of assets. These shall include:-

9.4.1 recording managerial responsibility for each asset;

9.4.2 identification of additions and disposals;

9.4.3 identification of all repairs and maintenance expenses;

9.4.4 physical security of assets. Where practical, assets should be marked as Health Board property;

9.4.5 periodic verification of the existence of, condition of, and title to, assets recorded; and

9.4.6 identification and reporting of all costs associated with the retention of an asset.

9.5 The Chief Executive shall designate a senior officer as the Caldicott Guardian. The Caldicott Guardian shall establish the systems for the maintenance of an Information Asset Register, as part of the Board’s system of Information Governance.

10 BANKING AND CASH HANDLING
10.1 The Director of Finance shall manage the Board's banking arrangements and advise the Board on the provision of banking services and operation of accounts. This advice shall take into account guidance/Directions issued from time to time by the Scottish Government.

10.2 The Director of Finance shall ensure that the banking arrangements operate in accordance with the Scottish Government banking contract (GBS) and the Scottish Public Finance Manual.

10.3 The Board shall approve the banking arrangements. No employee may open a bank account for the Board’s activities or in the Board’s name, unless the Board has given explicit approval.

10.4 The Director of Finance shall:-

10.4.1 establish separate bank accounts for non-exchequer funds;

10.4.2 ensure payments made from bank or GBS accounts do not exceed the amount credited to the account, except where arrangements have been made;

10.4.3 ensure money drawn from the Scottish Government against the Cash Requirement is required for approved expenditure only, and is drawn down only at the time of need;

10.4.4 promptly bank of all monies received intact. Expenditure shall not be made from cash received that has not been banked, except under arrangements approved by the Director of Finance; and

10.4.5 report to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

10.5 The Director of Finance shall prepare detailed instructions on the operation of bank and GBS accounts, which must include:-

10.5.1 the conditions under which each bank and GBS account is to be operated;

10.5.2 ensuring that the GBS account is used as the principal banker and that the amount of cleared funds held at any time within exchequer commercial bank accounts is limited to a maximum of £50,000 (of cleared funds);

10.5.3 the limit to be applied to any overdraft;

10.5.4 those authorised to sign cheques or other orders drawn on the Board's accounts; and

10.5.5 the required controls for any system of electronic payment.
10.6 The Director of Finance shall:-

10.6.1 approve the stationery for officially acknowledging or recording monies received or receivable, and keep this secure;

10.6.2 provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

10.6.3 approve procedures for handling cash and negotiable securities on behalf of the Board.

10.7 Money in the custody of the Board shall not under any circumstances be used for the encashment of private cheques.

10.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Board is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.
11 STORES

11.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:-

11.1.1 kept to a minimum;

11.1.2 subject to annual stocktake; and

11.1.3 valued at the lower of cost and net realisable value.

11.2 The Chief Executive shall delegate the responsibility for the control of stores to officers throughout the organisation.

11.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

11.4 The Director of Finance shall approve procedures for stocktaking, and there shall be a physical check covering all items in stock at least once a year.

11.5 The Chief Executive shall delegate the responsibility for the control of pharmaceutical stocks to an appropriately qualified member of the Directorate of Public Health.

11.6 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Director of Pharmacy.

11.7 Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Director of Finance or the Director of Pharmacy.

11.8 The designated Manager/Director of Pharmacy shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 15, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

11.9 For goods supplied via central NHS warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.
12 Income, Fees and Charges

General

12.1 The Director of Finance shall design and implement systems for the recording and collection of all monies due.

Fees and Charges

12.2 The Board shall follow the Scottish Government’s guidance in setting prices for services.

12.3 The Director of Finance shall approve all fees and charges other than those determined by the Scottish Government or by statute.

12.4 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

12.5 The Director of Finance shall approve the level of rentals for newly acquired property and shall regularly review rental and other charges.

12.6 The Director of Finance shall be consulted about the pricing of goods and services offered for sale and nationally negotiated rates shall be observed.

12.7 Independent professional advice on matters of valuation may be taken as necessary.

Debt Recovery

12.8 The Director of Finance shall take appropriate recovery action on all outstanding debts, including write-off action after all reasonable steps have been taken to secure payments.

12.9 Income not received shall be dealt with in accordance with losses procedures.

12.10 Overpayments should be detected (or preferably prevented) by the Board’s system of control and recovery initiated and taken to resolution.
13 SERVICE AGREEMENTS FOR PATIENT SERVICES

General

13.1 The role of the Board is to achieve long-term health gain for the resident population of Lothian. It pursues this through its strategic planning, public health and health promoting functions.

13.2 The Chief Executive shall negotiate service agreements for the provision of services to patients in accordance with any agreed regional or local health plans, and for any non-contracted and unplanned activity.

13.3 The Director of Finance shall ensure all systems associated with service agreements operate in such a way as to maintain patient confidentiality, as agreed with the Board’s Caldicott Guardian.

13.4 The Director of Finance shall ensure that all agreements satisfy the requirements of budgetary control and the Board’s financial targets.

Where Lothian Board is the Provider

13.5 The Chief Executive shall ensure that service agreements for provision of services recover the costs borne by the Board, and minimise any risks to the Board.

13.6 The Director of Finance shall advise the Chief Executive regarding:-

13.6.1 costing and pricing of services;

13.6.2 payment terms and conditions; and

13.6.3 amendments to agreements.

13.7 The Director of Finance shall set charges for services, including non-contracted activity (cross-border) and unplanned activity (‘UNPACS’) (cross-Health Board boundary), in accordance with national guidelines.

13.8 The Director of Finance shall produce regular reports to the Board detailing actual and forecast income, linked to activity, with a detailed assessment of the impact of the variable elements of income.

Where the Service Provider is any other Organisation

13.9 The Director of Finance shall ensure that:-

13.9.1 service agreements placed are within the resources available to the organisation; and

13.9.2 providers are paid in accordance with the terms of the service agreement, and any relevant national guidance.
13.10 The Director of Finance shall review service concession agreements with third parties for elements containing leases. This is to ensure that the expenditure arising from these is properly accounted for under the requirements of the extant accounting standards.
14 RISK MANAGEMENT & INSURANCE

14.1 The Chief Executive shall ensure that the Board has a programme of risk management which will be approved and monitored by the Board and which complies with the standards issued by NHS Healthcare Improvement Scotland.

14.2 The programme of risk management shall include:-

14.2.1 a process for identifying and quantifying risks and potential liabilities;

14.2.2 engendering among all levels of staff a positive attitude towards the control of risk;

14.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

14.2.4 contingency plans to offset the impact of adverse events;

14.2.5 audit arrangements including: internal audit, clinical audit, health and safety review; and

14.2.6 arrangements to review the risk management programme.

14.3 An annual risk management report shall be prepared confirming whether adequate and effective risk management systems were in place throughout the year, and will highlight any areas of material risk. This shall be used as a source of assurance and will inform the content of the Governance Statement.

14.4 The Director of Finance shall ensure that insurance arrangements exist in accordance with the risk management programme.
15 INFORMATION TECHNOLOGY

15.1 The Chief Executive shall designate a senior officer as the lead senior officer for ehealth, who shall also be the designated Senior Information Risk Owner (SIRO) (as defined by the Department of Health, The Caldicott Guardian Manual 2010). ehealth is the use of information, computers and telecommunications in support of meeting the needs of patients and health of citizens. The lead senior officer for ehealth is only responsible for those systems that are supported by the ehealth directorate.

15.2 The lead senior officer for ehealth shall ensure that there is an NHS Lothian ehealth strategy. The lead senior officer for ehealth shall ensure that there is effective engagement with healthcare professionals to inform the development and implementation of the ehealth strategy.

15.3 Executive directors shall ensure that the ehealth directorate has planning input to all new/refurbishment build projects to ensure that they incorporate the latest technologies to deliver the required services, but also ensure their compatibility with the existing NHS Lothian infrastructure.

15.4 The lead senior officer for ehealth shall ensure that on the acquisition of any new computer hardware or software Health Board procurement guidelines have been adhered to and adequate option appraisals undertaken.

15.5 In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of NHS organisations wish to sponsor jointly) all responsible directors and employees will send to the Medical Director:-

15.5.1 details of the outline design of the system;
15.5.2 contract details and/or standard contract conditions; and
15.5.3 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.6 The lead senior officer for ehealth shall draw up an IT Security Policy and Standards document and ensure that it is effectively communicated to all members of staff of the Health Board. This will require to be approved by the Board’s Caldicott Guardian.

15.7 The lead senior officer for ehealth shall draw up business continuity plans to ensure minimal disruption to business operations in the event of an interruption in the operation of Health Board IT/IS systems that are supported by the ehealth directorate.

15.8 The Director of Finance, who is responsible for the accuracy and security of computerised financial data of the Board, shall:-

15.8.1 devise and implement any necessary procedures to ensure adequate protection of the Board’s data, programs and computer hardware for which
he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

15.8.2 ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure the security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

15.8.3 ensure that, in the appropriate environments, adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

15.8.4 ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

15.9 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested before implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them before implementation.

15.10 The Director of Finance shall ensure that for contracts for computer services for financial applications with another body, the Health Board shall periodically seek assurances that adequate controls are in operation.

15.11 Where computer systems have an impact on corporate financial systems the Director of Finance shall ensure that:-

15.11.1 systems acquisition, development and maintenance are in line with corporate policies such as an eHealth Strategy;

15.11.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

15.11.3 Finance staff have access to such data; and

15.11.4 such computer audit reviews as are considered necessary are being carried out.

15.12 For all other IT systems not currently supported by ehealth or the responsibility of the Director of Finance (as defined above), the executive director with lead responsibility for the system shall ensure that the requirements of this section are applied to that system.
16 RETENTION OF DOCUMENTS

16.1 The Chief Executive shall be responsible for maintaining archives for all documents in accordance with the NHS Code of Practice on Records Management.

16.2 The documents held in archives shall be capable of retrieval by authorised persons.

16.3 Documents held under the Code shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed.
17 PRIMARY CARE CONTRACTORS

17.1 In these SFIs and all other Board documentation, Primary Care contractor means:-

17.1.1 an independent provider of healthcare who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the United Kingdom (UK); or

17.1.2 an employee of a National Health Service organisation in the UK who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the UK.

17.2 The General Manager, Primary Care Contracts, shall devise and implement systems to control the registers of those who are entitled to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in Lothian. Systems shall include criteria for entry to and deletions from the registers.

17.3 The Director of Finance shall agree the Service Level Agreement (s) with NHS National Services Scotland for:-

17.3.1 the development, documentation and maintenance of systems for the verification, recording and receipt of NHS income collected by or on behalf of primary care contractors; and

17.3.2 the development, documentation and maintenance of systems for the verification, recording and payment of NHS expenditure incurred by or on behalf of primary care contractors.

17.4 The agreements at paragraph 17.3 shall comply with guidance issued from time to time by the Scottish Government. In particular they shall take account of any national systems for the processing of income and expenditure associated with primary care contractors.

17.5 The Director of Finance shall ensure that all transactions conducted for or on behalf of primary care contractors by the Board shall be subject to these SFIs.
18 LOSSES AND SPECIAL PAYMENTS

18.1 The Director of Finance shall issue procedures on the recording of and accounting for losses and special payments, to meet the requirements of the Scottish Public Finance Manual. These procedures shall include the steps to be taken where the loss may have been caused by a criminal act.

18.2 The Scheme of Delegation shall describe the process for the approval of the write-off of losses and making of special payments.

18.3 The Director of Finance shall be authorised to take any necessary steps to safeguard the Board's interests in bankruptcies and company liquidations.

18.4 For any loss, the Director of Finance should consider whether any insurance claim can be made.

18.5 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.
19 THEFT, FRAUD OR ANY OTHER FINANCIAL OR LEGAL IRREGULARITIES

19.1 Whenever any matter arises which involves, or is thought to involve, fraud, theft or other irregularity, the Director of Finance (the Board’s designated Counter Fraud Champion) or the Chief Internal Auditor (the Board’s designated Fraud Liaison Officer) must be notified immediately. Guidance and contact information will be made widely available throughout NHS Lothian.

19.2 The Board shall work in partnership with NHS Scotland Counter Fraud Services towards the prevention and detection of fraud and other irregularities. The Board will assist in any necessary investigations, and comply with any reporting requirements. The Board and NHS Scotland Counter Fraud Services will work together in accordance with the terms of a partnership agreement. Following discussion with Counter Fraud Services, the Board may also report cases of fraud to the Police.

19.3 The Fraud Liaison Officer shall facilitate the collation and reporting of returns in the event of thefts (of NHS property only). However, the local operational manager is responsible for reporting thefts to the police, securing the area, and notifying the Fraud Liaison Officer (via the incident module on DATIX). The manager shall complete any required returns.

19.4 The Fraud Liaison Officer shall make information on frauds and thefts available for reporting, including for SFR 18 and supporting schedules.

19.5 The Director of Finance shall ensure comprehensive reports of frauds and thefts are available to the external auditor, and the Scottish Government as necessary. However, NHS Scotland Counter Fraud Services is responsible for nationally reporting fraud and other irregularities.

19.6 In the event of a loss through fraud or theft, the local manager is responsible for taking any necessary remedial action to prevent its recurrence, by reviewing the adequacy of the relevant systems of control. No such action should be taken however if it would prove prejudicial to the effective prosecution of the case.
20 ANNUAL ACCOUNTS AND REPORTS

20.1 The Director of Finance shall prepare and submit financial returns and reports to the Cabinet Secretary. This will be consistent with any guidance issued by the Scottish Government and the Treasury, the Board’s accounting policies, and generally accepted accounting practice.

20.2 The Audit & Risk Committee shall review the annual accounts prior to them submitted to the Board for approval.

20.3 The Chief Executive shall ensure that there is a formal record of the presentation of the annual accounts to the Board.

20.4 The Board shall publish an annual report, in accordance with the Scottish Government’s guidelines on local accountability and requirements. The Director of Finance shall prepare a Financial Statement for inclusion in the Board’s Annual Report.

20.5 The Board shall present its annual report at a public meeting.
21 PATIENTS' PROPERTY

21.1 The Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

21.2 The Chief Executive shall ensure that patients or their guardians, as appropriate, are informed before or at admission, by:-

21.2.1 notices and information booklets;

21.2.2 hospitals admission documentation and property records; and

21.2.3 the oral advice of administrative and nursing staff responsible for admissions, that the Board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

21.3 The Director of Finance shall issue procedures on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

21.4 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

21.5 The Director of Finance shall prepare an abstract of receipts and payments of patients' private funds in the form laid down by the Scottish Government. This abstract shall be audited independently and presented to the Audit & Risk Committee annually, with the auditor in attendance at the meeting. The Committee is delegated the responsibility to review and recommend the approval of the abstract and draft management representation letter, to the Board. The abstract, the management representation letter, and the associated audit report must be received and approved by the Board.
22 FUNDS HELD ON TRUST (Endowments)

22.1 Members of Health Boards become Trustees of the charity known as the “Edinburgh and Lothians Health Foundation” ex officio by reason of their Board appointment. The appointment as Trustee is legally distinct from the appointment as a Board member. The Trustees collectively are an unincorporated body distinct from Lothian NHS Board.

22.2 The responsibilities of the trustees shall be discharged separately from the responsibilities of members of Lothian NHS Board and its employees. The trustees shall be accountable to the Office of the Scottish Charities Regulator for all charitable funds held on trust.

22.3 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds. The Trustees shall separately approve a Charter and other policies and procedures as required to discharge their responsibilities as trustees.

22.4 These SFIs shall apply to the management of funds held on trust, unless the trustees instruct otherwise.

22.5 The Director of Finance shall prepare annual accounts for funds held in trust, to be audited independently and presented annually to the Trustees.
LOTTHIAN NHS BOARD SCHEME OF DELEGATION
## CONTENTS

<table>
<thead>
<tr>
<th>No</th>
<th>TOPIC</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Introduction</strong></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td><strong>Governance &amp; Performance Management</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Healthcare Governance and Risk Management</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Staff Governance</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>Research Governance</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Financial Governance</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>Patient Focus and Public Involvement</td>
<td>14</td>
</tr>
<tr>
<td>6</td>
<td>Performance Management</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td><strong>Strategic Direction &amp; Planning</strong></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Leadership</td>
<td>17</td>
</tr>
<tr>
<td>8</td>
<td>Communications</td>
<td>19</td>
</tr>
<tr>
<td>9</td>
<td>Strategy Development (including Local Delivery Plan)</td>
<td>20</td>
</tr>
<tr>
<td>10</td>
<td>Health Improvement &amp; Screening Programmes</td>
<td>21</td>
</tr>
<tr>
<td>11</td>
<td>Regional Planning &amp; Managed Clinical Networks</td>
<td>24</td>
</tr>
<tr>
<td>12</td>
<td>Service Redesign</td>
<td>25</td>
</tr>
<tr>
<td>13</td>
<td>Shared Services</td>
<td>27</td>
</tr>
<tr>
<td>14</td>
<td>Joint Working</td>
<td>28</td>
</tr>
<tr>
<td>15</td>
<td>Business Continuity Planning</td>
<td>29</td>
</tr>
<tr>
<td>16</td>
<td>Emergency Planning</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td><strong>Delivery</strong></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Provision of Healthcare Services</td>
<td>33</td>
</tr>
<tr>
<td>18</td>
<td>Complaints Handling</td>
<td>35</td>
</tr>
<tr>
<td>19</td>
<td>Healthcare Associated Infection</td>
<td>36</td>
</tr>
<tr>
<td>20</td>
<td>Incident Management</td>
<td>39</td>
</tr>
<tr>
<td>21</td>
<td>Child Protection Services</td>
<td>40</td>
</tr>
<tr>
<td>22</td>
<td>Primary Care Contracting</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td><strong>Financial Scheme of Delegation</strong></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Approval of Items to be included in the NHS Lothian Capital Programme – Funding of Initial Development of Concept</td>
<td>43</td>
</tr>
<tr>
<td>24</td>
<td>Approval of Items to be included in the NHS Lothian Capital Programme – Business Cases</td>
<td>44</td>
</tr>
<tr>
<td>25</td>
<td>Approval of Items to be included in the NHS Lothian Capital Programme – Use of frameworks such as Frameworks Scotland</td>
<td>46</td>
</tr>
<tr>
<td>26</td>
<td>Requirements for Market Testing and Tendering (Capital and Revenue)</td>
<td>49</td>
</tr>
</tbody>
</table>

Continued/
## CONTENTS

<table>
<thead>
<tr>
<th>No</th>
<th>TOPIC</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Award of Capital Tenders</td>
<td>50</td>
</tr>
<tr>
<td>28</td>
<td>Capital Expenditure – Delegation of Authority and Approval of Expenditure</td>
<td>51</td>
</tr>
<tr>
<td>29</td>
<td>Revenue Expenditure – General Arrangements</td>
<td>53</td>
</tr>
<tr>
<td>30</td>
<td>Revenue - Contracts and Service Agreements for Healthcare Services</td>
<td>56</td>
</tr>
<tr>
<td>31</td>
<td>Revenue - Contracts and Service Agreements for Other Specified Services</td>
<td>57</td>
</tr>
<tr>
<td>32</td>
<td>Revenue – Use of Management Consultants</td>
<td>59</td>
</tr>
<tr>
<td>33</td>
<td>Revenue - Travel and Reimbursement of Expenses</td>
<td>63</td>
</tr>
<tr>
<td>34</td>
<td>Revenue – Private Finance Initiative/ Public Private Partnerships</td>
<td>64</td>
</tr>
<tr>
<td>35</td>
<td>Virement</td>
<td>65</td>
</tr>
<tr>
<td>36</td>
<td>Asset Transactions</td>
<td>66</td>
</tr>
<tr>
<td>37</td>
<td>Financial Services</td>
<td>67</td>
</tr>
<tr>
<td>38</td>
<td>Losses and Special Payments</td>
<td>69</td>
</tr>
<tr>
<td>39</td>
<td>Signing of Contract Documentation</td>
<td>75</td>
</tr>
<tr>
<td>40</td>
<td>Payroll</td>
<td>76</td>
</tr>
</tbody>
</table>
INTRODUCTION

Lothian NHS Board, as required by its Standing Orders, has developed and approved this Scheme of Delegation to describe the broad roles of the organisation it governs (commonly referred to as “NHS Lothian”), its partners, and its employees, in delivering the Board’s functions and objectives. It has been developed to assist employees and any other interested stakeholders understand where responsibilities and accountabilities lie, and embed internal control throughout the organisation.

All of the Board’s policies and other publications are available on the intranet, and employees are directed to make use of the intranet to find information. The Board’s policies can be found on the intranet at: Corporate>Policies

Employees can also access instructions from the Scottish Government (HDL, CEL etc.) and other material relating to NHS Scotland at www.show.scot.nhs.uk Information on the detailed responsibilities associated with individual posts are set out in approved job descriptions

Lothian NHS Board has assigned a Director to each section of this Scheme of Delegation. As at November 2012, the names of the Executive Board members are:

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Board Members</td>
<td></td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Tim Davison</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Dr David Farquharson</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Susan Goldsmith</td>
</tr>
<tr>
<td>Nurse Director</td>
<td>Melanie Hornett</td>
</tr>
<tr>
<td>Director of Public Health &amp; Health Policy</td>
<td>Dr Alison McCallum</td>
</tr>
</tbody>
</table>

In this Scheme there is reference to the Joint Management Team which includes various members of senior management, and is chaired by the Chief Executive. The Chief Executive shall determine the membership of the Joint Management Team.

Within this Scheme the Joint Management Team as a group has delegated authority to approve certain transactions, and this is detailed in:
- Section 24 – Business Cases
- Section 29 – Revenue Expenditure – General Arrangements
- Section 30 – Revenue – Contracts and Service Agreements for Healthcare Services
- Section 31 – Revenue- Contracts and Service Agreements for Other Specified Services

The Joint Management Team must achieve a quorum of three executive board members in order to exercise the above delegated authority.
INTRODUCTION (continued)

NHS Lothian has a telephone directory which contains the up-to-date contact details of these officers, and it can be found on the intranet at:
http://intranet.lothian.scot.nhs.uk/NHSLothian/system/Pages/phone.aspx
Another way to find it on the intranet is to click on the “Telephone Directory” tab, which is present at the top of the screen any time you are on the intranet.

With respect to internal financial control, and the application of sections 4, and 23-34 of this Scheme, all employees should observe the following principles:

- All figures in this schedule are inclusive of VAT.
- Managers can only act on the delegated limits in this schedule on the condition that there is an approved budget in place before the commitment of expenditure.
- Officers named in this Scheme of Delegation are free to delegate authority to the managers in their team. Nevertheless the named officers in this Scheme will remain personally accountable for all financial transactions within their area of responsibility, and the actions of the individuals to whom they delegate financial authority to.
- All budget holders are required to formally agree their annual budgets and are accountable for their budgetary performance. It is essential that expenditure levels do not exceed the agreed delegated budget.
<table>
<thead>
<tr>
<th>1. Healthcare Governance and Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible Directors for this Section</strong></td>
</tr>
<tr>
<td>Medical Director and Nurse Director</td>
</tr>
<tr>
<td>The Director of Public Health &amp; Health Policy is the lead executive for Information Governance. The Healthcare Governance Committee oversees Information Governance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Role of NHS Board</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• To ensure that high quality, safe, effective, and patient-centred care is delivered across NHS Lothian.</td>
</tr>
<tr>
<td>• To ensure that standards of care promulgated by the Scottish Government Health Directorate, and by NHS Scotland Special Health Boards and agencies are implemented and monitored.</td>
</tr>
<tr>
<td>• To ensure that there are effective assurance systems in place to provide a sound framework for healthcare governance and risk management across NHS Lothian.</td>
</tr>
<tr>
<td>• To ensure that there are effective assurance systems in place to provide a sound framework for information governance across NHS Lothian.</td>
</tr>
</tbody>
</table>

| **Role of Medical Director and Nurse Director led corporate functions.** |
| N.B. The Director of Human Resources & Organisational Development led corporate function hosts the Occupational Health and Safety, which is a clinical function. |
| • Ensure that effective frameworks, strategies and systems exist throughout NHS Lothian to support high quality, safe, effective, and patient-centred care. |
| • Ensure the provision of a support function for operating units. |
| • Support the functioning of the Healthcare Governance Committee. |
| • Co-ordinates systems of organisational learning for healthcare governance and risk management. |
| • Presents regular reports to the Board. |
### Role of all other areas.

- To implement, monitor and review healthcare governance and risk management strategies and procedures.
- To ensure satisfactory operational response to action plans arising from external or internal reviews and audit, including complaints, compliments, and critical incident reporting.
- Ensure that undergraduate and postgraduate teaching and training are delivered to required standards set by regulatory authorities and Higher Education Institutions.
- To develop and support a culture of transparent reporting of errors, and near misses, fair and just investigation and corrective action to prevent recurrence.
- To implement and monitor the implementation of policies and procedures.
- To implement and monitor the implementation of standards care to the required published standards.
- To deliver an annual quality improvement programme.
- Ensure that information governance policy, strategy and procedures are complied with, and to support corrective action to ensure high standards of security and confidentiality of personal information.

### Role of Partners

- To independently establish standards and provide a fair and robust assessment of the Board’s performance against those standards.
- Partners in the delivery of service to share information and work within a joint framework to deliver against healthcare governance and risk management standards.

### Reference Documents

- MEL (2000) 29: Clinical Governance
- HDL (2001) 74: Clinical Governance Arrangements
- NHS QIS Standards for Clinical Governance and Risk Management (October 2005)
- Information Governance Strategy (2007)
- Terms of Reference for the Healthcare Governance Committee.
- NHS Lothian Quality Improvement Strategy 2011-14
- NHS Lothian Information Governance Policy (2009)
2. Staff Governance

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Human Resources and Organisational Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of NHS Board</td>
<td></td>
</tr>
<tr>
<td>- Create the culture and put in place structures and systems to ensure effective partnership approach throughout the organisation.</td>
<td></td>
</tr>
<tr>
<td>- Make expectations clear in regard to HR performance management, and establish monitoring systems.</td>
<td></td>
</tr>
<tr>
<td>- Ensure systems are in place to monitor compliance with statutory requirements and to the Board’s Health and Safety Policy, and ensure that corrective action is taken immediately when deficiencies are identified.</td>
<td></td>
</tr>
<tr>
<td>- To ensure adherence to the Staff Governance Standard that staff are:</td>
<td></td>
</tr>
<tr>
<td>- well informed</td>
<td></td>
</tr>
<tr>
<td>- appropriately trained</td>
<td></td>
</tr>
<tr>
<td>- involved in decisions that affect them</td>
<td></td>
</tr>
<tr>
<td>- treated fairly and consistently,</td>
<td></td>
</tr>
<tr>
<td>- have a safe working environment.</td>
<td></td>
</tr>
<tr>
<td>- To ensure that no applicant or employee receives less favourable treatment on the grounds of age, disability, gender, health status, marital status, membership or non-membership of a political party or trade union, previous criminal convictions not related to the post, race (including colour, nationality, ethnic or national origin), religion or belief, responsibility for dependants, sexual orientation, or by conditions or requirements which cannot be shown to be justifiable. The Board will take appropriate positive action to help us in meeting our commitment to having a workforce which reflects the diversity in our local population.</td>
<td></td>
</tr>
<tr>
<td>- To ensure NHS Lothian Health and Safety Policy meets, as a minimum, statutory requirements.</td>
<td></td>
</tr>
</tbody>
</table>
## 2. Staff Governance (continued)

| Role of Director of Human Resources & Organisational Development led corporate function | • To develop and implement an HR & OD strategy and associated policies to deliver upon the Staff Governance Standard.  
• To provide the professional and operational lead on human resource management and organisational development practice.  
• To ensure that the workforce is fit for purpose to provide quality healthcare services.  
• To maintain competent and professional levels of Occupational Health and Safety support services to provide advice and service delivery.  
• To implement effective audit of the organisation’s compliance with Health and Safety policy. |
|---|---|
| Role of all other areas | • To implement Board policies and procedures pertinent to staff governance.  
• To effectively line manage employees and develop them in order to deliver upon the organisation’s objectives and to meet service requirements, using the Board’s appraisal / PDPR systems.  
• To deliver the above in the context of local priorities, as informed by the outcomes of risk management activities.  
• To ensure effective two-way communications with staff.  
• To manage the arrangements for staff governance with the forthcoming Integration agenda.  
• To establish and maintain in partnership systems for the delivery of NHS Lothian Health and Safety policy including the commitment for year on year improvement in health and safety performance. |
| Role of Partners | • To recognise and support requirements of staff governance accountabilities on NHS Board. The Board has delegated the responsibility for the approval of Human Resource policies to the Lothian Partnership Forum.  
• Create conditions to support effective joint working arrangements for staff. |
| Reference Documents | • NHS Lothian Health & Safety Policy (July 2011)  
• NHS Lothian Equality & Human Rights Scheme 2010-13  
• NHS Lothian Human Resources and Organisational Development Strategy (November 2011- March 2014)  
• NHS Scotland Staff Governance Standard (4th edition) (June 2012)  
The Board has a suite of HR policies which can be found on the intranet at Corporate>Policies>NHS Lothian Employment Policies |
## 3. Research Governance

| Role of NHS Board | • To foster a culture in which high quality research and development can flourish with Higher Education Institution partners, towards the delivery of benefits to patient care.  
• To ensure that research by the Board conforms to research governance standards as published from time to time.  
• To encourage research & development in areas of relevance to the work of the Board.  
• To ensure transparency in the accounting of Research and Development funding. |
| Role of Director of Public Health & Health Policy led corporate function | • To appoint and supervise a Director of Research and Development and support function.  
• To assimilate the findings of research and ensure that these influence practices and procedures of the Board.  
• To operate the NHS Lothian Research Governance Committee, and report biannually to the Healthcare Governance Committee. |
| Role of all operational areas | • To conduct all research & development activity in compliance with Board policies and procedures.  
• To support high quality research and development, and ensure efficient and effective recovery of resources. |
| Role of Partners | • To work with the University of Edinburgh to develop a joint research and development support function and procedures  
• To work with the Board on research & development projects that may cover several organisations, and share information as required. |
• Research Governance Framework for Health and Social Care (2nd edition)  
• Research Governance Framework Local Implementation Plan  
• NHS Lothian Policy for the Management of Intellectual Property (January 2012)  
• ACCORD Quality Strategy (3 March 2011) |
## 4. Financial Governance

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Finance</th>
</tr>
</thead>
</table>

### Role of NHS Board
- To discharge its responsibilities in accordance with the relevant legislative requirements of the European Parliament, and the United Kingdom and Scottish Parliaments.
- To comply with any Directions or guidance issued by the Scottish Ministers.
- To conduct its activities in an open and accountable manner. Its activities and organisational performance will be auditable.
- To perform its activities within the available financial resources at its disposal.
- To conduct its activities in a manner that is cost effective and demonstrably secures value-for-money.

### Role of Director of Finance led corporate function
- To provide the professional lead on accountancy and financial management.
- The provision of appropriate advice to the Board and technical expertise to the organisation towards the achievement of the financial governance objectives listed above.
- Championing the understanding of financial management issues and the principles of internal control throughout NHS Lothian.

### Role of all operational areas
With respect to delegated authority to approve decisions and transactions with a financial impact, please refer to Sections 23-34 in this scheme of delegation.

Generic responsibilities for “Money and Resources” have been developed in the UHD “Governance through Leadership Summary Line Accountability Matrix, and are set out below.

**Director of Operations**
- Plan and deliver safe, effective, personalised and affordable clinical services.
- Lead and support the delivery of challenging and realistic savings plans.
- Maximise current capital assets and influence future NHSL estate strategy to support clinical service improvement.

**Divisional Nurse Director**
- Accountable for the management of the divisional nursing directorate related expenditure on staff and supplies.
- Lead specific savings work schemes as commissioned by the Director of Nursing.
- Influence N&M related expenditure on staff and supplies to maximise the overall return on investment in nursing & midwifery and clinical support roles.

**Divisional Medical Director**

- Accountable for the management of the divisional medical directorate related expenditure on staff and supplies.
- Lead specific savings work schemes as commissioned by the Medical Director.
- Influence related expenditure on staff and supplies to maximise the overall return on investment in medical staffing, drugs and clinical supplies.

**Associate Director of Operations**

- Support the Director of Operations in the design and implementation of safe, effective, personalised and affordable clinical services and related savings plans.
- Lead the scoping and development of any cases relating to: capital and/or environmental improvements to underpin delivery of the Quality Strategy.
- Lead specific LRP schemes.

**Associate Divisional Medical Director**

- Accountable for the management of medical related expenditure on staff.
- Manage local controls to avoid and minimise expenditure i.e. rostering, sickness, bank, agency.
- Ensure compliance with conditions for research & development grants and other income streams e.g. Additional Costs of Teaching

**Chief Nurse / Midwife**

- Accountable for the management of nursing and midwifery related expenditure on staff and supplies.
- Manage local controls to avoid and minimise expenditure i.e. rostering, sickness, bank and agency.

**Clinical Director**

- Accountable for the management of medical staff and related resources within budget.
- Establish local controls to avoid and minimise expenditure i.e. rostering, sickness, bank and agency.
- Ensure ‘rota masters’ deliver working patterns that are clinically/cost effective and European Working Time Directive compliant.
<table>
<thead>
<tr>
<th>Service Manager</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accountable for the management of administrative &amp; clerical and technical staff resource within the agreed budget.</td>
<td></td>
</tr>
<tr>
<td>• Lead specific LRP schemes as commissioned by the Associate Director of Operations.</td>
<td></td>
</tr>
<tr>
<td>• Manage the process for option appraisals and business cases relating to capital and/or environmental improvements to underpin delivery of the Quality Strategy.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Nurse/ Midwifery Manager</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accountable for the management of nursing and midwifery staff and related resources within budget.</td>
<td></td>
</tr>
<tr>
<td>• Establish local controls to avoid and minimise expenditure i.e. rostering, sickness, bank and agency.</td>
<td></td>
</tr>
<tr>
<td>• Ensure Senior Charge Nurses deliver working patterns that are patient focused and clinically and cost effective.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Senior Charge Nurse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implement local controls to avoid and minimise expenditure and live within budget. Examples; rostering, sickness, bank and ward supplies.</td>
<td></td>
</tr>
<tr>
<td>• Roster staff to ensure working patterns are patient centred, clinically and cost effective.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of Partners</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• To work with the relevant functions and departments towards the delivery of cost-effective services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference Documents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standing Financial Instructions</td>
<td></td>
</tr>
<tr>
<td>• Financial procedures on specific subjects</td>
<td></td>
</tr>
<tr>
<td>• UHD “Governance through Leadership Summary Line Accountability Matrix (February 2011)</td>
<td></td>
</tr>
</tbody>
</table>
### 5. Patient Focus and Public Involvement

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Human Resources and Organisational Development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of NHS Board</strong></td>
<td></td>
</tr>
<tr>
<td>• To promote patient focus and public involvement throughout the Board.</td>
<td></td>
</tr>
<tr>
<td>• Ensure systems are in place to monitor compliance with legal requirements and Board policy in relation to Health and Safety (as it relates to patients and the general public) and ensure that corrective action is taken immediately when deficiencies are identified.</td>
<td></td>
</tr>
<tr>
<td><strong>Role of Director of Human Resources and Organisational Development led corporate function</strong></td>
<td></td>
</tr>
<tr>
<td>• Co-ordinate and monitor the Patient Focus and Public Involvement (PFPI) Action Plan for NHS Lothian through the PFPI Management Group</td>
<td></td>
</tr>
<tr>
<td>• Ensuring that effective systems exist throughout the organisation, and the provision of a support function</td>
<td></td>
</tr>
<tr>
<td>• Development of policy, strategies and the work plan</td>
<td></td>
</tr>
<tr>
<td>• Agree common standards for patient and public communications and disseminate throughout the organisation and implement Patient Information Strategy.</td>
<td></td>
</tr>
<tr>
<td>• Co-ordination of the system of organisational learning in relation to patient focus and public involvement</td>
<td></td>
</tr>
<tr>
<td>• Presenting annual report to the Board and updates to the Healthcare Governance Committee</td>
<td></td>
</tr>
<tr>
<td><strong>Role of all operational areas</strong></td>
<td></td>
</tr>
<tr>
<td>• To deliver upon the PFPI Action Plan</td>
<td></td>
</tr>
<tr>
<td>• Responsible for operational response to action plans arising from reviews of patient focus and public involvement activity</td>
<td></td>
</tr>
<tr>
<td>• To follow Board policies and procedures</td>
<td></td>
</tr>
<tr>
<td>• To seek the views of patients, carers and the public on services provided and as a result to improve the care and treatment of patients</td>
<td></td>
</tr>
<tr>
<td>• To involve patients, carers and the public in service redesign and development</td>
<td></td>
</tr>
<tr>
<td>• To take responsibility for the delivery upon patient focus and public involvement standards within its sphere of responsibility</td>
<td></td>
</tr>
<tr>
<td>• To ensure that their commitment to Health and Safety policy compliance extend to patient and public aspects of the role</td>
<td></td>
</tr>
<tr>
<td>• CH (C) Ps to maintain an effective and formal dialogue with their local communities through the local public partnership forum of each CHP/ CHCP.</td>
<td></td>
</tr>
</tbody>
</table>

Continued/
## 5. Patient Focus and Public Involvement

| Role of Partners | Review bodies to independently establish standards, and provide a fair and robust challenge to the Board, and provide an assessment of its performance.  
|                 | Patients, carers and members of the public to contribute to the planning and development of services and provide feedback on their experience of the services. |
| Reference Documents | Section 2B of National Health Service (Scotland) Act 1978  
|                    | Quality Improvement Scotland Clinical Governance & Risk Management Standards  
|                   | National Standards for Community Engagement (Communities Scotland/ Scottish Executive 2005)  
|                 | Involving People, Improving People’s Experience and Care Strategy 2009-13  
|                  | Informing, Engaging and Consulting People in Developing Health and Community Care Services CEL (4) 2010  
|                | Participation Standard for the NHS in Scotland (August 2010)  
|                  | See also Section 8 – Communications |
# 6. Performance Management

| Role of NHS Board | • The Chairman to ensure that board members are provided with accurate, timely and clear information.  
• The Chairman to arrange the regular evaluation of the performance of the Board, its committees and executive & non-executive members.  
• Provide a single focus of accountability for the performance of the local NHS system, including the Local Delivery Plan and delivery against relevant Single Outcome Agreements. |
|---|---|
| Role of Director of Strategic Planning, Performance Reporting & Information | • To establish governance and reporting systems throughout the organisation.  
• To design and implement efficient systems to provide performance information as requested by the Board, its committees and management.  
• To review performance against target and advise of areas requiring corrective action as required.  
• To seek continuous improvement |
| Role of all operational areas | • The Joint Management Team to secure the achievement of performance objectives and targets in relation to service delivery, quality, and financial performance.  
• To deliver Best Value and seek continuous improvement.  
• To review performance against target and take corrective action as required.  
• To provide timely performance information to the Board.  
• To use the Board’s appraisal / PDP systems to ensure optimal performance. |
| Role of Partners | • To work in partnership and seek ways of working to deliver upon established goals and targets.  
• Work with CH (C)Ps in developing plans including alignment with Local Delivery Plan and Single outcome agreement targets. |
| Reference Documents | • *The Good Governance Standard for Public Services*, January 2005  
• UK Code of Corporate Governance, Financial Reporting Council, June 2010  
• NHS Lothian Local Delivery Plan  
• Quality Improvement Scotland Clinical Governance & Risk Management Standards  
• Single Outcome Agreements.  
• NHS Lothian Quality Improvement Strategy 2011-14 |
## 7. Leadership

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Chief Executive</th>
</tr>
</thead>
</table>

### Role of NHS Board

- It is the role of the Chairman to provide leadership to the governance functions of the Board, ensuring effectiveness in all aspects of its role and setting its agenda.
- Leadership of the corporate entity that is NHS Lothian is a shared enterprise between the Chairman, Chief Executive, executive Board members, and other senior colleagues.
- The Chairman will also facilitate the effective contribution of non-executive Board members and ensuring constructive relations between executive and non-executive Board members.
- Establishing and managing links to the Scottish Government.

### Role of members of the Joint Management Team

- The Chief Executive has overall executive responsibility for the effective direction and management of the organisation, and additionally is the Accountable Officer (as set out in the Public Finance and Accountability (Scotland) Act 2000).
- All members of the Joint Management Team are accountable and responsible for the areas under their control, and are to provide leadership to these areas, whilst contributing to the overall programme of work of the Joint Management Team.
- All members of the Joint Management Team are accountable and responsible for implementing the NHS Lothian Quality Improvement Strategy and the Efficiency & Productivity Framework in line with Lothian NHS Board Corporate Objectives and Local Delivery Plan requirements, on a continuous and sustainable basis.
- To provide visible leadership and support to frontline staff encouraging team working and celebrating success.
- To empower frontline staff by devolving management authority and accountability.
- To coordinate joint working with other organisations where appropriate.

Continued /
### 7. Leadership

<table>
<thead>
<tr>
<th>Role of Partners</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support the development of all leaders to ensure they are fully informed on the requirements and contributions of partner organisations</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference Documents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• NHS Lothian Community Health Partnership Scheme of Establishment (Annex 2)</td>
<td></td>
</tr>
<tr>
<td>• UK Code of Corporate Governance, Financial Reporting Council, June 2010</td>
<td></td>
</tr>
<tr>
<td>• HDL (2005) 28 – <em>Delivering the benefits of pay modernisation in NHS Scotland.</em></td>
<td></td>
</tr>
<tr>
<td>• NHS UK Institute for Innovation and Improvement via <a href="http://www.institute.nhs.uk">www.institute.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>• Memorandum to Accountable Officers, Public Finance And Accountability (Scotland) Act 2000.</td>
<td></td>
</tr>
<tr>
<td>• <a href="http://www.nhsscotland.scot">Leadership Qualities Framework NHSS</a></td>
<td></td>
</tr>
<tr>
<td>• NHS Lothian Quality Improvement Strategy 2011-14</td>
<td></td>
</tr>
<tr>
<td>• NHS Lothian Human Resources and Organisational Development Strategy (November 2011- March 2014)</td>
<td></td>
</tr>
</tbody>
</table>
## 8. Communications

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of NHS Board</strong></td>
<td></td>
</tr>
<tr>
<td>• Establishing an open culture that supports effective internal and external communications, and seeking assurance that the communication processes are working effectively.</td>
<td></td>
</tr>
<tr>
<td>• The Chairman, the executive and non-executive Board members have a shared responsibility for ambassadorial communication with external partners, and communication throughout the Board itself.</td>
<td></td>
</tr>
<tr>
<td><strong>Role of Director of Communications led corporate function</strong></td>
<td></td>
</tr>
<tr>
<td>• To develop and implement a Communications Strategy and putting in place communication processes to deliver the executive functions of the Board, and interaction with the organisation's stakeholders</td>
<td></td>
</tr>
<tr>
<td>• To ensure adherence to the Staff Governance Standard, in that all employees are well informed.</td>
<td></td>
</tr>
<tr>
<td>• To provide strategic communications advice to the Board, Joint Management Team and senior personnel.</td>
<td></td>
</tr>
<tr>
<td>• To ensure that all Board members are well-informed and up-to-date of any relevant issues.</td>
<td></td>
</tr>
<tr>
<td>• To manage the reputation of the organisation through proactive and reactive media and stakeholder briefings.</td>
<td></td>
</tr>
<tr>
<td>• To develop and manage the branding of all Board publications.</td>
<td></td>
</tr>
<tr>
<td><strong>Role of all operational areas</strong></td>
<td></td>
</tr>
<tr>
<td>• To ensure that staff receive the Lothian Report (The Team Brief) and have opportunity for feedback and comment.</td>
<td></td>
</tr>
<tr>
<td>• To work with the Communications directorate in responding to media enquiries.</td>
<td></td>
</tr>
<tr>
<td>• To brief the Communications directorate on any significant incidents and of any potential good news stories.</td>
<td></td>
</tr>
<tr>
<td>• To maintain local systems of communication to ensure that all stakeholders are kept informed on a timely basis of any issues pertinent to the effective functioning of the organisation.</td>
<td></td>
</tr>
<tr>
<td><strong>Role of Partners</strong></td>
<td></td>
</tr>
<tr>
<td>• To work in partnership with the Board in support of effective communications.</td>
<td></td>
</tr>
<tr>
<td><strong>Reference Documents</strong></td>
<td></td>
</tr>
<tr>
<td>• NHS Lothian Community Health Partnership Scheme of Establishment (Annex 2)</td>
<td></td>
</tr>
<tr>
<td>• Quality Improvement Scotland Clinical Governance &amp; Risk Management Standards</td>
<td></td>
</tr>
<tr>
<td>• Communications Plans for CHPs (2007/08)</td>
<td></td>
</tr>
<tr>
<td>• NHS Lothian Corporate Communications Strategy (March 2008)</td>
<td></td>
</tr>
<tr>
<td>• See also Section 5 – Patient Focus and Public Involvement</td>
<td></td>
</tr>
</tbody>
</table>
9. Strategy Development (Including Local Delivery Plan)

<table>
<thead>
<tr>
<th>Role of NHS Board</th>
<th>Role of Director of Strategic Planning, Performance Reporting &amp; Information</th>
</tr>
</thead>
</table>
| • Ensure development of strategies and prioritisation of health services for the population in Lothian, including tertiary services.  
• Non-executive members to add value to strategy development through the provision of strategic challenge and scrutiny to executive proposals.  
• To develop strategies in liaison with regional and local partners, outlining necessary steps for progress against strategies and required outcomes outlined in the Local Delivery Plan and equivalent documents such as Single Outcome Agreements.  
• To collaborate with other Boards in the interests of the improvement of health of the wider population of Scotland. | • Overarching coordination and development of the Board’s service strategy, including formation of the 5 year plan, Planning for the Future, Local Delivery Plan, performance monitoring of corporate and HEAT targets and fit with the NHS in Lothian Planning cycle and the work of the Planning Group.  
• Inform, consult and engage the public on strategies as required.  
• Directing which services are required to meet assessed health need |

<table>
<thead>
<tr>
<th>Role of all operational areas</th>
<th>Role of Partners</th>
</tr>
</thead>
</table>
| • Be involved in development of strategy.  
• Empower staff to contribute.  
• Ensure where appropriate that strategies are implemented  
• Maintain an effective and formal dialogue with their local communities through the public partnership fora, so that there is wider public involvement in planning and decision-making | • Contribute to development of strategies.  
• Working in conjunction with the Board to develop and implement joined up solutions.  
• Patients, carers and members of the public to contribute to the planning and development of NHS Lothian services and strategies. |

<table>
<thead>
<tr>
<th>Reference Documents</th>
<th></th>
</tr>
</thead>
</table>
| • NHS Lothian Community Health Partnership Scheme of Establishment  
• NHS Reform (Scotland) Act 2004 (Part 1, Section 7)  
• HDL 2002 (42) Consultation and Public Involvement in Service Change (21 May 2002)  
• HDL 2004 (46) – Regional Planning.  
• HDL 2006 (12) – Delivering for Health.  
• National Standards for Community Engagement (Communities Scotland/ Scottish Executive 2005) |
## 10. Health Improvement & Screening Programmes

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Public Health and Health Policy</th>
</tr>
</thead>
</table>
| Role of NHS Board                    | • To protect and improve the health of the people of Lothian.  
|                                      |   To establish system-wide health priorities in context of national priorities.  
|                                      | • To participate in national screening programmes, and instigate local programmes as required. |
| Role of Director of Public Health & Health Policy led corporate function | The Director of Public Health & Health Policy has a broad remit that is not confined to what is described in this section on “Health Improvement”. This Director has an independent advisory and advocacy role designed to enable the Board to deliver its duty to improve health under the Health Acts. The discharge of this remit covers all aspects of the Board’s activities. With respect to Health Improvement, the Director of Public Health and Health Policy, as lead officer is responsible for:  
|                                      | • Leading the delivery of targeted and measurable action leading to tangible outcomes and demonstrable reduction in health inequalities;  
|                                      | • Horizon scanning, assuring the direction and implementation of health policy and healthy public policy;  
|                                      | • Surveillance and analysis of the health of the population to monitor, investigate and recommend interventions to reduce the risks to health and burden of disease faced by current and future populations.  
|                                      | • Setting the strategic framework for improving health and reducing health inequalities, and monitoring delivery against agreed priorities and targets;  
|                                      | • Developing and promoting health impact assessment (including tools to assess equality and diversity) as part of policy making at all levels;  
|                                      | • To apply Equality and Diversity Impact Assessments (EDIA) to all future strategies, service plans and policies.  
|                                      | • Ensuring that needs and successful initiatives at neighbourhood and operational levels are fed into strategies and priorities at NHS Board level for inclusion in mainstream services;  
|                                      | • Facilitating the sharing of evidence, expertise and best practice;  
|                                      | • Ensuring a programme of professional development for staff working in new roles and/or new environments;  
|                                      | • Overseeing investments in health improvement programmes, and offering advice on funding from other potential sources;  
|                                      | • Assuring the delivery of health services that contribute to reductions in health inequalities;  
|                                      | • Assuring the quality of the health inequalities evaluation programme;  
|                                      | • Advocating for the needs of disadvantaged or under-served groups;  
|                                      | • Ensuring that the Board participates in the development of the research and development agenda for health improvements and health inequalities;  
|                                      | • Developing multi-agency relationships to address wider determinants of health. |
### 10. Health Improvement & Screening Programmes

#### Role of all operational areas

- Contribute to the development and implementation of Joint Health Improvement Plans with local authority partners through the community planning framework.
- Identify the health needs of their local populations and develop programmes to address those needs.

As part of their core objectives:

- take action to reduce health inequalities
- prioritise health improvement
- plan for health improvement
- strengthen partnership working
- build capacity and resources for health improvement
- integrate improving health activity across all functions/services.

- To apply Equality and Diversity Impact Assessments (EDIA) to all future service plans and policies.
- To deliver and plan its services informed by the outcomes of work from this area.

#### Screening Programmes (all parts of NHS Lothian)

The Director of Public Health & Health Policy shall:

- Plan and coordinate screening programmes throughout Lothian to meet national standards.
- Provide resource including designated coordinator.
- Agree local screening policy.
- Implement changes in line with national policy.
- Monitor activity and quality.

All other relevant operational areas shall:

- Be accountable for delivery of screening programmes in line with national and local policy to meet agreed standards, and ensure staff are appropriately trained.
- Provide agreed monitoring data from screening.
- Participate in screening coordination groups
- Primary and community services to lead on the delivery of relevant aspects of screening of children

#### Role of Partners

- To work with the Board to tackle the causes of poor health and health inequalities.
10. Health Improvement & Screening Programmes

<table>
<thead>
<tr>
<th>Reference Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Addressing Health Inequalities in Lothian (Board paper, 25 January 2006)</td>
</tr>
<tr>
<td>• See also Section 6 “Performance Management”</td>
</tr>
</tbody>
</table>

The role of the Director Public Health and Health Policy is governed by several Acts of Parliament\(^1,2,3\), a number of international health regulations\(^4\) and is directed further by Scottish Government Strategies such as Equally Well\(^5\), its anti-poverty strategy\(^6\) and Policies such as those for cancer screening \(^7,8\), amongst others.


### 11. Regional Planning and Managed Clinical Networks

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Strategic Planning, Performance Reporting &amp; Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of NHS Board</strong></td>
<td>Through the processes of strategic planning and service re-design, to provide services to individuals and communities in a manner that is fit for purpose.</td>
</tr>
<tr>
<td></td>
<td>To participate in regional planning with other boards in accordance with SGHD guidance.</td>
</tr>
<tr>
<td></td>
<td>To deliver upon the statutory duty to co-operate with other Boards.</td>
</tr>
<tr>
<td></td>
<td>To delegate authority to the Chief Executive to act on its behalf at the Regional Planning Group (SEAT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of Director of Strategic Planning, Performance Reporting &amp; Information led corporate function</th>
<th>To provide professional support to SEAT as and when required.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To present SEAT material to the Board for approval as required by the SEAT Framework of Governance.</td>
</tr>
<tr>
<td></td>
<td>To ensure that the Board is kept informed of any SEAT issues and developments.</td>
</tr>
<tr>
<td></td>
<td>To provide leadership and guidance to Lothian Managed Clinical Networks.</td>
</tr>
<tr>
<td></td>
<td>To lead specific projects on behalf of SEAT.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of all operational areas</th>
<th>To participate in the agreed SEAT Work Plan and Framework of Priorities and Investments.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To link into Regional and Local Workforce Planning</td>
</tr>
<tr>
<td></td>
<td>To be formal members of relevant Managed Clinical Networks (MCNs).</td>
</tr>
<tr>
<td></td>
<td>To potentially host MCNs in the future on behalf of the Board or SEAT.</td>
</tr>
<tr>
<td></td>
<td>To appoint a lead (as appropriate) for every MCN on a sessional basis.</td>
</tr>
<tr>
<td></td>
<td>To participate in the agreed SEAT Work Plan and Framework of Priorities and Investments.</td>
</tr>
<tr>
<td></td>
<td>To link into Regional and Local Workforce Planning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of Partners</th>
<th>To participate in regional planning with other boards in accordance with SGHD guidance.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reference Documents</th>
<th>HDL (2004) 46, Regional Planning Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SEAT Framework of Governance (approved by Board on 22 November 2006)</td>
</tr>
<tr>
<td></td>
<td>NHS Lothian Community Health Partnership Scheme of Establishment</td>
</tr>
<tr>
<td></td>
<td>HDL (2007) 21 – Strengthening the Role of Managed Clinical Networks</td>
</tr>
<tr>
<td></td>
<td>See also Section 12 – Service Re-design.</td>
</tr>
<tr>
<td>12. Service Redesign</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Responsible Director for this Section</strong></td>
<td><strong>Director of Strategic Planning, Performance Reporting &amp; Information</strong></td>
</tr>
</tbody>
</table>
| Role of NHS Board | • To assess patients needs in the medium to long term, and then to consider how services are provided and organisations structured.  
• To establish appropriate governance arrangements for service re-design. |
| Role of Director of Strategic Planning, Performance Reporting & Information led corporate function | • To lead on service re-design in accordance with agreed strategy, and in line with other relevant strategies e.g. Workforce and Estates.  
• To ensure services are redesigned in recognition of national and regional planning priorities and the identified needs of the local population, and to co-operate with other boards in taking this forward.  
• To provide strategic direction for service modernisation and to ensure deliverability of redesign activities in line with achievement of system-wide responsibilities and targets.  
• To manage strategically the pay modernisation “toolkit” and service improvement “toolkit” to help deliver service change. |
| Role of all operational areas | • To develop and implement a programme of re-design within the context of agreed strategy.  
• Leading the re-design of the delivery of individual clinical services within its scope of operations and in accordance with the Five Year Plan.  
• Take responsibility for specified capital projects  
• Influence/involvement through representation on relevant committees and groups  
• Create capacity to deliver services more innovatively and effectively  
• Support the integration of primary and specialist services.  
• Initiate service redesign proposals/ Contribute to Change and Innovation Plan  
• Implement programme of service redesign  
• Take forward integration of health services, underpinned by service redesign  
• Lead on local service redesign  
• Improve access to health services  
• Take responsibility for specified capital projects  
• Leading the re-design of the delivery of individual clinical services within its scope of operations. |
<p>| Role of Partners | • Partners to support service redesign through active participation for example through the work around Shifting the Balance of Care and the Integrated Resource Framework, and opportunities for greater integration of care. |</p>
<table>
<thead>
<tr>
<th>Reference Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian Community Health Partnership Scheme of Establishment</td>
</tr>
<tr>
<td>HDL (2005) 28 – <em>Delivering the benefits of pay modernisation in NHS Scotland.</em></td>
</tr>
<tr>
<td><em>Improving Care, Investing in Change Programme Initial Agreement</em></td>
</tr>
<tr>
<td>HDL (2007) 21 – Strengthening the Role of Managed Clinical Networks</td>
</tr>
<tr>
<td>See also Section 11 – Regional Planning and Managed Clinical Networks.</td>
</tr>
</tbody>
</table>
## 13. Shared Services

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Human Resources &amp; Organisational Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of NHS Board</td>
<td>To participate in the national shared services agenda, and to cooperate with other public bodies and agencies.</td>
</tr>
</tbody>
</table>
| Role of Director of Human Resources & Organisational Development led corporate function | • To develop a framework for shared services and how they will interface with core clinical services.  
• To develop a delivery culture.  
• Agree accountability arrangements and standards of practice.  
• Ensure equity of access.  
• To ensure that the Board achieves efficiencies as a result of the investment in shared services.  
• To foster relationships with other public sector organisations, with a view to the development of shared services and other collaborative working arrangements.  
• To lead the examination of options for collaborative working arrangements with other public sector organisations, and implement any approved projects.  
• To keep staff comprehensively appraised of developments and any changes in a timely manner.  
• To implement the Organisational Change policy. |
| Role of all operational areas.       | To contribute towards the detailed planning of shared services systems, and ensure that all operational factors have been considered.  
• To keep staff comprehensively appraised of developments and any changes in a timely manner.  
• To align its structures and systems with the resultant shared services model. |
| Role of Partners                     | Participate in development of common systems and harmonisation arrangements as appropriate |
| Reference Documents                  | Building A Better Scotland (November 2004)  
A Shared Approach to Building a Better Scotland (May 2006)  
Better Health, Better Care (August 2007) |
## 14. Joint Working

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Strategic Planning, Performance Reporting &amp; Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of NHS Board</td>
<td>Ensure effective joint working with local authority and other partner agencies in providing health and social care services.</td>
</tr>
</tbody>
</table>
| Role of Director of Strategic Planning, Performance Reporting & Information led corporate function, in conjunction with the Director of Health & Social Care, CHCP Director, and CHP General Manager (East & Midlothian) | • Establish governance arrangements and framework for effective joint working with local authorities and other partners.  
• Monitor effectiveness of joint working through the performance management system, including the Local Delivery Plan, Single Outcome Agreements and change fund plans. |
| Role of all operational areas        | • Work with all partners to develop plans and joint performance/outcome targets (e.g. Single Outcome Agreements) that support the delivery of national and local strategic priorities, and improve the health of local communities.  
• Deliver services that are in line with agreed plans and performance requirements.  
• Harmonise systems and working practices that require the input of different organisations, for the benefit of the patient/recipient of the services. |
| Role of Partners                     | • Work in partnership to deliver on the Single Outcome Agreements. |
| Reference Documents                  | • NHS Lothian Scheme of Delegation Framework *(February 2004)*  
• NHS Lothian Community Health Partnership Scheme of Establishment  
• 4 Local Partnership Agreements *(April 2004)* extended.  
• Single Outcome Agreements.  
• NHS Lothian Local Delivery Plan  
• West Lothian CHCP Framework of Governance  
• CH(C) P Sub-Committee Standing Orders |
## 15. Business Continuity Planning

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Strategic Planning, Performance Reporting &amp; Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of NHS Board</td>
<td>To be assured that the Board complies with its responsibilities under the Civil Contingencies Act 2004 as a category 1 responder, and that its services and functions can be maintained in the event of any of our resources (e.g. facilities, employees, supplies) ceasing to be available.</td>
</tr>
</tbody>
</table>
| Role of Director of Strategic Planning, Performance Reporting & Information led corporate function | • To provide a common methodology to be applied at a Strategic and Tactical level when the Board is presented with a disruptive incident to business  
• To enable the Board to plan and deliver services in a controlled manner where business continuity risks are effectively identified and assessed  
• To ensure that appropriate controls and responses are in place, and contingency plans have been developed for when normal services become compromised for whatever reason  
• To be responsible for the development of policies and structures at corporate and tactical levels and the development and implementation of Business Continuity Plans and process for all services.  
• With the support of local staff, develop and maintain a business continuity focus for the organisation that will include ensuring the ongoing review of plans, training, and exercising and communication requirements.  
• Link local Business Continuity work with corporate goals and promote a Business Continuity aware culture.  
• Establish and support Business Continuity frameworks throughout the Board and with other Health Boards and partner organisations  
• Ensure the alignment of the activities of the Board with those of partner organisations, in support of efficient, effective and equitable delivery of health and social care services to the people of Lothian. |

Continued/
## 15. Business Continuity Planning (continued)

<table>
<thead>
<tr>
<th>Role of all operational areas</th>
<th>To provide a recognised Business Continuity co-ordinator for their area of business to co-ordinate, deliver and maintain Operational and Tactical level plans for their area of business and where necessary include these responsibilities in Job descriptions and appraisals.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To organise and deliver post specific training to test plans, processes and procedures which are in place.</td>
</tr>
<tr>
<td></td>
<td>Adhere to Change Management Control procedures to maintain Business Continuity Plans for their area of business.</td>
</tr>
<tr>
<td></td>
<td>To test the adequacy and effectiveness of local Business Continuity Plans, and ensure that lessons are learnt for the benefit of business continuity should a disruptive event materialise.</td>
</tr>
<tr>
<td></td>
<td>To participate in NHS Lothian Strategy Business Continuity Group meetings.</td>
</tr>
</tbody>
</table>

| Role of Partners | To link NHS Lothian Business Continuity Planning with other Health Boards and Partner organisations, in line with “Preparing Scotland’s” promotion of Scottish resilience. The focus is on enhanced preparation, response and recovery from disruptive challenges with effective partnership working from local communities to UK Government. |

<table>
<thead>
<tr>
<th>Reference Documents</th>
<th>Civil Contingency Act 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preparing Scotland</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.scotland.gov.uk/Publications/2007/06/12094636/0">http://www.scotland.gov.uk/Publications/2007/06/12094636/0</a></td>
</tr>
<tr>
<td></td>
<td>BS 25999</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.bsonline.bsi-global.com/">http://www.bsonline.bsi-global.com/</a></td>
</tr>
<tr>
<td></td>
<td>NHS Lothian Major Incident Strategic Response Plan (May 2010)</td>
</tr>
<tr>
<td></td>
<td>NHS Lothian Tactical and Operational Plans by Directorate</td>
</tr>
<tr>
<td></td>
<td>Business Continuity Management Intranet Page</td>
</tr>
</tbody>
</table>
### 16. Emergency Planning

<table>
<thead>
<tr>
<th>Role of NHS Board</th>
<th>Role of Director of Public Health &amp; Health Policy led corporate function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible Director for this Section</strong></td>
<td><strong>Ensure that the Board has arrangements in place to effectively respond to any emergencies and major incidents.</strong></td>
</tr>
<tr>
<td><strong>Director of Public Health &amp; Health Policy</strong></td>
<td><strong>To ensure that the Board has plans as required under the Civil Contingency Act (2004), as a Category 1 responder, to deal with any emergencies that may affect maintaining the normal activity of the service.</strong></td>
</tr>
<tr>
<td><strong>Role of Director of Public Health &amp; Health Policy</strong></td>
<td><strong>To integrate planning and management of major incidents into the planning and management of every service.</strong></td>
</tr>
<tr>
<td><strong>led corporate function</strong></td>
<td><strong>To develop a system for responding to a major incident and ensuring that essential healthcare needs are met effectively when normal services become overloaded, restricted or non-operational for whatever reason.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>To attend Lothian and Borders Strategic Co-coordinating Group (SCG) meetings for emergency planning and management of major incidents and emergencies.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>To ensure appropriate liaison between the Joint Management Team, other NHS boards, Lothian and Borders SCG and the Scottish Government as part of management of major incidents and emergencies.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>To ensure a co-ordinated delivery of a single integrated response to a major incident from the outset.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>To ensure collaboration and co-operation with other local responders in planning, training and exercising plans; assessing community risk and responding to major incidents.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Assess the risk of emergencies and major incidents occurring.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>To enter into mutual aid arrangement with other boards to provide reciprocal support for major incidents whose impacts may prove to be beyond the resources of the Board, either due to the scale and complexity or because of the healthcare services required.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>To ensure rapid, accurate and reliable transmission of information, to all relevant parties, that is essential for effective co-ordination and control of major incidents.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>To ensure effective communication with the public in the event of a major incidents.</strong></td>
</tr>
</tbody>
</table>

Continued/
### 16. Emergency Planning (continued)

| Role of all operational areas | • To develop and exercise emergency plans.  
|                              | • To train and maintain a major incident response teams.  
|                              | • To develop and maintain a lockdown plan for hospitals  
|                              | • To ensure that there are mutual aid arrangements with each other and with other hospitals in other boards areas for major incidents whose impacts may exceed their resources.  
|                              | • To participate in emergency planning exercises.  
|                              | • To participate in Emergency Planning Strategic Advisory Group Meetings.  

| Role of Partners | • Co-operate with the Board.  
|                 | • Share information with the Board.  

| Reference Documents | • Office of Public Sector Information. The Civil Contingencies Act. 2004 and the Contingency Planning (Scotland) Regulations 2005  
|                    | http://www.opsi.gov.uk/legislation/scotland/about.htm  
|                    | http://www.scotland.gov.uk/Publications/2003/01/16243/17308  
|                    | • Scottish Government. Preparing Scotland: Scottish Guidance on Preparing for Emergencies. 2007,  
|                    | • Lothian and Borders Emergency Planning Strategic Co-ordinating Group Generic Response Plan  
|                    | • NHS Lothian Major Incident Strategic Response Plan (May 2010).  
|                    | • Emergency Planning intranet page  


### 17. Provision of Healthcare Services

<table>
<thead>
<tr>
<th>Responsible Directors for this Section</th>
<th>Chief Executive, Nurse Director, Medical Director, Directors of Health &amp; Social Care, General Manager (East &amp; Midlothian CHPs)</th>
</tr>
</thead>
</table>
| Role of NHS Board                      | - The discharge of all governance requirements for the whole of Lothian NHS Board, with the executive board members leading the performance management of the entire organisation towards the delivery of Best Value (including meeting Scottish Government and statutory targets, and the attainment of accreditation on quality standards).  
- To ensure the effective operation of Managed Clinical Networks, both in terms of local MCNs and those undertaken on a regional or national basis. |
| Role of members of the Joint Management Team | - Strategic decision-making.  
- Ensuring the provision of services is in line with national and local priorities.  
- Securing and influencing funding with SGHD.  
- Establish rules for intervention when exception reporting indicates need.  
- To provide the professional lead in corporate functions. |
| Role of operational areas              | - Responsible for acute specialist services delivered from WGH, St John's Hospital, Royal Infirmary of Edinburgh and Royal Hospital for Sick Children, Royal Victoria Hospital, Liberton Hospital, Princess Alexandra Eye Pavilion, Lauriston Building, as well as from a range of outpatient and community facilities.  
- The Royal Edinburgh Hospital provides acute adult psychiatric and mental health services, including treatment for learning disabilities and dementia. Its specialist services include centres for the treatment of eating disorders, alcohol problems and young people's mental health.  
- Ensure service provision according to overarching strategy.  
- Accountable for the operational delivery of services based on patient need and resource availability.  
- The development of business cases to support service changes.  
- Meet local and national targets.  
- Ensure provision of those services locally which it is the duty of the NHS Board to provide or secure provision of.  
- Responsibility to exercise strong management control of local services in order to maximise integration of primary and secondary care.  
- To manage the implementation of independent family health service contracts.  
- To ensure the delivery of the Lothian Unscheduled Care Service (GP Out-of-Hours). |

Continued /
### 17. Provision of Healthcare Services

| Role of Partners | • Work with the Board to improve health of local communities  
|                  | • Contribute to planning processes  
|                  | • Effective involvement from public/patient/ carer/community groups.  
|                  | • Accountable for the operational delivery of services within their area of responsibility  
|                  | • Provide feedback for service providers on patient / public experience  
|                  | • Support education of service users  
| Reference Documents | • NHS Lothian Community Health Partnership Scheme of Establishment  
|                     | • NHS Lothian website.  
|                     | • MEL (1999) 10 – Introduction of Managed Clinical Networks  
|                     | • HDL (2007) 21 – Strengthening the Role of Managed Clinical Networks  
|                     | • Local Delivery Plan  
|                     | • A Sense of Belonging: a joint strategy for the mental health and wellbeing of Lothian’s Population 2011-16.  

## 18. Complaints Handling

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Human Resources and Organisational Development</th>
</tr>
</thead>
</table>

### Role of NHS Board
- To ensure complaints are dealt with quickly and effectively.
- To receive quarterly reports at Board meetings with regards to complaints management performance.
- To receive assurance that changes to working practices are made as a consequence of lessons learned from complaints.

### Role of Director of Communications led corporate function
- Take responsibility for delivering the Board’s patient feedback and complaints processes, and ensure that all necessary organisational learning takes place (including lessons learned from the work of the Scottish Public Services Ombudsman).
- To implement the national complaints procedure, “Can I Help You?”
- To incorporate certain information on complaints within the Board’s annual report.
- To prepare quarterly reports at Board meetings with regards to complaints management performance.
- To establish mechanisms to ensure learning from all complaints can be shared across throughout the organisation.

### Role of operational areas.
- To implement the Board’s Complaints Management policy and establish procedures for all aspects of complaints management.
- To appoint Complaints Officers with sufficient seniority to deal with any complaints quickly and effectively.
- Directors of Operations, CHP General Managers, and the Head of Health (West Lothian) to be signatories to complaints letters.
- To ensure that all staff are appropriately trained and equipped to resolve issues at direct care level appropriately.
- Complaints officers to develop ways to encourage patient feedback, and manage the operation of the complaints procedure within statutory direction.
- To ensure there is appropriate action taken and improvements made to services as a result of the learning from complaints.
- To provide any required support to staff who are involved in the complaints process.

### Role of Partners
- To provide independent support for complainants.
- To agree a level of service with NHS Lothian Board that will satisfy the above objective and be consistent with the national complaints procedure.
- To ensure there is appropriate action taken and improvements made to services as a result of the learning from complaints.

### Reference Documents
- NHS Lothian Complaints Management Policy: Investigating and Responding to a Complaint – Guidance for all Staff (June 2011)
- Staff Support and Confidential Counselling Service (see intranet)
## 19. Healthcare Associated Infection

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Director of Public Health &amp; Health Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of NHS Board</strong></td>
<td></td>
</tr>
<tr>
<td>• To ensure that the NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection (HAI) and any other guidance / instructions are being adhered to throughout NHS Lothian.</td>
<td></td>
</tr>
<tr>
<td>• To provide assurance and information to the public that will:</td>
<td></td>
</tr>
<tr>
<td>1. Inform, and reassure public confidence that healthcare services within the hospital and community are as safe and effective as practicable;</td>
<td></td>
</tr>
<tr>
<td>2. Raise awareness, knowledge and involvement of their expected roles and responsibilities in limiting the spread of infection;</td>
<td></td>
</tr>
<tr>
<td>3. Enable them to make informed choices about care and treatment.</td>
<td></td>
</tr>
<tr>
<td><strong>Role of Director of Public Health &amp; Health Policy led corporate function</strong></td>
<td></td>
</tr>
<tr>
<td>• To provide the Board with regular reports on progress and actions to reduce Healthcare Associated Infection.</td>
<td></td>
</tr>
<tr>
<td>• To provide Healthcare Workers with details of their roles and responsibilities in preventing and minimising the risk of transfer of micro-organisms and blood borne pathogens from both recognised and unrecognised sources of infection.</td>
<td></td>
</tr>
<tr>
<td>• To ensure there is a framework of policies and systems in control of infection to enable NHS Lothian to satisfy the HAI Inspectorate and meet the QIS Standard on Healthcare Associated Infection.</td>
<td></td>
</tr>
<tr>
<td>• To ensure that the Quality Improvement Teams within NHS Lothian are aware of the requirement to implement HAI related policies and procedures, and monitor the same.</td>
<td></td>
</tr>
<tr>
<td>• To develop best practice as informed by evidence and expert advice.</td>
<td></td>
</tr>
<tr>
<td>• To develop and assure surveillance systems</td>
<td></td>
</tr>
<tr>
<td>• To be assured as to the implementation of HAI policies and procedures throughout NHS Lothian and independent contractors.</td>
<td></td>
</tr>
<tr>
<td><strong>Role of Partners</strong></td>
<td></td>
</tr>
<tr>
<td>• To ensure public / patient representation at appropriate committees.</td>
<td></td>
</tr>
<tr>
<td>• To contribute to the development of patient focussed information.</td>
<td></td>
</tr>
<tr>
<td>• To raise and represent public concerns in relation to HAI.</td>
<td></td>
</tr>
<tr>
<td>To support the development of systems to reassure public and patient confidence on actions taken by NHS Lothian to minimise and manage the risk of HAI.</td>
<td></td>
</tr>
</tbody>
</table>

Continued/
### 19. Healthcare Associated Infection (continued)

<table>
<thead>
<tr>
<th>Role of operational areas</th>
<th>Healthcare Workers (HCWs):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All HCWs must:</strong></td>
<td>• Comply with Infection Control policies and guidance including Standard Precautions.</td>
</tr>
<tr>
<td></td>
<td>• Prior to undertaking any procedure consider if there is any possible risk from infection or exposure to body fluids and wear appropriate personal protective clothing to prevent such contamination.</td>
</tr>
<tr>
<td></td>
<td>• Ensure the Infection Control team is informed of any outbreaks or HAI related incidents.</td>
</tr>
<tr>
<td></td>
<td>• Report, using the Incident Reporting System, if there is personal contamination with blood, body fluid or faeces.</td>
</tr>
<tr>
<td></td>
<td>• Where appropriate contribute to the prevention of HAI through surveillance and root cause analysis.</td>
</tr>
<tr>
<td><strong>Managers:</strong></td>
<td>• Ensure HCW compliance with the Infection Control policy.</td>
</tr>
<tr>
<td></td>
<td>• Undertake a risk assessment of the potential blood and body fluid contamination to HCWs from procedures or incidents in their area.</td>
</tr>
<tr>
<td></td>
<td>• Ensure HCWs under their supervision are aware of, and have access to, this policy.</td>
</tr>
<tr>
<td></td>
<td>• Ensure HCWs have access to personal protective clothing to prevent exposure.</td>
</tr>
<tr>
<td></td>
<td>• Ensure compliance with HAI audits and completion of any remedial action required to improve standards.</td>
</tr>
<tr>
<td></td>
<td>• Ensure HAI is included in Personal Development Plans for all staff.</td>
</tr>
<tr>
<td></td>
<td>• To provide guidance to staff on an individual case basis where staff screening is being considered as part of an HAI incident management investigation.</td>
</tr>
<tr>
<td></td>
<td>• To ensure any HAI investigation is focused on service improvement and not blame culture.</td>
</tr>
<tr>
<td><strong>Infection Prevention and Control Teams (IPCTs):</strong></td>
<td>• Act as resource for information and support.</td>
</tr>
<tr>
<td></td>
<td>• Provide education opportunities on the Infection Control policies and guidelines.</td>
</tr>
<tr>
<td></td>
<td>• Monitor the implementation of the Standard Precautions Policy in the clinical settings.</td>
</tr>
<tr>
<td></td>
<td>• Assist managers to audit the implementation of the policy.</td>
</tr>
<tr>
<td></td>
<td>• Regularly review and update the policy.</td>
</tr>
<tr>
<td><strong>Health &amp; Safety, Occupational Health:</strong></td>
<td>• Perform pre-employment health screening, particularly relevant for exposure prone procedures.</td>
</tr>
<tr>
<td></td>
<td>• Act as a resource for information and support.</td>
</tr>
<tr>
<td></td>
<td>• Consult with managers, supervisors, ICTs and HCWs regarding personal protective equipment.</td>
</tr>
<tr>
<td></td>
<td>• Analyse and evaluate data from occupational exposures to provide data to feedback to HCWs and managers on personal exposure injuries.</td>
</tr>
</tbody>
</table>
## 19. Healthcare Associated Infection (continued)

<table>
<thead>
<tr>
<th>Reference Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NHS Quality Improvement Scotland, <em>Standards March 08 Healthcare Associated Infection</em></td>
</tr>
<tr>
<td>• Infection Control Manual – see Infection Control intranet page.</td>
</tr>
<tr>
<td>• Recruitment Guidance pack – see Human Resources/Recruitment and Personnel Services website.</td>
</tr>
</tbody>
</table>
# 20. Incident Management

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>Medical Director.</th>
</tr>
</thead>
</table>

## Role of NHS Board
- To foster a culture of openness, learning and support in relation to the reporting of and response to incidents.
- To ensure that effective systems of critical incident reporting and escalation procedures are in place and working. This function is delegated to the Healthcare Governance Committee.

## Role of Medical Director
- Ensure there is an adequate system of incident management to support the delivery of the QIS Standard on Healthcare Governance and Risk Management.

## Role of operational areas.
- The management of incidents and consequences needs to remain within the current line management structure to ensure the appropriate management and change. The Lead Directors are defined as the Medical Director, Nurse Director and CH(C)P General Managers in Primary Care, and they are responsible for Incident Management, including family liaison, and will be supported professionally by medical or nursing colleagues at local or board level as appropriate.
  - To efficiently capture all incidents as defined by the Board’s procedures.
  - To analyse and interpret the reports of incidents as described in the Incident Management Policy and Operational Procedure, and identify any trends.
  - To identify any learning points and effect remedial action to avoid a recurrence of the incident.

## Role of Partners
- To share statistical information and lessons learned to support future benchmarking exercises and organisational learning.

## Reference Documents
- NHS Lothian Incident Management Policy
- NHS Lothian Incident Management Operational Procedure
## 21. Child Protection Services

<table>
<thead>
<tr>
<th>Responsible Board Member for this Section</th>
<th>Nurse Director</th>
</tr>
</thead>
</table>
| **Role of NHS Board** | - To provide strategic leadership on child protection issues.  
- Participate in Edinburgh, Lothian and Borders Executive Group  
- Ensure Child Protection Services are appropriately resourced and are working effectively |
| **Role of Nurse Director led corporate function** | - Ensure policies are developed and rolled out across Lothian  
- Ensure appropriate training is available for all staff  
- Ensure that recruitment of staff has a robust system to do both enhanced and non-enhanced checks  
- Provide assurance to the Board via the Healthcare Governance Committee of the quality and effectiveness of Child Protection Services through regular reports and audits |
| **Role of operational areas** | - Ensure policies are implemented and embedded  
- Ensure staff have appropriate training and are released to participate  
- Participate in staff screening  
- Participate in audit mechanisms to provide assurance of the quality and effectiveness of Child Protection Services  
- Be a significant influence in planning and resource allocation  
- Deliver specified child protection services  
- Integrate community child health services  
- Lead on implementation/monitoring of child health surveillance |
| **Role of Partners** | - Work jointly with NHS and other partners at both the operational and strategic level, including implementing "For Scotland’s Children"  
- Fulfil statutory duties  
- Operate in accordance with agreed principles and procedures. |
| **Reference Documents** | - Edinburgh and Lothian Child Protection Guidelines Health and Interagency (June 2007)  
- Child Protection intranet page for wide range of material on this subject. |
## 22. Primary Care Contracting

<table>
<thead>
<tr>
<th>Responsible Director for this Section</th>
<th>General Manager (East &amp; Midlothian CHPs)</th>
</tr>
</thead>
</table>
| Role of NHS Board                    | Hold contracts for independent contractor services, and ensure that they are managed in accordance with the relevant statutory regulations.  
Ensure that all payments to contractors are made in accordance with the Standing Financial Instructions. |
| Role of General Manager led corporate functions | Accountable for ensuring adequate governance arrangements are in place for the Primary Care Contracting Organisation (PCCO) and the Primary Care Joint Management Group, and that these fit into the overall system of corporate governance in NHS Lothian.  
Devolved management and decision-making of all aspects of the PCCO functions on behalf of the budget holders and ultimately the Board.  
To ensure that the PCCO is provided with the necessary clinical leadership and advice so as to allow it to operate effectively. |
| Role of the Primary Care Contracting Organisation | To provide strategic leadership within NHS Lothian on all aspects of Primary Care Modernisation, by proactively developing, implementing and managing strategies that respond to the strategic changes in primary care services, in line with Delivering for Health.  
To lead and manage the development of contracts with Independent Contractors (General Medical Practitioners, General Dental Practitioners, Pharmacists, Optometrists) in conjunction with and on behalf of budget holders, working within the broad strategic framework in the context of corporate working, Local Delivery Plan, and Primary Care Modernisation Strategy.  
Devolved management and decision-making of independent contractor service contracts (on behalf of the Board) for pharmacists, dentists, opticians, GPs, GPs working under Section 17 (GMS), Section 17 C (former PMS), and Section 2C (Direct Provision arrangements) to ensure services are provided in an interactive and complementary manner for the benefit of the local community. This will include the interpretation and application of national regulations for primary care contracting.  
To manage all matters relating to discipline as it relates to primary care contractors, including liaison with the Board’s Reference Committee and the Board’s Discipline Committee. The PCCO will be empowered to conclude disciplinary matters in accordance with agreed documented procedures.  
To provide regular reports to the Primary Care Joint Management Group on PCCO performance and matters requiring their approval or referral to other Board Committees.  
To agree with other stakeholders within NHS Lothian their requirements of the PCCO. |
### 22. Primary Care Contracting (Continued)

| Role of operational areas (other than the PCCO) | • To incorporate independent contractors and their staff within an overall local ‘corporate identity’ through shared training, education and communication and staff partnership arrangements.  
• To be responsible and accountable for the expenditure incurred in primary care contracting which is managed by the PCCO.  
• To participate as members of the Primary Care Joint Management Group, and ensure that PCCO activities are consistent with other Board strategies and initiatives.  
• To set the strategic direction for independent contract negotiations and be involved in both commissioning and delivering effective systems of governance of the independent contracts.  
• To provide any material required by the Board’s Committees to allow them to discharge their governance responsibilities.  
• To contribute to the development of the systems of control in PCCO, and participate in their application as required. |
| Role of Partners | • Independent contractors to actively contribute to the development of services.  
• To comply with national terms and conditions. |
| Reference Documents | • CEL 24 (2011): Payment Verification Procedures (October 2011)  
• CEL 16 (2012): Revised Payment Verification Protocol – Primary Medical Services (May 2012)  
• Terms of reference for the Primary Care Joint Management Group (July 2009) |
## 23. Approval of Items to be included in the NHS Lothian Capital Programme – Funding of Initial Development of Concept

<table>
<thead>
<tr>
<th>What does this section cover?</th>
<th>This concerns the development of any concept or scheme for inclusion in the capital plan up to the approval of the Initial Agreement (where required – See Section 24).</th>
</tr>
</thead>
</table>
| Which budget holders’ are likely to incur revenue expenditure developing a future capital scheme? | • Director of Capital Planning & Projects  
• Director of Facilities  
• Associate Director of Facilities  
• Director of Ehealth  
• The lead service director / manager for the area that will be the beneficiary of the capital scheme.  
• The project sponsor (per the Scottish Capital Investment Manual) of major capital projects |
| Delegated authority of budget holder. | The budget holder is only limited by his or her available budget and his or her individual delegated authority (see **Section 29**).  

The budget holder must observe the principles within this Scheme of Delegation, namely that he/she must have a budget in place before they incur expenditure, and that he/she ensures that the resultant expenditure does not exceed his/her available budget. |
### 24. Approval of Items to be included in the NHS Lothian Capital Programme – Business Cases

**Overview of process**

- An Initial Agreement and Standard Business case must be prepared and submitted for approval for all schemes which involve alterations to buildings or the estate, and schemes that include capital expenditure, regardless of how the schemes are financed, e.g. capital resource limit, National Services Division grants, donations. (Please see exception for schemes < £250k below)

- Business cases should be prepared in accordance with the Scottish Capital Investment Manual (SCIM). [http://www.scim.scot.nhs.uk/Approvals/Delegated.htm](http://www.scim.scot.nhs.uk/Approvals/Delegated.htm) The approving bodies (below) will require assurance from this process that all risks have been clearly identified, and that there are controls in place to manage those risks. The Capital Investment Group shall determine for construction projects the suitability of the application of Frameworks Scotland methodology, or any other local framework arrangements (See Section 25).

- The Board’s delegated limits for the approval of capital schemes is £5m for non-Information Management & Technology (IM&T) schemes and £2m for IM&T schemes. (SCIM).

- For projects beyond these delegated limits an Initial Agreement (IA), Outline Business Case (OBC) and Full Business Case (FBC) will all need to be produced, and each document must in turn be taken through the approval groups identified in this section.

- For construction and IM&T projects please refer to the SCIM website, which sets out the required business case documentation for different levels of capital schemes.

- Regardless of the delegated limits for the approval of business cases, the Board is required to comply with the Scottish Government’s Property Transactions Handbook for transactions for all proposed land and property transactions (i.e. acquisitions or disposals by any method). This must be done concurrently with the business case process. The effect of this is that certain matters will require approval from the Scottish Government before a transaction can be progressed.

- When a scheme is approved as set out below, the approving body shall approve the capital budget to be allocated, and who the budget holder for the scheme is. No person may commit the Board expenditure to capital scheme until a capital budget has been formally allocated by this process.

- All items requiring review and approval should be agreed by the relevant management team before being referred to the approval bodies described below.
### 24. Approval of Items to be included in the NHS Lothian Capital Programme – Business Cases (continued)

<table>
<thead>
<tr>
<th>Schemes over the Board’s delegated limit (£5m for non-IM&amp;T, £2m for IM&amp;T)</th>
<th>Following review by the Finance &amp; Resources Committee, the business case must be referred to the Board. The Board must approve the Initial Agreement, Outline Business Case, and Full Business case in turn, and provide confirmation of its support prior to formally submitting the item to SGHD for approval.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schemes from £0.5m up to £5m</td>
<td>The item should be reviewed and approved in the following order: 1. The Capital Steering Group or the Lothian Medical Equipment Review Group or the ehealth senior management team. 2. Capital Investment Group. 3. Joint Management Team 4. Finance &amp; Resources Committee.</td>
</tr>
<tr>
<td>Schemes from £250k up to £0.5m</td>
<td>The item should be reviewed and approved in the following order: 1. The Capital Steering Group or the Lothian Medical Equipment Review Group or the ehealth senior management team. 2. Capital Investment Group.</td>
</tr>
</tbody>
</table>
| Schemes up to £250k | **MEDICAL EQUIPMENT**  

For **NEW** medical equipment under £250k, an Initial Agreement and an equipment form (from the NHS Lothian Capital Planning Guidance Manual) is to be completed, rather than a Standard Business Case.  

For **REPLACEMENT** medical equipment under £250k, only an equipment form needs to be completed (i.e. an Initial Agreement and Standard Business Case is not required.)  

The finance directorate must review and approve all proposals. Thereafter the Lothian Medical Equipment Review Group (LMERG) must approve the schemes.  

**ALL OTHER SCHEMES**  

An Initial Agreement and Standard Business Case must be completed.  

The finance directorate must review and approve all proposals. Thereafter the item should be reviewed and approved by the Lothian Capital Steering Group or the ehealth senior management team (for schemes related to eHealth). |
### 25. Approval of Items to be included in the NHS Lothian Capital Programme – Use of Frameworks such as Frameworks Scotland

<table>
<thead>
<tr>
<th>What does this section cover?</th>
<th>This section applies when the Board is a participating member of a procurement framework arrangement, or when the Board has set up a local framework. This explains the chronological steps of a scheme that is managed through Frameworks Scotland, and the officers / groups in NHS Lothian with delegated authority to make decisions at each stage. However the same principles should be applied to any other framework.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval of the suitability of, and the extent of application of Frameworks Scotland methodology or the local framework arrangements (for smaller schemes) to a construction project.</td>
<td>This will be determined by the NHS Lothian Capital Investment Group (see Section 24). If a project is within the scope of Frameworks Scotland, then Frameworks Scotland must be used. Lothian NHS Board must approve any decision to depart from this process (per paragraph 7.7 of the Standing Financial Instructions).</td>
</tr>
</tbody>
</table>
| Appointment to the position of Project Director and Capital Project Manager for capital construction projects. | - Appointed Project Sponsor  

The posts must be in the funded establishment, or for external appointments, affordable within the project budget. The Project Sponsor shall formally communicate any delegated budgetary responsibilities to the Project Director and Project Manager.  

The nominees or holders of the position of Project Director and Project Manager (if different individuals) must be clearly documented in the Initial Agreement documentation, and subsequently the Outline and Full Business Cases.  

Please refer to Health Facilities Scotland published guidance and the Scottish Capital Investment Manual on the role of the Project Director and Project Manager.  

The Project Director and Project Manager shall be assigned appropriate delegated authority to permit them to approve project transactions that are associated only with the project and commensurate with their project responsibilities. This may mean that their personal transaction limit for specific projects is different from that conferred to them for routine revenue and capital expenditure. This process shall be managed through the Authorised Signatory Database, and the delegated limits must be approved by the Project Sponsor. |
25. Approval of Items to be included in the NHS Lothian Capital Programme – Use of Frameworks such as Frameworks Scotland

| Approval of Project Initiation Document | • Appointed Project Sponsor  
The Project Director should prepare the PID for approval by the Project Sponsor, and this should identify the resources available to the Project Director. |
| Awarding of Professional Services Contracts (PSCs) | • Director of Capital Planning & Projects  
• Associate Director of Facilities (for projects with a capital value below £5m)  
• Project Director (for contracts specific to their project) |
| Approval of the financial envelope within which the target price is to be agreed. | Please refer to **Section 24** of this Scheme of Delegation.  
The estimated financial value should be included in the Initial Agreement documentation, and presented to the approving group(s) as stipulated in **Section 24**. |
| Selection and appointment of Principal Supply Chain Partners (PSCP) | • Appointed Project Sponsor  
The costs associated with this appointment must be within the previously agreed financial envelope. |
| Negotiation with the PSCP to set the target price, with respect to the factors of time, quality and resources. | • Director of Capital Planning & Projects  
• Associate Director of Facilities (for projects with a capital value below £5m)  
• Project Director (for contracts specific to their project)  
The above officers have delegated authority to negotiate details which satisfy the previously agreed financial envelope and timescale for the project. |
| Approval of the Target Price | This depends on the scale of the project. Please refer to **Section 24** of this Scheme of Delegation. It is expected that the target price should be incorporated within the Final Business Case.  
This should minimise risk exposure, as a more accurate target price will be based upon a substantially completed design. (Ref: Frameworks Scotland – The Guide, Issue 1.0, December 2008).  
Following approval of the target price, the approving body shall specify what officer will implement its decisions, e.g., signing the Framework contract with the agreed details identified. |
### 25. Approval of Items to be included in the NHS Lothian Capital Programme – Use of Frameworks such as Frameworks Scotland

| Approval of project variations (time, quality and resources) within the agreed target price. | • Capital Project Manager named in the Contract. |
| Approval of Changes to the Target Price | Approval to change the target price can only be given by the body that has final authority to agree the target price for that project. Please refer to Section 24 of this Scheme of Delegation. Following approval of the proposed change, the approving body shall specify what officer will implement its decisions, e.g. agreeing the changes with the contractor, signing the Framework contract with the agreed details identified. |
26. Requirements for Market Testing and Tendering (Capital and Revenue)

What does this section cover?

- The Board procures goods and services which are funded by capital and revenue budgets, and aims to secure Best Value whilst doing so. A key part of this is having a fair and transparent approach to the selection of the providers of goods and services. The Board shall observe the Key Procurement Principles as set out in CEL (05) 2012.

- If a supply is already covered by an existing contract as a result of a previous and current procurement process (e.g. Frameworks Scotland, NHS National Procurement, Procurement Scotland, OGC, HUBco), then the Board does not need to conduct any market testing. (See Section 7 of the Standing Financial Instructions).

- For all other expenditure, tendering or market testing must be conducted in accordance with the provisions below.

- The Director of Finance has delegated authority to waive tendering requirements in certain circumstances. Section 7 of the Standing Financial Instructions sets out these circumstances and the process of approval. Managers are advised to contact the Procurement department in the first instance.

<table>
<thead>
<tr>
<th>Supply of goods and services</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>over £49,999</td>
<td>This supply falls into the scope of the Public Contracts (Scotland) Regulations 2012 and will require to be tendered in accordance with its provisions. Managers should contact the Procurement function for advice as to how to proceed. <a href="http://intranet.lothian.scot.nhs.uk/NHSLothian/Corporate/A-Z/Procurement/Pages/ProcurementContactList.aspx">http://intranet.lothian.scot.nhs.uk/NHSLothian/Corporate/A-Z/Procurement/Pages/ProcurementContactList.aspx</a></td>
</tr>
<tr>
<td>and up to £49,999</td>
<td></td>
</tr>
<tr>
<td>over £25,000 and up to £49,999</td>
<td>Some form of competitive tendering is required. Managers should contact the Procurement function for advice as to how to proceed.</td>
</tr>
<tr>
<td>over £10,000 and up to £25,000</td>
<td>Competitive quotation - The budget holder should ensure that at least 2 written quotations are secured prior to awarding a contract.</td>
</tr>
<tr>
<td>from £2,501 - £10,000</td>
<td>One written quotation should be considered.</td>
</tr>
<tr>
<td>up to £2,500</td>
<td>There is no requirement for a quotation.</td>
</tr>
</tbody>
</table>
### 27. Award of Capital Tenders

**Overview of process**

- This section applies where the Board has undertaken a tendering exercise for the procurement of goods or services, which will be funded from the capital programme. It therefore does not relate to schemes covered by an established procurement framework (as described in Section 25), or revenue expenditure.

- The following groups / individuals can award tenders up to the values stated below, provided that the value of the preferred bid is within the approved budget for the scheme (see Section 24).

- If the best tender is above the approved budget for the scheme in the Board’s capital programme, then the tender cannot be awarded. In these circumstances the designated budget holder must apply to the relevant approval body (See Section 24) for an increase to the scheme’s budget to cover the cost.

- Following the decision to award a capital tender, please refer to Section 39 to determine which officers can sign the associated documentation required to form a contract.

<table>
<thead>
<tr>
<th>Any tender award of a value from £1m</th>
<th>Two of the following Executive Board members must approve the award.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chief Executive; Director of Finance; Medical Director; Director of Public Health &amp; Health Policy; Nurse Director.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any tender award of a value under £1m</th>
<th>The relevant budget holder for the service to which the project relates, from the following list;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chief Executive; Director of Finance; Medical Director; Director of Public Health &amp; Health Policy; Nurse Director; Director of Human Resources &amp; Organisational Development; Director of Strategic Planning, Performance Reporting &amp; Information; CHP General Manager – Midlothian &amp; East Lothian; Director of Health &amp; Social Care- Edinburgh; CHP General Manager- Edinburgh; CHCP Director – West Lothian; Head of Health (West Lothian);</td>
</tr>
</tbody>
</table>

For tender awards up to £500,000, in addition to the posts above, the relevant budget holder for the service to which the project relates, from the following list:-

- Director of Operations; Director of Facilities; Director of E-Health
### 28. Capital Expenditure – Delegation of Authority and Approval of Expenditure

| Delegation of authority and approval of expenditure | • This section is concerned with expenditure arising from schemes approved as part of the Board’s capital plan (*See Sections 24-27*).  

• Capital schemes or projects can be made up of several smaller pieces of work. The approval process (*Section 24*) will identify and approve a Budget Holder for each piece of work, and the finance directorate will assign a unique code to it. The designated budget holder is the authorised signatory for the code, and the approving body (*Section 24*) will determine his or her delegated authority to approve expenditure for that code only. The individual’s established delegated authority for his or her revenue budget (*Section 29*) has no bearing or relevance to the delegated authority for a code that is used for a capital scheme or project. If any transaction is over £250,000 it will require two individuals each with a personal delegated authority of £250,000 to approve the transaction.

• The budget holder shall have his or her authority to approve expenditure against the code recorded on the Authorised Signatory Database. *As with all budgets this delegated authority can only be exercise when there is an available budget in the code, and the budget holder is responsible for monitoring this.* The delegated authority will end once the associated piece of work has been completed.

• The budget holder may delegate authority to others to approve expenditure against the code, and this must be done through completion of an authorised signatory database form. Nevertheless the budget holder will remain personally accountable for all financial transactions for the code, and the actions of the individuals to whom they delegate financial authority to.

• There may be items of expenditure that are chargeable to the code that require to be recognised as revenue expenditure. This will be identified at the planning stage (*Section 24*), and the finance directorate shall establish a system to ensure that capital and revenue elements are distinctly accounted for.

• All expenditure must be processed on official orders through the approved procurement channels. All items procured shall be in line with any awarded tenders (*Section 27*) and through the use of the Board’s established contracts with other relevant suppliers. |

Continued/
### 28. Capital Expenditure – Delegation of Authority and Approval of Expenditure (continued)

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The total value of an order should be recognised when determining who the appropriate signatory is for the order.</td>
</tr>
<tr>
<td></td>
<td>• Officers must establish systems to ensure that all ordered goods &amp; services or works completed have in fact been received before “receipting” the supply in the ordering system. For this purpose, the value of a particular invoice is not relevant to the application of this section: the officer is confirming receipt of a supply, rather than approving the expenditure. The officer confirming receipt must be different from the officer who approved the order.</td>
</tr>
<tr>
<td></td>
<td>• In the event of an invoice being received, and there is not an authorised and receipted order available, the invoice becomes the prime document for the approval of expenditure and the value of the invoice. The application of this Section will determine who the signatory must be. The absence of an approved order constitutes a breach of the Standing Financial Instructions.</td>
</tr>
</tbody>
</table>
### 29. Revenue Expenditure – General Arrangements

<table>
<thead>
<tr>
<th>General Provisions for the delegation of authority and approval of expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This section is concerned with all expenditure from revenue budgets.</td>
</tr>
<tr>
<td>• All budget holders are required to formally agree their annual budgets with their line manager, and are accountable for their budgetary performance. It is essential that expenditure levels do not exceed the agreed delegated budget.</td>
</tr>
<tr>
<td>• Managers can only act on the delegated limits in this schedule when they have been formally delegated a budget for that expenditure, and there is budget available to cover the proposed expenditure before the commitment (i.e. approving an order) is made.</td>
</tr>
<tr>
<td>• All figures in this schedule are inclusive of VAT.</td>
</tr>
<tr>
<td>• The total value of an order should be recognised when determining who the appropriate signatory is for the order e.g. if it is a 3 year contract, then the 3 year cost is the value to use.</td>
</tr>
<tr>
<td>• Officers named in this section may delegate authority to others to approve general revenue expenditure in their area of responsibility, and this must be done through completion of an authorised signatory database form. Nevertheless the named officers will remain personally accountable for all financial transactions for the code, and the actions of the individuals to whom they delegate financial authority to.</td>
</tr>
<tr>
<td>• Only the officers identified in this section can approve further delegation through an authorised signatory database form. The employees that are conferred delegated authority as a result this process cannot delegate further.</td>
</tr>
<tr>
<td>• This general provision for further delegation of authority does not apply to revenue expenditure that is described at Sections 30, 31 and 32 of this Scheme of Delegation. In those sections, the officers identified in the sections must approve the proposed transaction. If those officers are not available, then the matter should be referred up to the next level of authority (which may be an executive Board member or the Joint Management Team, depending on the value of the transaction).</td>
</tr>
</tbody>
</table>

Continued/
### 29. Revenue Expenditure – General Arrangements (Continued)

<table>
<thead>
<tr>
<th>General Provisions for the delegation of authority and approval of expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All expenditure must be processed on official orders through the approved procurement channels for that type of expenditure. <strong>The necessary approvals must be given before placing the order.</strong></td>
</tr>
<tr>
<td>• All items procured should be in accordance with any contracts or agreements previously established as a result of the required market testing as described at <strong>Section 26</strong>. All procurement activity should be in accordance with the Standing Financial Instructions, and administered through the systems that the Board establishes for that purpose. Advice on the process can be found on the intranet at: Corporate&gt;A-Z&gt;Purchase to Pay (P2P)</td>
</tr>
<tr>
<td>• Where a contract for general supply to the organisation is in place, the total amount for a period of supply should be identified (if fixed amount) or reasonably estimated, and an appropriately authorised order should be raised on the system for that supply.</td>
</tr>
<tr>
<td>• Officers must establish systems to ensure that all goods &amp; services ordered have been received prior to “receipting” the supply in the ordering system being used. For this purpose, the value of a particular invoice is not relevant to the application of this section: the officer is confirming receipt of a supply, rather than approving the expenditure. The officer confirming receipt must be different from the officer who approved the order.</td>
</tr>
<tr>
<td>• In the event of an invoice being received, and there is not an authorised and receipted order available, the invoice becomes the prime document for the approval of expenditure and the value of the invoice will determine who the signatory must be. The absence of an approved order constitutes a breach of the Standing Financial Instructions.</td>
</tr>
</tbody>
</table>
The table below sets out the required authority for different levels of expenditure. **However employees should refer to Sections 30-34 for the specific requirements that must be followed for certain classes of expenditure.**

<table>
<thead>
<tr>
<th>Expenditure Level</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any item over £2m</td>
<td>Joint Management Team</td>
</tr>
<tr>
<td>Any item over £250,000 but under £2m</td>
<td>The budget holder (who must have a personal authorised signatory limit of £250,000) and any executive board member.</td>
</tr>
<tr>
<td>Officers with a delegated authority up to £250,000</td>
<td><strong>Executive Board Members</strong> - Chief Executive; Director of Finance; Medical Director; Director of Public Health &amp; Health Policy; Nurse Director.</td>
</tr>
<tr>
<td>Officers with a delegated authority up to £150,000</td>
<td><strong>Corporate Budgets</strong> - Director of Human Resources &amp; Organisational Development; Director of Strategic Planning, Performance Reporting &amp; Information; Director of Facilities; Director of Ehealth</td>
</tr>
<tr>
<td>Officers with a delegated authority up to £100,000</td>
<td><strong>CHP/CHCP Budgets</strong> - CHP General Manager – Midlothian &amp; East Lothian; Director of Health &amp; Social Care- Edinburgh; CHP General Manager- Edinburgh; CHCP Director – West Lothian; Head of Health (West Lothian).</td>
</tr>
<tr>
<td>Officers with a delegated authority up to £50,000</td>
<td><strong>UHD Budgets</strong> – Director of Operations</td>
</tr>
<tr>
<td>Officers with a delegated authority up to £20,000</td>
<td><strong>Executive Board Members</strong> - Chief Executive; Director of Finance; Medical Director; Director of Public Health &amp; Health Policy; Nurse Director.</td>
</tr>
</tbody>
</table>
30. Revenue - Contracts and Service Agreements for Healthcare Services

<table>
<thead>
<tr>
<th>What does this section cover?</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Contracts for Research and Development income and expenditure.</td>
</tr>
<tr>
<td></td>
<td>• Income from other bodies for the provision of services by the Board.</td>
</tr>
<tr>
<td></td>
<td>• National Services Division Contracts</td>
</tr>
<tr>
<td>Expenditure</td>
<td>• Expenditure on NHS contracts and NHS service agreements, unscheduled activity with other NHS bodies.</td>
</tr>
<tr>
<td></td>
<td>• Purchase of healthcare from non NHS organisations, e.g. private sector, voluntary organisations.</td>
</tr>
<tr>
<td></td>
<td>• Resource transfer.</td>
</tr>
</tbody>
</table>

**All agreements entered into must be within approved budgets.** Furthermore all agreements should be subject to competitive evaluation to determine if Best Value is being delivered, and to observe the Standing Financial Instructions.

It is possible that strategic partnerships (e.g. with Universities) may facilitate agreements that deliver Best Value within an agreed quality and resource framework. However in all cases, the requirements of the Public Contracts (Scotland) Regulations 2012 will be followed. Please refer to Section 26 of this Scheme of Delegation for further advice.

All expenditure should be directed through the Board’s ordering systems as described in Section 29.

<table>
<thead>
<tr>
<th>Delegated Budgetary Authority</th>
<th>Any amount over £1.5m per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Joint Management Team</td>
</tr>
<tr>
<td>£0.5m to £1.5m per annum</td>
<td>• Any two from the following list (one of whom should be the budget holder); Chief Executive; Director of Finance; Medical Director; Director of Public Health &amp; Health Policy; Nurse Director; Director of Human Resources &amp; Organisational Development; Director of Strategic Planning, Performance Reporting &amp; Information</td>
</tr>
</tbody>
</table>

Up to £0.5m per annum

**Corporate** - Associate Medical Director- Research & Development; Director of eHealth.

**CHP/ CHCP** - The relevant budget-holder i.e. one of- CHP General Manager (East & Midlothian), West Lothian CHCP Director, Head of Health (West Lothian); Director of Health & Social Care (Edinburgh): CHP General Manager- Edinburgh;

**UHD** – Director of Operations
31. Revenue - Contracts and Service Agreements for Other Specified Services

<table>
<thead>
<tr>
<th>What does this section cover?</th>
<th>This section relates to contracts and service agreements for both income &amp; expenditure for the following categories of activity.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>All agreements entered into must be within approved budgets.</strong> Furthermore all agreements should be subject to competitive evaluation to determine if Best Value is being delivered, and to observe the Standing Financial Instructions. It is possible that strategic partnerships (e.g. with Universities) may facilitate agreements that deliver Best Value within an agreed quality and resource framework. However in all cases, the requirements of the Public Contracts (Scotland) Regulations 2012 will be followed. Please refer to Section 26 of this Scheme of Delegation for further advice.</td>
</tr>
<tr>
<td></td>
<td>All expenditure should be directed through the Board’s ordering systems as described in Section 29.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational Health / Health &amp; Safety</th>
<th>Any amount over £250k per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Joint Management Team</td>
</tr>
<tr>
<td></td>
<td>£150k to £250k per annum</td>
</tr>
<tr>
<td></td>
<td>• Director of Human Resources &amp; Organisational Development</td>
</tr>
<tr>
<td></td>
<td>Up to £150k per annum</td>
</tr>
<tr>
<td></td>
<td>• Director of Occupational Health &amp; Safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Library Services / Regional NHS Education for Scotland Initiatives</th>
<th>Any amount over £250k per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Joint Management Team</td>
</tr>
<tr>
<td></td>
<td>£150k to £250k per annum</td>
</tr>
<tr>
<td></td>
<td>• Director of Human Resources &amp; Organisational Development.</td>
</tr>
<tr>
<td></td>
<td>Up to £150k per annum</td>
</tr>
<tr>
<td></td>
<td>• Associate Director of Human Resources (Workforce Development)</td>
</tr>
</tbody>
</table>

Continued/
### 31. Revenue - Contracts and Service Agreements for Other Specified Services (continued)

<table>
<thead>
<tr>
<th>Maintenance Contracts / Utilities</th>
<th>Any maintenance / utilities expenditure that is required to be directed through National Procurement must be contracted through that route.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For expenditure out of the scope of National Procurement, the following officers have delegated authority to agree contracts and service agreements.</td>
</tr>
<tr>
<td></td>
<td><strong>Any amount over £250k per annum</strong></td>
</tr>
<tr>
<td></td>
<td>• Joint Management Team</td>
</tr>
<tr>
<td></td>
<td><strong>£150k to £250k per annum</strong></td>
</tr>
<tr>
<td></td>
<td>• Medical Director (for Ehealth)</td>
</tr>
<tr>
<td></td>
<td><strong>Up to £150k per annum</strong></td>
</tr>
<tr>
<td></td>
<td>• Director of Capital Planning &amp; Projects</td>
</tr>
<tr>
<td></td>
<td>• Director of Facilities</td>
</tr>
<tr>
<td></td>
<td>• Associate Director of Facilities</td>
</tr>
<tr>
<td></td>
<td>• Director of Ehealth</td>
</tr>
<tr>
<td>Key Definitions</td>
<td>MANAGEMENT CONSULTANTS</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>Management Consultants have two characteristics:</td>
</tr>
<tr>
<td></td>
<td>1. They are engaged to work on specific projects that are regarded as outside the usual business of the Lothian NHS Board and there is an identified end-point of their involvement.</td>
</tr>
<tr>
<td></td>
<td>2. The responsibility for the final outcome of the project largely rests with Lothian NHS Board.</td>
</tr>
<tr>
<td></td>
<td>PROFESSIONAL ADVISORS</td>
</tr>
<tr>
<td></td>
<td>Professional Advisors have two characteristics:</td>
</tr>
<tr>
<td></td>
<td>1. They are engaged on work that is an extended arm of the work done in-house.</td>
</tr>
<tr>
<td></td>
<td>2. They provide an independent check.</td>
</tr>
<tr>
<td></td>
<td>An example of professional advice is the engagement of VAT advisors on the accounting treatment of VAT in relation to the Board’s activities.</td>
</tr>
<tr>
<td></td>
<td>Professional Advisors are commonly engaged in major capital projects, e.g. architects, quantity surveyors, structural engineers.</td>
</tr>
<tr>
<td></td>
<td>For the purposes of applying this section of the Scheme of Delegation, professional advisors are not management consultants, and this section does not apply to professional advisors.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What does this section cover?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This section has been prepared to support the application of Section 7 of the Standing Financial Instructions (Non Pay Expenditure) for the subject of management consultancy.</td>
</tr>
<tr>
<td>• This section sets out the process and the key controls to be followed with respect to the engagement of management consultants.</td>
</tr>
</tbody>
</table>

All expenditure should be directed through the Board’s ordering systems as described in Section 29.
### 32. Revenue – Use of Management Consultants (continued)

<table>
<thead>
<tr>
<th><strong>Step 1</strong> – Clearly define what the assignment is.</th>
<th>This is a task for the Project Lead – the manager who has identified a potential need to engage management consultants. The scope and objectives of the assignment should be clearly defined – what is the problem that is to be solved? What is the scale of the activity, what departments/services are involved?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 2</strong> – Assess whether internal resources (the Board’s own employees or suppliers within the scope of what they are already contracted to do) can perform the task.</td>
<td>The potential assignment should be critically reviewed, and broken down into its constituent parts. If some or all of the work is within the responsibilities of employees or contractors, then normally it should be done by them. Management consultants should only be engaged if the assignment is beyond the capacity and/or capability of internal resources to complete the assignment within the required timeframe. The Project Lead should reduce the costs and risks associated with engaging management consultants by ensuring that any elements of the assignment that can be done in-house to the required quality are completed in-house. This should include considering redeploying or seconding employees to do the work. On the occasions where it is decided that the assignment cannot be delivered by internal resources, go to <strong>Step 3</strong>. The Project Lead should prompt a review of how capacity and capability can be put in place for future assignments.</td>
</tr>
<tr>
<td><strong>Step 3</strong> – Contact Procurement and document your requirements.</td>
<td>1. The Project Lead must contact the Procurement Department and ask for a “Pre-engagement Review Form. The Form must be completed with the details of Steps 1 &amp; 2. 2. The Form must identify the benefits to the Board (in terms of outcomes criteria) from the assignment, and how management will use the outputs of the assignment. Procurement will use these criteria in the tender documentation, and they will be used to support monitoring of progress and post-completion evaluation. 3. The Form must set out the minimum qualifying criteria for a bidder. This will be used by the Procurement function to advertise the assignment and short-list bids. 4. The Form must include an estimate of the anticipated cost of the consultancy and identify the budget to cover the costs. 5. The Form must be approved by one of the following officers before being returned to Procurement – Chief Executive; Director of Finance. (The approving officer and the Project Lead should be different people). <strong>Procurement will not proceed unless this authorisation is in place.</strong></td>
</tr>
</tbody>
</table>
### 32. Revenue – Use of Management Consultants (continued)

#### Step 4 – Going to Market

- The Procurement function will prepare and issue tender invitations to the market, based on the instructions given on the approved form.

- The Procurement will follow the requirements of Section 7 of the Board’s Standing Financial Instructions with regard to tendering and contracting. In the event that it is decided that tendering processes are not appropriate, the requirements of the Board’s Standing Financial Instructions must be followed. The Director of Finance must approve the decision to waive the tender process, and this must be formally documented. The Head of Procurement must place this in the Waiver of Tender Register.

- Assignments will be offered to the market as distinct items, i.e. a contractor will not be automatically given a follow-on assignment associated with another tendered assignment. However the Board may enter into a call-off framework contract with a number of consultancies in the interests of efficient procurement.

- The Procurement Department will maintain a register of all call-off contracts. The Procurement Department will perform and document systematic reviews of relationships with management consultants, to ensure that they are not self-perpetuating.

- The Procurement Department will use standard documentation to record the process of evaluation of bids and the award of contract. This will include a record of whether:
  - The Consultants are capable of performing the assignment.
  - The assignment will deliver Best Value.
  - The award of the contract is compliant with the Board’s Standing Financial Instructions.

  The Procurement Department will hold this record in a register.

- All assignments must have a defined contract duration, with a specified contract delivery or financial cap. The Procurement department will use a standard formal contract for all assignments. The contract will explicitly cover the payment of expenses and place a limit on the amount payable.
| Step 5 – Client Evaluation of the Performance of the Management Consultants at the conclusion of the assignment. | The Project Lead shall prepare an evaluation report on each assignment immediately following its completion. The Procurement department will provide a standard template for this purpose. The report shall cover:

- Was the work completed on time?
- Were the costs contained within the contracted figure?
- Did the consultants carry out all their contractual obligations?
- Were the terms of reference discharged?
- How did the consultants key people perform?
- Were effective and realistic solutions proposed?
- Did the engagement represent Best Value?

The Project Lead must send this report to the officer who approved the assignment (See Step 3), and send a copy to Procurement. If the approving officer is satisfied, he or she must notify the Procurement department, to confirm that the order for services has been satisfactorily completed. The Procurement department can then “receipt” the order on the ordering system, and this will allow the invoice to be paid. |
### 33. Revenue - Travel and Reimbursement of Expenses

| What does this section cover? | In line with the NHS Lothian Expenses Policy & Procedure, for the purposes of continuity planning, the details of all journeys beyond Scotland should be reviewed and approved in advance of the trip being undertaken. Employees are expected to follow appropriate arrangements to make the most cost-effective use of resources when incurring expenses on Board activities. Further advice on this can be found on the intranet at: Corporate>A-Z>Pay Office-Payroll>Expenses and Car Leasing  
Any amount for an event in or journey made within the UK  
- The relevant budget holder  
Any amount for an event in or journey made to an overseas destination  
- Corporate—Chief Executive; Director of Finance; Medical Director; Director of Public Health & Health Policy; Nurse Director; Director of Human Resources & Organisational Development; Director of Strategic Planning, Performance Reporting & Information; any Associate Director; Director of Facilities; Director of Ehealth; General Manager (PCCO)  
- CHP/CHCP - CHP General Manager – Midlothian & East Lothian; Director of Health & Social Care- Edinburgh; CHP General Manager- Edinburgh; CHCP Director – West Lothian; Head of Health (West Lothian);  
- UHD - Associate Medical Director (UHD); Director of Operations; Associate Director of Nursing (UHD); |
<table>
<thead>
<tr>
<th>What does this section cover?</th>
</tr>
</thead>
<tbody>
<tr>
<td>34. Revenue – Private Finance Initiative / Public Private Partnership Payments</td>
</tr>
<tr>
<td>This refers to the expenditure that arises from PFI/PPP contracts, following the completion of the build phase and during the operational phase.</td>
</tr>
<tr>
<td>Any contractual payments: – fixed and variable (e.g. patient meals).</td>
</tr>
<tr>
<td><strong>Approval of the order</strong> – Budget holder for the contract (or his or her delegate).</td>
</tr>
<tr>
<td><strong>Confirmation of Receipt of goods or services</strong> – To be provided by the Director of Facilities or Associate Director of Facilities or their nominated officers.</td>
</tr>
<tr>
<td>Ad-hoc – minor works/ service changes</td>
</tr>
<tr>
<td><strong>Approval of the order</strong> – The relevant budget holder must approve a minor works form.</td>
</tr>
<tr>
<td><strong>Confirmation of Receipt of goods or services</strong> – To be provided by the Director of Facilities or Associate Director of Facilities or their nominated officers.</td>
</tr>
<tr>
<td>Additional Works</td>
</tr>
<tr>
<td>These are likely to be of a value higher than £5,000 and shall be directed through the capital approval route. (see <strong>Section 24</strong>)</td>
</tr>
</tbody>
</table>
### 35. Virement

| What does this section cover? | The process of virement is defined as follows:

“The agreed transfer of money from one budget heading to another within a financial year. The budget headings can be under the control of one manager, or alternatively under the control of several managers.”

The Standing Financial Instructions state:

“5.12 The Chief Executive may agree a virement procedure that would allow budget holders to transfer resources from one budget heading to another.

5.13 If the budget holder does not require the full amount of the budget delegated to him for the stated purpose (s), and virement is not exercised, then the amount not required shall revert back to the Chief Executive. For all incidents of virement, an officer from the finance directorate must review and approve the virement.”

The following officers are permitted to approve virement transactions for their budgets. |

| Any Amount | • Executive Board Members (see Section 29)

• Director of Human Resources & Organisational Development; Director of Strategic Planning, Performance Reporting & Information; Director of Facilities; Director of Ehealth; CHP General Manager – Midlothian & East Lothian; Director of Health & Social Care- Edinburgh; CHP General Manager- Edinburgh; CHCP Director – West Lothian; Head of Health (West Lothian) |
| Up to £100,000 | Director of Capital Planning & Projects; Associate Director of Facilities; Head of Catering Services; Head of Domestic Services; Head of Logistics; Site Chief Pharmacist |
| Up to £20,000 | Assistant General Manager; Chief Nurse; Clinical Director; Allied Health Professional Manager; Service Manager-Mental Health (West Lothian); Head of Service- Community (West Lothian); Divisional Nurse Director; Divisional Medical Director; Associate Director of Operations; Associate Divisional Medical Director; Clinical Director; Service Manager; Chief Nurse/ Midwife/ Professional; Deputy Director of Public Health |
### 36. Asset Transactions

<table>
<thead>
<tr>
<th>What does this section cover?</th>
<th>This section relates to miscellaneous asset transactions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposal of fixed assets (other than land and buildings)</td>
<td>All transactions to be referred to the Lothian Capital Investment Group for approval. (See Section 24)</td>
</tr>
<tr>
<td>Land &amp; Property and Equipment Leases</td>
<td>For land, property and equipment leases the Present Value of the minimum payments required under the lease contract will determine the appropriate level of authority and signatory. Such payments will include any incidental fees, commissions, documentation or registration costs, or lease premiums as well as normal annual rentals payable over that minimum period.</td>
</tr>
</tbody>
</table>

In such circumstances the **Director of Facilities, Associate Director of Facilities or Service managers** will need to seek such appropriate financial advice as required on whether any lease agreement will require approval from the capital budget. The financial advice will consider the minimum period of the lease against the overall life of the asset (as determined by its depreciation period) and whether the minimum payments required over the lease represents substantially all of the equivalent normal capital cost of the asset being procured.

Any lease or rental agreement where the total minimum payment over the lease period is less than £5,000 should be considered as revenue expenditure. For "grouped assets" (as defined by the Capital Asset Manual) where the total minimum payments over the lease period is less than £10,000, such agreements should also be treated as revenue expenditure.

**All leases should be reviewed to give assurance that the terms and conditions of the lease are satisfactory, and where applicable is in accordance with the Board’s estates strategies and plans, and that the NHS Scotland Property Transactions Handbook has been followed.**

The value of the lifetime cost of the lease should be quantified, the signatory will be:

- **Land & Property Leases**
  - Chief Executive or Director of Finance

- **Equipment Leases**
  - Any member of the Joint Management Team

<table>
<thead>
<tr>
<th>Notification and Certification of Property Transactions (per Property Transactions Handbook)</th>
<th>Chief Executive</th>
</tr>
</thead>
</table>
## 37. Financial Services

<table>
<thead>
<tr>
<th>What does this section cover?</th>
<th>This section relates to financial functions and controls administered by Financial Services.</th>
</tr>
</thead>
</table>
| Statutory deductions from payroll i.e. PAYE, superannuation, national insurance deductions, and arrestments. Voluntary deductions from payroll e.g. GAYE, trade union fees. | One of the following officers:  
Associate Director of Finance (Primary Care); Associate Director of Finance (Strategy); Head of Financial Services; Financial Controller (Financial Accounting) |
| Establishment of a cash float (any amount) | The Head of Financial Services or the Financial Controller (Financial Accounting) must grant approval of the establishment of a cash float. |
| Cheque Signatories - General | All designated cheque signatories must be included in the bank mandate. Only an Associate Director of Finance (or the Director of Finance) PLUS one other Level 1 or Level 2 signatory may approve changes to the designated cheque signatories, and sign the letter to the bank to instruct it to alter the bank mandate.  
The required signatories depends on the value of the payment, as follows:  
> £100,000 – One Level 1 signatory plus any other signatory.  
£25,000 - £100,000 – One Level 1 or Level 2 signatory plus any other signatory.  
£2,000 - £25,000 – Any two signatories.  
< £2,000 – Any one signatory. |
| Cheque Signatories – Level 1 | Director of Finance; Associate Director of Finance (Primary Care); Associate Director of Finance (Strategy); CHP General Manager – Midlothian CHP & East Lothian CHP; General Manager Edinburgh CHP; Director of Operations; Associate Director of Nursing (UHD). |
| Cheque Signatories – Level 2 | Head of Finance (CHCP/CHPs); Finance Manager- Income and Projects; Head of Financial Services; Head of Finance (PCCO); Head of Finance (UHD); Head of Corporate Reporting & Corporate Governance; Financial Controller (Financial Accounting). |
| Cheque Signatories – Level 3 | Any Assistant Head of Finance (UHD); Finance & Performance Manager (CHCP/CHPs/); Financial Controller (Accounts Payable); Financial Accountant. |
### 37. Financial Services (continued)

| Electronic Banking – General Provision | On each occasion that a profile is to be allocated to an officer (per the 3 sections below), that allocation shall be recorded in an internal mandate. An Associate Director of Finance (or the Director of Finance) PLUS one other Level 1 or Level 2 signatory must approve the mandate.

The Financial Controller (Financial Accounting) shall maintain a complete record of these mandates. |
| --- | --- |
| Electronic Banking – Bankline | The system profiles are granted to each of the following officers:

**Read only** – Treasury Assistant

**Preparer** – Treasury Team Leader; Senior Treasury Assistant

**Authoriser** – Head of Financial Services; Head of Finance (PCCO); Financial Controller (Financial Accounting); Financial Controller (Accounts Payable); Financial Accountant.

**Administrator** - Head of Financial Services; Financial Controller (Financial Accounting); Treasury Team Leader.

N.B. There is a systematic control that requires the approval of two administrators to authorise any administrative changes to the system. |
| Electronic Banking – CitiDirect | The system profiles are granted to each of the following officers:

**Read only** – Treasury Assistant

**Preparer** – Treasury Team Leader; Senior Treasury Assistant

**Authoriser** – Head of Financial Services; Head of Finance (PCCO); Financial Controller (Financial Accounting); Financial Controller (Accounts Payable); Financial Accountant.

N.B. HM Treasury administer this system. |
| Electronic Banking – BACSTEL IP | The system profiles are granted to each of the following officers:

**Preparer** – Senior Treasury Assistant; Treasury Assistant.

**Authoriser** – Head of Financial Services; Head of Finance (PCCO); Financial Controller (Financial Accounting); Financial Controller (Accounts Payable); Financial Accountant; Treasury Team Leader

**Administrator** - Head of Financial Services; Financial Controller (Financial Accounting).

N.B. An administrator may grant the “Preparer” profile to another officer, in the event of a vacancy or absence of both a Senior Treasury Assistant and a Treasury Assistant. This will only be a temporary measure to support business continuity. |
### 38. Losses and Special Payments

<table>
<thead>
<tr>
<th>What does this section cover?</th>
<th>This section relates to the approval of losses and special payments as defined by CEL (2008) 44. The Director of Finance must periodically report all losses (of whatever class) to the Lothian NHS Board Audit &amp; Risk Committee. For proposed losses to be written off and proposed special payments that are above these delegated limits, management must refer these items to the Audit &amp; Risk Committee before seeking authorisation from the Scottish Government Health Directorate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theft / Arson/ Wilful Damage</td>
<td>The relevant Associate Director of Finance for the budget head where the loss was incurred can approve the write-off of losses up to the following amounts:</td>
</tr>
<tr>
<td>1. Cash</td>
<td>£20,000</td>
</tr>
<tr>
<td>2. Stores/ Procurement</td>
<td>£40,000</td>
</tr>
<tr>
<td>3. Equipment</td>
<td>£20,000</td>
</tr>
<tr>
<td>4. Contracts</td>
<td>£20,000</td>
</tr>
<tr>
<td>5. Payroll</td>
<td>£20,000</td>
</tr>
<tr>
<td>6. Buildings/ Fixtures</td>
<td>£40,000</td>
</tr>
<tr>
<td>7. Other</td>
<td>£20,000</td>
</tr>
<tr>
<td>Fraud, embezzlement &amp; other irregularities (including attempted fraud)</td>
<td>The relevant Associate Director of Finance for the budget head where the loss was incurred can approve the write-off of losses up to the following amounts:</td>
</tr>
<tr>
<td>8. Cash</td>
<td>£20,000</td>
</tr>
<tr>
<td>9. Stores/ Procurement</td>
<td>£40,000</td>
</tr>
<tr>
<td>10. Equipment</td>
<td>£20,000</td>
</tr>
<tr>
<td>11. Contracts</td>
<td>£20,000</td>
</tr>
<tr>
<td>12. Payroll</td>
<td>£20,000</td>
</tr>
<tr>
<td>13. Other</td>
<td>£20,000</td>
</tr>
<tr>
<td>14. Nugatory and Fruitless Payments</td>
<td>A &quot;fruitless payment&quot; is a payment for which liability ought not to have been incurred, or where the demand for the goods and service in question could have been cancelled in time to avoid liability. The relevant Associate Director of Finance for the budget head where the loss was incurred can approve the write-off of losses up to £20,000.</td>
</tr>
<tr>
<td>38. Losses and Special Payments (continued)</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>15. Claims Abandoned</strong></td>
<td>The relevant Associate Director of Finance for the budget head where the loss was incurred can approve the write-off of losses up to the following amounts:</td>
</tr>
<tr>
<td></td>
<td>a) Private Accommodation - £20,000</td>
</tr>
<tr>
<td></td>
<td>b) Road Traffic Acts - £40,000</td>
</tr>
<tr>
<td></td>
<td>c) Other - £20,000</td>
</tr>
<tr>
<td><strong>Stores Losses</strong></td>
<td>The relevant Associate Director of Finance for the budget head where the loss was incurred can approve the write-off of losses up to £40,000 in the following categories:</td>
</tr>
<tr>
<td></td>
<td>16. Incidents of the Service – Fire, Flood, Accident</td>
</tr>
<tr>
<td></td>
<td>17. Deterioration in Store.</td>
</tr>
<tr>
<td></td>
<td>19. Other causes.</td>
</tr>
<tr>
<td><strong>Losses of Furniture &amp; Equipment and Bedding &amp; Linen in Circulation</strong></td>
<td>The relevant Associate Director of Finance for the budget head where the loss was incurred can approve the write-off of losses up to £40,000 in the following categories:</td>
</tr>
<tr>
<td></td>
<td>20. Incidents of the Service – Fire, Flood, Accident</td>
</tr>
<tr>
<td></td>
<td>22. Other causes.</td>
</tr>
</tbody>
</table>
### 38. Losses and Special Payments (continued)

<table>
<thead>
<tr>
<th>23. Compensation Payments – Legal Obligation - Clinical</th>
<th>The SGHD must be notified immediately of all possible cases of compensation payments (made under legal obligation, for both clinical and non-clinical claims), irrespective of the limit of delegation. Please contact the Associate Director of Finance for assistance if required. All compensation payments must be notified to the attention of an Executive Board member (see Section 29). The source of the claim (area of budgetary responsibility) will normally determine who the appropriate Board member should be. The following officers can approve payments up to £250,000: The relevant budget holder from the following list:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Chief Executive; Director of Finance; Medical Director; Director of Public Health &amp; Health Policy; Nurse Director; Director of Human Resources &amp; Organisational Development; Director of Strategic Planning, Performance Reporting &amp; Information; CHP General Manager – Mid &amp; East; Director of Health &amp; Social Care-Edinburgh; CHP General Manager-Edinburgh; CHCP Director – West Lothian; Head of Health (West Lothian); Director of Operations</td>
<td></td>
</tr>
<tr>
<td>24. Compensation Payments – Legal Obligation – Non-Clinical</td>
<td>The following officers can approve payments up to £100,000: The relevant budget holder from the following list:</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>- Chief Executive; Director of Finance; Medical Director; Director of Public Health &amp; Health Policy; Nurse Director; Director of Human Resources &amp; Organisational Development; Director of Strategic Planning, Performance Reporting &amp; Information; CHP General Manager – Mid &amp; East; Director of Health &amp; Social Care-Edinburgh; CHP General Manager-Edinburgh; CHCP Director – West Lothian; Head of Health (West Lothian); Director of Operations</td>
<td></td>
</tr>
</tbody>
</table>

Continued/
### 38. Losses and Special Payments (continued)

| EX-GRATIA PAYMENTS | Ex gratia payments are payments which a health body is not obliged to make or for which there is no statutory cover or legal liability. **All ex-gratia payments must be reviewed and counter-signed by either an Associate Director of Finance, the Head of Financial Services, or the Financial Controller (Financial Accounts).**  
For the following categories of payments, the following officers have delegated authority to approve such payments from their budgets:  
- Chief Executive; Director of Finance; Medical Director; Director of Public Health & Health Policy; Nurse Director; Director of Human Resources & Organisational Development; Director of Strategic Planning, Performance Reporting & Information; CHP General Manager – Mid & East; Director of Health & Social Care-Edinburgh; CHP General Manager-Edinburgh; CHCP Director – West Lothian; Head of Health (West Lothian); Director of Operations |

| 25. Extra Contractual Payments | An extra contractual payment is one which, although not legally due under the original contract or subsequent amendments, appears to be an obligation which the Courts might uphold. Such an obligation will usually be attributable to action or inaction by a health body in relation to the contract. A payment may be regarded as extra contractual even where there is doubt whether or not the health body is liable to make it, e.g. where the contract provided for arbitration but a settlement is reached without recourse to arbitration. A payment made as a result of an arbitration award is contractual.  
An ex gratia payment to a contractor is one not legally due under the contract or otherwise, and usually represents compensation on grounds of hardship. Any such payment would have to be fully justified on value for money grounds.  
The aggregate of payments from whatever cause under a single contract governs the need for prior reference to the Scottish Government Health Directorate (SGHD). If the Board has any reason to suspect that the ultimate total will exceed its delegated powers it should consult the SGHD.  
The delegated limit for this category is **£20,000**. |
### 38. Losses and Special Payments (continued)

<table>
<thead>
<tr>
<th>Category</th>
<th>Delegated Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Compensation Payments – Ex Gratia – Clinical</td>
<td>£250,000</td>
</tr>
<tr>
<td>27. Compensation Payments – Ex Gratia – Non-Clinical</td>
<td>£100,000</td>
</tr>
<tr>
<td>28. Compensation Payments – Ex Gratia – Financial Loss</td>
<td>£25,000</td>
</tr>
<tr>
<td>29. Compensation Payments – Ex Gratia – Other Payments</td>
<td>£2,500</td>
</tr>
</tbody>
</table>

In addition to the signatories above, the General Manager (Primary Care Contracts) has delegated authority to make these payments in this category for the Primary Care Contracting Organisation.

Continued /
### 38. Losses and Special Payments (continued)

| 30. Damage to Buildings and Fixtures – Incidents of the Service – Fire, Flood, Accident, Other Causes | The relevant Associate Director of Finance for the budget head where the loss was incurred can approve the write-off of losses up to £40,000. |
| 31. Extra-Statutory & Extra-regulationary payments | These are payments considered to be within the broad intention of a statute or statutory regulation but which go beyond a strict interpretation of its terms. In some cases where health bodies have followed departmental guidance, the SGHD will advise the health bodies to classify the payments as extra statutory. In all other cases where health bodies would be acting, or believe they may have acted, beyond the strict interpretation of statute or statutory regulation they must inform the SGHD who will advise them whether the payments may be treated as extra statutory or that the payments are beyond their powers (ultra vires). Extra statutory or extra regulationary payments must not be classified as ex gratia. The Board has no delegated authority to approve these payments. |
| 32. Gifts in cash or kind | The relevant Associate Director of Finance for the budget head where the payment is proposed can approve payments up to £20,000. |
| 33. Other losses | These are losses that do not fall within the definitions of theft, arson, wilful damage, fraud, embezzlement and attempted fraud (loss categories 1-13 above) and would have fallen within the previously available categories of “Cash Losses – overpayment of salaries, wages and allowances” and “Cash Losses –other”. The relevant Associate Director of Finance for the budget head where the loss was incurred can approve payments up to £20,000. |
### 39. Signing of Contractual Documentation

**What does this section cover?**
The following individuals may sign contractual documentation on behalf of the Board, provided the decision to enter that contract has been made after following applicable due process (see Sections 24, 25, 26, 27, 28, 30, 31, 32).

**Land and Property Transactions**
The power to purchase or dispose of land (and associated property) is reserved to the Scottish Ministers (per Section 79 of the National Health Service (Scotland) Act 1978). Officers shall follow the requirements of Section 24 of this Scheme of Delegation, and the NHS Scotland Property Transactions Handbook when considering these matters.

Once the above processes have concluded and the necessary approvals are in place, only the following individuals may execute legal instruments on behalf of the Scottish Ministers. These individuals must take particular care to ensure that all prior Scottish Government approval required by the Property Transactions is in place before they exercise this delegated authority:

**All Acquisitions**
- Chief Executive
- Director of Finance

**Disposals where the subjects of sale or lease would not continue to be used for NHS purposes by another party**
- Chief Executive
- Director of Finance

**Disposals where the subjects of sale or lease (such as health centres or partnership ventures) would continue to be used for NHS purposes by another party**
- The execution of legal instruments is reserved to the Scottish Ministers

**Completion of associated contract documentation to put in place contracts as a result of decisions relating to building or maintenance projects or any procurement contracts**
The following individuals can sign off contractual documentation on behalf of the Board. However before doing so, that person needs to be satisfied that due procurement process has been followed, and the terms of the contract are acceptable to the Board. The signatory may not have been directly involved in the procurement processes, however should receive a report from the officers involved giving a briefing on the procurement exercise, and assurance that due process has been followed.

- Any member of the Joint Management Team.
- Director of Facilities; Director of Ehealth; CHP General Manager- Edinburgh; Head of Health (West Lothian); Director of Operations (UHD); Director of Capital Planning & Projects; Associate Director of Facilities; Head of Procurement
<table>
<thead>
<tr>
<th><strong>40. Payroll</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What does this section cover?</strong></td>
</tr>
<tr>
<td><strong>Payment of Hours through SSTS</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Other Payments that cannot be processed via SSTS, e.g. allowance codes, waiting time initiatives payments per consultant contract</strong></td>
</tr>
</tbody>
</table>
COMMITTEE MEMBERSHIPS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree to appoint John Iredale and Robert Wilson as Non-Executive Board Members of the Service Delivery Group and to appoint Kay Blair as a member of the Finance & Resources Committee, the Audit & Risk Committee and the Edinburgh Joint Board of Governance.

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

2 Recommendations

2.1 It is recommended that the Board agrees to confirm the appointment of John Iredale and Robert Wilson to the Service Delivery Group and Kay Blair as a member of the Finance & Resources Committee, the Audit & Risk Committee and the Edinburgh Joint Board of Governance.

3 Discussion of Key Issues

3.1 The Service Delivery Group was established at the Private October Board meeting to replace the Service Redesign Committee and the Improving Care Investing in Change Executive Group. The Service Delivery Group will It is proposed that a new operational delivery group is established to:

- Set the detailed workplan for strategic service redesign, within the parameters of the Strategic Clinical Framework, for Joint Management Team approval.
- Check that service and support strategies in development fit the Strategic Clinical Framework, prior to CMT/HB approval.
- Ensure progress of the workplan through linkages to financial plan, capital plan, efficiency and productivity plan, workforce plan, redesign plans and organisation development plan.
- Agree actions to allocate corporate resources to progress workplan and address blockages.

4 Key Risk

4.1 If members are not appointed the Service Delivery Group will not have any non-executive representation. This may diminish the board's understanding of, and contribution to, service redesign.

4.2 As Kay Blair’s appointment took effect from 1 November she is not currently a member of any Board Committees.
5 Risk Register
5.1 There are no implications for NHS Lothian’s Risk Register

6 Impact on Inequality, Including Health Inequalities
6.1 Not required as this is an administrative matter.

7 Involving People
7.1 The Board Chairman has discussed these proposals with the members concerned.

8 Resource Implications
8.1 There are no resource implications.

Peter Reith
Secretariat Manager
2 November 2012
peter.reith@nhslothian.scot.nhs.uk
SHADOW HEALTH & SOCIAL CARE PARTNERSHIP BOARD MEMBERSHIPS

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree to appoint members of the Shadow Health & Social Care Partnership Boards for Edinburgh and West Lothian. Any member wishing additional information should contact the Chairman in advance of the meeting.

2 Recommendations

2.1 It is recommended that the Board agrees to confirm the following appointments:

Edinburgh Shadow Health & Social Care Partnership Board -

Chair: (Cllr R Henderson)
Vice Chair: Mrs S Allan
Board Member: Ms K Blair
Board Member: Dr R Williams
Board Member: Mr R Wilson

West Lothian Shadow Health & Social Care Partnership Board -

Chair: (Cllr F Toner)
Vice Chair: Dr M Bryce
Board Member: Mrs A Mitchell

2.2 Recommendations for appointment to the Shadow Health and Social Care Partnership Boards for Midlothian and East Lothian will be brought forward to a future Board meeting.

3 Key Risk

3.1 If members are not appointed the Shadow Health & Social Care Partnership Boards will not be able to meet.

4 Risk Register

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

5 Impact on Inequality, Including Health Inequalities

5.1 Not required as this is an administrative matter.
6 Involving People

6.1 The Board Chairman has discussed these proposals with the members concerned.

7 Resource Implications

7.1 There are no resource implications and no additional cost attaches to these appointments.

Peter Reith
Secretariat Manager
19 November 2012
peter.reith@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 To provide an update on the progress and impact of the Scottish Patient Safety Programme (SPSP) in NHS Lothian acute hospitals.

1.2 To inform the board of new targets for phase 2 of the SPSP and plans for implementation.

1.3 To update the board on development of new patient safety programs for Primary Care, paediatrics, mental health and maternal health.

2 Recommendations

The board is asked to note:

2.1 The findings of a recent Autumn Harvest site visit to the Royal Infirmary, the Western General Hospital, St John’s Hospital and the Royal Hospital for Sick Children from Healthcare Improvement Scotland (HIS) summarising key successes and challenges over the past year (Report - Appendix 1).

2.2 The many demonstrable successes where robust processes have been embedded and made a demonstrable improvement in patient outcomes (Appendix 2).

2.3 The remaining challenges of implementation especially around medicines management and the identification and rescue of the deteriorating patient in order to achieve the 20% reduction in Hospital Standardised Mortality Rate.

2.4 The infrastructure that is required to support, sustain and expand the programme.

3 Discussion of Key Issues

3.1 Background

The Scottish Patient Safety Program was launched in January 2008 with engagement of all health boards across Scotland. Over the first 5 years, the program aimed to improve the reliability and safety of everyday healthcare systems and processes by using evidence-based tools and techniques including improvement methodology and regular data measurement to demonstrate change.
The methodology was adopted from evidence from the Institute for Healthcare improvement (IHI) in the USA and IHI have provided support and mentoring at a national level throughout the first 5 years of the programme.

### 3.1.1 Aims

The high level objectives for the program over the first 5 years are to demonstrate

- a 15% reduction of hospital standardised mortality rates across Scotland as measured by HSMR by across and
- a 30% reduction in adverse event rates on case note review as measured using the Global Trigger Tool (GTT)

The specific programme targets are embedded within 5 distinct workstreams (see Appendix 1 for descriptions of workstreams) and include:

- Ensuring early recognition and interventions for deteriorating patients
- Preventing adverse drug events
- Preventing harm from high alert medications such as warfarin and insulin
- Delivering evidence-based care for congestive heart failure
- Reducing surgical complications
- Preventing central line infections
- Preventing surgical site infections
- Preventing ventilator associated pneumonia
- Preventing pressure ulcers
- Reducing incidence of staphylococcus aureus (MRSA plus MSSA) infection
- Driving a change in the safety culture in NHS organisations

Many of the interventions required within the program involve application of BUNDLES of care. A ‘bundle’ is a small set of evidence based practices, generally 3-5, that, when performed collectively and reliably, have been proven to improve patient outcomes. Processes are embedded using quality improvement methodology and measures are made of both application of the PROCESSES of care and of the OUTCOMES for each measure.

### 3.1.2 New developments

Based on the existing model, additional national targets have been set for 2012 to improve the reliability of care delivery for management of sepsis and avoidance of venous thromboembolism (VTE) both of which make a significant contribution to avoidable mortality and morbidity.

The effectiveness of the SPSP, which was initially aimed only for the acute hospital inpatient areas, has resulted in the government supporting the development of new programmes in primary care, paediatrics, mental health and maternity services. Some of these programmes are more challenging as the evidence base linked to outcomes is not as readily available and have to be developed.

In NHS Lothian, following the successful implementation of care rounding in the Royal Victoria Building, the practice is being spread to other inpatient areas with the aim of reducing patient harm through the reduction of falls and pressure ulcers. This approach was highlighted as good practice at the HIS Autumn Harvest visit as
is providing great insight into how this intervention can capture both the person-centred intention and also increase reliability of assessment for falls, pressure area care, etc. Specifics of these new workstreams and progress against targets will be the subject of future reports.

The new targets for the National SPSP for December 2015 are
- a 20% reduction in HSMR
- At least 95% of people receiving care do not experience harm

3.1.3 Building an infrastructure

Reduction in variation and increase the reliability of delivery of essential interventions to a level of 95% compliance or better is one of the key aims of all of the programs. This is brought about by frontline multi-disciplinary teams reliably implementing evidence based interventions, by building teams able to develop and deliver continuous quality improvement and by strengthening the leadership and culture of safety in the organisation.

Workforce capacity for improvement has been developed through hundreds of frontline clinical staff and managers attending national SPSP learning events over the last 5 years and applying this to their own practice. The Leadership provided by the Associate Medical Director for Safety has been pivotal in engaging medical staff and building improvement capacity. NHS Lothian has four IHI trained Improvement Advisors and seven qualified SPSP Fellows and three who are just beginning their training. All are using their learning and experience to lead on improvement projects and mentor others. In this they have the support of the senior management team. NHS Lothian is currently mapping Quality Improvement capacity and capability within the organisation with the aim of developing a 'quality hub' consisting of a range of staff with quality improvement expertise within Lothian.

Multi-disciplinary team working and good communication are essential to implement the interventions stipulated by the programme and to achieve the outcomes. A good understanding of using data over time to measure improvement is also a requirement. The simplification, standardisation and the consideration of human factors within processes are core elements of the work. Greater automation and information technology support has been demonstrated to be effective in many situations.

Much of the work of the patient safety program has overlaps with other programmes and support services such as Infection Prevention and Control Team, the Delivering Better Care Programme, Risk Management, Clinical Education and Development, e-Health and Information Services. It is important that these are integrated to share expertise and minimise duplication of effort so the patient safety becomes an embedded aspect of routine practice for everyone.

Progress towards SPSP goals and maintenance of reliability when achieved is monitored through a process of self-reporting. An infrastructure for safety has had to be designed and implemented, providing technical expertise, information
technology support and a system for spread. This has allowed development of the programme from the four pilot teams in 2008 to supporting over 200 clinical areas and has presented immense challenges in terms of education, support for improvement, data collection, reporting and understanding.

Much of the burden of data collection and entry to demonstrate compliance with SPSP and other overlapping programs of work falls on nursing staff and there is a need for rationalisation of this requirement for data across all schemes. Some senior charge nurses have developed an effective system for measuring quality as part of their routine work, providing immediate feedback and taking appropriate action.

To reduce the data burden on frontline staff the Clinical Governance Team have developed systems to support single data entry for quality and safety data which can be used for multiple purposes and enables reporting from ward to Board and Nationally. A custom built Quality Improvement Data System (QIDS) is currently being used by all the acute inpatient areas to report their quality data. This resource is being spread to include mental health, primary care and community services.

The Ward Scorecard is a data system which brings together process and outcome data on quality and safety measures as well as staffing, activity and finance information for the wards so that they can see the impact of any changes over time.

3.2 Outcomes

Please see Appendix 2 which highlights process and outcome measures related to a range of interventions discussed below. Key SPSP process and outcome data forms part of the monthly Quality Report dashboard.

3.2.1 Hospital Standardised Mortality Rate

From December 2009 Information Services Division (ISD) has produced quarterly hospital standardised mortality ratios (HSMR) for all Scottish hospitals participating in the Scottish Patient Safety Programme (SPSP). The intention is to allow monitoring of time trends in mortality for Scotland and at individual hospital level. The aim of the Scottish Patient Safety Programme is to reduce hospital mortality across Scotland by 15% by December 2012 from a baseline at October 2006. A new target of a 20% reduction by December 2015 has been set for phase 2 of the program.

The HSMR remains below 1 for all acute Lothian sites Royal Infirmary of Edinburgh (RIE)(.75), the Western General Hospital (WGH)(.69) and St. John’s Hospital (SJH)(.81). According to the ISD figures released in November for the quarter to June 2012, all three acute hospitals have seen reductions in HSMR i.e. 5% reduction for WGH, which at .69 has one of the lowest mortality rates in Scotland, a 6.3% reduction for SJH and a 10% reduction for RIE. The HSMR for Scotland is 0.88 and the overall reduction for Scotland is 11.4% from baseline in October 2006.
3.2.2 Adverse Event Rate

A multi-disciplinary team on each of the main hospital sites including RHSC, review 20 sets of randomly selected notes from a list of deaths and discharges for a particular month to identify the rate of harm to patients and learn from this. The target reduction for the adverse event rate in adult acute inpatients (excluding obstetrics) as measured using the Global Trigger Tool (GTT) is 30%. A 46% reduction has been achieved in NHS Lothian. The HIS team report that “NHS Lothian is providing outstanding data in the field of adverse event improvement methodology and leadership. Their >40% reduction in adverse events based on a mature use of GTT and staff engagement is inspiring”. The reduction is likely to be primarily as a result of the reduction in infections and it is anticipated that the additional improvements in the management of the deteriorating patient, sepsis, venous thromboembolism (VTE) and medicines management will contribute to a further reduction over time (Appendix 2 Chart 4).

3.2.3 Infection prevention bundles

Compliance with the Ventilator Acquired Pneumonia Bundle (VAP)

The critical care workstream has been the most successful work stream as they are small units, with tighter staff groups, who had audit and robust data measurement already in place, although this does not diminish the complexity and the amount of effort they have put into achieving their outcomes which the HIS team described as inspiring.

The three Critical Care Units across Lothian have been working on the VAP bundle for more than 4 years and have made significant improvements in reducing the number of infections and increasing the number of days between infections compared to their baselines. The overall VAP rate for NHS Lothian shows a significant reduction. The results show a significant reduction in the VAP rate and illustrate the relationship between improved compliance and reliability with the VAP bundle and the improved outcome (Appendix 2. Charts 6, 7 & 8).

Compliance with the Central Venous catheter (CVC) bundle & CRBSI

The insertion and maintenance of CVC’s is done in specialised areas such as theatres, ICU and renal where they have very robust and exacting measurement of compliance and practice is good. The reliable compliance with the CVC insertion and maintenance bundles and the improved outcomes is clearly demonstrated.

Ward 20 WGH have achieved 575 days between CRBSI’s from a baseline of 15 days. Where CRBSI was previously considered to be a common side effect of care on ITU, we now have a culture where every CRBSI that occurs is investigated and learning is fed back to clinical staff through the ward safety brief, morbidity and mortality and Quality Improvement Team meetings.
Peripheral Vascular Bundle (PVC)

The PVC bundle aims to improve reliability around standards for insertion of peripheral lines and regular review of necessity to minimise the chance of developing Staph Aureus Bacteraemia (SAB). This has been implemented in all appropriate areas of the acute division and there has been an improvement in compliance with the bundle and the related outcome (reduced SAB) both in critical care and general ward areas.

Blood Cultures

One of the key targets of the 90 day rapid cycle improvement programme to reduce Staph Aureus Bacteraemias (SABs) undertaken in 2011, was to reduce the number of contaminated blood cultures taken. There is evidence that contaminated blood cultures (false positives) increase patients’ median length of stay by 4.5 days on average at a cost of £32601 - £52000 per patient as a result of unnecessary antibiotics, investigations & increasing laboratory costs. This also affects reported rates of bacteraemias for surveillance purposes. Feedback from wards who were best in class to others, educational input and feedback to wards on performance resulted in changes in procedures and practice has resulted in a sustained reduction from 7.4% to 3.7% currently.

C. Difficile (C.Diff) risk assessment

The C.Diff bundle was the first to be tested and implemented in NHS Lothian using model for improvement methodology with rapid and sustained improvement in outcome. The reduction in personal and organisational cost as a result of this improvement is not to be underestimated and we need to ensure that compliance remains reliable. Ward access to the scorecard will enable the wards to link process with outcome measures more easily.

Antibiotic prescribing

Part of the C.Diff bundle includes appropriate antibiotic prescribing. Currently the nursing staff audit antibiotic prescribing and there is a particular issue around the medical staff recording indication and review/stop dates. The new version of the prescription chart has indication but does not prompt for stop/review dates and this is under review with a view to bringing about the necessary changes.

Hand Hygiene

There has been a sustained improvement across the board with regard to hand hygiene. From the outset of the programme it was agreed that not only would the opportunities taken to perform hand hygiene be measured but the technique and whether staff were wearing jewellery and were bare below the elbows were also to be included. This stringent standard has now been adopted in all the boards. The independent audits undertaken by the Hand Hygiene Coordinator supports the findings of the self reported audits. The compliance with hand hygiene has contributed to the overall improvement in the reduction in infections.
Compliance with the Urinary Catheter Insertion and Maintenance Bundle

Urinary tract infections (UTI) are the most common infections acquired in hospitals and long-term care facilities. Several studies have indicated that between 75 and 80% of all healthcare associated UTIs follow the insertion of a urinary catheter and it is estimated that around 26% of all hospitalised patients have a urinary catheter inserted during their stay in hospital. A bundle has therefore been developed to encourage consideration of whether a catheter is really required, appropriate insertion and maintenance is delivered and to expedite removal at the earliest opportunity. The new documentation being tested has a section for the Catheter Associated Urinary Tract Infection (CAUTI) bundle which is well received and should improve awareness, compliance and record keeping. On the whole compliance with the CAUTI bundle is good but linking compliance with outcome on the scorecard would be helpful. The insertion bundle is currently being tested by the community nursing team and the intention is that they will spread that to nursing homes. A reduction in CAUTI is being considered as part of the national harm free care targets.

The Sepsis Bundle

The implementation of the national Sepsis bundle is embryonic. The measures, case ascertainment, data collection and reporting is challenging. The new Standardised Early Warning Score (SEWS) chart has been amended to include ‘think sepsis’ and Sepsis Bundle prompts and early feedback suggests that medical and nursing staff have found this helpful in identifying patients with signs of sepsis. There are a number of pilot areas testing ways of improving recognition and rapid response to sepsis. The sepsis project is part of the deteriorating patient work stream and will contribute to the reduction in HSMR

3.3. The management of the deteriorating patient

A core element of the General Ward Work stream is the early recognition and management of the patient who is becoming acutely unwell which is key to improving patient outcomes in acute hospitals.

The identification of deteriorating patients is primarily triggered by the competent use of the Standardised Early Warning Score Chart (SEWS). The compliance with SEWS has improved as can be seen by the compliance results across the board, and this has been validated by independent annual audits by medical staff as well as the Adverse Event Reviews. A revision of SEWS has taken place to address the weaknesses that have been highlighted through serious adverse events and to include information about the sepsis bundle. This has been tested by wards and medical staff and will be relaunched in November supported by multi-disciplinary education.

The Salford Bundle for the identification, escalation and rapid response to deteriorating patients and was tested and implemented at St John’s Hospital last year and the improvement has been sustained. There is a plan to support the
spread of this to the other inpatients areas in the board in a coordinated and integrated manner supported by the Education and Development Team.

A structured anticipatory care ward round where goals are set and shared with the patients and a plan is agreed for review and action for patients who are at risk of deterioration has been developed and implemented in the Acute receiving Unit. This has demonstrated improved processes and outcomes. Structured ward rounds are part of the Salford Bundle and support is being provided to the spread it to other services in NHS Lothian and was shared with other boards at the NHS Scotland event and at the SPSP Learning session in November.

A SPSP Fellow has developed a structured handover for medical staff which has been incorporated into TRAK. It is particularly important for the handover between the day teams to Hospital At Night. A teaching pack has been developed in collaboration with National Education Scotland which is now available to all staff in Scotland and over the last two years the Fellow has taught all the junior doctors how to do a good handover. Safety briefings are a core structural element for raising concerns and communicating about safety. These now take place a month and compliance is at 98%

The collection of robust data on the cardiac arrest outcomes as the outcome measure for this work stream has been a challenge. The cardiac arrest form is being redesigned to ensure more complete data which will improve our understanding of process and outcome. Clinical services are in the process of reviewing their cardiac arrest calls and responses with a view to improving them.

A dashboard of measures has been agreed and will be reported monthly and quarterly by hospital site to ensure that appropriate progress is made and identified gaps addressed. The effective management of deteriorating patients is pivotal to the reduction in HSMR.

3.4 Safety in surgery. The perioperative Workstream

3.4.1 Surgical Safety briefings

Use of a safety checklist prior to surgery has been demonstrated to reduce surgical complications in a large scale international study and was recommended by the World Health Organisation and embedded in the surgical workstream of the SPSP. As well as acting as a prompt to check that the patient and procedure are correct and that key interventions (such as antibiotic prophylaxis) have been administered, use of the checklist helps to open channels of communication amongst staff in the operating theatre so that if anyone in the team has concerns they are able to voice them and they will be listened to. Implementing it into surgery was challenging both from practical organisational perspective, but also as it required a change in culture and behaviours. Initially led by one surgeon and one anaesthetist in one operating theatre, the surgical checklist is now accepted and used in all operating theatres across Lothian. The use of the safety checklist has now spread to other areas where interventional procedures take place such as radiology and cardiology.
Prelist briefing is a process with all parties present prior to the operating list being started to iron out any potential problems and risks. It creates a more proactive and cohesive theatre team and more robust safety system in theatre. This system change has been successfully and reliably implemented in the Department of Clinical Neurology at WGH. The HIS visiting team were inspired by the effectiveness and efficiency of this team with regard to their process and raised it as best practice at the national safety learning session on the 8th November. The learning and practice from that theatre is slowly being spread to others however other competing organisational targets such as the theatre start time make it challenging to achieve this.

3.4.2 Surgical Site Infection Bundles

Delivery of prophylactic antibiotics in a timely manner and maintenance of normal body temperature and blood glucose (diabetic patients) in the perioperative period are all evidence based interventions which have been shown to reduce the risk of development of surgical site infection in the postoperative period.

Normothermia

Maintaining patients temperature at normal levels during a surgical or interventional procedure is a challenge however it is important for their comfort, but importantly is linked to a reduction in infections. Appendix 2 shows improvement in the maintenance of normothermia through application of national guidelines for patient warming during surgery.

Glucose control

For diabetic patients maintaining their blood sugar levels within normal range during the perioperative period is important and has an impact on infection. Appendix 2 shows that there is good compliance with this important aspect of care in some operating theatres.

Antibiotic prophylaxis

Antibiotic prophylaxis where required should be administered within 30-60 minutes before incision before skin incision to allow optimum perfusion and maximum effectiveness of the prophylaxis. Compliance with this practice was previously demonstrated to be reliable when using paper data collection forms. A reduction in apparent reliability corresponding to introduction of an electronic system (ORSOS) is likely to be an anomaly of data capture and is being investigated.

Surgical Site Infections (SSI)

Surgical site infection is the outcome measure associated with application of the SSI bundle of care including reliable perioperative antibiotic administration, temperature control and control of diabetes where appropriate. Regular measures of SSI rates are made in surgery for hip fracture, hysterectomy and caesarean section. The current reduction of 32% does not achieve the 50% target set by the SPSP. The patients who are at most risk are those with high body mass index and diabetes, so there is a focus on improving care for these patients.
and a root cause analysis (RCA) is undertaken for all infections. The development of systems to measure surgical site outcomes via the infection control system is welcomed by the surgeons who have previously not had access to this information.

3.5 **Medicines Management**
For all the health Boards in Scotland, the medicines management workstream has been the most challenging to progress and its easy to forget some of the excellent work that is being delivered day to day on many sites. (See HIS report, Appendix 1 p17)

3.5.1 **Medicines reconciliation**

The aim of medicines reconciliation is to obtain a reliable list of medication patients are on when they are admitted cross-checked using a second information source and accurately transferring that information onto the prescription chart. Decisions on continuing, withholding or adjusting medications should be documented at admission, transfer and discharge so the GP receives with clear explanations of the changes made to medication during the patient’s inpatient episode.

The challenges around reliable implementation of this process are many but these are being addressed using a variety of interventions across Lothian.

Practical challenges to accessing electronic information about patient’s medication in the community (The Emergency Care Summary: ECS) have been addressed nationally and work is underway to improve the interface between the ECS and TRAK care system to improve ease of information transfer. Use of an electronic system within renal services has been demonstrated to improve compliance with medicines reconciliation for a group of patients who have a number of complex medicines. (see Appendix 2 Chart 28 ) and further work in WGH has demonstrated that that enabling medical staff to access the Emergency Care Summary significantly improves medicines reconciliation and speeds up effective discharge communication.

Recent implementation of the Green Bag scheme in Lothian, in which patients will be asked to bring their medicines into hospital, will also help to improve cross checking of medications, make the process more reliable, prevent missed or late doses and reduce waste and costs. Although pharmacists have an important role to play in assisting with medicines checking and in identifying potential errors early, they are not available 24/7 and cannot review the medication for all patients. It is therefore the role and responsibility of all clinicians to ensure that the processes for safe prescription and administration are in place and adhered to.

A number of initiatives in Lothian have demonstrated clear improvements in accuracy of medicines reconciliation. A team at St John’s Hospital have achieved sustained improvement in reconciling medicines on admission and discharge with up to 95% of kardexes and immediate Discharge Letters (IDLs) now accurate including diagnosis, care arrangements and follow up. This has been done by working in close liaison with West Lothian GPs to ensure that changes meet their requirements and there is two-way feedback.
An initiative to improve “team working” and opinions about prescribing errors and medicine reconciliation in order to change the culture and behaviour with regard to medicines in the RIE has demonstrated a sustained improvement in compliance with medicines reconciliation and achieve a median of 80% (Appendix 2 Chart 27). Plans for spreading this best practice to other teams in Medical and Associated Services has been developed along with a plan for raising awareness of best practice with education and support.

Six GP practices in NHS Lothian are piloting a process for medicines reconciliation.

3.5.2 High risk medicines

Best practice has been established with regard to the high risk medicines of warfarin and insulin but this has to be spread to all other clinical areas and linked to the improvements made in the community and GP practices. In February this year several seminars were held to share best practice and to encourage the spread. A number of challenges to enable systematic changes to take place such as the standardisation of guidance for insulin prescribing have been addressed by senior managers to enable the challenges to spread to be overcome.

Warfarin management

Best practice in warfarin management has been established in cardiology. They have developed processes and guidance to support the accurate prescribing of warfarin to manage INR levels and reduce the risk of bleeding. The challenging aim of reducing INRs >6 has been demonstrated and sustained through implementing a variety of changes.

The HIS team were encouraged by the fact that 93 GP Practices (74% of all practices) are participating in the primary care safety programme to improve the management of warfarin.

Compliance with Venous Thomboembolism prophylaxis (VTE)

Ensuring that patients receive appropriate and timely VTE prophylaxis reliably is critical to safe outcomes for surgical patients. Appendix 2 shows that the compliance with the administration of VTE in theatres is generally good and has improved. As mentioned previously, although this has been part of the perioperative workstream from the start, it is now an additional priority for SPSP for all patient groups with the focus on the assessment and the recording of risk which up until now has largely been implicit rather than explicit. Having an effective process for assessment and prevention will reduce avoidable harm and contribute to HSMR reduction. We are fortunate that the national lead for this work stream is also leading the work in NHS Lothian.
Insulin Management

The diabetes team have been developing best practice with regard to insulin prescribing and management in a number of pilot wards and have been able to demonstrate improvements in glucose control. They have standardised guidance and charts which has resulted in a 50% reduction in insulin management errors and will benefit the whole organisation.

The ‘Think Glucose’ campaign is being piloted by means of a government grant. Baseline data are being gathered and documents / changes being developed with the view to all of Scotland learning about the benefits of this work

3.5.3 Medicine administration error reductions

In 2011 The Nurse Director set a target of 15% reduction in nursing medication administration errors that resulted in major harm or death

In September 2011, ten wards were selected on which supported, focused improvements could be tested and implemented. A Failure Modes and Effects Analysis (FMEA) was conducted in each area determining what goes wrong, why, associated risk, action plans. Support was provided for improvement and a sharing of ideas and learning. Although this work was aimed at reducing medication administration errors, other factors such as medicines reconciliation and prescribing have an impact on administration. Multi-disciplinary teams have worked together to address these issues

To share the learning and best practice the Associate Nurse Director launched a “Medicines Month” in September to:

- raise awareness of the aim to the multi-disciplinary team
- bring all strands of work together
- raise awareness of possible local improvements for all areas
- raise personal accountability awareness (and NMC Standards for Medicines Management Standard 8)
- share improvements
- promote and ensure that the correct up-to-date documentation is in place
- promote our Quality Improvement Data System (QiDS)
- provide support, expertise and executive leads
- launch a joint collaborative of disciplines to achieve improvement

750 staff attended the road shows across NHS Lothian which were manned by pharmacists, education facilitators, nursing staff and managers and there was much sharing and learning. The next step is the development of resources to support the spread of best practice.
3.6 The Leadership Workstream

The role of leadership within the boards is to support the improvement of safety and quality outcomes by developing the infrastructure, provide oversight to programme and to promote the position of safety and quality in the organisation. The monthly Quality Report dashboard provides key SPSP process and outcome data which along with the Executive WalkRounds enables the Board to have oversight of the program.

Executive Leadership Walkrounds

The aim of the leadership walkrounds is for executive managers and clinical teams to have the opportunity to talk about safety concerns, to track progress, celebrate success, to improve communication, remove barriers and support good ideas. International evidence has been able to link the number of safety walkrounds with an improvement in the safety culture. A total 141 walkrounds have taken place since March 2008. In 2011 a review of the role and impact of all the organisational walkrounds was undertaken. Following positive feedback from executives and ward staff it was agreed that the safety walkrounds would continue. Walkrounds are currently under review again. Further input to safety walkrounds at executive and non-executive level is highly desirable to drive improvement in safety culture in the organization. This was also commented on by the HIS visiting team.

4 Key Risk
4.1 Failure to spread and sustain good practice from pilot areas

5 Risk Register
5.1 Failure to comply with national standards with potential impact on patient improvement and outcomes of care, and external inspections

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

7 Resource Implications
7.1 The resource implications are the time it takes clinicians to collaborate, collect data and make the appropriate improvements. The resources to develop and spread the safety programme to new areas such as Women and Children’s Services, Mental Health, General Practice and Community Services
List of Appendices

Appendix 1: The Healthcare Improvement Scotland Autumn Harvest Report
Appendix 2: SPSP Highlights September 2012
Autumn Harvest
Board Report

Board: NHS Lothian
Hospital: Royal Hospital for Sick Children, Royal Infirmary Edinburgh, St John’s Hospital and Western General Hospital

Date of visit: Wednesday 10th & Thursday 11th October

Board Contact: Annette Henderson

Faculty Lead: Brian Robson

Faculty members: Carol Sinclair, Carol Haraden, Neil Houston, Susan McGaff and Caroline Ashton

The purpose of this visit is to

- Collate learning of good practice from the first phase of the Scottish Patient Safety programme
- Identify areas of success and factors leading to that success.
- Look at spread of interventions within Boards
- Identify themes for focus of the next phase of the programme

This learning will be shared at LS 9. Detailed entries will help to identify best practice and the factors supporting it.

- **Progress** - against the work stream driver diagrams
- **Challenges** – with meeting those aims
- **Spread** – of critical interventions e.g. EWS
- **Interventions/Tips & Tricks** – successful interventions, what helped?
- **20 % Mortality Aim** – how are Boards planning to implement/accelerate interventions to reduce mortality?
- **95% Harm Free Care** – how are Boards preparing?
Overall Summary

Healthcare Improvement Scotland would like to thank the staff of NHS Lothian for hosting the Harvest Visit this year and commend Annette Henderson and her team for the comprehensive overview of all the work that is ongoing across the Board provided before the visit.

Previous SPSP site visits to NHS Lothian have commented on the foundations having been laid down for continuous quality improvement in NHS Lothian. The 2012 harvest visit faculty have found these foundations to be not only solid but being built upon across a range of areas of improvement. The energy, passion and commitment of staff in so doing is palpable and we commend NHS Lothian on its commitment to supporting and driving this work.

Leadership – We saw clear evidence of committed leadership from ward staff, clinical teams, support services, structural and professional leaders and from Board Executives. NHS Lothian are creating the environment to allow radical socio-technical changes such as the ‘capacity briefing’ at the RHSC and the safety briefing in the DCN theatres. These are stand-out examples of cultural changes which are improving care, accelerating safety, enabling teamwork and changing culture.

The visit team would encourage NHS Lothian’ Board, and specifically non-executive leaders to consider how they are reflecting on ‘Boards on Board’ and also how they engage with these changes across the organisation, including considering again how they might input to leadership walkrounds.

Standardisation to support reliable care – The visit team saw many excellent examples of clinicians and managers working together to consider the best available evidence and how they might build reliable delivery into their area and the wider system. Your pharmacy systems are world-class with standardisation, safety and commitment to automation having a direct impact on patient safety, efficiency and freeing up trained staff to work on the huge challenges around medication safety at ward level. Your clinical teams working on standardising and simplifying complex areas of anticoagulation, thromboprophylaxis, insulin management, acute assessment, acute ‘flow’ and even the fundamental ward-round are delivering amazing results.

The visit team would encourage NHS Lothian to consider the further implementation and spread of these tests of standardisation can be obtained and specifically to consider how eHealth can support these developments.

Quality improvement capacity and capability – NHS Lothian is clearly aiming to being a high-performing organisation that continues to make significant progress across many of the aims of the programme and is clearly committed to developing its own capacity and capability in QI and safety with further support for SPSP Fellows, Improvement Advisors and its outstanding commitment to simulation and educational programmes. The Secure Foundations in Lothian programme demonstrates NHS Lothian’s firm commitment to modern, applicable education, learning and skills development and should be widely shared.

The visit team would encourage NHS Lothian to consider what their overall aim is in relation to capacity and capability in Quality Improvement and consider within this how they ‘mainstream’ and sustain the various outstanding examples we saw.

Sustaining and securing the new SPSP aims – NHS Lothian is amongst the most advanced systems in using data for improvement in Scotland and the visiting team saw many examples of this at Board, system, unit and individual QI project level. NHS Lothian should consider focusing on a small number of interventions that will drive improvement in HSMR.

The visit team reflected with leadership on the modest gains in HSMR across Lothian sites and asked that NHS Lothian consider again which interventions will accelerate this trajectory.
Both mornings were started with visits to morning safety briefings. The comprehensive overview from the team at the Royal Hospital for Sick Children demonstrates a wider application of the safety briefing and allows the hospital team to gain an immediate understanding of what staff, beds and facilities are available allowing the management team to address any concerns before they become issues.

The Peri-operative pre-list briefing allows all theatre staff to speak in a safe and secure environment that empowers all members of the teams to raise and address any potential equipment and staffing concerns. This team has collected some great examples of issues raised that were addressed immediately, saving time, money and ensuring the patient has no delays in their operation. After some initial resistance this briefing is now attended by at least one member of each theatre team.

The visit team was heartened to hear feedback from one attendee that the briefing was now seen as an essential part of each day. Faculty cannot stress highly enough how important it is that junior doctors have the values being taught to them, starting on their careers with NHS Lothian, mirrored in the behaviours of consultants and others. Wherever possible, continual Quality Improvement should be incorporated into job descriptions, annual evaluations and built into human resources planning and education to ensure that it is not person dependant.

The visit team was impressed with the simulation centre based at St John’s Hospital and the Secure Foundation Programme education strategy being rolled out to FY1 doctors to improve their understanding of quality improvement and patient safety; this is very striking especially the ability to make it multi-professional. The encouragement in the use of DATIX to record incidents for improvement within this cohort of doctors should be spread to other areas.

A “Pull” system in place across ERI has decreased delays to acute admission to a specialty ward; there is a structured nurse handover as patient collected with a management plan handed over at same time. All of this contributes to better management and prognosis for patients. This was tested hospital wide for two days before being implemented fully – we encourage NHS Lothian to explore this achievement to consider how this done and what factors are transferable to other areas.

The visit team was impressed by the number of small tests and improvements that teams around NHS Lothian have implemented, however NHS Lothian requires to address the
issue of adding interventions (e.g. insulin protocols) and key data, that have been tested, onto the electronic system and automate as far as is possible.

**Themes**

**Education** – NHS Lothian has developed an educational package for FY1 which focuses on continual Quality Improvement and continues to support staff to gain knowledge through SPSP Fellowship and Improvement Advisor programmes.

**Leadership** – Engagement of Non-executives has been challenging and more structured support to assist them in understanding Patient Safety and Quality Improvement is required.

**Sustainability** – NHS Lothian has encouraged the teams to use the Model for Improvement across different areas, not just those aligned to SPSP.

**Information Technology** – Teams across all sites are developing spreadsheets and data collection systems independently as there is a perceived lack of IT support to assist in this.
|--------------|--------------------------------------------------------------------------------------------------|
| **HSMR**     | The announcement, by the Cabinet Secretary in June, of the new aim of a 20% reduction in HSMR has given NHS boards an opportunity to consider the further improvements and interventions that can have an effect on their data. NHS Lothian’s site HSMRs have made modest progress in relation to many other sites across Scotland can demonstrate a reduction of 8 – 12% but there is still potential to improve.  

The visit team invited the leadership in NHS Lothian to consider what is not working and what the Board will do to improve and accelerate their HSMR reduction. The visit team agreed that some of the reductions seen at other NHS boards can be attributed to a review of how incidents are coded, however with the appliance of SPSP bundles and methodology, further improvements can be achieved and this will reduce the overall HSMR data.  

There are many great examples of activities contributing to reduced avoidable mortality including the renewed focus on rescue of deteriorating patients, Sepsis and VTE and the introduction of reliable systems would allow NHS Lothian to dramatically improve the number of patients who are being harmed needlessly.  

A number of interventions mentioned will improve safety and quality but are likely to have little impact on mortality per se e.g. nutritional care, falls or pressure ulcers. Whilst faculty recognise the importance of addressing these areas, it may be helpful to specifically identify NHS Lothian’s high impact mortality interventions.  

There are challenges of working across 5 sites – data capture being well-managed but room for improvement in sharing and spreading good practice. There is strong use made of data but would appear to be a disconnect between SPSP and the Board – possibly a lack of understanding on how SPSP data is calculated and the narrative behind it. Healthcare Improvement Scotland measurement and data team may be able to assist.  

NHS Lothian should methodically analyse what high performing teams are systematically doing and consider whether it is repeatable across other areas. |
| **Adverse Events** | NHS Lothian is providing outstanding data in the field of adverse event improvement methodology and leadership. Their >40% reduction in adverse events based on a mature use of GTT and staff engagement is inspiring.  

The clinical governance team are contributing across areas where they can maximise their input/impact e.g. VTE form.  

Harm-free care:  

Work on ‘care rounding’ is providing great insight into how this intervention can capture both the person-centred intention and also increase reliability of assessment for VTE, falls, etc. |
Leadership
Outcome

Primary Drivers

Provide the Leadership System to Support the Improvement of Safety and Quality Outcomes in your Board

Develop the infrastructure to support quality and safety improvement

Provide oversight to programme

Promote the position of safety and quality in the organization

Secondary Drivers

Establish an SPSP Implementation Committee
Ensure a feedback mechanism for issues raised in Walk-rounds
Ensure the development of a measurement system used to understand and drive patient care quality and safety indicators
Assign a senior leader to each improvement area (critical care, general ward, medicines management and peri-operative care)

Meet with the Programme Manager remove barriers
Meet regularly with the SPSP Implementation Committee to track progress and remove barriers
Display the Gantt chart that depicts progress toward SPSP goals

Ensure that the senior team participates in Walk-rounds
Place safety and quality issues at the top of senior leader meeting agendas
Add SPSP progress and outcomes to the Board agenda

The Institute for Healthcare Improvement 2008
Successes

Supporting documentation on NHS Lothian’s Quality Improvement, ‘values into action’ approach and commitment to learning from the recent ‘investigation into management culture’ was helpful background on the leadership focus in NHS Lothian.

Senior leadership commitment of resources to education and learning. In particular the additional funding to allow the FY1 induction to be held over 4 days shows an increased awareness of the importance of this group. The Secure Foundations modules being applied in NHS Lothian, the investment in the simulation centre and investment in clinical skills training are all examples of investment that can be shared nationally. Aware of the potential for this to have possible duplication across boards especially when Junior doctors are moving between boards.

NHS Lothian described a focus and investment in middle management engagement and development – e.g. Napier/Harvard etc and this is to be commended.

The Associate Nurse Director had supported and helped coach a SPSP Fellow with an ambitious project to improve flow of patients to wards from the combined assessment unit. This support and buy-in at senior level had clearly allowed the project to spread very quickly which is fantastic. The FY education and induction is to be commended and a largely standardised induction across Scotland would reduce waste, improve care, improve staff satisfaction and reduce cost. We would encourage NHS Lothian to share their experience widely and commend to deaneries, NES and Scottish Government. Faculty would commend NHS Lothian on its engagement and leadership involvement of senior consultants for VTE/Sepsis both internal and national roles – this display of local improvement and national leadership is exemplary.

Challenges

NHS Lothian should encourage visible engagement of the Chair and Non-Executives and promote the position of safety and quality improvement within the organization, the new Chief Executive Officer has multiple competing priorities however has indicated his personal commitment to this work. The CEO also highlighted his interest in encouraging national bodies to align the methodologies and messages from inspection and improvement to minimise waste, minimise unnecessary staff stress and confusion and maximise improvements for patients.

The visit team would suggest that ICT solutions and adaptations of current IT systems require to be prioritised as a matter of urgency, a formalised e-Strategy for Lothian considering feedback from SPSP Faculty and staff may help with this.

Clinical leadership
Lack of support for SPSP Fellows leading on various streams e.g. Claire Gordon (support with data collection and presentation/tests of change) – worthy of exploring at local level.

The visit team congratulate NHS Lothian on the reductions achieved so far in HSMR and would ask the Board to consider how to now escalate this to achieve the stretched aim announced by the Cabinet Secretary in June.

The strong and effective SPSP programme leadership and influence is evident and this is essential to allow NHS Lothian to be able to apply Quality Improvement across numerous areas and sites at one time.

The visit team recognise the strong commitment to education, skills and operational improvement from NHS Lothian.

Some good examples – Care Rounds in RVB/MoE, “Pull” system across wards in ERI – LEAN/RIE project

Use of SPSP Fellows, Improvement Advisers and other QI skilled individuals across a large healthcare system.
### Critical Care

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
</tr>
</thead>
</table>
| Improve Critical Care Outcomes (Reduce mortality, infections and other adverse events) | Provide appropriate, reliable and timely care to critically ill patients using evidence-based therapies
Integrate patient and family into care so they receive the care they want
Develop an infrastructure that promotes quality care
Create a highly effective and collaborative multidisciplinary team and safety culture | Reduce complications from ventilators
Reduce complications from central venous catheters
Optimal glucose control
Prevent healthcare associated infections and cross contamination
Proper sepsis recognition and treatment
Involve patient/family in daily goal setting process
Promote open communication among team and family
Ensure clarification of care wishes and end of life care planning
Ensure appropriate infrastructure and leadership to provide consistent, reliable, evidence based care
Improve ICU throughput
Ensure competent staff with knowledge in improvement work
Reliable care planning, communication and collaboration of a multi disciplinary team |
CRITICAL CARE

Successes
The Intensive Care Unit at the Western General Hospital continues to lead the way in person-centred care and shows maturity with reviewing and displaying of their data. Data is displayed at the main entrance beside the relative waiting area and staff are available to speak to relatives at any time. There is open visiting for the ward and family daily goals are embedded in the daily ward round. The unit will also phone the family GP to ensure that they are aware their patient is in Intensive Care.

The visit team would like to commend the work by the team in ICU on helping bereaved relatives and carers, which is seen as an essential part of the working of the unit. Providing a personal card and information about bereavement services has helped staff and relatives cope with loss on the unit and staff have pulled together a trolley to hold cards, boxes and other items for relatives who have lost someone in the unit. The staff do not provide bereavement counselling but will direct relatives to a service best suited to their individual needs.

The visit team noted that the ICU had previously achieved over 500 days without a CBSI and are now building this again, currently standing at 56 days, however what was demonstrated is that staff have learned how to investigate such incidents and have the confidence to review their methods.

The ICU team have segmented the population within the unit of VAP as this had seemed problematic, this has demonstrated a core of patients who will acquire VAP and can now be addressed. The visit team is not sure that across the country everyone has got to that point.

Standardised approaches have really taken off with trolleys for intubation, central lines etc – ‘making it easy to do the right thing’. The ICU team has tested and implemented a standardised Airways trolley and this is now going to be rolled out across all of NHS Lothian. Education using the Emergency Airway Management Course has increased staff confidence on using this.

The visit team was introduced to Dr Anthony Bateman who is behind a Home ventilation service which is offering amazing opportunities for patients who require ventilation support to ‘enjoy rather than endure’. Although started in ICU operates as a networked service across Scotland with great local support.

A new film highlighting the challenges that can be overcome with assistance is available online at http://www.alifeworthlivingfilm.com/

Challenges
The home ventilation team are attempting to reduce burden on patients visiting hospitals for clinics by using email to communicate with them. There are barriers to prevent the use of email and individual process for each patient? Although small patient numbers, is this replicated elsewhere and sends out message to clinicians that e-health not supporting these patient focussed developments. This is an issue for leadership to consider how to better assist.

The introduction of standardised trolleys across numerous areas and sites - making it easy to do the right thing.

Data display is innovative – make the data tell a story and don’t be afraid to share

Segmentation of VAP data (e.g. neuro – higher risk and different aetiology) – understand what your data is telling you.
General Ward

**Outcome**

- Improved general ward outcomes (Reduced infections, crash calls, pressure ulcers, AE in CHF and AMI patients)
- Provide appropriate, reliable and timely care to patients using evidence-based therapies
- Create a highly effective and collaborative multidisciplinary team and safety culture
- Ensure patient and family centered care
- Develop an infrastructure that promotes quality care

**Primary Drivers**

- Early warning system (EWS) to identify patient deterioration
- Prevent healthcare associated infections
- Prevent pressure ulcers
- Deliver reliable evidenced based care to CHF and MI patients

**Secondary Drivers**

- Reliable care planning, communication and collaboration of a multi disciplinary team
- Involve patient/family in goal setting process
- Promote open communication among team and family
- Ensure clarification of care wishes and end of life care planning
- Ensure patient's physical comfort
- Optimise transitions to home or other facility (CHF, MI)
- Optimise flow and efficiency in admission process, handoffs, discharge process, routine care for high volume clinical conditions (CHF, MI)

The Institute for Healthcare Improvement 2008
General Ward

Successes
There is early use of deteriorating patient dashboard of measures which is encouraging consideration of measurement of contributing factors (e.g. DNACPR) and outcomes. There is exemplary work on VTE assessment and prophylaxis, anticoagulation management, insulin management.

The new Royal Victoria Building is one of the most impressive units the team has seen over the entire visit. Although the staff were initially concerned about the introduction of single person rooms this has proven to be a great benefit to patients who deserve this. The staff focussed on ‘what matters to me’ from patients perspective and the medicines for the elderly team had introduced care rounding, before the move to the new building and this has seen the transfer to the new building be very calm and settling for patients. The team was gladdened to observe great care in such a lovely place, 21st century facilities which, as SCN Kirsten Smith highlighted was ‘exactly what our patients deserve’

All the rooms are easily sterilised and patients have their own rooms and are able to make them more homely, this has made them less likely to wander around and reduces the falls risk. Before moving to the new building they introduced a bundle of care rounding frequency, this has gone through lots of change and testing and is now on version17. Staff believe that patients are far more settled and have seen a 75% reduction in buzzer calls. By increasing the fixed times for care rounding the patient is more settled and reduces the time where they are waiting for someone to come to them. The senior nurse on the ward visited has introduced a drop in session on Thursdays to be available to relatives and carers and has open visiting where relatives are invited to come at any time during the day after 10.00am. There is an aim that consultants are available for appointments and will normally have seen a relative of the patient within 24hrs.

The visit team was introduced to Patrick Rafferty, an SPSP Fellow, who outlined an entire new way of working within the Combined Assessment Unit. By testing for a couple of days across the whole of the RIE, a new system was introduced to transfer patients to wards and, with support of leadership, redesigned the flow of patients. This has improved the patient journey and has allowed the wards to review their own capacity and agree movement of patients.

The patient journey was seen as being critical to the success of implementing this change and has been influential in it becoming a success so far. Patients have commented that they now feel that they are expected on wards and are made to feel welcome when they arrive. An important step implementing this system was to map the movements of porters and to look at when were the busy times. This included the porters in the conversation and they were more open to look at and match capacity. This is still in the early stages of testing but the transfer time has been reduced from 4 hrs to 20 mins, freeing up capacity in the Combined Assessment Unit to turn round patients quicker.

The Royal Hospital for Sick Children has introduced an algorithm which allows Advanced Nurse Practitioners and non-medical staff to prescribe medication on discharge and allow patients to be able to depart once discharged. These staff are non-rotating unlike doctors and can be a long term resource to improve the patient journey.

The visit team visited looked at the introduction of SEWS on one ward which has been effective. Training in how to complete SEWS, how to escalate and to whom is showing improvement however this is still being conducted on notes and paper and a highly standardised system like this which improves patient care should be fast tracked to be included onto any automated ward management system.

There were many examples of excellent spread of the Early Warning Score across wards and examples of wards holding white board meetings for safety briefings. Wards have developed white board with essential patient data, however there are limitations due to lack of tech solutions such as eWhiteboards.
NHS Lothian has embraced the Sepsis and VTE work that is being led nationally by SPSP, raising awareness on admission at the front door and has two VTE pre-operative risk assessment forms which are being tested in the RIE and St Johns. The current test is to review whether all staff are aware of the current local protocol. The visit team suggested using informal feedback to speed up the process of testing. It also beneficial to assess what does not work, as well as what does. Nurses now empowered to escalate when identifying new risk, maximising ANP and non-medical prescribing.

Involvement of frontline clinicians is proving essential in driving the improvement programme and these doctors are willing to share their own stories and journeys, it has been helpful for them to share how they have tackled resistance, addressing concerns helps. A sticker to be added to the patient medicines card and poster highlighting the importance of pre-op assessment is helping ensure as will having the pre-op assessment document in electronic form.

Reporting of VTE on DATIX in Glasgow suggests that the numbers recorded are only the tip of the iceberg, finding instances where VTE could have been avoided has a huge impact on building will around prevention of VTE. The teams in the coagulant and DVT clinics are collecting just enough data to gain an understanding of the problem.

Initial data is showing a reliability of screening for Sepsis where there is engagement at the front door. The Royal Infirmary Edinburgh is using a shock chart in the combined assessment unit. This is a process measure and needs to be linked to outcome. The team is also developing data collection spreadsheets and this should be tested at the same time to ensure what is being recorded is useful.

The SPSP fellow attached to the A&E in Western General Hospital is attempting to introduce improvements in blood culture trolleys, dedicated triage and other interventions but has struggled to delegate the collection of data to other members of the team.

Each patient admitted will have a SEWs carried out within 10 mins of arrival and the unit is testing an amended SEWS chart which also includes Sepsis, and the Scottish Ambulance Service are also interested in testing a pre-hospital screening tool. During discussion with senior staff there would appear to be variable understanding on key signs of sepsis in admission areas especially with regards the temperature range. Embedding SIRS into SEWS form has worked for some but confidence to interpret and react to the data seems a challenge.

The main focus is to ensure that no matter who is the first person to be with the patient, they will instigate the Sepsis 6 and take a blood culture using the trolley which is still undergoing testing to review how it works. The visit team suggested that making the information gathering part of the process will make it easier to collect this data and seem less of a chore. The balancing measure for this would be a comparative increase in use of antibiotic and this is being monitored. An area of concern is that the availability of the anti-microbial policy which is online and not easily accessible.

Data is displayed in the Doctors room, continually reinforcing the improvement message and giving feedback in an easy to understand way. The visit team suggested that the display could demonstrate the link between process and outcome which would assist doctors see the difference reliable process makes, ensure when there are gaps in the data that this is shown in the display to ensure there is a true picture of the situation being shown.

The unit is also testing medicines reconciliation, and are unable to demonstrate that all of the indicators are being met. The visit team suggested breaking the bundle down into separate components before testing the composite of all the measures.

- Two sources used
- Complete list
- Allergies list
- Green-bag
- Pharmacist check

A checklist is being tested on QID system however there is no baseline to measure against, although the visit team did not see this on the site visit.
Challenges
- ICT solutions for displaying and tracking core patient data
- Staff keen to keep to the “old ways”

There are challenges around the spread beyond pilot sites of some of the standardisation e.g. standardised ward rounds, insulin management etc - without supporting technologies e.g. eForms on Track, track-and-trigger tools for alerting if increase EWS etc

- Coloured magnets to “flag” patients
**Peri-operative Outcome Primary Drivers**

- Provide appropriate, reliable and timely care to patients using evidence-based therapies to prevent surgical site infections
- Create a team culture attuned to detecting and rectifying intra-operative errors
- Provide appropriate, reliable and timely care to patients using evidence-based therapies to prevent peri-operative cardiovascular events

**Secondary Drivers**

- **Prevent Surgical Site Infections**
  - Ensure proper prescribing and administration of prophylactic antibiotics
  - If at all possible avoid hair removal; if hair removal is necessary, avoid the use of razors
  - Maintain normal blood glucose level (for known diabetic patients)
  - Ensure normal body temperature (excludes cardiac patients)

- **Use briefings**
- Use standard intra-operative procedures to prevent AEs
- Undergo team training
- Maintain team focus during surgery
- Have responses to intra-operative adverse events ready

- **Identify patients at risk**
- DVT prophylaxis
- Continuation of beta blockers

Improved peri-operative Outcomes (Reduced peri-operative adverse events: infections, cardiovascular events)

The Institute for Healthcare Improvement 2008
Peri-operative

**Successes**
The pre-list briefing included staff from all theatre teams and has been adapted to suit this area of NHS Lothian. The theatre team are putting any issues identified at the surgical brief on a blog to share the learning. The great use of case studies identifying issues raised should be shared with other teams to demonstrate benefits of the safety briefings. The team is testing having different members lead the briefing so that everyone is comfortable doing so to ensure the brief does not become person dependant.

The team in the neuro-surgery unit are committed in their insistence that if there is no representation from all key players in theatre for the pre-op brief then the patients from that list will not be called for. The pre-list brief was obviously well arranged, and took 9 minutes to complete and there was great turn-out of staff. It was well run, quick and clearly the flattening of hierarchy where the nurse felt comfortable when asking a surgeon to clarify which instruments are to be used in his particular theatre.

On leaving this area the team visit lead was approached by a neurosurgeon who had attended the brief who commented that that “I don’t know why everyone doesn’t do this... in fact I don’t know why they are allowed not to do this” “I now consider the safety brief is as important to my patients safety as what I do as a surgeon during surgery”. The visit team feel that this is a great endorsement of the effectiveness of the safety brief and the buy-in from staff.

The pre-list brief has introduced a standardised way of ensuring that a process is in place which reduces delays for the patient, ensures equipment is available and teams know exactly what is required, where and when. The Breast surgery team is a small team which was already in the mindset of how to do this better and are now improving the surgical pause which is much smoother than elsewhere and demonstrates great spread.

**Challenges**
The challenge NHS Lothian is to share this best practice with other surgical teams taking the basic pre-list brief and adapting for each specialities.

**Interventions/Comments/Tips & tricks - successful interventions, challenges, what worked & why.**

One-liners! “No Show, No Call” – if you don’t come to the briefing your patient won’t be called.

Staying true to the vision and bringing the early adopters with you and using them to gather the rest

Small tests of change when needed but knowing when to go to scale quickly

Team in the Western General have pulled together a folder with the various cases where safety issues have been highlighted in the safety briefing and should be shared not only within NHS Lothian but to other Boards as well.
Medicines

Outcome

Primary Drivers

Use standardised protocols and algorithms for high risk meds
Routine and reliable patient and laboratory monitoring
Identify high risk areas using FMEA
Pharmacy consultation service

Identify patients at risk with high-alert medications
Standardise recovery protocols (e.g. opiate over-sedation)

Accuracy of medicines at the interface
“One stop” delivery system
Reliable in-hospital handoffs
Communication with primary care
High risk medicines management services

Secondary Drivers

Coordination of care

Patient and family involvement

The Institute for Healthcare Improvement 2008
**Medicines**

**Successes**
The visit team was shown around the pharmacy services in Royal Infirmary Edinburgh which has demonstrated an outstanding commitment to standardisation, introducing safer processes, automation and freeing up skilled staff to do the skilled work at ward level is amazing – bottle this and share widely!

There is also testing of using green bags for patients on admission and a key measure of the success of this should be a respective increase in use of patients own medicines, this will hopefully see a reduction of hoarding at home and improve the patient’s stay whilst in hospital as they will be using medication that is familiar to them.

The visit team were shown a project aimed at reducing nursing medication errors, linking to Releasing Time to Care, Green Bags and Safe to Ask work and linking to Patient Forum Public Initiative forums in this. Introduction of a ‘daily medical review’ rather than medicines reconciliation which can be misunderstood.

NHS Lothian demonstrated highly mature use of the Failure Modes Effects Analysis in looking at recent medication errors and is making the links to other programmes of work, such as Think Glucose. Insulin management: ownership of data; standardised documentation – errors down by 50% by printing guidance on reverse of insulin management form; training modules; peri-op guidance/scheduling of diabetic pts; links to Think Glucose programme; TG magnets on white board – timely meals and referrals to Diabetic Specialist Team

FMEA identification of 10 high risk areas; “Medicines matter” roadshow – medical director and pharmacy input as well as nursing, links to RTC and under/post graduate education

The visit team was encouraged by the work which has been introduced in Primary Care on warfarin and high risk medicines. There is high engagement from GPs with early spread evident.

The Royal Hospital for Sick Children has introduced algorithms to assist Band 7 Nurse Prescribing/Nurse-led Discharge for one-stop dispensing in wards to speed up discharge.

The Adoption of Green Bags across NHS Lothian supports effective and timely medicines reconciliation and review and prevents missed or late doses. This is being used at point of admission and by the Scottish Ambulance Service as well as at point of discharge. Anecdotal evidence indicates that patients get used to it and even begin to use it for GP and Primary Care appointments. The green bag also supports assessment of how patients use their medicines at home and identifies gaps between the ECS and contents of Green Bag. Increased use of will reduce medication expenditure and increase compliance with the medicines reconciliation bundle.

**Challenges**

- Vulnerability to one-stop dispensing in wards when pharmacy experience pressures
- Reducing nursing and FY med errors – making it easy to do the right thing alongside education/knowledge management
- Aligning with national projects of unified nursing documentation and Kardexes
- Medicine Recon/Review for all patients (or agreed national goals) – finding the compelling story that “hooks” staff

Although the general perception that dispensing of patient medication is the main cause of delays to hospital discharge, the pharmacy team have looked at the system and are confident that this is not the case in a great many situations. Consideration should also be given as to when the prescription is written and by whom as to whether the pharmacy is receiving the script in time and whether ICT solutions are maximised.
- Leadership throughout pharmacy service
- Links to national programmes that can assist/enable/accelerate eg RTC, national unified documentation.
- Making it someone’s SPSP project.
The team was advised that the RHSC has devised formulae to allow nursing staff to prescribe to support efficient and effective timely discharge and this has benefitted patients in allowing discharge without waiting for medical staff to prescribe. This reduces the wait for a doctor to prescribe medicines and allows parents or guardians to be discharged sooner. The visit team would suggest that this could be shared amongst NHS Lothian and further afield as a best practice.

Spread & Reliability of interventions
- Pharmacy – highly reliable and sustainable in ERI. Challenges for non-centralised elements of pharmacy and the interfaces where delays/errors can occur e.g. portering schedules, poor planning of discharges and late prescribing especially for FYs
- Making it relevant and real – gaps/ad hoc: what the data
APPENDIX 2 - Highlights from SPSP November 2012

Charts 1 HSMR at RIE

Quarter | SMR | Overall Change
June-Sep 2012 | 0.72 | -10.0%

A regression line through data points from October-December 2007 to the current HSMR in January-March 2012 is used to smooth out seasonal variations in HSMR and to monitor long term change.

Charts 2 HSMR at St John’s Hospital

Quarter | SMR | Overall Change
April-June 2012 | 0.61 | -6.3%

A regression line through data points from October-December 2007 to the current HSMR in January-March 2012 is used to smooth out seasonal variations in HSMR and to monitor long term change.
APPENDIX 2 - Highlights from SPSP November 2012

Charts 3 HSMR at the Western General Hospital

Source: IQC Scotland (SCIMR) trend data. Notifies the comprehensiveness of SCIMR standardisations to 1.0 for individual hospitals as of 29th September 2012.

Change in HSMR over time in Western General Hospital

<table>
<thead>
<tr>
<th>Quarter</th>
<th>SMR</th>
<th>Overall Change Since Oct-Dec 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-Jun 2013p</td>
<td>0.69</td>
<td>-5.5%</td>
</tr>
</tbody>
</table>

A regression line through data points from October-December 2007 to the current HSMR in January-March 2012 is used to smooth out seasonal variations in HSMR and to monitor long-term change.
APPENDIX 2  - Highlights from SPSP November 2012

Chart 4 Reduction in the adverse event rate as measured using the Global Trigger Tool

RIE, WGH & SJH

Rate of Adverse Events per 1000 patient days
(as at 25th October 2012)

Baseline Median = 52

13 data points below baseline median = a sustained shift in the data.
New median = 28 per 1000. This is a 46% reduction from baseline

Chart 5
NHS Lothian

Leadership Walkrounds Completed
APPENDIX 2 - Highlights from SPSP November 2012

Chart 6 Reduction in the VAP rate for all of Critical Care in NHS Lothian

NHS Lothian
Ventilator Acquired Pneumonia (VAP) RATE

[Graph showing reduction in VAP rate from July 11 to June 12]

Chart 7. Improved process compliance with the Ventilator Acquired Pneumonia Bundle in ITU WGH

ITU
WGH

[Graph showing compliance with the VAP Bundle from Feb-08 to Sep-12]

Compliance with VAP Bundle

Baseline median at 83%

Data collection process changed significantly new six month baseline at 63%

7 points over baseline was an unsustained shift in the data

Now showing a sustained shift to 93% compliance

7 months at 100% compliance

Last non neuro vap in April '12
APPENDIX 2 - Highlights from SPSP November 2012

Chart 8. Related improvement in the outcome for Ventilator Acquired Pneumonia in ITU WGH

Days between VAP (Non-neuro)
Current Number of days since last VAP = 207

Six month Baseline = 20 days between Non-neuro VAPs

9 points over baseline (including current value) = sustained improvement

Chart 8. Improved process compliance with the Central Venous Catheter bundle

Compliance with CVC Maintenance Bundle
Process now reliable at 100%
Chart 9. Related improvement in the outcome. This chart that shows the number of central venous catheter days between each infection. The higher the data point the more days there are between each CRBSI so the better the outcome for the patients. WGH ICU achieved 575 days between infections before last infection.

Days between CVC infection

Current Number of days since last CVC Infection = 71

Baseline Median = 15 days between CVC Infection

New median of 44 days between infections = 3 fold improvement on baseline

Chart 10. Overall outcome: The catheter related Bloodstream infection rate for all of NHS Lothian has been reduced.
APPENDIX 2 - Highlights from SPSP November 2012

Chart 11. Peripheral Vascular Cannula Bundle compliance in ITU WGH

Baseline Median was 60%

7 points above median was a shift in the data, but was not sustained

New median at 80%

Chart 12. Linked to outcome i.e Staph Aureus Bacteraemia Rate for all critical care patients

Baseline Median (2007) 2.5 per 1000

Sustained shift in the data detected from October 2008

New Median = 1 per 1000
= 60% reduction
APPENDIX 2  - Highlights from SPSP November 2012

Chart 13. Outcome: Staph Aureus Bacteraemia Rate for all wards

<table>
<thead>
<tr>
<th>General Ward</th>
<th>RIE, WGH &amp; SJH</th>
</tr>
</thead>
</table>

**Chart 13.**

- **SAB RATE**
- **2007 Baseline Median = 0.45 per 1000**
- Sustained Shift from Jan 2011 onwards = 38% reduction in SAB Rate

**Chart 14**

A significant reduction in all contaminated blood cultures

*Blood Culture Contamination Rate for NHS Lothian - All Contaminated Blood Cultures*

The Chart above the Blood Culture Contamination Rate for the Location specified above. When we identify bacteria commonly found on the skin or in the environment from blood cultures we consider these to be contaminants. However, there are times when these contaminants could be true infections.

Contaminated blood cultures have implications for patients, clinicians, Trusts, and NHS Lothian. These include money wasted on unnecessary investigations, interventions and hospital costs increased waiting lists for admissions and investigations. Reduced bed availability leading to boarding and Decline in reputation as a quality organisation.

**Comments**

- Upper Control Line (UCL)
- Warning Line (WL)
- Average
- Contamination Rate
- Lothian Rate

Produced using NHS Lothian Infection Prevention and Control Chart Generator version 3.0.0. Data is provisional and subject to change. Information shown is only valid until 30th December 2012.

Copyright NHS Lothian.

Printed: 13 November 2012 13:18:22
APPENDIX 2 - Highlights from SPSP November 2012

Chart 15: Significant reduction from baseline in C. Diff sustained for critical care areas

Critical Ill Patients
RIE, WGH & SJH

Baseline Median (2007) = 1.6
Sustained shift in the data detected from June 2009
New Median = 1 per 1000
= 38% reduction

Chart 16. Significant reduction from baseline in C.Diff sustained for all ward areas

General Ward
RIE, WGH & SJH

Baseline Median = 1.65
Sustained improvement three times
Current Median = 0.54
APPENDIX 2  - Highlights from SPSP November 2012

Chart 17: Compliance with hand hygiene for opportunity and technique for all disciplines in ward areas

General Ward  
RIE, WGH & SJH  
Compliance with Hand Hygiene

Current Median = 94

Chart 18: Compliance with Standardised Early Warning Score to recognise and respond to patient deterioration

% Compliance with SEWS

90%  
New process compliance at 92%

Baseline Median 85%  
compliance
APPENDIX 2 - Highlights from SPSP November 2012

Chart 19: % of All staff trained in the use of SBAR tool for improving and standardising communication

- Current Median: 84%
- 2010 Baseline: 69%
- Dec 09: Only 9 locations reported to date
- Dec 10: 27 locations reported to date

Chart 20: Increase in the number of Safety briefings taking place in NHS Lothian

Number of Surgical Safety Briefs Performed Each Month
Running Total = 103226
APPENDIX 2 - Highlights from SPSP November 2012

Chart 21: Compliance with the Surgical Safety Checklist in theatre before knife to skin

Chart 22: Compliance with normothermia in theatre

Current Median = 98.61
APPENDIX 2 - Highlights from SPSP November 2012

Chart 23: Compliance with perioperative blood glucose control

Day Surgery

Chart 24: Compliance with on time antibiotic compliance in theatre

Theatre 14
APPENDIX 2 - Highlights from SPSP November 2012

Chart 25: Surgical Outcome: Reduction in Surgical Site Infection for Hip replacement, Caesarean Section & Hysterectomy

Surgical Site infection (HIP, CAESAREAN, ABDO HYST)

Sustained improvement from April 2010 means Median now 32% lower

2009 Baseline = 3.4%

Chart 26: Compliance with DVT prophylaxis in theatre

Compliance with DVT Prophylaxis

Theatre 15
RIE
APPENDIX 2 - Highlights from SPSP November 2012

Chart 27: Compliance with medicines Reconciliation in Combined Assessment Area RIE

- Baseline median = 20%
- Sustained improvement means median is now 46%
- Eleven points over current baseline shows further sustained improvement (new median will be 80%)

Chart 28: Compliance with Medicines Reconciliation in Renal

- Baseline median = 14%
- Sustained improvement means median is now 60%
APPENDIX 2  - Highlights from SPSP November 2012

Chart 29: Reduction in the risk associated with warfarin management in cardiology RIE

FMEA: Management of warfarin

Chart 30: Outcome: A reduction in the % of INR’s greater than 6 for patients on warfarin in cardiology

62.5% reduction in INRs greater than 6
Chart 31: Outcome: A reduction in the % of INR’s greater than 6 for patients on warfarin in NHS Lothian

NHS Lothian

% INRs >6

New median = 0.75