NHS Lothian Board

Wed 07 April 2021, 09:30 - 12:30

MS Teams

Agenda

1. Welcome

Verbal *Esther Roberton*

2. Apologies for Absence

Verbal *Esther Roberton*

3. Declaration of Interests

Verbal *Esther Roberton*

Members 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. It is also a member's duty under the Code of Conduct to ensure that changes in circumstances are reported within one month of them changing. Please notify changes to Georgia.Sherratt@nhslothian.scot.nhs.uk

For further information around declarations of interest please refer to the code of conduct section of the Board Members' Handbook.

Items for Approval or Noting

4. Items proposed for Approval or Noting without further discussion

Decision *Esther Roberton*

4.1. Minutes of Previous Board Meeting held on 03 February 2021

For Approval *Esther Roberton*

03-02-20 Public Board Minutes (final draft to Board).pdf (11 pages)

4.2. Finance & Resources Committee Minutes - 20 January 2021

For Noting *Martin Hill*

FR 20-01-21 Minutes signed.pdf (7 pages)

4.3. Healthcare Governance Committee Minutes - 12 January 2021

For Noting *Fiona Ireland*

HGC 12-01-21 Minutes signed.pdf (6 pages)

4.4. Staff Governance Committee Minutes - 16 December 2020

For Noting *Bill McQueen*

SGC 16-12-2020 Minutes (Final Signed).pdf (11 pages)

4.5. Edinburgh Integration Joint Board Minutes - 15 December 2020

For Noting *Angus McCann*

Edinburgh Integration Joint Board Minutes 15-12-20.pdf (5 pages)

4.6. West Lothian Integration Joint Board Minutes - 19 January 2021

For Noting *Bill McQueen*

West Lothian IJB Minute January 2021.pdf (6 pages)

4.7. East Lothian Integration Joint Board Minutes - 10 December 2020

For Noting *Peter Murray*

East Lothian IJB Minute 10-12-20.pdf (6 pages)

4.8. Midlothian Integration Joint Board Minutes - 10 December 2020

For Noting *Carolyn Hirst*

MIJB Minute 10122020.pdf (9 pages)

4.9. Appointment of Members to Committees

For Approval *Esther Roberton*

7 April 21 Board appointments report (final to Board).pdf (4 pages)
App 1- NHSL Reference Committee TOR April 2021 (draft 220321).pdf (2 pages)

4.10. Review of the Standing Financial Instructions

For Approval *Susan Goldsmith*

070421 -Board SFIs cover (draft to Board 230221).pdf (2 pages)
Standing Financial Instructions (draft to Board 070421).pdf (46 pages)

4.11. Review of the Scheme of Delegation

For Approval *Susan Goldsmith*

7 April 2021 Board Cover draft SoD (to Board 220321).pdf (2 pages)
Scheme of Delegation (draft to Board on 220321).pdf (54 pages)

4.12. NHS Lothian Health and Safety Policy

For Approval *Tracey Gillies*

NHSL Board_Health and Safety Policy_070421.pdf (2 pages)
HS Policy Implementation and Comm Plan.pdf (7 pages)
Draft Health and Safety Policy v5.pdf (27 pages)

4.13. Outline Business Case - Western General Hospital Energy Infrastructure - Phase 2

For Approval *Jim Crombie*

Final SCO4-2 Energy Infrastructure_Phase 2_Cover Paper_Board Submission 26 03 21.pdf (4 pages)
SC04-2_WGH Energy Infrastructure OBC phase 2 v5.pdf (65 pages)

4.14. Review of Pharmacy Practices Committee Terms of Reference

For Approval *David Small*

Cover Board Paper April 2021 - PPC ToR 07 04 21 FINAL.pdf (2 pages)

Board Paper April 2021 - Appendix 1 PPC Remit 07 04 21 FINAL.pdf (2 pages)

Items for Discussion

5. Board Chair's Report - April 2021

Verbal *Esther Roberton*

6. Board Executive Team Report - April 2021

Discussion *Calum Campbell*

BET Report 7 April 2021.pdf (18 pages)

7. Opportunity for Committee Chairs or IJB Leads to Highlight Material Items for Awareness

Verbal *Esther Roberton*

8. NHS Lothian Board Performance Paper

Discussion *Jim Crombie*

Board Paper Performance_April2021 for submission.pdf (19 pages)

9. NHS Lothian Did Not Attend Policy

Discussion *Jacquie Campbell*

Board Paper_DNA policy April 21 Final_.pdf (3 pages)

10. COVID Vaccination Performance

Discussion *Alex McMahon*

Board Paper Covid Vaccination 070421.pdf (6 pages)

11. Covid19 and Inequalities

Discussion *Katie Dee*

2021 03 25 Covid and inequalities Board.pdf (21 pages)

12. Lothian Strategic Development Framework Architecture

Discussion *Colin Briggs*

Board Paper LSDF Architecture April 2021 v2.pdf (8 pages)

13. Engagement Framework

Discussion *Judith Mackay*

- Cover Paper_Public Engagement Framework_March2021.pdf (2 pages)
- Appendix 1_NHS Lothian Engagement Framework_March2021_FINAL.pdf (5 pages)
- Appendix 2_Action Plan Public Engagement Framework_300321.pdf (3 pages)

14. NHS Lothian Corporate Objectives 2021/2022

Discussion *Calum Campbell*

- Board Paper CMT Objectives 2021-22.pdf (2 pages)
- CMT Objectives 2021-22 FINAL.pdf (26 pages)

15. February 2021 (Month 11) Financial Position

Discussion *Susan Goldsmith*

- 2021 Mth 11 Financial Performance Forecast - Board 07-04-21_FINAL.pdf (3 pages)

16. NHS Lothian 5-year Financial Outlook and Outline Plan 2021/2022

Discussion *Susan Goldsmith*

- 2021 Financial Plan Paper for Board April 21 - DRAFT v3.pdf (14 pages)

17. Corporate Risk Register

Discussion *Tracey Gillies*

- Board Corporate Risk Register Paper 7 April 2021 Final.pdf (16 pages)

18. RHCYP, DCN & CAMHS Project Update

Verbal *Susan Goldsmith*

19. Any Other Business

Verbal *Esther Roberton*

20. Reflections on the Meeting

Verbal *Esther Roberton*

21. Future Board Meeting Dates

For Noting *Esther Roberton*

23 June 2021 * (Annual Accounts)
04 August 2021
06 October 2021

22. Invoking of Standing Order 5.23 - Resolution to take items in closed session

Decision *Esther Roberton*

LOTHIAN NHS BOARD

Minutes of the meeting of Lothian NHS Board held at 09.30am on Wednesday 03 February 2021 using Microsoft Teams.

Present:

Non-Executive Board Members: Ms E Roberton (Chair); Mr M Hill (Vice-Chair); Mr M Ash; Mr M Connor; Dr P Donald; Cllr G Gordon; Ms C Hirst; Mr A McCann; Mrs A Mitchell; Mr P Murray; Mr W McQueen; Cllr F O'Donnell; Cllr D Milligan; Mr T Waterson; Dr R Williams; Ms K Kasper; Ms N McKenzie; Mr J Encombe and Prof. S Chandran.

Executive Board Members: Mr C Campbell (Chief Executive); Ms T Gillies (Executive Medical Director) and Professor A McMahon (Executive Director, Nursing, Midwifery & AHPs – Executive Lead REAS & Prison Healthcare).

In Attendance: Mr J Crombie (Deputy Chief Executive); Mrs J Butler (Director of HR & OD); Mrs J Mackay (Director of Communications & Public Engagement); Mr P Lock (Director of Improvement); Mrs J Campbell (Chief Officer, Acute Services); Mr C Briggs (Director of Strategic Planning); Mr C Marriott (Deputy Director of Finance, NHS Lothian); Mr A Short (Chief Officer, West Lothian HSCP)(from 11:35am); Mr A Mackenzie (Psychiatry CT3, NHSGGC, C Hirst Paired Learning Partner); Ms Leigh Brown (Senior Charge Nurse, RIE – Shadowing Mr Waterson); Mr A Payne (Head of Corporate Governance) and Mr C Graham (Secretariat Manager)

Apologies for absence: Ms F Ireland (Non-Executive Director); Ms K Dee. (Interim Director of Public Health and Health Policy) and Mrs S Goldsmith (Director of Finance).

102. Declaration of Financial and Non-Financial Interest

102.1 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.

102.2. Cllr Gordon declared that he was Chair of the Edinburgh International Conference Centre which will be used as a mass vaccination centre.

103. Chair's Introductory Comments

103.1 The Chair welcomed members and guest to the meeting and the Board passed its congratulations to Mr Lock on the birth of his daughter.

103.2 The Chair also welcomed new Board Members - Ms Nancy McKenzie, Mr Jock Encombe and Professor Siddharthan Chandran to their first meeting. The Board noted that this would be Cllr O'Donnell's final meeting as she would be stepping down from the Board on 23 February 2021 and wished her all the best in her new role.

Items for Approval

103.2 The Chair reminded those present that the Board agenda was made up of two separate sections. The first was the section for approval commonly referred to as "the consent agenda". The Chair reminded members that they had the opportunity to advise in advance if they wished matters to be moved out of this section. There had been no such requests.

103.3 Minutes of Previous Board Meeting held on 09 December 2020 – Minutes were approved

103.4 Finance & Resources Committee Minutes – 25 November 2020 – Minutes were noted

103.5 Healthcare Governance Committee Minutes – 10 November 2020 – Minutes were noted

103.6 Audit and Risk Committee Minutes – 23 November 2020 – Minutes were noted

103.7 Staff Governance Committee Minutes – 21 October 2020 – Minutes were noted

103.8 Edinburgh Integration Joint Board Minutes – 27 October 2020 – Minutes were noted

103.9 West Lothian Integration Joint Board Minutes – 10 November 2020 – Minutes were noted

103.10 East Lothian Integration Joint Board Minutes – 29 October 2020 – Minutes were noted

103.11 Midlothian Integration Joint Board Minutes – 08 October 2020 – Minutes were noted

103.12 Appointment of Members to Committees – The Board agreed to:

- Re-nominate Martin Hill as a voting member of Edinburgh IJB for the period from 1 March 2021 to 31 July 2023.
- Re-nominate Bill McQueen as a voting member of West Lothian IJB for the period from 1 April 2021 to 31 January 2022.
- Re-nominate Angus McCann as a voting member of Midlothian IJB for the period from 4 April 2021 to 31 August 2023.
- Appoint Councillor George Gordon as the Chair of the Pharmacy Practices Committee.
- Appoint Vinny Bilon, David Massie and Gordon Stuart as 'contractor pharmacist' members of the Pharmacy Practices Committee.

103.13 Review of Terms of Reference of the Finance and Resources Committee – The Board agreed to approve the revised terms of reference of the Finance & Resources Committee.

103.14 Update on the Epidemiology of COVID-19 in Lothian - The Board Agreed to note the report briefing on the current trends around COVID-19.

Items for Discussion

104. Board Chair's Report – January 2021

104.1 The Chair briefed the Board on recent events and pieces of work that she had been involved with this included induction meetings with the new Board members and fortnightly meetings with public health minister.

105. Board Executive Team Report – January 2021

105.1 The Board received the Board Executive Team report and there was discussion on the following specific sections:

- **Recovery Plan** - Mrs Mitchell asked about the timescale for recovery. Mr Campbell confirmed that recovery would probably take a couple of years this would be to clear the backlog, whilst recognising NHS Lothian's disadvantaged starting point in comparison to other boards, in terms of capacity and the lack of infrastructure even before the pandemic to meet demand.

  Cllr Milligan asked about services in the post pandemic period. Mr Campbell stated that there would be changes to how services were provided. Ideally this would be the separation of elective and emergency services, but this would not be totally achievable. In the wider context the use of single room accommodation would be looked at to make sure infection control standards could be more easily complied with. There is a need for a national strategy for recovery and this had been articulated to Scottish Government.

- **Staffing levels at St John's Hospital** – Prof. McMahon stated that there remains a challenge around recruitment and retention of staff. There were currently 7 beds closed at St John's Hospital so that safe staffing could be in place, however this increased pressures. West Lothian College were providing assistance in some support roles. The sustainability of the workforce model was being reviewed to see if the skill mix could be adapted for wards moving forward.

- **Recruitment of Clinical Educators** - Professor McMahon reported that support to care homes continued and that with funding now in place recruitment of 6 clinical educators and 5 tissue viability nurses was underway. The appointment of an Associate Director for Infection Control was noted.

- **Matter of Focus Midlothian** – Mr Campbell confirmed that this was a new tool being introduced by Midlothian IJB and that he would ask the Midlothian Chief Officer to provide further information on this to the other IJB Chief Officers as part of a wider roll out.

- **2021/22 Objectives** – The Board noted that the Corporate Management Team had held a session to develop a first draft of the objectives and that engagement with the Board, on these objectives, would take place once

these had been checked and formatted.

- **New Whistleblowing Standards** – Mrs Butler reported that the implementation of the standards was on track, for directly employed staff, from 1 April 2021. Arrangements for independent contractors were more challenging and this had been fed back to the Scottish Government. Ms Kasper added that the first Non-Executive Director Whistleblowing Champions Network group would meet tomorrow with the aim to have the conversation around this challenge and to work behind the scenes on how best to approach this.

- **Virtual/Scheduled Minor Injury Assessment Activity** – noted that levels were likely to have been low due to the soft launch to the national communications while processes are tested and workforce at NHS24 and board flow centres are expanded. Lothian had advertised the new pathways for patients locally but there was opportunity to build on this and make access easier. Part of the anxiety around this was the significant pressure this could place on the workforce system and it was noted that NHS24 had struggled to get staff in place for a harder launch. It was hoped that over time the number of people with a scheduled appointment for A&E would increase whilst A&E would remain open for blue light cases. The Board noted that Mr Campbell was the co-chair on the national group and that the evaluation relating to paediatric attendances was currently ongoing.

- **Flu Vaccination** – Noted that there had been very few flu admissions this year and low prevalence within the community.

- **Response to the Edinburgh Poverty Commission** – Noted that the Executive Leadership Team response to the Edinburgh Poverty Commission was submitted in December 2020 and gave NHS Lothian's commitment to work with partners on strategies to end poverty in Edinburgh by 2030. A new NHS Lothian wide group would be established to consider a range of issues including employability, procurement and NHS Lothian's role as an anchor institution. This work would include the four IJBs as part of a joined-up approach.

- **Testing Expansion Programme** - Dr Donald asked about testing results and the impact on staffing and services. Mr Briggs stated that a detailed report could be developed and reported to the upcoming Planning, Performance and Delivery Committee in March. Mr Briggs added that the Lauriston East Hub testing facility was now open and that the lab would significantly add to the capacity to run symptomatic and asymptomatic testing of the general population. Staff testing was being successfully rolled out to all patient facing staff directly employed by NHS Lothian and the Scottish Government were likely to announce the expansion of this to GP practices later today.

106. Opportunity for committee chairs or IJB leads to highlight material items for awareness.

- **Finance and Resources Committee –** Mr Hill reported that the committee was continuing to scrutinise the response to the Royal Hospital for Children and Young People audit recommendations, and looking to strengthen governance and senior responsible officer management arrangements around this and for future projects. A detailed report would go to the next Finance and Resources Committee. The committee had also been discussing Scottish Government advice that there would be no additional new capital funding of large projects in Scotland over the next 5 years. Consideration was being given to how this impacted the ambitions of the Board; the need to look at more innovative solutions to problems other than capital investment and the continued push to regularise NHS Lothian's NRAC position.

107. Vaccination Programme Update

107.1 Mr Briggs introduced the report updating the Board on the Covid Vaccination Programme. Mr Briggs outlined the following figures for Lothian as at 9pm on 02 February 2021, according to the national vaccination management tool:

- **55,845** citizens had received a jab.
- **27,721** over 80s have been vaccinated by GPs – this was over and above the vaccination management tool figure above.
- **5604** over-75s had been vaccinated by GPs.
- The gross number was therefore **89,170.**

107.2 The Board noted that the paper suggested the adult population of the Lothians to be 807,746. This figure cannot be assumed to only be Lothian residents, however, as staff will travel from outside the Lothians to work here.

107.3 Mr Briggs also confirmed that:

- 42,756 staff had been vaccinated, including unpaid carers, social care and NHS Lothian staff
- 92% of care home residents had received their first vaccination. 7% could not receive their vaccination due to being Covid positive, and 1% refused the vaccination.
- All eligible patients in our HBCCC facilities had been vaccinated.

107.4 The Board noted that in relation to vaccination clinics the centres at Edinburgh International Conference Centre and the Royal Highland Showground were now open and that Health and Social Care Partnership colleagues were taking forward the local clinics. Mr Briggs reported that vaccine wastage was running at around 1.5% and this was better than the national assumption of 5%.

107.5 The Board recognised the challenges in relation to public perception of the pace of vaccination. The suggestion that Lothian was lagging behind other boards was not warranted. The national vaccination management tool does not currently reflect the activity performed by GPs, leading to the reported figures for NHS Lothian to be understated.

107.6 Other challenges were noted in relation to vaccine supply; the visibility of this; the balance between vaccine for 1st and 2nd doses and the need to have phased opening of mass vaccination centres so that the workforce can be confirmed.

107.7 The Board noted that the mechanism in Lothian was not the same as other parts of Scotland. In Lothian 75 to 79-year olds and the people who are Extreme Clinically Vulnerable were being vaccinated through GP practices. The 70 to74-year olds were going through the mass vaccination centres. It was noted that there were schedules for all age groups but there remained concerns around vaccine supply.

107.8 In relation to the 2nd doses for staff and staff who missed 1st doses, Mr Briggs confirmed that the intention had always been to run 1st dose staff vaccines up to 31 January 2021, due to the challenges with moving to mass vaccination centres and vaccine supply. The Board noted that staff had been given notice about 1st dose staff programme closing and staff, sites and teams had been asked to identify people missed or any urgent cases. There would now be a system of transferring 1st dose staff appointments from the staff programme into the mass vaccination centres, with the plan for 1500 to 2000 staff per week through the centres over 10 weeks. The final communications around this would be going out today.

107.9 Mr Briggs highlighted that the Scottish Government guidance around who were eligible staff for vaccine was very broad and open to different interpretations. It would be easy to place a large part of the general population into these groups. Therefore, NHS Lothian had developed some principles around eligibility, which it was hoped to agree with the four local authorities.

107.10 The Board discussed the need for improved systems around data reporting, given it was likely that this would not be a one-off vaccination programme and there needed to be confidence in the data being provided. It was noted that the aligning of GP systems with boards had been an ongoing issue for some time. There was also a need to improve confidence in national planning assumption modelling as this had an impact on vaccine supply management.

107.11 Dr Williams reminded the Board of the incredible achievement to get the vaccination programme up and running, and recognised the extraordinary efforts made by colleagues. He highlighted that before 1 February there were no mass vaccination centres in existence. Dr Williams noted that the process for volunteering appeared to be a national process rather than a local one. He suggested that a local approach may have been more efficient and effective. Mr Campbell confirmed that there would be a review of lessons learned at some point which would inform future vaccination programmes.

107.12 Cllr O'Donnell asked about vaccination roll out in East Lothian. It was noted that the addition of mass vaccination centres at Queen Margaret University (from 10 February 2021) and East Lothian Community Hospital would substantially increase capacity.

107.13 Cllr O'Donnell also asked about impact on health Inequalities. Mr Briggs suggested that a report be brought to a future Board meeting from Public Health colleagues, but he was not aware of any inequality around vaccine supply in East Lothian. The Community Hospital had already carried out a substantial amount of staff vaccinations.

107.14 Mrs Mitchell raised the visibility of vaccine supply. The Board noted that visibility was two weeks to one month ahead. Mr Campbell confirmed that Lothian's plan as submitted to Scottish Government had been accepted. However there had now been a request from Scottish Government to accelerate the Royal Highland Showground site to open today rather than the 15 February 2021. This had been done with the caveats that initial military support be provided to cover the gap, and confirmation that additional vaccine supply would be in place given the accelerated rate. The Board noted that the Scottish Government had accepted these caveats and that current vaccine visibility was up to 1 April 2021.

107.15 The Chair welcomed this comprehensive update and the Board expressed its appreciation to all colleagues involved in establishing a successful Covid vaccination programme.

108. Scheduled and Unscheduled Care Performance

108.1 Ms Campbell updated the Board on performance for Scheduled Care standards: New Outpatient ('OP'), Treatment Time Guarantee ('TTG'), Diagnostic key test and 31 & 62 Day Pathway Cancer pathways. The report also included the 4-hour emergency access standard and the performance on delayed discharges. The report also covered the ongoing risk to long waits, the impacts of Covid between now and the end of March 21, as well as the positive impact of clinical prioritisation. An update on unscheduled care activity and pressures over the festive and recent periods was also included.

108.2 Ms Campbell presented an update to the Board covering the information outlined in Appendix 1B of the report. The presentation covered the impact of Covid on performance; demand and activity; reducing long waits for the most urgent patients and implications for big services with waits over 52 weeks (ophthalmology, dermatology and oral surgery). It was noted that all new patients were clinically prioritised before being added onto waiting lists and patients receive a letter detailing the evaluation of clinical priority and what this means for their wait.

108.3 There was discussion on vaccine roll-out modelling and the ability of services to reopen; the use of telephone and video consultation options; the extent of which Lothian's challenges were common to other boards and ways of reorganising service delivery and benchmarking; what the future demand profile for NHS Lothian may look like up to March 2022; and alignment with

the national recovery plan. Ms Campbell added that the biggest constraint for outpatient services remained the two-metre physical spacing and the impact that this had on flow and in the clinical areas. This had led to a mixed clinical service delivery model of face-to-face, telephone and video consultations.

108.4 The Board noted that the majority of theatres had now been successfully remobilised but capacity was still down due to required cleaning and fallow time between patients. However, there were a small number of green pathways that allowed fallow time to be reduced but there were restrictions around these. There was ongoing work to look at maximising theatre capacity and the workforce implications around this, but this may require an in-sourced model to allow full exploitation of capacity.

108.5 Ms Campbell confirmed that there was a full programme of work between acute and HSCP colleagues to look at community-monitoring closer to home and other non-acute service options, rather than attending hospital. In relation to additional support measures being put in place to support people where operations were significantly delayed, Ms Campbell stated that orthopaedics colleagues had good links with patients, and were providing advice and support around exercises, pain management and maintaining mobility throughout their wait. Physiotherapy support was also available.

108.6 Dr Donald asked about patient confidence and anxiety about attending hospital slots at Spire Healthcare. Ms Campbell reassured the Board that the Spire facilities had been given to NHS Lothian but the surgeons remained NHS Lothian's staff and the governance arrangements remain the same.

108.7 The Board agreed to the recommendations as outlined in the report:

- Acknowledged the impact of the first and second waves of Covid on OP, TTG and
- Diagnostic performance. The reintroduction of services and screening has not impacted cancer waiting times performance, although some diagnostic capacity remains reduced.
- Take limited assurance that remobilisation will mitigate increasing numbers of long-wait patients for scheduled care and cancer services, against proactively dealing with on-going Covid demand, winter activity and a known backlog of patients from the first wave arising from cessation of routine activity. This will impact on over 52 weeks from January 21.
- Acknowledged that 61.9% of patients were seen within the Treatment Time Guarantee
- (TTG) in November 20 – a month-on-month improvement since August 20. Provisionally, 8,902 inpatients were waiting longer than 12 weeks by the end of December 20.
- Acknowledged that 4-hour Emergency Access Standard performance was 83.4% for December 2020.
- Acknowledged that NHS Lothian has implemented the first phase of the redesign of urgent care programme. This is part of the national roll out of NHS24 providing a national single point of access via 111 from 1 December 2020, for people with non-life

threatening injuries and illnesses to get advice and treatment as close to home as possible.

- Recognised that while the number of delayed discharges have increased since April 2020, numbers are still historically low for Lothian. There has been a 31% reduction of delays in December 2020 compared to December 2019. HSCPs and acute teams continue to work together to improve discharge planning, transfers of care and embedding Home First approach to reduce number of delays and associated occupied bed days.

109. December 2020 Financial Position

109.1 Mr Marriott updated the Board on the NHS Lothian financial position at Period 9 and set out the financial impact from Covid-19 to date.

109.2 There was discussion on the core and deficit position; Covid costs and funding; prescribing expectations and the local remobilisation plan. The key risks involved with Covid costs and funding coming forward were currently being worked through. Any impact from EU Exit was still unknown.

109.3 There was also discussion on social care funding; the sustainability of this going forward and the financial consequences of Covid. The Board noted that discissions on the Covid budget for the next financial year remained ongoing with Scottish Government colleagues.

109.4 Mr Murray suggested that social care funding be a priority point for discussion at the Board's Planning, Performance and Delivery Committee when the strategic plan was being revised. There was a clear issue around the ability to sustain strong transformation programmes for the four IJBs. Mr Campbell confirmed this would be picked up for the March session.

109.5 Dr Williams highlighted the implementation of an uplift to the secondary care budget as indicated by the First Minister. Mr Marriott confirmed that national work on this was underway and that a group had been set up to model the impact of this uplift from 8-11%.

109.6 The Board is agreed to accept the report as a source of moderate assurance that the Board will achieve a breakeven position in this financial year.

110. Corporate Risk Register

110.1 Miss Gillies introduced the report providing an update on the NHS Lothian's Corporate Risk Register for assurance.

110.2 There was discussion on the Risk Register review and the development of a more agile and responsive mechanism for reviewing risks and ensuring clearer control measures are in place to mitigate risks. The Risk Register would go on a more frequent, meaningful basis to the Corporate Management Team over the coming months as the mechanism is developed and formally written up.

110.3 Mr Murray suggested that rather than having a specific Covid risk, it would be more helpful to understand how Covid was impacting other main risks. Miss Gillies stated that this was part of the evolving thinking of the Covid position, and part of the move to living with Covid and incorporating aspects of that into what is taken on board. There was also discussion on the short term and long-term nursing workforce risks. Miss Gillies confirmed that these were risks that were regularly considered through the Board's Staff Governance Committee.

110.4 The Board recognised the need for a more agile risk management system that can be easily updated to reflect conversations, discussion and progress being made against risks. Miss Gillies added that it was not just agility that was needed but the understanding of what was within the Board's control and where the Board would expect mitigations to be in place.

110.5 The Board accepted the recommendations in the report:

- Accepted the risk assurance table as a summary of all risks including levels of assurance and grading, as agreed by the relevant committee.
- Noted that a high-level review of the risks on the corporate risk register and associated processes had been shared with the Chief Executive to identify the next steps.
- Noted that processes had been put in place to report, review and escalate adverse events relating to the Covid vaccination programme.

111. RHCYP, DCN & CAMHS Project Update

111.1 Mr Marriott updated the Board on the status of the project as it approaches final completion. The Board noted that ventilation works would be complete in the coming days ahead of the required independent validation and assurances from the Board's Authorised Engineer and Technical Advisors. The planned move of Child and Adolescent Mental Health services had also gone well.

112. Any Other Business

112.1 There was no other business.

113. Next Board Meeting

113.1 The next Board meeting would be held on 7 April 2021.

114. Standing Order 5.23 Resolutions to take Items in Closed Session

114.1 The Board agreed to invoke Standing Order 5.23 to allow a meeting of Lothian NHS Board to be held in Private. The reason for this was due to the commercial and confidential nature of the business to be discussed.

Chair's Signature ……

Date ……

Esther Roberton
Interim Chair – Lothian NHS Board

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 20 January 2021 by videoconference.

Present: Mr M. Hill, Non Executive Board Member (chair); Mr C. Campbell, Chief Executive; Ms S. Goldsmith, Director of Finance; Mr A. McCann, Non Executive Board Member; Cllr J. McGinty, Non Executive Board Member; Mr B. McQueen, Non Executive Board Member; Mr P. Murray, Non Executive Board Member; Professor M. Whyte, Non Executive Board Member.

In Attendance: Mr N. Bradbury, Capital Finance Manager; Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Mr I. Graham, Director of Capital Planning and Projects; Dr J. Hopton, Programme Director, Facilities (item 47.5); Ms F. Ireland, Deputy Director, Corporate Nursing and Business Support; Ms C. Kelly; Strategic Programme Manager (item 47.3); Mr T. Logan, Head of Operations, Hard Facilities Management; Mr C. Marriott, Deputy Director of Finance; Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes); Ms I. Tricker, Assistant Finance Manager; Mr M. Wilde, Business Partner, Finance (item 46.3).

Apologies: Ms T. Gillies, Medical Director; Professor A. McMahon, Executive Nurse Director.

Chair's Welcome and Introductions

The Chair welcomed members to the meeting and members introduced themselves.

Members were reminded that they should declare any financial or non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. No interests were declared.

45. Committee Business

45.1 Minutes and Actions from Previous Meeting (25 November 2020)

45.1.1 Members accepted the minutes from the meeting held on 25 November 2020 as a correct record.

45.1.2 The updated cumulative action note had been previously circulated.

46. Capital

46.1 Property and Asset Management Investment Programme

46.1.1 Mr Graham presented the previously circulated paper. It was noted that all procurement projects were advertised online on the Scottish procurement site and were therefore visible both locally and internationally to bidders.

46.1.2 In response to a question on changes to building planning due to isolation and distancing needs in response to COVID-19 Mr Graham advised that single rooms

were becoming the policy principle rather than four bedded rooms but that lack of space was a challenge. This would be considered on an individual project basis.

46.1.3 The problem with the Regional Infectious Diseases Unit, which was an old temporary building, was that it was not flexible enough to maximise use of beds during COVID-19. Ms Goldsmith advised that old buildings across the estate did not meet current standards or have facilities to cohort patients. This was acknowledged on the investment plan and was on the risk register. An initial agreement was in progress on RIDU reprovision and would be submitted to this Committee. Estates expenditure related to COVID-19 was being tracked and would be included in what the Scottish Government had agreed to pay on capital expenditure related to COVID-19.

46.1.3 Building new estate with flexibility of use was challenging as the different ventilation, water and oxygen systems required for different clinical functions would increase capital and operational costs.

46.1.4 Ms Goldsmith advised that the response from the Scottish Government and the Capital Investment Group on the initial plans for the new cancer centre had been positive. The Scottish Government had stated that there was no capital funding available for large projects in Scotland over the next 5 years but they recognise that improved cancer services in south east Scotland were required to improve patient outcome and that there would also be economic benefits. More work on evidencing improved patient outcomes had been requested after which the case would be presented to the Scottish Government Health Capital Investment Group and hopefully proceed to development of an outline business case.

46.1.5 Regarding the increased costs of delivering the changes required to the children's hospital contract it was noted that IHSL had agreed to provide a written report on why there had been this increase from the original estimates.

46.1.6 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

46.2 <u>Initial Agreement: RIE Lifecycle Decant Modular Unit</u>

46.2.1 Ms Campbell presented the previously circulated paper. She advised that a detailed plan was associated with this programme of work and that if the modular unit was also to be required for winter capacity this would be built in as part of the plan. It was suggested that a permanent decant space may be of use given ongoing maintenance requirements in the hospital; Ms Campbell advised that this could be considered but a more permanent design would be required than that being proposed.

46.2.2 It was noted that the new Royal Hospital for Children and Young People would not be fully occupied in the first years due to the design capacity allowing for increasing demand, so space for lifecycle works would be available. Ms Goldsmith also noted that the RHCYP had a modern contract with more information about how lifecycle works would be carried out.

46.2.3 Members accepted the recommendations laid out in the paper.

46.3 Update on Commercial Strategy; RIE PPP Contract and Management of PPP Portfolio

46.3.1 Ms Goldsmith introduced Mr Wilde to the meeting and he presented the previously circulated paper. He summarised that the aim was to clarify the interpretation of the contract between the two parties so that any further performance problems did not result in having to resort to legal redress. If this did not result in improved performance than further steps would be considered and any proposals would be brought to the Committee.

46.3.2 Mr Wilde advised that the Key Performance Indicators had been part of the contract since the beginning. As part of the contract Consort was required to self monitor performance, but NHS Lothian also had an obligation to shadow monitor and this may not have been managed to NHS Lothian's advantage in the past.

46.3.3 Mr Wilde advised that Consort were aware of the approach being taken by NHS Lothian.

46.3.4 Members accepted the recommendations laid out in the paper agreed to receive a further update at the next meeting. **SG**

46.4 Car Parking at the Royal Infirmary of Edinburgh; permanent abolition of charges

46.4.1 Ms Goldsmith presented the previously circulated paper. Mr Crombie advised that allowing access to the car park free of charge came with a risk of increased access and lack of space. Currently patients were accessing the car park for routine services in addition to an increased number of staff using the car park because of the Government advice to avoid using public transport. To mitigate this risk a priority system would be needed to control the number of cars on site.

46.4.2 Electric car charging points, cycle storage and cycle paths would be part of the car park design and would go towards meeting climate change and sustainability commitments.

46.4.3 Ms Goldsmith advised that the complexity of the contract meant that it could take some months to reach an agreement.

46.4.4 Members accepted the recommendations laid out in the paper and agreed to receive an update at the next meeting, which would include details on mitigation of both the finance and the traffic management risk as well as a clarification of what needed to be agreed with Consort and the expected timescale. **SG**

46.5 Royal Hospital for Children and Young People and Department of Clinical Neurosciences – General Update

46.5.1 Ms Goldsmith gave a verbal update. A delay with the installation of the critical care pendants was due to engineers from the supplier having to isolate due to a case of COVID-19. Ventilation works were completed and would be tested that week by the contractor and the following week by NHS Lothian. A revised complete handover date had been agreed with IHSL for 8 February 2021 with an expected move in date before Easter 2021.

46.6 Royal Hospital for Children and Young People Audit Recommendations

46.6.1 Mr Bradbury gave a presentation. It had been agreed that the Board's responses to the audit recommendations would be completed by February 2021 but significantly more work would be required to meet all of the requirements; this update was to allow the Committee to comment and give approval on the approach being taken.

46.6.2 It was noted that governance processes had to be relevant and accessible to those working on the ground making day to day decisions in order to work. It was suggested that capacity should be built into the work plans of key clinical individuals whose input was required on projects such as these.

46.6.3 Mr Bradbury advised that external partners such as the university and local authorities as well as others were integral to the process laid out and would be part of stakeholder engagement.

46.6.4 The proposed process would allow scaling, was designed to work with projects of all sizes and would include an early step to identify which groups needed to be involved. This had happened previously but the new process would make it more formal and systematic and would require a more detailed record of decisions made.

46.6.5 Members supported the approach laid out and agreed that making methodical strategic decisions early on in the process should make projects more efficient.

46.7 Update on the Scottish Hospitals Public Inquiry

46.7.1 Mr Payne introduced the previously circulated paper. Ms Goldsmith advised that there would be a requirement for further resources to manage information sharing moving forward. She advised that the first hearing would be on 22 June 2021 with substantive hearings for three weeks from 20 September 2021. More information about the Inquiry was available on their website.

46.7.2 Mrs Goldsmith advised of a delay to the technical expert advice commissioned by MacRoberts on the Board's behalf. A report was expected soon for submission to this Committee. **SG**

47. Revenue

47.1 Financial Position – December 2020

47.1.1 Mr Marriott presented the previously circulated paper. The position was stabilising as plans were now in place for Scottish Government to provide funding for additional costs due to COVID-19.

47.1.2 It was noted that as part of the contract for independent contractors, dentists and opticians continued to be paid during the period of closure in 2020. This was agreed at Scottish Government level and there would be additional payments as the delayed treatments take place.

47.1.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance, providing the Scottish Government met all Covid 19 funding requirements.

47.2 5 Year Financial Outlook and Outline Plan 2021/22

47.2.1 Mr Marriott presented the previously circulated paper. Members noted the uncertainty around latent demand for services moving out of the emergency position and the impact of the delayed diagnosis and treatments. A national strategy was needed to ensure recovery and waiting times were fair across Scotland.

47.2.2 It was noted that new staff recruited to work in the laboratories and on the test and protect and the vaccination programmes were mainly employed on short term contracts. More details on the staffing agenda with financial information would be included in the financial plan. These costs would be added to the COVID costs to be funded by the Scottish Government.

47.2.3 The need to work with Health and Social Care Partnerships and the use of directions was discussed and Mr Campbell noted the commitment to developing an organisational strategy which would be whole system.

47.2.4 Members accepted the recommendations laid out in the paper and agreed that there could be no assurance on the ability to provide a balanced financial position in the next five years due to the risks and uncertainty of the current situation.

47.3 Nursing and Midwifery eRostering

47.3.1 The chair welcomed Ms Ireland to the meeting and she presented the previously circulated paper. It was noted that this project began in 2015 and took longer than was expected, using additional resources. Ms Ireland advised that it had not been possible for the new rostering system to interface with the existing payroll system SSTS and so band 2 data entry assistants had been employed to input the data. SSTS was a legacy system and the double key system would only continue until the electronic interface could be achieved.

47.3.2 It was noted that the national plan for eRostering had recently awarded a contract to the same company that NHS Lothian was using. The national implementation was therefore at an early stage and was not likely to be fully operational for another five years. NHS Lothian would therefore deliver the patient safety and financial benefits of using eRostering much earlier. The national contract included a requirement for an interface with SSTS and this could be incorporated into NHS Lothian's system when available.

47.3.3 Having raised concerns at the absence of measurable benefits and high costs involved so far, members nevertheless agreed that implementation of eRostering had benefited patient safety and would have financial benefits in the future, noting that roll out to other staff groups such as portering was also being considered.

47.3.4 Members accepted the recommendations laid out in the paper.

47.4 Risk 3189: Facilities Fit for Purpose

47.4.1 Mr Crombie noted that on page 3 of the previously circulated paper the risk grading should read '12' rather than '16'. The chair welcomed Mr Logan to the meeting and he presented the paper. Members agreed the systematic approach to what needed to be done to mitigate the risk and agreed to receive a further update and review of risk level in six months' time when significant elements of the plan were expected to have been completed. **JCr**

47.4.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

47.5 Climate Change and Sustainability

47.5.1 Ms Hopton gave a verbal update. The Board had approved the Sustainable Development Framework in December 2020 which had allowed NHS Lothian to join the local Climate Compact the first meeting of which would be held on 28 January 2021. There had been a good media and social media response to the Framework, which was now available to the public online. The Communications team was working on translating the document into accessible web pages.

47.5.2 The Biodiversity Audit would be submitted to the next Finance and Resources Committee after having been considered at the Lothian Capital Investment Group. This would help teams to think more about the value of NHS Lothian's assets. **JH**

47.5.3 The Western General Hospital energy efficiency infrastructure would reach the outline business case stage shortly and be submitted to the Finance and Resources Committee.

47.5.4 The Scottish Government fund for smaller sustainability projects would result in a programme of investments of £2-3 million by the end of 2021.

47.5.5 Members noted the achievements made in a relatively short period and looked forward to a further update at the next meeting.

48. Committee Business

48.1 Reflection on the Meeting

48.1.1 The chair agreed to update the Board on the following items: the Royal Hospital for Children and Young People audit recommendations and progress with the Inquiry; and the lack of opportunity for capital projects in the next five years and the implications on the new cancer centre.

48.2 Committee Members

48.2.1 This was Professor Whyte's last meeting as her term as Board Member came to an end. The chair thanked her for her help, advice and significant contribution to this Committee.

49. Date of Next Meeting

49.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 10 March 2021**.

50. Meeting Dates in 2021

50.1 Further meetings in 2021 would take place on the following dates:
- 21 April 2021
- 2 June 2021
- 14 July 2021
- 25 August 2021
- 13 October 2021
- 17 November 2021.

Signed by the Chair on 19-03-2021

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 1.00pm on Tuesday 12 January 2021 by video conference.

Present: Professor M. Whyte, Non Executive Board Member (chair); Dr P. Donald, Non Executive Board Member; Ms P. Collings, Patient and Public Representative; Councillor G. Gordon, Non Executive Board Member; Ms C. Hirst, Non Executive Board Member; Ms F. Ireland, Non Executive Director; Mr S. Kerr, Patient and Public Representative; Ms L. Rumbles, Partnership Representative

In attendance: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Ms J. Campbell, Chief Officer, Acute Services; Mr C. Bruce, Lead on Equalities and Human Rights (item 7.1); Ms L. Cowan, Chief Nurse, East Lothian Health and Social Care Partnership; Ms J. Craig, Chief Midwife (observing); Mr J. Crombie, Deputy Chief Executive; Dr K. Dee, Interim Director of Public Health and Health Policy; Ms T. Gillies, Medical Director; Ms L. Guthrie, Associate Director for Infection Prevention and Control (observing); Ms P. Holland, Project Manager (item 7.1); Ms M. Hughes, Chief Nurse, West Lothian Health and Social Care Partnership; Ms J. Long, Recovery Programme Director (item 7.1); Dr N. Maran, Associate Medical Director for Patient Safety (item 8.5); Ms G. McAuley, Nurse Director; Ms J. McKee, Graduate Management Trainee (observing); Dr A. Mackenzie, Scottish Clinical Leadership Fellow (observing); Professor A. McMahon, Executive Nurse Director; Ms J. Morrison, Head of Patient Experience; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Professor A. Timoney, Director of Pharmacy; Mr P. Wynne, Nurse Director Edinburgh Health and Social Care Partnership.

Apologies: Mr D. Small, Director of Primary Care Transformation.

Chair's Welcome and Introductions

The Chair welcomed members to the meeting and members introduced themselves.

Members were reminded that they should declare any financial or non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. No interests were declared.

49. Minutes from Previous Meeting (10 November 2020)

49.1 The minutes from the meeting held on 10 November 2020 were approved as a correct record.

49.2 The updated cumulative action note had been previously circulated.

50. Patient Story

50.1 Ms Collings presented the patient story, which was based on a fictional patient A who represented the concerns and questions members of the public may have about the roll out of the COVID-19 vaccination programme, including planning, timescales and a public communications plan.

50.2 Ms Gillies and Dr Dee advised that the vaccination programme would aim to vaccinate the priority groups as quickly as possible and that a plan was in place to achieve this, although it was noted that vaccine supply was a limiting factor. Although there was a national communications campaign, it was noted that better communications for patients who will receive their vaccination at their GP practice would be helpful.

51. Emerging Issues

51.1 Infected Blood Inquiry

51.1 Ms Gillies gave a verbal update. The UK-wide Infected Blood Inquiry was gathering information and was a follow on to the previous Penrose Inquiry in Scotland, a review of historical circumstances involved in the use of infected blood products. Ms Gillies advised that at this point in the Inquiry NHS Lothian had been asked to respond regarding its role in the events being reviewed, and that the response was being considered.

51.2 Exit from the European Union

51.2.1 Ms Gillies presented the previously circulated paper. The risks in NHS Lothian were overseen by NHS Lothian's Gold Command group and this would continue. The risk level would be reviewed after six months.

51.2.2 Members accepted the recommendations laid out in the paper and accepted significant assurance on oversight, moderate assurance on workforce impact and limited assurance on supply chain impact. It was agreed that a brief update would be brought to the Committee at the meeting in May 2021. **TG**

52. Person Centred Care

52.1 Equalities Impact Assessment for change in policy for access to Emergency Care

52.1.1 The chair welcomed Ms Long to the meeting and she presented the previously circulated paper. It was noted that the availability of sufficient capacity in NHS 24 and the health board to deal with the new access route had always been a risk and that this was being monitored. There had been a high number of calls during the holiday period and this was being reviewed.

52.1.2 A communications campaign on radio and by post would commence in the next week, encouraging patients to call 111 in the first instance and this would divert them to the relevant service including the Lothian flow centre, minor injuries and the Emergency Department.

52.1.3 Ms Long advised that the initial pilot for call MIA used a mobile number which was then moved to an 0300 number which charged local rates. The 111 number was now the universal number and this was free to access. The introduction of alternative close to home hubs for those without online access was being worked on. Patients who did arrive at the Emergency Department without having called 111 first would not be turned away but they would be encouraged to call 111 on any future occasions. The

aim was to ensure a consistent pathway for patients, no matter what the entry point, although the risk of this not being achieved was acknowledged.

52.1.4 It was noted that the EIA process included a focus group of 15 members of the public and Members suggested that this may not have been broad enough to include contributions from all vulnerable groups, for instance those with mental health conditions, drug and alcohol users and the homeless. Mr Bruce advised that links with these groups were being worked on and it was hoped they could be included in the next iteration of the process.

52.1.5 Ms Collings noted that the patient group had raised the issue of privacy on an online consultation for patients who may live in shared accommodation. Ms Long advised that there would always be the option for the patient to make a face to face appointment.

52.1.6 Ms Gillies advised that some aspects of the service design had been decided nationally and were not within local control.

52.1.7 Members accepted the recommendations laid out in the paper and agreed that a further update on the service would be brought to the Committee in six months' time. **JC**

53. Safe Care

53.1 Healthcare Associated Infection Update

53.1.1 Professor McMahon presented the previously circulated paper and introduced Ms Guthrie, who had been appointed to the new post of Associate Director for Infection Prevention and Control.

53.1.2 Regarding the nationally set targets for reduction of healthcare associated infections, which were made more challenging each year, Mr McMahon advised that the targets now included community acquired infections, which the team had less control over the acquisition of. Nonetheless, he advised that there there was scope for further reductions particularly in acute services. Performance continued to be good and was within the Scottish average.

53.1.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance. It was agreed that at the next meeting in March 2021, in addition to the HAI update, there would be a further paper specifically focussed on COVID-19 outbreaks and mitigations. **AMcM**

53.2 REAS Inpatient Capacity

53.2.1 Professor McMahon presented the previously circulated paper. Regarding a strategy for an expected increase in demand, particularly as a consequence of the COVID-19 pandemic, he advised that work continued with the Health and Social Care Partnerships and with charity organisations to build increased capacity in services in the community. There was a current dependency on in-patient beds. Commissioning and staffing of new resources was challenging but this was being worked on and overseen by the Mental Health Programme Board chaired by Judith Proctor as Chief Officer of Edinburgh Health and Social Care Partnership. As money was released from

in-patient beds this would follow the patients into the community and would provide resource for staffing alternative services.

53.2.2 Members noted the work ongoing but wished to caveat the assurance taken with acknowledgement of the extra pressure on mental health services of COVID-19 and the current challenges. Members therefore accepted **limited** assurance for acute inpatient capacity but otherwise **moderate** assurance across all services outlined within the report.

53.3 Oversight of Care Homes

53.3.1 Professor McMahon presented the previously circulated paper. He confirmed that it was expected that all older people's care home residents and staff would have received the COVID-19 vaccine by the end of January 2021 and that progress was being reviewed at the Gold Command meetings. It was noted that, where there were outbreaks in care homes, delivery was delayed as vaccination could not take place within 4 weeks of an individual having had the virus or being a contact.

53.3.2 Mr Kerr reported that the patient and public representatives group had commended the hard work on the new responsibilities for care homes. It was noted that the two 'Gold' groups at the top of the oversight structure were for the health board and the Council which each had their own reporting structures.

53.3.3 In response to a question regarding the Care Inspectorate identifying specific care homes as 'weak' and the continued outbreaks of infection in care homes, Professor McMahon advised that constant messaging regarding infection control precautions and a quick response to indications of cases were the best means of limiting outbreaks in care homes; the capacity for the Infection Prevention and Control Team was a factor here. Other factors included educationand clinical skills levels in care home staff, the layout and fabric of the buildings, and care home staff who have to work across multiple care homes to earn a living. Ms Myles advised that provision of education and training for care home staff to identify when a resident was deteriorating using an assessment tool was being developed.

53.3.4 Ms Gillies advised that because of the short timescale for learning about COVID-19 the fact that outbreaks were still happening in both acute settings and care homes did not necessarily reflect an inability to follow the known standards and guidelines but that these standards may not be sufficient as our knowledge of the disease was incomplete.

53.3.5 Members accepted the recommendations laid out in the paper and accepted **moderate** assurance on the governance structure and **limited** assurance on the four other aspects laid out in the paper.

53.4 Discharge of Patients to Care Homes

53.4.1 Professor McMahon presented the previously circulated paper regarding the review of patients discharged from hospital to care homes between 1 March and 31 May 2020.

53.4.2 Members accepted the recommendations laid out in the paper.

53.5 Patient Safety Annual Report

53.5.1 Ms Gillies introduced the previously circulated paper and welcomed Dr Maran to the meeting to present. It was noted that at item 4.3.2 in the paper should read 'unadjusted' mortality rather than 'adjusted.'

53.5.2 Dr Maran advised that, although this report was specifically focussed on the processes of the patient safety programme because these must be reported nationally, the quality strategy which underpinned all improvement work in NHS Lothian used a much wider range of indicators incorporating patient experience markers and considering an service in a holistic way.

53.5.3 Members accepted the recommendations laid out in the paper and accepted significant assurance on oversight of safety and moderate assurance on progress of improvement work during the pandemic.

54. Effective Care

54.1 REAS Services – Child and Adolescent Mental Health Service

54.1.1 Professor McMahon presented the previously circulated paper. Concern was raised that the impact of schools being closed and GP contact being online rather than face to face meant that referrals would be impacted. Professor McMahon advised that access to the service was still available via these routes and there had been regular meetings keeping review of the situation and any safety issues reported.

54.1.2 A thematic review of seven cases of suicide had been circulated as part of the report. It was noted that the issues highlighted here were around improvements in language and coordination of care, but were not related to access issues as all these young people were already receiving care.

54.1.3 It was agreed that acceptance of the recommendations and level of assurance would be deferred to a further update at the meeting in July 2021 where the paper would be restructured to show details about the different services. **AMcM**

55. Exception Reporting Only

Members noted the following previously circulated papers:

55.1 Diabetic Retinopathy Screening Annual Report
55.2 Palliative Care Managed Clinical Network Annual Report
55.3 HIS Inspection Report, Midlothian Community Hospital
55.4 Clinical Policy Approval Arrangements Annual Report

56. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

56.1 Area Drug and Therapeutics Committee, 2 October 2021.

57. Corporate Risk Register

57.1 Ms Bennett presented the previously circulated paper noting that many of the risks allocated to this committee had been discussed as part of the agenda for this meeting. Members accepted the recommendations laid out in the paper.

58. Any Other Business

58.1 Healthcare Governance Committee Chair

58.1.1 This was the last meeting with Professor Whyte as Chair as her term as a Board member was coming to an end. Professor Whyte thanked members for their attendance and contribution to the meeting and Ms Gillies thanked Professor Whyte on behalf of the Executive Team and Committee members for her chairmanship.

59. Date of Next Meeting

59.1 The next meeting of the Healthcare Governance Committee would take place at **1.00pm** on **Tuesday 23 March 2021** by video conference.

60. Further Meeting Dates

60.1 Meetings would take place at **1.00pm** on the following dates in 2021:
- 25 May 2021;
- 27 July 2021;
- 7 September 2021;
- 9 November 2021.

Signed by the Chair: 23/03/21
Original kept to file

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 9.30 on Wednesday 16 December 2020 via Microsoft Teams.

Present: Mr W. McQueen, Non Executive Board Member (Chair); Mrs J. Butler, Director of Human Resources; Professor A. McMahon, Executive Nurse Director; Mrs J. Campbell, Chief Officer – Acute Services, (until 10:30am) Ms H. Fitzgerald, Partnership Representative; Ms J. Clark, Partnership Representative; Mr T. Waterson, Employee Director, Non-Executive Board Member; Ms C. Hirst, Non-Executive Board Member; Ms K. Kasper, Non Executive Board Member, Whistleblowing Champion; Councillor J. McGinty, Non-Executive Board Member and Ms A. Mitchell, Non-Executive Board Member.

In Attendance: Mrs R. Kelly, Deputy Director of Human Resources; Mr C. Bruce, Equalities and Human Rights Lead (item 30.2); Mr G. Curley, Director of Operations, Facilities (item 27.1); Mr S. Haddow, Head of Medical Workforce Planning (item 30.4); Mr N. McAlister, Head of Workforce Planning (Item 27.3); Ms A. Langsley, Associate Director of Organisational Development and Learning; Mr I. Wilson, Director of Occupational Health and Safety and Mr C Graham, Corporate Governance Team (minutes).

Apologies: Councillor D. Milligan, Non-Executive Board Member; Miss T. Gillies, Medical Director and Mr J. Crombie, Deputy Chief Executive;

Chair's Welcome and Introductions

Members were reminded that they should declare any financial or non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. No interests were declared.

25. Minutes and Action Note of the Previous Meeting of the Staff Governance Committee held on 21 October 2020

25.1 The minutes from the meeting held on 21 October 2020 were approved as a correct record.

25.2 Members noted the previously circulated updated cumulative action note.

26. Matters Arising

26.1 Staff Governance Work Plan Update - Mrs Kelly presented the paper asking the Committee to approve the updated Staff Governance Workplan for 2020/21. The Workplan outlines the various papers that come to the Committee ensuring that each element of the Staff Governance standard is met. The updated Workplan was to focus the Committee's work for the remainder of this financial year and then the 2021/22 Workplan would come for approval.

26.1.1 To date the Workplan for the Committee has been based on the themes in Eveyone Matters which used to be updated on annual basis but for the last few years there has been no updated version of Everyone Matters with the key themes simply rolling over into the following year. The expectation had been that the Scottish Government's People Strategy or Plan would have been produced this year to

replace Everyone Matters but this had not happened due to other priorities. It was agreed therefore that the basis of the future Workplan for the Committee would need to be reviewed in advance of the development of the plan for 2021/22. Mrs Butler, Mrs Kelly would have further disuccions about this with the Chair and look to tie in the NHS Lothian corporate objectives also.

BMc/JB/RK

26.2 Mandatory Training Compliance - Mrs Butler confirmed that at the moment it was not possible to report on mandatory training although managers at a local level can still continue to monitor compliance. The Committee noted that the national workplan had been further delayed by Covid19. The NHSiS Employers Group did not have time to focus on the workplan at the moment and there was no timescale for completion currently. A Learnpro dashboard to help with performance management was being looked at for next year.

27. Assurance and Scrutiny

27.1 Corporate Risk Register

3328 Traffic Management Risks

27.1.1 The Chair welcomed Mr Curley to the meeting and he gave a verbal update. Limited assurance was offered regarding safe traffic management at the acute sites. This is due to a number of issues many of which are outwith the Facilities Team's control such as guidance to avoid public transport and car sharing when traveling to hospital, new services coming onto the sites and significant developments such as the St John's Hospital Elective Centre, RIE Trauma development and Royal Edinburgh Hospital infrastructure upgrading all of which are increasing the traffic on the Acute sites.

27.1.2 Mr Curley reported that there had also been an increase in verbal abuse towards traffic management staff. A consistent response to this was being taken and messages around the unacceptability of this had been issued through the Communications Speed Read. The Committee emphasised that abuse to staff was not acceptable and should be dealt with through the appropriate procedures where such unacceptable behaviour is displayed. It was also noted that a Pan Lothian Transport Management Group had been established.

27.1.3 There was discussion on supporting car parking staff and interventions in place to deal with verbal abuse including the use of body cameras to de-escalate situations. The Committee noted that the development of a bespoke RIE transport and logistics team was underway and that this team would help to move forward staff support and training with endorsement from HR. The new team would be in place in the next two weeks.

27.1.4 Mrs Butler flagged recent leadership work and appetite from staff to create a bottom up movement for civility and kindness.

27.1.5 Mr Curley also reported that monies had been successfully secured to introduce temporary parking arrangements on sites and approval to add almost 300 new spaces at RIE was at the final planning approval stage with approval expected in the coming days.

27.1.6 Other funding requests relating to traffic management were noted as was the allocation that had come through the Board's Gold Command Group for development of the RIE site. The Committee noted that the Gold Command allocation would be underwritten by Scottish Government as Covid19 costs.

27.1.7 The Committee noted the traffic management current position and accepted the levels of assurances as outlined in the paper.

3455 Management of Violence and Aggression

27.2 Professor McMahon introduced the report providing an update to the Committee on work being undertaken to support and improve the current level of support to staff on Violence and Aggression (V&A) management, given that this has been and remains a high risk on the Board's corporate risk register

27.2.1 Mr Wilson highlighted current challenges around V&A training and the information from Edinburgh HSCP around the work on lone worker devices. The lone worker device work had looked at who had these devices, who was using them and who was responsible for the management of these devices. There had also been a Datix exercise undertaken which had identified three logged incidents in the last three years relating to devices, whilst there was no indication of any significant or moderate harm caused there was concern that incidents were not being logged. A review was therefore being undertaken and online training being offered but there had not been good uptake around this.

27.2.2 The Chair thanked Mr Wilson for the update and the Committee would await to see what information comes out of the EHSCP work. The Committee also noted the Lone Worker Policy would be due for review shortly but that this would be part of a Once for Scotland approach and that work was currently on pause due to the pandemic. It was hoped to recommence work on nationally on the Once for Scotland policies in April 2021, but in the interim it had been agreed that technical updates to Lone Working and V&A policies should be done.

27.2.3 There was further discussion on amber and red alerts and the systems and controls that were in place which had to be addressed. The Committee accepted that this was why limited assurance was being offered around implementation and moderate around process. Currently if there was an incident there was no assurance that effective controls were in place. The Committee agreed that this area needed to be revisited and would come back to the next meeting as part of the V&A update. The Board's Health and Safety Committee would also be asked to provide a clear action plan on delivery against this within each business unit, not just Edinburgh HSCP, and this would also come back. Professor McMahon suggested that business unit reports be staggered over the course of the year, he would pick this up outside the meeting with Miss Gillies.

AMcM/TG

27.2.4 The Committee noted the steps being taken to review the organisation's approach to the management of violence and aggression and strengthen organisational assurance. The Committee also noted that the key areas where violence and aggression are highest i.e. within the Royal Edinburgh Hospital and Emergency Departments are well covered and there is good compliance with training.

27.2.5 The committee agreed to take a limited level of assurance regarding the implementation of the actions and a moderate level of assurance in relation to the process as detailed in the report.

3527 Medical Workforce Sustainability

27.3.1 Mr McAlister updated the Committee on the current level of risk in relation to medical workforce sustainability.

27.3.2 The Committee discussed trained doctors recruitment; the impact of the pandemic on recruitment and training; the drop off in trainee recruitment fill rate; nursing posts fill rate of 96%; the GP training programme and impact over the next 3 years and the St John's Hospital paediatric service which had been under Royal College of Paediatrics and Child Health review but the Paediatric Programme Board had now been dissolved as the service could not provide full out of hours cover.

27.3.3 The Committee accepted the recommendations in the report, namely to:

- acknowledge the significant impact that the pandemic has had on the recruitment to trained doctor posts, in terms of fill rates and the number of applications.
- acknowledge the highly successful national and regional recruitment to training grade posts.
- acknowledge the impact of the Covid pandemic on medical training and the range of measures that have been taken at a UK, Scottish and Board level to minimise the risk to services associated with interruptions to trainee progressions.
- support the work of medical education and service leads in establishing the new lengthened internal medicine training programme and measures that have been taken to avoid a potential detrimental impact for some services.
- acknowledge that the workforce sustainability risk at the paediatric unit at St John's Hospital has been successfully resolved by successful recruitment.
- note the level of risk remains unchanged at high and that the impacts of the covid-19 pandemic and any further waves have the potential to increase risks further. The committee is asked to accept a moderate level of assurance that the controls in place mitigate any risks to immediate patient safety and quality of care related to this.

3828 Nursing Workforce – safe staffing levels

27.4 Professor McMahon outlined the report updating on the risk around safe staffing levels risk (ID 3828) on the corporate risk register; advising that the Health and Care Staffing (Scotland) legislation (commonly referred to as the "safe staffing legislation"), temporarily suspended by the Scottish Government in March 2020 is currently operating at a reduced capacity within NHS Lothian and summarising the Board's Covid19 oversight arrangements in relation to impact on the workforce.

27.4.1 There was discussion on the staffing pressures which every Board were facing at the moment due to the pandemic. There were several Boards making mutual aid requests particularly around nursing staff. Within Lothian there had been constraints around nurse staffing at St John's Hospital and the site management team had been working to ensure safe staffing was in place over the last few weeks, this had required some bed closures in order to maximise the staffing available. As well as Acute nursing pressures on all sites, there was additional pressure with

nurses required to support care homes also. For care home support each HSCP had tried to create pools of staff to reduce staff movement across care homes.

27.4.2 The Committee noted that Staff Bank had been working hard to do all it could in relation to nurse staffing including cold calling of staff, use of NMC emergency register, contacting returners and recently retired staff and continuing to block book agency staff. Clinical Research nurses were also being utilised as weekend cover. Professor McMahon made the point that for obvious reasons the Board were presently reluctant to cancel nurses annual leave. Mr Waterson added that Unison had offered some trained vaccinators to support the staff vaccination programme and to take pressure of nurse staffing.

27.4.3 Professor McMahon updated on the Safe Staffing legislation. The Committee noted that there was not currently a real timeline but that NHS Lothian were enacting the principles of the legislation currently. There was a proposal for an update on nurse staffing to go to the NHS Lothian Board meeting in February 2021, given the predicted difficult January for staff. The Committee supported this proposal.

27.4.4 The Committee agreed to the recommendations in the report:

- to extend the remit of risk 3828 to include the risks pertinent to the wider workforce groups covered by the Health and Care Staffing Scotland legislation.
- to retain the risk level of risk ID 3828 at high but to increase the risk score from 12 to 16 as a consequence of the continuing impact of the COVID 19 pandemic on the workforce.
- to take significant assurance that there is a robust corporate oversight mechanism to prioritise and co-ordinate the responses across the workforce.
- to take limited assurance that there is sufficient capacity to meet the increasing demands to meet Covid 19 programmes of work and localised pressures arising from staff absences and increased Covid activity.

27.5 <u>Health and Safety Assurance</u>

27.5.1 Mr Wilson presented the previously circulated paper. Members accepted the recommendations and quarter two assurance levels laid out in the report:

- Manual Handling – limited assurance
- Workplace inspections – moderate assurance
- Environmental Ligatures – moderate assurance
- Windows and Balconies –– moderate assurance

27.6 <u>Staff Engagement and Experience Framework - 2018-20 – End of Framework Report</u>

27.6.1 The Committee received the report updating on the delivery of the actions in the Staff Engagement and Experience Delivery Framework (SEEDF) 2018 – 2020 plan. The Committee noted the section of the report outlining areas for improvement and the indication of key actions to be delivered in later stages of the framework and the evidence around these.

27.6.2 The Committee agreed to take moderate assurance that the actions to deliver the ambitions of the Staff Engagement and Experience Framework 2018 – 2020 had been achieved and learning had been woven into the second iteration of the plan.

27.6.3 The Committee noted that where actions from the delivery plan for the period 2019/20 had not been closed they had been picked up and would be progressed via the 2020 - 2023 Framework and associated delivery plan where appropriate.

28. Sustainable Workforce

28.1 Workforce Report

28.1.1 Mrs Kelly explained that this was the usual workforce report which had been coming to the Committee but had been paused recently due to the pandemic.

28.1.2 The Committee noted that the staff absence during Covid19 had been lower than expected when looking at October 2019 to October 20 or April 2020 to October 2020 data. Current workforce issues were around nurse staffing and the potentially increasing Covid19 related absence. There is also a Covid19 absence code so these absences are in addition to normal sickness absence codes. The Committee asked if staff uptake of flu vaccination could be added to the report and that the information also be added into the Board Bulletin to update Board Members. Mrs Butler and Mrs Kelly would look to take this action forward – JB/RK

28.1.3 The Committee noted the updated Workforce Report for November 2020 and the actions being taken to address some of the issues raised in the Report.

28.2 Regional Recruitment Transformation Business Case

28.2.1 Mrs Butler reported that NHS Lothian had been successful in being identified as the employer for the East Region Recruitment services and that focus would now move from transformation towards implementation. Given current pressures and the work involved there would need to be a senior leadership post recruited to lead this work and a summer 2020 phased approach was planned. Mrs Butler would bring further updates back to the Committee as appropriate.

29. Capable Workforce

29.1 Working Across Boundaries

29.1.1 Mrs Butler outlined the report providing a further update to Committee on the action plan for Everyone Matters relating to working across boundaries to share good practice in learning & development and organisational development. It was noted that the last update provided to the Committee was on 30 October 2019.

29.1.2 The Committee is agreed to take a significant level of assurance that the broad range of work is continuing or in-progress to support and deliver the key commitments as set out in the Everyone Matters: 20:20 Workforce Vision relating to working across boundaries.

30. Healthy Organisational Culture

30.1 COVID Situational Update

30.1.1 Mrs Butler provided an update on the current Covid19 situation. The update covered the expansion of healthcare worker testing for Covid; the vaccination programme as it pertains to staff; workforce planning and additional recruitment efforts.

30.1.2 The Committee noted that the vaccination programme for staff had commenced on the 8th of December as planned and would be rolled out on a phased basis over the coming weeks.

30.1.3 In relation to vaccines, the AstraZeneca vaccine was expected to be approved shortly and stocks would then be received in January 2021. Mass vaccination centres would also be developed in addition to local vaccination clinics and would be in place early in the New Year.

30.1.4 There was discussion on issues with the Call Centre booking system. Mrs Butler confirmed that messaging around prioritisation was being developed and that a late change in eligibility criteria over the weekend by the Scottish Government had not helped. The work teams had done to get NHS Lothian to the current position at such pace and scale had been outstanding.

30.1.5 Mrs Kelly updated on workforce planning and recruitment for the mass vaccination centres. The Committee noted that our recently retired staff had been contacted in addition to those indivdiuals who had applied through the National Recruitment Portal earlier in the year and also our Staff Bank. Ms Hirst asked about local authority information, Mrs Butler stated that there would be a separate conversation with local authority chief executives in the coming week in terms of engagement with the mass vaccination programme. It was noted that there had also been significant communication to all Board Non-Executive members.

30.1.6 Mrs Butler also explained current development in relation to the expansion of the staff testing programme. The Committee noted the Scottish Government request to expand twice weekly testing to all patient facing staff using lateral flow tests. For Lothian this equated to circa 20k staff, twice weekly. Any positive lateral flow tests would then have to be confirmed through a lab PCR test. It was hoped to roll this out earlier in December but there had been a delay with guidance. NHS Lothian would begin testing prior to the festive break in eight areas identified and work to build up this testing during January 2021.

30.2 Advancing Equalities Update

30.2.1 Mrs Kelly introduced a report on the Advancing Equalities Action Plan 2020-21 and the actions taken within NHS Lothian to advance race equality since the last report to the Committee on 21 October 2020.

30.2.2 Mrs Kelly explained that the Action Plan included actions due in December 2020 in relation to increasing our staff reporting on protected characteristics. However, these actions would now be picked up from January 2021 as there was limited communications capacity due to the pandemic to assit with the publicising of this

campaign. The Committee noted that Staff Networks were working to develop action plans for the end of March 2021.

30.2.3 Mr Bruce updated on the survey of the BME Staff Network members. There had been 40 responses to date and around two-thirds had responded that they knew about the Risk Assessment Tool, around 47% had used the tool to calculate their Covid age and of that 47%, around a third had discussed the findings with their manager with 1 in 10 reported a change at work as a result of completing the assessment.

30.2.4 The Committee agreed to take significant assurance that progress is being made to deliver on the actions contained in the Advancing Equalities Action Plan .

30.3 Whistleblowing Monitoring Report

30.3.1 Mrs Kelly introduced the report on the monitoring data for the Whistleblowing cases that have been raised within NHS Lothian and providing an update on arrangements for the new National Whistleblowing Standards. The Committee noted that since the last report there had been two new whistle-blowing cases added and these were detailed in the Appendix to the report.

30.3.2 Mrs Kelly reported that a small group had been established to look at the implementation arrangements for the new Standards and this group were reviewing recording mechanisms, co-ordination of the process and training. It was also important to note that the concern around the April 2021 implementation date of the new Standards as they related to independent contractors had been discussed with the Board's Corporate Management Team to consider how best to engage with the independent contractors given the current demands on their time.

30.3.3 Ms Kasper added that as the Board's Whistle-Blowing Champion, she had been approached by the Scottish Government to update on the Board's current arrangements and preparation for the new Standards. This approach had been discussed with Mrs Butler. Ms Kasper confirmed that she would be going back to the Scottish Government with a positive response that the Board's current practices and governance were robust but recognising that there were also challenges. It was noted that each health board's Whistle-Blowing Champion had been contacted by the Scottish Government. Ms Kasper had been in discussion with her equivalent colleagues in other health boards and consideration was being given to establishing a Whistle-Blowing Champions network.

30.3.4 In relation to Speak Up, the information around contacts included in the report was noted. As previously agreed by the Committee, the SPEAK UP Ambassadors would attend every second Staff Governance meeting to provide updates.

30.3.5 The Committee agreed to take moderate assurance based on the information contained in the paper that systems and processes are in place to help to create a climate in NHS Lothian which ensures employees have absolute confidence in the fairness and objectivity of the procedures through which their concerns are raised and are assured that concerns raised will be acted upon.

30.3.6 The Committee noted the current position with the implementation of the new National Whistleblowing Standards and the number and types of cases raised through the Speak Up Initiative from April 2020 to 4 December 2020.

30.4 Everyone Matters Presentation and iMatter Update

30.4.1 Everyone Matters Presentation

30.4.1.1 Mr Haddow gave a presentation on the Everyone matters pulse survey national report 2020. The presentation covered the survey of staff experiences over a 6-month period during the Covid pandemic and was published at the start of December. The survey had included 4 ONS questions and 2 open ended questions along with some demography information. The Committee noted that when these results were compared to the annual iMatter survey NHS Lothian remained in a middle table position, with no red flags.

30.4.1.2 Mr Haddow added that this was the largest survey NHS Lothian had issued as it included all Health and Social Care staff as well as Doctors in Training. Lothian's response rate had been 42% against the national rate of 43%.

30.4.1.3 The survey asked staff about work related and personal worries as part of the open-ended questions. Responses in relation to work had included concerns around patient care, excess workload, Covid safe workplaces, home working and IT support. Personal worries had been around own personal health and family health and wellbeing.

30.4.1.4 The survey had also asked staff about support. Work related support responses had included teams, managers colleagues, ability to go to work, appreciation of being able to work at home and other flexible arrangements to working. Personal support response had been around family, friends, exercise, relaxation, inner strength and resilience.

30.4.1.5 Mr Haddow stated that the responses in this survey could not be directly compared to the iMatter results but due to the volume of results it could be said that this was a true reflection of how staff felt over this period. Mrs Butler confirmed that it would be unlikely that a specific action plan would be produced for this survey.

30.4.1.6 The next steps would now be to present the results to the Board's Corporate Management Team and Lothian Partnership Forum on 22 December and share results with staff and managers. The corporate response would inform the next iteration of NHS Lothian's Staff Experience and Engagement Framework and Staff Wellbeing Strategy.

30.4.1.7 The Chair thanked Mr Haddow for the presentation and the slides would be circulated to the Committee electronically.

30.4.2 The circulated update paper on iMatter was noted. Mrs Kelly stated that it was not yet clear around the roll out of iMatter 2021 and a further update would come to the Committee meeting in February 2021.

30.5 Staff Wellbeing During COVID

30.5.1 Ms Langsley provided an update on the ongoing staff wellbeing response to Covid-19 and beyond.

30.5.2 The update covered areas of activity funded by the Scottish Government; the significant investment from the Edinburgh and Lothian's Health Foundation in staff wellbeing initiatives and the development of research and innovation work to address the impact of the Covid-19 pandemic on staff mental health and well-being in NHS Lothian. An initial thematic analysis of a range of different data sets gathered during Covid -19 on staff wellbeing has been conducted by Edinburgh University. NHS Lothian would be using this data to inform its research question and next steps.

30.5.3 Ms Langsley reported that the paper also covered the range of activity that was not Covid related this included wellbeing seminars around resilience and home working and a very successful virtual Staff Wellbeing week.

30.5.4 The Chair asked about extra funding around psychological support and capacity. Ms Langsley confirmed that the supply of psychology workforce had been raised and interviews for new posts would take place in the coming week. Professor McMahon added that there was a good supply of psychology graduates.

30.5.5 The Committee agreed to note the actions in place to support the ongoing staff wellbeing activity in response to Covid-19 and our plans to continue and embed this work as we move to the 'new normal' state and also agreed to take a significant level of assurance that NHS Lothian continues to place staff wellbeing at the forefront of our activity and have robust plans in place to progress this work as we move through and beyond the phases of the pandemic.

30.5.6 The Committee noted the levels of sickness absence as outlined in the report Appendix and noted the significant investment from the Edinburgh and Lothian's Health Foundation in staff wellbeing initiatives, which was to be commended.

31. For Information and Noting

31.1 Staff Governance Statement of Assurance Need

31.1.2 The Committee approved the updated Statement of Assurance Need for 2020/21.

31.2 The Committee noted the following minutes for information:

- Minutes of the Staff Engagement and Experience Programme Board – 28/09/2020
- Minutes of the Workforce Development Programme Board – 08/10/2020
- Minutes of the Lothian Partnership Forum held on 27/10/2020

32. AOCB

32.1 Mr Waterson raised a concern about the length of today's meeting and that future meetings needed to be more focused. The Chair agreed to look at this for future meetings.

33. Date of Next Meeting

33.1 The next meeting of the Staff Governance Committee would take place at **9.30** on **Wednesday 17 February 2020**.

34. 2021 Meeting Dates

34.1 Meetings would take place on the following dates in 2021:

- 17 February 2021;
- 26 May 2021;
- 28 July 2021;
- 20 October 2021;
- 15 December 2021.

Signed by the Chair
Date: 17 February 2021

Original kept to file

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 15 December 2020

Held remotely by video conference

Present:

Board Members:

Angus McCann (Chair), Councillor Ricky Henderson (Vice-Chair), Councillor Robert Aldridge, Colin Beck, Carl Bickler, Andrew Coull (to item 8), Councillor Phil Doggart (from item 7 onwards), Christine Farquhar, Helen FitzGerald, Councillor George Gordon (to item 6), Kirsten Hey, Jackie Irvine (to item 3), Jacqui Macrae (to item 6), Councillor Melanie Main (from item 3 onwards), Peter Murray, Moira Pringle, Judith Proctor, Ella Simpson and Richard Williams.

Officers: Ann Duff, Tom Cowan, Linda Irvine Fitzpatrick, Tony Duncan, Rachel Gentleman, Lauren Howie, Angela Lindsay, Jenny McCann and Julie Tickle.

Apologies: Martin Hill and Ian McKay.

1. Minutes

Decision

To approve the minute of the Edinburgh Integration Joint Board of 27 October 2020.

2. Rolling Actions Log

The Rolling Actions Log for December 2020 was presented.

Decision

1) To agree to close the following actions:

- Action 1 – Edinburgh Joint Carers Strategy
- Action 5 – Provision of General Medical Services – Edinburgh South

- Action 7 (2) – Governance Report
- Action 10 – Finance Update
- Action 11 – Update on Recruitment of Carer and Service User Reps

2) To note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted.)

3. Chief Social Work Officer's Annual Report 2019/20

The Chief Social Work Officer presented her annual report for 2019/20. The report covered a number of areas including the key issues for social work and social care in Edinburgh, updates on finance, service quality and delivery, workforce planning and performance information.

The report also reflected on the challenges social work services had faced as a result of the Covid-19 pandemic.

Decision

1) To note the Chief Social Work Officer's Annual Report for 2019/20 as attached at Appendix 1 to the report.

2) To request information from adult support and protection on 'elder abuse' to be circulated to members.

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

4. Financial Framework 2021-2024

A report presented the medium term three-year financial outlook for 2021-24 to the Board. The report built on the previous financial outlook for 2020-23 and introduced the new Integration and Sustainability Framework which had been developed in response to the longer term financial challenges facing the IJB.

Decision

1) To support the development of an Integration and Sustainability Framework as set out in the report.

2) To note the initial financial outlook for 2021-2024.

(Reference – report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

5. City Vision 2050

A report was considered on the City Vision 2050 which had been supported and endorsed by the Strategic Planning Group on 15 September 2020.

The Edinburgh City Vision 2050 had been in development since 2016 and had been endorsed by the Council's Policy and Sustainability Committee in June 2020. It focussed on four key themes of fair, pioneering, welcoming and thriving. Significant public and stakeholder engagement had been undertaken on the Vision before being finalised by a steering group of partners.

Decision

1) To acknowledge the strategic intent of the Edinburgh City Vision 2050.

2) To agree to sign up to the City Vision 2050 Charter at Appendix 2 to the report.

3) To refer the monitoring of the Edinburgh City Vision 2050 and how it impacted on health and social care to the Futures Committee.

(References – Strategic Planning Group of 15 September 2020, item 8; report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

6. Annual Review of Directions

The annual review of directions was presented to the Board following consideration by the Performance and Delivery Committee on 16 November 2020. It had been agreed that directions would be reviewed on an annual basis to consider whether they should be retained, revoked, varied or superseded.

Decision

1) To note the report which had been circulated was an incorrect version and the correct report would be provided.

2) To note that the Performance and Delivery Committee had considered the annual review of Directions report which covered the period October 2019 to March 2020.

3) To approve the new and varied Directions provided at Appendix 2 to the Performance and Delivery Committee report dated 16 November 2020.

4) To recognise the progress made with directions and key performance indicators over the past year.

(References – Performance and Delivery Committee of 16 November 2020, item 8; report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

7. Preparations for Winter 2020-2021

An overview of the preparations for Winter 2020-21 was presented. This included information on the early preparations, funding allocations, the flu campaign and the required submissions of plans to the Scottish Government and the Lothian Unscheduled Care Committee. The report also covered the additional impact of Covid-19 on this year's plans.

Decision

1) To note the progress with the plans for Winter 2020/21.

2) To accept the report as a source of reassurance that the Partnership had developed a robust winter strategy; taking on board learning from the evaluation of the previous winter campaign and a review of the local response to the Covid-19 pandemic.

3) To note that the preparations for Winter 2020/21 were interlinked with other workstreams such as the Redesign of Urgent Care and Home First, and align with the remobilisation plan.

4) To request a briefing for members with further information on the 'long Covid' support service.

5) To note that a report would be submitted to a future Board meeting on the flu vaccination programme with lessons learned and the financial implications.

6) To request clarification on the breakdown of the £1.45m allocation received by NHS Lothian for supporting the costs of winter 2020/21.

(Reference – report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

Declarations of interest

Christine Farquhar declared a non-financial interest in the above item as a former trustee of VOCAL.

Ella Simpson declared a non-financial interest in the above item as EVOC was involved in the co-ordination of winter pressures work.

8. Integration Joint Board Risk Register

The current IJB risk register and an update on the activity to manage, mitigate and escalate risks were considered.

Decision

1) To note the continued development of the IJB risk register.

2) To note the introduction of 'risk profile cards' for 'very high', 'high' and 'medium' risks.

3) To agree that the mitigating controls identified against these current risks were adequate.

4) To take into account the concerns expressed around carer, service user and third sector representation and engagement and to note these would be considered by the Audit and Assurance Committee.

5) To request further information on the capital arrangements and processes to come forward through the Strategic Planning Group.

(Reference – report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

9. Board Assurance Framework

An update was provided on the IJB's assurance framework. It was proposed that an assurance level should be included in reports to the Board and committees and that a mechanism for reviewing the work of the committees should be adopted.

Decision

1) To agree to adopt the approach to including assurance levels in IJB reports.

2) To agree to adopt the suggested mechanism for reviewing the work of the committees.

3) To amend the Committee Effectiveness Survey form to refer to 'Chair' rather than 'Chairman' at A5 and to include all relevant policies and strategies at C5.

(Reference – report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

10. EIJB Development Session Programme

Members were asked to agree arrangements for development sessions and the focus of these for 2021. Approval was also sought to establish a Budget Working Group to focus specifically on the budget planning process.

Decision

1) To agree the overarching themes for the development session programme.
2) To agree the three strands of the Board's programme across development, engagement and budget setting.
3) To approve the establishment of a Budget Working Group to replace informal budget development sessions.
4) To request that members submitted any suggestions for topics to be considered which would be included in the poll sent to members to prioritise topics for each session.
5) To agree to hold ad-hoc meetings where necessary.

(Reference – report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

11. Committee Update Report

A report was presented which provided an update on the work of the IJB committees which had met since the last Board meeting. In addition to the summary report, draft minutes of each committee were submitted for noting.

Decision

To note the update and the draft minutes of the committee meetings.

(Reference – report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within WEBEX VIRTUAL MEETING ROOM, on 19 JANUARY 2021.

Present

Voting Members – Bill McQueen (Chair), Martin Connor, Damian Doran-Timson, Martin Hill, Katharina Kasper, Dom McGuire, and George Paul

Non-Voting Members – Allister Short, Elaine Duncan, Steven Dunn, Mairead Hughes, Jo MacPherson, Alan McCloskey, Caroline McDowall, Ann Pike, Patrick Welsh and Rohana Wright

Apologies – Harry Cartmill and David Huddlestone

In attendance – Martin Higgins (NHS Lothian), Carol Holmes (NHS Lothian), Lorna Kemp (Project Officer), Yvonne Lawton (Head of Strategic Planning and Performance), Sharon Leitch (Senior Auditor), James Millar (Standards Officer), Fiona Wilson (Team Manager, Community Health and Care Partnership)

1 DECLARATIONS OF INTEREST

There were no declarations of interest made.

2 MINUTES

The Board approved the minutes of its meeting held on 10 November 2020, subject to correcting Alan McCloskey's name in the sederunt.

3 MINUTES FOR NOTING

a The Board noted the minutes of the West Lothian Integration Joint Board Audit Risk and Governance Committee meeting held on 2 December 2020.

b The Board noted the minutes of the West Lothian Integration Joint Board Strategic Planning Group held on 22 October 2020.

4 MEMBERSHIP & MEETING CHANGES

The Clerk advised that there was nothing to report under this item.

5 ANTI-POVERTY AND HEALTH AND WELLBEING UPDATE

The Board considered a report (copies of which had been circulated) by Martin Higgins providing an update on recent community planning work relating to COVID-19 with specific reference to health and wellbeing.

It was recommended that the Board note the continued involvement in joint community planning COVID-19 mitigation activity.

Decision

1. To note the terms of the report.

2. To consider how to distinguish strategic and leadership functions in community planning work

3. To further develop IJB's leadership role in community planning work involvement.

4. To monitor the subject of mental health issues via the SPG and consider future approaches when Covid circumstances change.

5. To consider inviting Martin Higgins to a future meeting of the IJB to provide another update.

6 CHIEF OFFICER REPORT

The Board considered a report (copies of which had been circulated) by the Chief Officer providing a summary of key developments relating to West Lothian IJB and updating Board members on emerging issues.

It was recommended that the Board note and comment on the key areas of work and service developments that have been taking place within West Lothian in relation to the work of the Integration Joint Board.

Decision

1. To note the terms of the report.

2. To circulate the letter from the Cabinet Secretary for Health and Sport regarding the Consultation to Include Integration Joint Boards as Category 1 Responders under the Civil Contingencies Act 2004.

3. Chief Officer to update members on vaccination progress every two weeks.

4. To include item on drug related deaths in the March meeting agenda.

5. To formally record thanks to all Health and Social Care Partnership staff, carers and third sector partners for managing the Covid crisis.

7 WEST LOTHIAN IJB 2020/21 BUDGET UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an interim update, in advance of the

Quarter 3 monitoring, on the 2020/21 budget position, including updated Covid-19 financial implications.

It was recommended that the Board:

1. Note the forecast outturn position for 2020/21 in respect of IJB delegated functions;

2. Note the latest estimated financial implications resulting from Covid-19 in relation to both expenditure and additional Scottish Government funding;

3. Note the key risks associated with the 2021/22 forecast position; and

4. Note the current position regarding the UK and Scottish Budgets for 2021/22.

Decision

To note the terms of the report.

8 CHIEF SOCIAL WORK OFFICER'S ANNUAL REPORT 2019-2020

The Board considered a report (copies of which had been circulated) by the Chief Social Work Officer providing an overview of the statutory work undertaken during the period 2019 – 20 and providing members an opportunity to comment.

It was recommended that the Board:

1. Note the contents of the Chief Social Work Officer's annual report for 2019-2020; and

2. Note that a draft of the report has been submitted to the Scottish Government Chief Social Work Advisor.

Decision

1. To note the terms of the report.

2. To provide further details regarding care home staffing levels.

3. To use outcomes of the recent Joint Inspection of the Effectiveness of Strategic Planning in the West Lothian Health and Social Care Partnership to provide an update on personalised care at a future IJB meeting.

9 HEALTH AND CARE GOVERNANCE GROUP UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Officer presenting proposals for moving the West Lothian Health

and Care Governance Group to an officer led committee and for the appointment of a permanent chair.

It was recommended that the Board:

1. Agree formally that the Health and Care Governance Group will be an officer led committee;

2. Approve the Head of Social Policy as the permanent chair of the group; and

3. Agree that minutes of the meetings of the Health and Care Governance Group will be submitted to the IJB to provide members with assurance around standards of health and social care services in West Lothian.

Decision

1. To approve the terms of the report.

2. To consider timing meetings of the Health and Care Governance Group to ensure timely distribution of meetings to the IJB for noting.

3. To note advice to the Health and Care Governance Group to consider the relationship between the group and the Clinical Governance Committee when reviewing the group's remit in order for clarity and avoidance of duplication of work.

10 REVISED MODEL CODE OF CONDUCT - CONSULTATION RESPONSE

The Board considered a report (copies of which had been circulated) by the Standards Officer asking members to consider a proposed response to the Scottish Government's consultation on a revision of the Model Code of Conduct.

It was recommended that the Board agree a response to the Scottish Government's consultation on a revised Model Code of Conduct.

Decision

To approve the recommendation in the report.

11 DRAFT EQUALITY OUTCOMES 2021-2025

The Board considered a report (copies of which had been circulated) by the Chief Officer presenting draft equality outcomes for 2021–2025 and seeking approval to commence a public consultation on those outcomes.

It was recommended that the Board:

1. Note the requirement for public bodies to develop and publish equality outcomes and to report on them every two years;

2. Note the Board is due to set new equality outcomes in April 2021 for the next four years;

3. Note the approach taken to developing the draft equality outcomes and alignment to the commission plans;

4. Agree the draft equality outcomes for public consultation; and

5. Agree the proposed approach to public consultation.

Decision

To approve the recommendations in the report.

12 SELF-EVALUATION ACTON PLAN PROGRESS UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Officer updating members on progress made against the joint action plan submitted to the Scottish Government at the request of the Ministerial Strategic Group for Health and Community Care following its Review of progress with Integration of Health and Social Care.

It was recommended that the Board:

1. Note that the Ministerial Strategic Group for Health and Community Care requested that every Health Board, Local Authority and Integration Joint Board jointly submit a self-evaluation of progress with integration to the Scottish Government and an associated plan for improvement;

2. Note that an action plan was agreed by all three partners and submitted to the Scottish Government on 23 August 2019;

3. Note the progress made against the agreed actions; and

4. Agree that actions considered to be partially complete or ongoing are captured or superseded by other, more recent plans and that monitoring this particular action plan is surplus to requirements for providing assurance to the Board.

Decision

1. To approve the recommendations in the report.

2. To add an update on the Communications and Engagement Strategy to the Workplan.

3. To ensure the Board maintains continued collaboration with carers.

13 REVISED REPORT TEMPLATE

The Board considered a report (copies of which had been circulated) by the Chief Officer seeking approval for the adoption of an updated report template to be used for meetings of the West Lothian Integration Joint Board, the Audit, Risk and Governance Committee and the Strategic Planning Group.

It was recommended that the Board:

1. Note the recommendation from the joint inspection on strategic planning in relation to establishing a clear identity for the integration authority to ensure its role in supporting the functions of the integration joint board is clearly evident to the people of West Lothian;

2. Note the Board agreed at its meeting of 10 November 2020, to establish a clear brand for integrated health and social care services that is recognisable to the West Lothian population – including the development of a campaign brand for the IJB and a revised report template that better reflects the identity of the Board; and

3. Agree the revised report template for the IJB, its Audit Risk and Governance Committee and the Strategic Planning Group.

Decision

1. To approve the recommendations in the report.

2. To include sustainability considerations in the integrated impact assessment form.

3. To organise an additional development session between February and May which would include discussion on sustainability.

14 WORKPLAN

A workplan had been circulated for information.

Decision

1. To note the workplan.

2. To add 6-monthly evaluation of Communications and Engagement Strategy to the workplan.

3. To add Carer Strategy updates to the workplan.

4. To move future IJB meetings to MS Teams platform and to organise a test/training session for members.

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 10TH DECEMBER 2020
VIA DIGITAL MEETINGS SYSTEM

Voting Members Present:
Councillor F O'Donnell (Chair)
Councillor S Akhtar (Items 4 – 7)
Dr P Donald
Councillor N Gilbert (Items 1, 6 & 2 – 5)
Ms F Ireland
Councillor S Kempson
Mr P Murray
Dr Richard Williams

Non-voting Members Present:
Mr D Binnie
Mr I Gorman
Ms M McNeill
Ms J Tait
Mr P White
Ms C Flanagan
Ms A MacDonald
Mr T Miller
Dr J Turvill

Officers Present from NHS Lothian/East Lothian Council:
Ms L Berry
Mr P Currie
Ms C Goodwin
Ms L Kerr

Clerk:
Ms F Currie

Apologies:
None

Declarations of Interest:
Item 7 – David Binnie declared an interest as this item dealt with his re-appointment. He would leave the meeting at the end of the preceding item of business.

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN IJB ON 29TH OCTOBER 2020 (FOR APPROVAL)

The minutes of the meeting on 29th October 2020 were approved.

2. MATTERS ARISING FROM THE MINUTES OF 29TH OCTOBER

The following matters arising were considered:

Independent Review of Adult Social Care (Item 5) – Paul White asked if the IJB's formal response to the review could be circulated to members. Claire Goodwin advised that it had been circulated after it was submitted to the Scottish Government but that she would re-send it.

Social Care Sustainability Payment (Item 6) – the Chair informed members that a very positive Internal Audit report on this scheme had been presented to the Audit & Risk Committee earlier in the week and had been very well received. She thanked officers for their effective administration of the scheme.

3. CHAIR'S REPORT

The Chair thanked members for their responses to both of the recent consultations: the Independent Review of Adult Social Care and the Inclusion of IJBs as Category 1 Responders.

She noted that this would be the IJB's last meeting of 2020 and she offered the thanks of the Board to all health and social care workers for their efforts to keep patients safe and well during the pandemic. She also offered her thanks to officers and partner agencies for their work on planning and implementing the roll-out of the COVID-19 vaccine.

Members agreed to take Agenda Item 6 next.

6. FINANCIAL UPDATE 2020/21

The Chief Finance Officer had submitted a report providing an update to the IJB on its year to date financial position in 2020/21 (Month 6) and the updated projected year end outturn, undertaken by both the IJB partners.

Ms Flanagan presented the report summarising the position in the health and social care budgets and confirming that regular dialogue continued with the partners over the likely impact of mobilisation and remobilisation plans. She reported that as at the end of September 2020 the IJB was £2.2m overspent, with a projected year end position of £4.7m overspent. She advised that their most recent return to the Scottish Government projected the total COVID-19 costs for the year to be £8.8m. The figures presented in this report did not include the additional funding from Government but this would shortly start to be allocated to the partners to cover backdated costs. Further funding was expected before the end of the financial year and work was underway to understand the impact going forward into 2021/22.

Responding to questions from members, Ms Flanagan provided further detail on the projected shortfall in the current financial year noting that the position remained fluid. She reiterated that she and her colleagues were working to understand the implications for 2021/22 and for the longer-term 5 year financial plan. She also provided an

explanation of the increase in the prescribing budget, part of which related to supply and cost issues.

Jon Turvill provided examples of the types of medications which were currently in short supply, alternatives which were now being recommended and some of the cost and clinical implications. He confirmed that all relevant guidance was being followed in prescribing alternative medications. However, he acknowledged that reviewing patients' medications had been increasingly challenging, particularly antidepressants, as it was not always easy to find time in the day to make contact with patients seeking repeat prescriptions.

Iain Gorman confirmed that a review was underway on to understand the impacts of changes in prescribing and to prepare a 'before and after' comparison. He suggested that additional scrutiny could be put in place, particularly given the added pressures on the prescribing budget.

Alison MacDonald said she recognised that prescribing was an area where further work was required and that it was a volatile market which could have significant financial impacts.

Responding to further questions from members, Ms Flanagan provided details of the pressures affecting the Set Aside budget, and the likelihood of receiving full funding of COVID-19 costs for 2020/21. She explained that funding was coming through more smoothly now and further allocations were expected in January and March 2021 and would be based on financial returns submitted to the Scottish Government. While she expected funding to continue, she emphasised the need to consider any financial off-sets, e.g. savings in the travel budget.

Ms MacDonald added that they had put in place a very thorough and transparent governance process for recording itemised costs associated with COVID-19 and had ensured that processes, such as the social care sustainability payments scheme, were administered in line with relevant Government requirements.

Decision

The IJB agreed to:

i. Note the financial forecasts provided by the partners;
ii. Note that additional COVID-19 funding was confirmed in November and, although not included in these reported Month 6 positions, will start to be allocated to the partners to cover backdated costs;
iii. Note ongoing uncertainties of COVID-19 and the remobilisation of services for both partners and the financial impact; and
iv. Note the Scottish Government budget timetable for 2021/22 and the consequences for both partners.

4. IMPROVING AND MAINTAINING DELAYED DISCHARGE PERFORMANCE THROUGH WINTER

The Chief Officer had submitted a report informing the IJB of requirements placed on East Lothian Health & Social Care Partnership (HSCP) to further improve on Delayed Discharge performance and to maintain improved performance over the winter months.

Paul Currie presented the report advising that, to take pressure off acute services, there was an expectation from the Scottish Government that HSCPs would focus on improving delayed discharge performance (to levels seen in April 2020) and to maintain

this through the winter period. Although East Lothian HSCP has one of the best delayed discharge performance levels in the country, November saw numbers which were higher than those recorded in April. He also outlined some of the planning work underway and examples of services already in place to address delayed discharges.

Mr Currie and Ms MacDonald responded to questions from members providing further information on the process for discharging those requiring care packages; unofficial targets to keep delayed discharges in single figures and the clinical and operational requirements to keep figures below 10. Ms MacDonald also outlined some of the investment in services such as Hospital to Home, Discharge to Assess and Care at Home which had helped to keep numbers low. She acknowledged the need to continue challenging themselves and to consider how services could work differently, and that continuing investment would be required to keep numbers at low levels.

Replying to further questions, Mr Gorman agreed that the impact of enhanced services needed to be properly evaluated and that the partners should be asked to reflect on how they made use of resources in the community. Ms MacDonald said she was mindful that there could be movement of work from secondary to primary care as part of the scheduling of unscheduled care and that this would also have funding implications.

Patricia Donald suggested the possibility of a development session to discuss these matters in more detail and this was welcomed by members.

In relation to maintaining performance on delayed discharges, Ms MacDonald said that they would continue to invest in resources with a proven track record and they would only discharge a patient where they knew it was safe to do so. Their ultimate aim was to move towards talking about integrated care rather than the focus being solely on delayed discharges.

Referring to patients with mental health concerns, she acknowledged that the type of bespoke packages required sometimes took longer to put in place. Options were under discussion to improve the position for dementia and learning disability patients, and all proposals would be brought to the IJB for consideration.

Decision

The IJB agreed to support co-ordinated work across the HSCP teams to deliver and to maintain an, as yet to be agreed, level of Delayed Discharge performance through winter.

5. ADULT SOCIAL CARE WINTER PREPAREDNESS PLAN 2020-21

The Chief Officer had submitted a report advising the IJB of the publication of the Adult Social Care Winter Preparedness Plan and presenting the implications of the Plan for the delivery of services through the winter period by East Lothian HSCP and partners.

Mr Currie presented the report noting its links to the preceding agenda item. He outlined the background to the Plan, its purpose and scope and highlighted the four main areas of focus. He also drew members' attention to the actions detailed in the report's appendix

Ms MacDonald provided an update on funding for the Plan, digital access and the roll out of the COVID-19 vaccine. She reminded members that much of this work had been outlined at the recent development session. She confirmed that the HSCP had received the funding requested from the Scottish Government and that it had targeted

investment in areas where there was evidence of results. She advised that 2 additional wards had been opened within the Community Hospital, separate to this funding, and would take patients from across Lothian, if required. She also reported that the Well Wynd Hub had recently won a national award and it was hoped to expand the service through identifying a second property in Dunbar.

In relation to the vaccination programme, Ms MacDonald informed members that Queen Margaret University would be used as a mass vaccination site and that the vaccination of frontline health and social care staff was beginning. Mr Gorman reported that the Safety Advisory Group was looking at the implications of the roll out for other organisations and co-ordinating with partner agencies over vaccination sites. Ms MacDonald concluded that the next phases of the roll out would, in part, be dependent on logistics and that the amount of doses being received had not been as high as expected. However, she hoped these issues would be smoothed out and that the advent of a second vaccine would help to speed up the process.

Members congratulated the staff of the Well Wynd Hub on their national award.

Ms MacDonald responded to questions. She said that testing of staff in care homes had been underway on a weekly basis for the past 3 months. While it was not mandatory, the majority of staff did take the opportunity and they would shortly be starting the roll out of visitor testing.

Mr Gorman added that care homes had been very responsive and were participating in testing to ensure that they operated as safely as possible.

Laura Kerr provided an update on a new day services pilot project in Dunbar which had received a very positive response and she informed members that a detailed report would be presented to the next meeting of the IJB. It was hoped that the pilot would influence the development of other services across the county.

The Chair reflected that the roll out of the vaccine would hopefully change the position for day centre services and she looked forward to receiving an update in the New Year.

Decision

The IJB agreed to:

i. Accept the Adult Social Care Winter Preparedness Plan and the requirements and actions within to ensure delivery of high quality and sustainable Adult Social Care services over the winter months;
ii. Note the actions underway and planned in East Lothian which support the requirements of the ASP Winter Plan; and
iii. Note the HSCP will scrutinise the ASP Winter Plan and agree other actions to deliver its requirements.

Sederunt: David Binnie left the meeting. Councillor Neil Gilbert lost connection.

7. RE-APPOINTMENT OF A NON-VOTING MEMBER OF THE IJB

The Chief Officer had submitted a report asking the IJB to agree to the re-appointment of David Binnie as a non-voting member representing carers.

The Clerk summarised the background and recommendation of the report. The Chair advised members that Mr Binnie had raised a concern over a perceived inequality in

the term of office for carer representatives being 2 years rather than 3 years, as was the case for most other members. A report would be brought forward to the next meeting of the IJB on the wider issue of terms of office but, in the meantime, the Chair proposed an amendment to the recommendation of the report: that Mr Binnie's re-appointment be for a period of 3 years. This motion was seconded by Councillor Akhtar.

The vote on the recommendation, as amended, was taken by roll call:

Councillor Shamin Akhtar	Agreed
Dr Patricia Donald	Agreed
Ms Fiona Ireland	Agreed
Councillor Susan Kempson	Agreed
Mr P Murray	Agreed
Councillor Fiona O'Donnell	Agreed
Dr Richard Williams	Agreed

Decision

The IJB agreed to the re-appointment of David Binnie as a non-voting member to represent careers, for a further period of 3 years.

Signed .....

Councillor Fiona O'Donnell
Chair of the East Lothian Integration Joint Board

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 10 December 2020	2.00pm	Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Cllr Catherine Johnstone (Chair)	Carolyn Hirst (Vice Chair)	Cllr Stephen Curran
Cllr Russell Imrie	Angus McCann	Cllr Pauline Winchester

Present (non-voting members):		
Morag Barrow (Chief Officer)	Alison White (Chief Social Work Officer)	Claire Flanagan (Chief Finance Officer)
Fiona Huffer (Head of Dietetics)	Hamish Reid (GP/Clinical Director)	Wanda Fairgrieve (Staff side representative)
James Hill (Staff side representative)	Keith Chapman (User/Carer)	

In attendance:		
Jill Stacey (Chief Internal Auditor)	Mairi Simpson (Integration Manager)	Jamie Megaw
Roxanne KIng	Gordon Fender	Mike Broadway (Clerk)

Apologies:		
Mike Ash	Tricia Donald	Cllr Derek Milligan
Cllr Jim Muirhead	Caroline Myles (Chief Nurse)	Johanne Simpson (Medical Practitioner)

Midlothian Integration Joint Board

Thursday 10 December 2020

1. Welcome and Introductions

The Vice Chair, Carolyn Hirst, welcomed everyone to this virtual Meeting of the Midlothian Integration Joint Board, explaining that she had been invited by the Chair, Councillor Catherine Johnstone to chair today's meeting. She extended a particularly warm welcome to Councillors Russell Imrie and Stephen Curran, who were substituting for Derek Milligan and Jim Muirhead respectively, and to local democracy reporter, Marie Sharp, who was also in attendance.

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of Interest

No declarations of interest were received.

4. Minute of Previous Meetings

4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 8 October 2020 were submitted and approved as a correct record.

4.2 The Minutes of Meeting of the MIJB Audit and Risk Committee held on 13 September 2020 were submitted and noted.

4.3 The Minutes of Meetings of the MIJB Strategic Planning Group held on 18 August and 28 October 2020 were submitted and noted.

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.1 Midlothian Response to Delayed Discharges – Presentation Alison White, Chief Social Work Officer and Head of Adult and Social Care provided a presentation on Midlothian's Response to Delayed Discharges in which she highlighted that the need to ensure that no	To thank Alison for her extremely helpful and informative presentation.		

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
one was unnecessarily admitted to an acute hospital bed or stayed in an acute hospital setting longer than necessary had been amplified by Covid-19, winter and Brexit. However, the solution to reducing delays was a complex one and in order to be able to put in place measures that truly address the problem, reduced delays and improved flow through the system, we must first understand the system and its processes, identify sticking points, reduce waste, streamline and reduce duplication. Alison then went on to outline some of the steps being taken to address these issues and highlighted possible ways in which MIJB might assist in supporting this work. There then followed a general discussion during which the need for a more holistic approach and better joint working across and between services was acknowledged. Whilst all the steps being taken were considered important, the introduction and development of a single point of access was particularly welcomed as an important step forward.			
Sederunt: Cllr Stephen Curran left the meeting, and Claire Flanagan (Chief Finance Officer) joined the meeting, at the conclusion of the foregoing item of business (14:50).			
5.2 Chief Officers Report This report provided a summary of the key service pressures and service developments which had occurred during the previous months across health and social care, highlighting in particular a number of the key activities, as well as looking ahead at future developments.	To note the content of the Chief Officer's Report.		

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
The Board, having heard from Morag Barrow, welcomed the good performance of Covid testing processes for staff and residents in local Care Homes, which were working well and the continuing push for expanded testing to cover the Care at Home team. With regards the availability of vaccine supplies, particularly post Brexit, Jamie Megaw sought to reassure Members that contingency plans were being put in place nationally to address this.			
5.3 Vision and Values The purpose of this report was to update the Board on the proposed final vision and values for the new Strategic Plan 2022-2025. The report explained that in order to meet the legal requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, Midlothian Health & Social Care Partnership required to publish a new Strategic Plan in 2022. An agreed vision was a key requirement of the Strategic Plan, as outlined in the 3-Step Improvement Framework for Scotland's Public Services 2013. Mairi Simpson was heard in amplification of the report advising that the final proposed vision and values were: **New Vision**: People in Midlothian are enabled to lead longer and healthier lives. **New Values**: Right support, right time, right place.	To approve the proposed new vision and values for the Strategic Plan 2022 - 2025.	Integration Manager	

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.4 Midlothian IJB Directions 2020 Update With reference to paragraph 5.3 of the Minutes of 8 October 2020, there was submitted a report the purpose of which was to provide the Board with an interim review of progress on all Directions which, following a review in October 2020 had been reissued to the Chief Executives of Midlothian Council and NHS Lothian. Mairi Simpson was heard in amplification of the report after which there was a general discussion during which it was noted that work was in hand to improve output and outcome measures for a small number of Directions, which would complement work to improve performance measures. Additionally, a reduction in the use of acronyms and greater clarity of where progress has been impacted by the coronavirus pandemic would be welcomed.	(a) To note the update of progress on Midlothian Integration Joint Board Directions to Midlothian Council and NHS Lothian; and (b) To note the proposed change to Direction 1 Action (iv), which was to be removed as there was no aim to increase the proportion of patients admitted to the RIE.	Chief Officer/ Integration Manager	
5.5 Independent Review of Adult Social Care The purpose of this report was to provide the Board with information regarding the scope of the Independent Review of Adult Social Care (IRASC) in Scotland, which had been announced by the First Minister, as part of the Programme for Government on 1 September. The report highlighted the scope of the review; the term of reference for which were appended to the report.	(a) To note the report; and (b) To agree to receive a further update in the New Year once the outcome of the review is known.	Chief Social Work Officer/ Clerk	

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Alison White was heard in amplification of the report making particular reference to having been involved in a meeting with the Chair of the Review and also in contributing to Social Work Scotland response.			
5.6 Clinical and Care Governance Report The purpose of this report was to provide assurance to the Board as to the clinical and care governance arrangements within Midlothian, along with highlight good practice and identify any emerging issues or risks. Additional reports would be submitted as appropriate throughout the year to provide updated information from specific service areas. Alison White and Fiona Huffer were heard in amplification of the report after which there was a general discussion on how the Quality Improvement Teams (QIT) would support the work of the Clinical and Care Governance Group (CCGG).	To note and approve the content of the report. .	All to note	
5.7 MIJB Improvement Goal Progress With reference to paragraph 5.4 of the Minutes of 14 February 2019, there was submitted a report updating the Board on performance and improvement towards achieving the Local Improvement Goals set by the MIJB based on the indicators recommended by the Ministerial Strategic Group (MSG) for Health and Community Care. The improvement goals focused on reducing unscheduled hospital and institutional care using	(a) To note the performance across the indicators; and (b) To note the inclusion of further information about performance in Midlothian against the Core Suite of Indicators.	All to note.	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
data provided by the Health and Social Care team at ISD Scotland. Jamie Megaw was heard in amplification of the report drawing particular attention to the summary of Midlothian MSG Indicator Performance (detailed in para 3.5 of the report) after which there was a general discussion on this and the work to improve the local performance measures.			
5.8 Covid Vaccination Jamie Megaw provided the Board with an update on the Covid Vaccination programme rollout in Midlothian. He explained that the clinic set up in Midlothian Community Hospital was operating close to its capacity of 500 patients daily focusing initially on those in the nationally set phase 1 priority group, which included those administering the vaccine, residents and workers in care homes, and other frontline health workers. They would be followed by the over 80s and those who were housebound in the New Year. There then followed a general discussion during which Jamie responded to Members questions and comments. Morag Barrow expressed her thanks to all those involved in getting the programme operational, at what was an especially busy time of year with the normal flu vaccination programme, take up for which had been very good.	(a) To note the update; and (b) To note that further updates would follow as the programme progressed.		

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Sederunt: James Hill left the meeting towards the conclusion of the foregoing item of business (15:54).			
5.9 Finance Update for 2020/21 and 5 Year Financial Plan This report set out the results of the MIJB's partner's (Midlothian Council and NHS Lothian) month 6 financial reviews and considered how this impacted on the projected financial position for the IJB for 2020/21. The report advised that since these forecasts had been prepared both IJB's partners had received confirmation on the COVID additional funding, this had not been included in these forecasts as this had not been confirmed at that point, and therefore an illustrative adjustment has been made to the pre COVID funding positions. The report also presented the Board with a medium term rolling 5 year financial plan (2020/21 to 2024/25) for noting which was prepared in a Business as Usual, pre COVID scenario and would be refined when clarity on future service provision was known. Claire Flanagan was heard in amplification of the report following which there was a general discussion.	(a) Noted the month 6 financial reviews undertaken by partners; (b) Noted the impact COVID has had on the IJB financial position; (c) Noted the COVID funding that has been confirmed since this review; and (d) Noted the pre-pandemic medium term rolling 5 year Financial Plan.	Chief Finance Officer	

6. Private Reports

No private business to be discussed at this meeting.

7. Any other business

No additional business had been notified to the Chair in advance.

8. Date of next meeting

The next meetings of the Midlothian Integration Joint Board would be held on:

- Thursday 14 January 2021 2pm Development Workshop
- Thursday 11 February 2021 2pm Midlothian Integration Joint Board

(**Action: All Members to Note**)

The meeting terminated at 4.03 pm.

NHS LOTHIAN

Board
7 April 2021

Chair

APPOINTMENT OF MEMBERS TO COMMITTEES

1 Purpose of the Report

1.1 Lothian NHS Board's Standing Orders state that "The Board shall appoint all Committee members". This report has been presented to the Board so that it may consider the recommendations from the Chair on committee appointments.

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

2 Recommendations

The Board is recommended to:

2.1 Stand down Bill McQueen and Dr Richard Williams as members of the Audit & Risk Committee.

2.2 Stand down Councillor John McGinty and Peter Murray as members of the Finance & Resources Committee.

2.3 Appoint Councillor Shamin Akhtar and Nancy McKenzie as members of the Finance & Resources Committee.

2.4 Appoint Jock Encombe as a member of the Healthcare Governance Committee.

2.5 Appoint Fiona Ireland as the Chair of the Healthcare Governance Committee.

2.6 Stand down Katharina Kasper as a member of the Remuneration Committee.

2.7 Appoint Nancy McKenzie as a member of the Remuneration Committee.

2.8 Stand down Councillor John McGinty and Councillor Derek Milligan as members of the Staff Governance Committee.

2.9 Appoint Prof. Siddarthan Chandran as a member of the Staff Governance Committee.

2.10 Appoint Councillor Shamin Akhtar as a member of the Pharmacy Practices Committee.

2.11 Nominate Nancy McKenzie as a voting member of the Edinburgh Integration Joint Board for the period from 7 April 2021 to 6 April 2024.

2.12 Nominate Jock Encombe as a voting member of the Midlothian Integration Joint Board for the period from 1 May 2021 to 30 April 2024.

2.13 Stand down Fiona Ireland as a member and chair of the Organ Donation Sub-Committee.

2.14 Appoint Jock Encombe as a member and chair of the Organ Donation Sub-Committee.

2.15 Approve the terms of reference of the Reference Committee (at appendix 1)

2.16 Appoint Tracey Gillies as the executive Board member of the Reference Committee.

3 Discussion of Key Issues

Review of the Membership of Committees

3.1 Over the past few months, the members have been reviewing the membership of committees, with a view to making the workload more manageable and the demands on members' time more equitable. This has led to agreement that in some cases the number of members on committees can be reduced, and that there can be a change to some members' portfolios. This report recommends several changes because of this review. The recommendations are to take immediate effect unless otherwise stated.

3.2 The Board's membership has changed since the last Board meeting, as Councillor Shamin Akhtar has joined the Board as East Lothian Council's stakeholder member, replacing Councillor Fiona O'Donnell. Michael Ash and Alison Mitchell will step down as Board members (and consequently as members of committees) when their terms of appointment end on 30 April 2021.

Audit & Risk Committee

3.3 The number of members on the committee will reduce from six to four. Bill McQueen and Dr Richard Williams will stand down as members of the committee.

Finance & Resources Committee

3.4 It is recommended that the Board stand down Councillor John McGinty and Peter Murray as members of the Committee. It is also recommended that the Board appoint Councillor Shamin Akhtar and Nancy McKenzie as members of the Committee.

Healthcare Governance Committee

3.5 This Committee has a vacancy due to Prof. Moira Whyte standing down from the Board. It is recommended that the Board appoint Jock Encombe as a member of the Committee.

3.6 Fiona Ireland is already a member of the Committee. The Board is recommended to appoint Fiona as the Chair of the Healthcare Governance Committee.

Remuneration Committee

3.7 It is recommended that the Board stand down Katharina Kasper as a member of the Committee. It is also recommended that the Board appoint Nancy McKenzie to the Committee.

Staff Governance Committee

3.8 It is recommended that the Board stand down Councillor John McGinty and Councillor Derek Milligan as members of the Committee. It is also recommended that the Board appoint Prof. Siddarthan Chandran as a member of the Committee.

Pharmacy Practices Committee

3.9 There are regulations which prescribe the membership and operation of this committee. It has seven members, being one NHS Board member, three pharmacists, and three lay members. The NHS Board member chairs the committee. The regulations allow deputies to be used provided that the when the committee meets the prescribed membership categories are there. For practical reasons the NHS Board has appointed several individuals to fill the positions, as this facilitates convening the committee when a hearing is required and allows a fresh panel to consider any appeals.

3.10 Councillor Fiona O'Donnell was a member of this Committee but is no longer a Board member. It is recommended that the Board appoint Councillor Shamin Akhtar as a member of the Pharmacy Practices Committee.

Edinburgh Integration Joint Board

3.11 There is a vacancy for a NHS Lothian voting member. It is recommended that the Board nominate Nancy McKenzie as a voting member for the period from 7 April 2021 to 6 April 2024.

Midlothian Integration Joint Board

3.12 Michael Ash's term as a voting member of Midlothian Integration Joint Board ends on 30 April 2021. It is recommended that the Board nominate Jock Encombe as his replacement as a voting member for the period from 1 May 2021 to 30 April 2024.

Organ Donation Sub-Committee

3.13 It is recommended that the Board stand down Fiona Ireland as the member and chair of the Organ Donation Sub-Committee. It is recommended that the Board appoint Jock Encombe as the member and chair of the Organ Donation Sub-Committee.

Reference Committee

3.14 The NHS (Discipline Committees) (Scotland) Regulations 2006 state that a Board may have a reference committee which shall include one member who is both an officer and member of the Board. The Board approved the current terms of reference of the Reference Committee on 4 April 2018, and they include a note that the Director of Public Health is currently the executive Board member. This is no longer the case. Appendix 1 sets out an updated term of reference, which simply translates the material into the format the Board now uses and doesn't include a note referring to the Director of Public Health. It is recommended that the Board approve

the refreshed terms of reference, and appoint Tracey Gillies as the executive Board member on the Reference Committee.

4 Key Risks

4.1 A committee does not meet due to not achieving quorum, leading to a disruption and delay in the conduct of the Board's governance activities.

4.2 The Board does not make the most effective use of the knowledge, skills and experience of its membership, leading to the system of governance not being as efficient and effective as it could be.

5 Risk Register

5.1 This report attends to gaps in committee membership, and it is not anticipated that there needs to be an entry on a risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This report does not relate to a specific proposal which has an impact on an identifiable group of people.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 This report does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently public involvement is not required.

8 Resource Implications

8.1 This report contains proposals on committee membership. It is probable that some of the members may require further training and development to support them in their new roles. This will be addressed as part of normal business within existing resources.

Alan Payne
Head of Corporate Governance
22 March 2021
alan.payne@nhslothian.scot.nhs.uk

Appendix 1: Draft Terms of Reference for the Reference Committee

FAMILY HEALTH SERVICE PRACTITIONERS DISCIPLINARY PROCEDURES

REFERENCE COMMITTEE

1. REMIT

There shall be an established Reference Committee for disciplinary matters in relation to Family Health Service Practitioners in compliance with the terms of the National Health Service (Discipline Committees)(Scotland) Regulations 2006 as amended. The Reference Committee will exercise the Health Board's functions under these regulations with respect to the referral of disciplinary matters.

The Reference Committee will also consider any referrals to the NHS Tribunal under the National Health Service (Tribunal)(Scotland) Regulations 2004 as amended.

In relation to General Dental Practitioners, Optometrists and Pharmacists, the Reference Committee will consider any referrals to the appropriate professional body (General Dental Council, General Optical Council and General Pharmaceutical Council).

Out of Remit
Referrals of General Medical Practitioners to the General Medical Council are handled by the Board's Medical Director as the Board's Responsible Officer in relation to Revalidation.

2. CORE FUNCTIONS

In relation to General Medical Practitioners, General Dental Practitioners, Optometrists and Community Pharmacists the Reference Committee will consider:

- Any disciplinary matters that may be referred under the Discipline Committee Regulations
- Any cases that may be referred to the NHS Tribunal

In relation to General Dental Practitioners, Optometrists and Community Pharmacists the Reference Committee will consider any referrals to the appropriate professional body (General Dental Council, General Optical Council and General Pharmaceutical Council.

3. MEMBERSHIP

- Non-Executive Board Member (Chair)
- Executive Board Member

4. QUORUM

No business shall be transacted at a meeting of the Committee unless a Non-Executive Board member and an Executive Board member are present.

5. FREQUENCY OF MEETINGS:

- As required

6. REPORTING ARRANGEMENTS:

The minutes of the Committee will be prepared following the Healthcare Improvement

Scotland Guidance Paper on Data redaction and Standardised Adverse Event Review Reports (December 2014). The Committee will report to the Board by means of submission of reports when required at the next available Board meeting.

7. REFERENCES

National Health Service (Discipline Committees)(Scotland) Regulations 2006 as amended
National Health Service (Tribunal)(Scotland) Regulations 2004
Healthcare Improvement Scotland Guidance Paper on Data redaction
Standardised Adverse Event Review Reports (December 2014)

8. DATE OF APPROVAL OF THESE TERMS OF REFERENCE: 07 APRIL 2021

9. DATE BY WHICH THESE TERMS SHOULD BE REVIEWED: APRIL 2023

NHS LOTHIAN

Board
7 April 2021

Director of Finance

REVIEW OF THE STANDING FINANCIAL INSTRUCTIONS

1 Purpose of the Report

1.1 The Board approved the Standing Financial Instructions on 21 June 2017 and they are due to be reviewed. This report is presented to the Board so that it may review and approve the proposed updated version.

1.2 Any member wishing additional information should contact the Director of Finance in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to review and approve the revised Standing Financial Instructions for use with immediate effect.

3 Discussion of Key Issues

3.1 The content of the Standing Financial Instructions is high level. Consequently there tends to be little changes over time. In the main the tracked changes represent refinements to the terminology in the text to clarify some points and keep it up to date.

3.2 The proposed changes also include:

Section 3 – Internal Audit	This reflects what the Standing Orders already say, in that the Board appoints the Chief Internal Auditor.
Section 10- Banking and Cash Handling	This recognises that project bank accounts exist and the Director of Finance is the Board's designated champion for them. Additionally the text has been revised to give the Board scope to delegate the authority to open an account to a committee. The Board asked for this at its meeting in December 2020.
Section 11- Stores	This has been updated to properly reflect the responsibilities for pharmaceutical stock.
Section 22 – Funds held on trust	This has been updated to reflect the governance arrangements within the Foundation to delegate authority to individuals and committees.

3.3 The Audit & Risk Committee reviewed the proposed revised SFIs on 22 February 2021 and agreed to recommend them to the Board for its approval.

4 Key Risks

4.1 The Board's Standing Financial Instructions are not a reliable because they are not up-to-date

5 Risk Register

5.1 This review will keep the Standing Financial Instructions. There is no need to add anything to the risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This is an administrative exercise which does not propose any changes which would affect an identifiable group of people.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 The paper does not relate to the planning and development of health services

8 Resource Implications

8.1 This is a housekeeping exercise and there are no resource implications.

Alan Payne
Head of Corporate Governance
23rd February 2021
alan.payne@nhslothian.scot.nhs.uk

~~APPENDIX 3~~

~~Appendix 3 to the NHS Lothian Standing Orders~~

STANDING FINANCIAL INSTRUCTIONS

Author(s): Alan Payne
Category/Level/Type: 1- Policy
Status: ~~Final~~Final Draft to Board for approval
Date of Authorisation:
Date added to Intranet:
Key Words: SFI, SFIs, Finance, Standing Financial Instructions, Governance

Version: 080221 – AP redraft
Authorised by:
Review Date:

CONTENTS

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 ("the Board") and its employees. They cover all activities, including when the Board is carrying out functions as directed by the ~~integration~~ Integration ~~joint~~ Joint ~~boards~~ Boards that it is a constituent authority of. The SFIs should be used with the Board's Standing Orders and the Board's Scheme of Delegation ~~(Annex 4 of the Standing Orders)~~.

1.3 The principles underlying this document are:-

1.3.1 The Board shall carry out its functions in line with relevant law and shall also comply with any ~~Directions~~ directions or guidance issued by the Scottish Ministers and comply with integration joint board directions.

1.3.2 The Board shall conduct its activities in an open and accountable manner. Its activities and performance will be auditable.

1.3.3 The Board shall perform its activities within the available financial resources.

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~~ Budget ~~holders~~ Holders and their staff, this will mean:-

1.5.1 Agreeing their ~~budget~~Budget~~,~~ and performing their duties strictly within that ~~budget~~Budget.

1.5.2 Following all of the Board's approved policies and procedures.

1.5.3 Acting within their levels of delegated authority.

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. A Budget Holder may also be a Local Authority Employee, as defined below.

1.7.7 “Employee” means an employee of the Board. Additionally 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.

1.7.8 “Local Authority Employee” means an employee of a local authority which is a party to an Integration Scheme with Lothian NHS Board, in circumstances where that employee carries out Directed Functions.

1.7.9 “Directed Functions” means a function which an Integration Joint Board has directed the Board to carry out under s.26 (1) of the Public Bodies (Joint Working) (Scotland) Act 2014.

1.7.10 "Chief Executive" means the chief officer of the Health Board.

1.7.11 "Director of Finance" means the chief financial officer of the Health Board.

1.7.12 "Legal Adviser" means the properly qualified person appointed by the Health Board to provide legal advice.

1.7.13 “Integration Joint Board” means a public body created under Section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014, which the Board has delegated some functions to through an ~~integration~~ Integration ~~scheme~~Scheme.

1.7.14 “Integration Functions” mean the functions that the Health Board has delegated to an Integration Joint Board through the relevant Integration Scheme.

1.7.15 “Integration Scheme” means the scheme prepared by the Health Board and the local authority, and approved by the Scottish Ministers, ~~–~~for the

local authority area under Section 1(2) of the Public Bodies (Joint Working) (Scotland) Act 2014.

1.7.16 "Edinburgh and Lothians Health Foundation" is the common name for registered charity called The Lothian Health Board Endowment Fund. The members of the Board are trustees of the charity, and it is administered under the relevant sections of the National Health Service (Scotland) Act 1978 and in line with the Charities and Trustee Investment (Scotland) Act 2005. The trustees are responsible for the general control and management of the charity, and they do so at arms-length from the conduct of the business of the Board.

1.7.17 "Accountable Officer" is the individual who is appointed to this role for the Board under the terms of Section 15 of the Public Finance and Accountability (Scotland) Act 2000 and the Accountability section of the Scottish Public Finance Manual.

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 All ~~budget~~ Budget ~~holders~~ Holders shall be provided with a summary of these SFIs with instructions as to where the full version can be located. ~~Budget holder~~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.

1.10 The Board shall review these SFIs no longer than 3 years after the date of their approval.

1.11 Local Authority Employees will remain employees of the relevant Local Authority~~,~~ and will not become employees of the Board unless expressly agreed otherwise. Nonetheless, it is anticipated that for the limited purpose of delivering the relevant Directed Functions, such Local Authority Employees will require to comply with certain relevant Board policies, including these SFIs. Local management will identify such policies.

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 Board's 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 approval.

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 (within the Scottish Government).

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 and is accountable, through NHS Scotland's Principal Accountable Officer, to the Scottish Parliament. This responsibility is detailed in the Accountable Officer memorandum.

2.7 The Chief Executive has overall executive responsibility for the Board's activities~~,~~ and shall ensure that the Board's meets its financial targets.

2.8 The Chief Executive shall ensure that an integration joint board shall have such information as it may reasonably require for the purposes of:

a) Preparing its Strategic Plan or a replacement Strategic Plan
b) Carrying out a review of the effectiveness of its Strategic Plan
c) Preparing its Performance Report
d) Determining whether to give a direction to the Board, and what the content of that direction should be.
e) To provide information as may be required by the content of a particular direction.

2.9 The Chief Executive shall ensure that all directors and relevant employees and relevant Local Authority 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 relevant Local Authority 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 or relevant Local Authority Employee;

2.12.3 the production of any cash, stores or other property of the health board under an employee's control or the control of a Local Authority Employee; and

2.12.4 explanations concerning any matter under investigation.

All Directors and Employees and Local Authority Employees

2.13 All directors and employees and Local Authority 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 of these SFIs);

b. ensuring that asset records/registers are kept up-to-date;

c. performing verification exercises to confirm the existence and condition of the assets, and the completeness of the appropriate asset register; and

d. following any prescribed procedures to notify the organisation of any theft, loss or damage to assets.

2.13.2 avoiding loss;

2.13.3 ~~securing~~ implementing the Duty of Best Value in ~~the use of resources~~Public Services (see the Scottish Public Finance Manual); and

2.13.4 following these SFIs and any other policy or procedure that the Board may approve.

2.14 All ~~budget holder~~Budget Holders shall ensure that:-

2.14.1 the Director of Finance receives all information that is required to prepare ~~budgets~~Budgets;

2.14.2 ~~budgets~~ Budgets are only used for their stated purpose; and

2.14.3 ~~budgets~~ Budgets are never exceeded.

2.15 When a ~~budget~~ Budget ~~holder~~ Holder expects his expenditure will exceed his delegated budget, he must secure an increased ~~budget~~Budget, or seek explicit approval to overspend before doing so.

2.16 All NHS Lothian staff and Local Authority Employees who commit NHS resources directly or indirectly must be impartial and honest in their conduct of business and all employees and Local Authority Employees must remain beyond suspicion.

2.17 All NHS Lothian employees and Local Authority Employees shall observe the requirements of MEL (1994) 48, which sets out the Standards of Business 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 and Local Authority 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 and Local Authority 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). An ~~integration~~ Integration ~~joint~~ Joint ~~board~~ Board will also have its own Code of Conduct made under that Act, and any Board members or employees appointed to an ~~integration~~ Integration ~~joint~~ Joint ~~board~~ Board shall be required to observe that 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 and Local Authority 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 INTERNAL AUDIT

3.1 Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve the Board's operations. It helps the Board accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

3.2 A panel chaired by a non-executive Board member, preferably the Chair of the Audit & Risk Committee, shall select and make a recommendation to the Board on whom to appoint as the Chief Internal Auditor. The Chair of the Audit & Risk Committee shall approve the composition of the panel. The Chief Internal Auditor shall lead the Board's internal audit function~~,~~ and be responsible for appointments to the internal audit team.

3.3 The Chief Internal Auditor shall ensure that the internal audit function operates in accordance with the Public Sector Internal Audit Standards (PSIAS), and shall provide assurance, at least annually, to the Audit & Risk Committee that this is being achieved.

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 assess whether the independence of the internal audit function remains intact. The Chief Internal Auditor shall report the results of this review to the Audit & Risk Committee. If necessary, the Chief Executive shall revise the Chief Internal Auditor's management reporting line to ensure independence is maintained.

3.5 All employees and Local Authority Employees shall, at the request from the Chief Internal Auditor or another member of the internal audit function, provide:-

3.5.1 access to all records, documents, correspondence or information relating to any transactions or matters, including documents of a confidential nature;

3.5.2 access at all reasonable times to any land, premises or employee of the health board or Local Authority Employees;

3.5.3 the production of any cash, stores or other property of the health board under an employee's or Local Authority Employee's control; and

3.5.4 explanations concerning any matter under review or investigation.

3.6 The Audit & Risk Committee shall normally invite the Chief Internal Auditor to attend Audit & Risk Committee meetings and any of its sub-committees. The Chief Internal Auditor shall have direct right of access to all Audit & Risk Committee members, the ~~Chairman,~~ NHS Board Chair and the Chief Executive. The Chief Internal Auditor has the right to meet in private with any of these individuals.

3.7 The Chief Internal Auditor shall prepare a risk-based Strategic Internal Audit Plan and an Internal Audit Charter for consideration and approval by the Audit & Risk Committee before the start of the audit year.

3.8 The Chief Internal Auditor shall issue a draft terms of reference for consideration by the lead executive (Audit Sponsor) and the relevant operational staff for the area under review (key contacts) before each audit. These shall set out the scope, objectives, resources and timescales for the audit. The Chief Internal Auditor shall give the sponsor and key contacts adequate time to consider and respond to the draft terms of reference before it is finalised. After that time, the Chief Internal Auditor may elect to finalise the terms of reference. The Chief Internal Auditor shall issue the final terms of reference before the start of the audit fieldwork.

3.9 The Chief Internal Auditor shall issue the draft report for an audit to the audit sponsor, and the audit sponsor shall have two weeks to provide a response. The sponsor, or his or her representative, should respond either in writing or during a close-out meeting with Internal Audit. If an appropriate response is not received, the Chief Internal Auditor may elect to present the report without a response to the Audit & Risk Committee. The Chief Internal Auditor shall develop an operational procedure for the distribution of all final reports, which will ensure that the Board's external auditor receives a copy of every report.

3.10 Management are responsible for ensuring that appropriate internal control systems exist within their own area (or parts thereof), and for deciding whether or not to accept and implement internal audit findings and recommendations. Where internal audit recommendations are not accepted, the audit sponsor should provide a comprehensive explanation to the Audit & Risk Committee, normally as part of the management response within the associated internal audit report.

3.11 Management must address issues raised in audit reports by the agreed target dates. The Chief Internal Auditor shall follow-up on the completion of management actions, and provide the Audit & Risk Committee with a progress report at each meeting setting out completion rates. The Audit & Risk Committee may invite the audit sponsor to attend meetings to respond to queries relating to outstanding internal audit recommendations for their area.

3.12 The Chief Internal Auditor shall prepare an Annual Internal Audit Report, in line with Public Sector Internal Audit Standards and any relevant Scottish Government directions, and present it to the Audit & Risk Committee to inform its review of the draft Governance Statement.

4 EXTERNAL AUDIT

4.1 The Auditor General for Scotland appoints the external auditor to the Board.

4.2 The appointed external auditor shall conduct their duties in line with what is required by law and Audit Scotland's Code of Audit Practice.

4.3 All employees and Local Authority Employees are to provide the external auditor:

- Access at all reasonable times to any documents or information that the Board holds; and
- Any assistance, explanation, or information as the external auditor considers necessary

4.4 The Director of Finance shall prepare accounts and make arrangements to provide any information that the external auditor may require, so as to support the efficient conduct of the external audit.

4.5 It is important that the Board's external auditors are independent and seen to be independent in the work that they undertake. It is therefore not appropriate for them to undertake any non-audit work that might be perceived to create a conflict of interest with their role as external auditors.

4.6 The Board's external auditors may be engaged to undertake additional services only if Audit Scotland has previously confirmed that it would be appropriate for them to do so. These additional services include the external audit of patients' funds accounts. The Foundation trustees appoint the external auditor of the endowment fund accounts, and consequently that appointment is not regarded as additional services by the Board's external auditor. The Director of Finance shall notify the Audit & Risk Committee of any such engagement at its next available meeting.

4.7 The Audit & Risk Committee shall:

- Approve the remuneration of the external auditors within the range that Audit Scotland has set
- Examine any reason for the resignation or dismissal of the external auditor
- Review and confirm the external auditor's strategy and plans
- Receive and review the outputs from the work of the external auditor.
- Ensure that the external auditor has direct access to the Board's Chair~~man~~ and the Chair of the Audit & Risk Committee.
- Meet the external auditor once a year without the presence of management
- Determine the process to monitor the performance of the external auditor, and reflect any such results from that process in the Audit & Risk Committee's annual report.
- Receive assurance that the external auditor has arrangements in place to maintain their independence and objectivity. This should include consideration as to whether any of the audit staff have any business interest with Lothian Health Board, or personal relationships with any of the Board employees or Local Authority Employees, which could compromise independence and objectivity.

- ❖ Set out in its annual report whether the external auditor has provided any additional services during the year.

4.8 In the event that there is a problematic working relationship between the external auditor and the Board, the Chair of the Audit & Risk Committee shall advise the Board of the circumstances.

5 FINANCIAL MANAGEMENT

This section applies to both revenue and capital ~~budgets~~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~~an operational plan in the form and for the period which the Scottish Government may prescribe. The Chief Executive shall submit ~~a Plan~~an operational plan for approval by the Board that takes into account financial targets and forecast limits of available resources. The ~~Local Delivery Plan~~operational plan shall contain:-

5.2.1 a statement of the significant assumptions within the ~~Plan~~operational plan; and

5.2.2 details of major changes in workload, delivery of services or resources required to achieve the operational plan.

5.3 Before the financial year begins, the Director of Finance shall prepare and present a financial plan to 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~~operational 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.

5.3.7 identify the proposed payments to each ~~integration~~ Integration ~~joint~~ Joint ~~board~~ Board for its ~~integration~~ Integration ~~functions~~Functions; and

5.3.8 identify the proposed amounts which are to be set aside for each ~~integration~~ Integration ~~joint~~ Joint ~~board~~ Board for the ~~integration~~ Integration ~~functions~~ Functions carried out in large hospitals

5.4 The Director of Finance shall calculate the payments and set-aside for each ~~integration~~ Integration ~~joint~~ Joint ~~board~~ Board in line with the process described in the relevant ~~integration~~ Integration ~~scheme~~Scheme.

5.5 The Health Board shall approve the financial plan for the forthcoming financial year.

5.6 The Health Board shall approve the payments and set-aside for each ~~integration~~ Integration ~~joint~~ Joint ~~board~~ Board and the associated schedule of payments for the forthcoming financial year, in line with its financial plan.

5.7 Upon receipt of directions from the ~~integration~~ Integration ~~joint~~ Joint ~~boards~~Boards, the Director of Finance shall assess whether the effect of those directions requires a change to the financial plan.

5.8 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.

5.9 The Director of Finance shall regularly update the Board on significant changes to the allocations and their uses.

5.10 The Director of Finance shall monitor the expenditure incurred in carrying out integration joint board directions against the funding given with each direction. The Director of Finance shall follow the processes described in the finance section of each ~~integration~~ Integration ~~scheme~~ Scheme for any issues that may arise, and the results will inform the financial planning process for the following year.

5.11 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.

5.12 The Director of Finance shall release capital funds allowing for project start dates and phasing.

Budgetary Control

5.13 The Board shall approve the opening ~~budgets~~ Budgets for each financial year on an annual basis. The Director of Finance shall review the directions of the ~~integration~~ Integration ~~joint~~ Joint ~~boards~~Boards. In the event that this review identifies a need to revise the opening ~~budgets~~Budgets, then the Director of Finance shall present the revised opening ~~budgets~~ Budgets to the Board for approval.

5.14 The Chief Executive shall delegate the responsibility for budgetary control to designated ~~budget~~ Budget ~~holders~~Holders. The Scheme of Delegation sets out the delegated authorities to take decisions and approve expenditure for certain posts. To support this process the Director of Finance shall administer a process to obtain evidence of their acceptance of the opening ~~budgets~~ Budgets from the following ~~budget~~ Budget ~~holders~~Holders:

- The Chief Executive and his or her direct reports.
- The direct reports to the Chief Officer (~~University Hospitals & Support~~Acute Services).

5.15 Where one of the above officers wishes to delegate the role of "~~budget holder~~Budget Holder" to one of his or her team, then the officer should ensure that the prospective ~~budget holder~~Budget Holder confirms his or her acceptance of the ~~budget~~Budget , and confirms to observe the Board's policies and procedures which are relevant to discharge of their duties and to use whatever financial systems may be in place.

5.16 Where a Local Authority Employee is to be either a ~~budget holder~~Budget Holder or is to be delegated authority to approve expenditure of any type, it is the responsibility of the relevant Director of Health & Social Care (Chief Officer) to ensure that the individual has the necessary access to the Board's policies & procedures and the relevant IT systems (e.g. procurement, payroll & expenses), and the capability to competently implement the Board's policies and procedures.

5.17 Employees and Local Authority Employees shall only act on their delegated authority when there is an approved ~~budget~~Budget in place to fund the decisions they make.

5.18 Delegation of budgetary responsibility shall be in writing and be accompanied by a clear definition of:-

5.18.1 the amount of the ~~budget~~Budget ;

5.18.2 the purpose(s) of each ~~budget~~Budget heading;

5.18.3 what is expected to be delivered with the ~~budget~~Budget in terms of organisational performance; and

5.18.4 how the ~~budget holder~~Budget Holder will report and account for his or her budgetary performance.

5.19 The Chief Executive may agree a virement procedure that would allow ~~budget holder~~Budget Holders to transfer resources from one ~~budget~~Budget heading to another.

5.20 If the ~~budget holder~~Budget Holder does not require the full amount of the ~~budget~~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.

5.21 The Director of Finance shall devise and maintain systems of budgetary control. These will include:-

5.21.1 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;

5.21.2 the issue of timely, accurate and comprehensible advice and financial reports to each holder of a ~~budget~~Budget, including those responsible for capital schemes, covering the areas for which they are responsible;

5.21.3 investigation and reporting of variances from agreed ~~budget~~Budgets;

5.21.4 monitoring of management action to correct variances; and

5.21.5 ensuring that adequate training is delivered on an on-going basis to ~~budget holder~~Budget Holders.

Monitoring

5.22 The Chief Executive shall submit any required monitoring forms to the Scottish Government.

5.23 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

Funded Establishment

6.1 The manpower plans incorporated within the annual ~~budget~~Budget will form the funded establishment.

6.2 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.

6.3 Only the Remuneration Committee can vary the establishment for posts directly accountable to the Chief Executive.

6.4 The Board shall follow national policy, procedures and guidance for the determination of commencing pay rates, conditions of service, etc, for employees.

Staff Appointments

6.5 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.

6.6 A director or employee or a Local Authority Employee may make a staff appointment if:-

6.6.1 the organisation's approved procedures permits the person to do so; or

6.6.2 the Remuneration Committee has approved the appointment (for posts directly accountable to the Chief Executive)

and

6.6.3 the appointment is within the limit of his approved ~~budget~~Budget and funded establishment.

Processing of Payroll

6.7 The Director of Finance is responsible for:-

6.7.1 specifying timetables for submission of properly authorised time records and other notifications;

6.7.2 the final determination of pay;

6.7.3 making payment on agreed dates; and

6.7.4 agreeing method of payment.

6.8 The Director of Finance shall issue instructions regarding:-

6.8.1 verification and documentation of data;

6.8.2 the timetable for receipt and preparation of payroll data and the payment of employees;

6.8.3 maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;

6.8.4 security and confidentiality of payroll information;

6.8.5 checks to be applied to completed payroll before and after payment;

6.8.6 authority to release payroll data under the provisions of the law relating to data protection, records management and information security~~Data Protection Act~~;

6.8.7 methods of payment available to various categories of employee;

6.8.8 procedures for payment by cheque, bank credit, or cash to employees;

6.8.9 procedures for the recall of cheques and bank credits;

6.8.10 pay advances and their recovery;

6.8.11 verification, authorisation and payment of expenses;

6.8.12 maintenance of regular and independent reconciliation of pay control accounts; and

6.8.13 a system to ensure the recovery from leavers of sums of money and property due by them to the Health Board.

6.9 Nominated employees and local authority employees shall have delegated responsibility for:-

6.9.1 completing and submitting payroll documentation, and other notifications in accordance with agreed timetables and any instructions from the Director of Finance; and

6.9.2 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 or Local Authority Employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance, or relevant counterpart in the Local Authority which employs the Local Authority Employee, must be informed immediately.

6.10 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

6.11 The Board shall delegate responsibility to the Director of Human Resources and Organisational Development for:-

6.11.1 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

6.11.2 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 all NHS boards, 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 ~~the~~ The Public Contracts (Scotland) Regulations 2015 (and any subsequent relevant legislation) and the Procurement Reform (Scotland) Act 2014 (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 these SFIs. The Board must approve any decision to depart from the requirements of this section 7.

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(and any subsequent relevant legislation)~~, 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.

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 The Director of Finance shall issue procedures on the use of petty cash which all employees and Local Authority Employees shall follow.

Tendering and Contracting

7.13 Competitive tenders for the supply and disposal of all goods and services shall be invited unless:-

7.13.1 The Scheme of Delegation (Annex 4 of Standing Orders) permits otherwise.

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 £49,999, 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 when required 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~~Budget Holder:

Value of Supply	*Process to Follow*
£10,001 - £25,000	Competitive Quotation – at least two written quotations should be considered.
£2,501 - £10,000	One written quotation should be considered.
Under £2,501	There is no requirement to get quotations.

In the event that it is not possible to satisfy the above requirements (e.g. it is not possible to get two quotations), the lead senior officer (procurement) may waive the requirements. The lead senior officer (procurement) shall establish procedures to be followed in these cases, with due regard the circumstances used for the waiver of competitive tendering

Supply of Value from £25,001 - £49,999

7.16 Where the estimated expenditure is within this range, employees and Local Authority Employees should refer the matter to the lead senior officer for procurement who shall determine the most appropriate procurement process for the supply.

Supply of Value greater than £49,999 - Waiver of Tender Requirements

This section must be read in conjunction with the Board's Scheme of Delegation, in particular *Section 4 – Requirements for Market Testing and Tendering (Capital and Revenue)*.

7.17 ~~Budget holder~~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:-

7.17.1 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.

7.17.2 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.

7.17.3 Specialist expertise is required and is available from only one source.

7.17.4 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.

7.17.5 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.

7.18 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 waiver formal tendering procedures, and which of the above clauses at 7.16 is being used.

7.19 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~~ The Public Contracts (Scotland) Regulations 2015 (and any subsequent relevant legislation) or the Procurement Reform (Scotland) Act 2014 (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.)

7.20 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 (SCIM). The authorisation process ~~shall be~~is described in the Scheme of Delegation.

8.2 The Chief Executive shall ensure that:-

8.2.1 the Board's Asset Management Strategy is informed by the contents of the integration joint boards' strategic plans and the Board's strategic plan;

8.2.2 to implement the Asset Management Strategy there is an adequate appraisal and approval process in place for determining capital expenditure priorities, which also considers the impact on revenue expenditure within the service arising from each proposal;

8.2.3 all stages of capital schemes are managed, and are delivered on time and to cost;

8.2.4 capital investment is not undertaken without confirmation that the necessary capital funding and approvals are in place; and

8.2.5 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 and risks compared with known costs to determine the deliverable option with the highest ratio of benefits to costs in light of the risks; 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~~.~~;

unless the requirement for business case is waived by the Board (and where applicable, with agreement from Scottish Government) as detailed in the Scheme of Delegation

8.4 The approval of a business case, when required, 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 a national framework/ procurement process 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 Scottish Government or Scottish Futures Trust directs the Board to use finance which is to be provided other than through its ~~Allocations~~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 implements the risk transfer to the private sector as laid out in Scottish Government or Scottish Futures Trust documentation.

8.7.2 Where the sum involved exceeds the Board's delegated limits (as detailed in the Scheme of Delegation – see **section 2** of the Scheme of Delegation),, the business case must be referred to the Scottish Government for approval or treated as per current guidelines.

8.7.3 The Board shall specifically agree the proposal and specify which officers are authorised to agree and sign the relevant contractual documentation.

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~~ implement the Duty of Best Value ~~for money~~(see 2.13.3) 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 or Local Authority 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~~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~~ directions issued from time to time by the Scottish Government. The Director of Finance shall be Board's 'Project Bank Account' champion for project bank accounts.

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 or Local Authority Employee may open a bank account for the Board's activities or in the Board's name, unless the Board or a committee of the Board (which the Board has delegated authority to open bank accounts) 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 or Local Authority 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~~Health Board. For pharmaceutical stocks, the delegation of the responsibility must legally always sit with the Director of Pharmacy or a named deputy.

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~~5 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 or named deputy.

11.~~7~~6 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 or named deputy.

11.~~8~~7 The designated Manager/Director of Pharmacy or named deputy 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~~8 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 and Local Authority 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 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 Health 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.

14.5 The Edinburgh and Lothians Health Foundation is responsible for establishing its own risk management arrangements.

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~~ Scottish Government guidance). 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 and Local Authority Employees will send to the lead senior officer for ehealth:-

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~~law relating to data protection, records management and information security;

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 15 of these SFIs 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 an 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~~lead senior officer for primary care contracting, 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~~ Primary ~~care~~ Care ~~contractors~~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~~ Primary ~~care~~ Care ~~contractors~~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~~ Primary ~~care~~ Care ~~contractors~~Contractors.

17.5 The Director of Finance shall ensure that all transactions conducted for or on behalf of ~~primary~~ Primary ~~care~~ Care ~~contractors~~ 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~~ describes 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 Board's designated Fraud Liaison Officer should be notified immediately. The Director of Finance shall ensure that guidance and contact information is 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 NHS Scotland 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 (whether an employee or local authority employee) is responsible for reporting thefts to the police, securing the area, and notifying the Fraud Liaison Officer (via the adverse event module on DATIX (or any other system the Board uses for this purpose)). 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 (in private session).

20.3 The Chief Executive shall ensure that there is a formal record of the presentation of the annual accounts to the Board. Once the annual accounts have been laid before the Scottish Parliament, the Board will publish the annual accounts on its website.

20.4 The Board shall publish an annual report, in accordance with the Scottish Government's guidelines on local accountability and requirements.

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~~ Board 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, 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~~ property 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~~property 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~~ trustees of the charity known as the "Edinburgh and Lothians Health Foundation" ex officio by reason of their Board appointment. The appointment as ~~Trustee~~ trustee is legally distinct from the appointment as a Board member. The ~~Trustees~~ 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~~,~~. However the trustees may adapt the provisions of the SFIs in order to best serve the requirements of the charity~~unless the trustees instruct otherwise~~. The trustees may, in accordance with the Edinburgh & Lothians Health Foundation Charter, issue instructions, procedures or internal control measures to support the discharge of the trustees' responsibilities. This includes the delegation of authority to individuals and committees.

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.

22.6 The Chair of the ~~Trustees~~ trustees of the Edinburgh and Lothians Health Foundation shall ensure that the ~~Trustees~~ trustees have a programme of risk management which will be approved and monitored by the ~~Trustees~~trustees, and which complies with the standards set out by the Office of the Scottish Charity Regulator and the Charities SORP.

NHS LOTHIAN

Board
7 April 2021

Director of Finance

REVIEW OF THE SCHEME OF DELEGATION

1 Purpose of the Report

1.1 The Board approved the Scheme of Delegation on 4th December 2019. Since 4th December 2019 the Director of Finance has approved two sets of changes to the Scheme of Delegation These changes have reflected the evolving nature of the Board's management structure as job titles changed.

1.2 This report presents a revised draft Scheme for the Board to review and approve. The Board's Standing Orders state that the approval of the Scheme of Delegation is a matter reserved to the Board.

1.3 Any member wishing additional information should contact the Director of Finance in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to review and approve this revised Scheme of Delegation for immediate use.

3 Discussion of Key Issues

3.1 The revised Scheme of Delegation is presented at Appendix 1 with all proposed amendments tracked. The key changes this draft Scheme of Delegation are.

General Principles of the Scheme Sections 1 & 2 - Approval of Items for the Capital Programme	These sections has been re-drafted in an attempt to make them simpler and clearer. It has been informed by: • Development work following the RHCYPDCN audit. • The Board decision to transfer the review of initial agreements from the F&R Committee to the Planning, Performance and Development Committee. • Legal advice on the drafting of the Scheme, to make it clear that the Board can directly approve an item itself without every subordinate group having to approve the item first. • Review points from the Audit & Risk Committee to strengthen the framework of controls associated with defined roles for capital projects.
Section 16 – Financial Services	A new type of bank account that was approved at the full Board at its meeting of 9th December 2020. It ensures recognised sub-contractors working on NHS capital projects will receive payment sooner than the previous method of payment to a main contractor who is expected to pass payments on to the sub-contractors they engage.

	This section has been updated to incorporate measures for project bank accounts, as well as changes to the financial services team.
Managerial changes	These are minor changes within East Lothian IJB and REAS management structure that that are requested as part of this review.

3.2 The Audit & Risk Committee reviewed this revised Scheme of Delegation on 22 February 2021, supported the changes to the Scheme, and raised some further review points. The members subsequently had an opportunity to consider an updated draft to address the review points, and the received feedback confirmed they are happy with the updates.

3.3 The review process highlighted that there may need to be further work on the controls relating to professional advisors and management are considering this. If this work concludes that there needs to be any further changes to the Scheme of Delegation, then management will present to the Board an updated Scheme for its review and approval.

4 Key Risks

4.1 The Board does not develop and maintain its Scheme of Delegation to reflect the organisation's needs and structure, leading to the Scheme becoming an unreliable and ineffective tool for operational and financial control.

5 Risk Register

5.1 This review will maintain the Scheme of Delegation as current guidance. Therefore there is no need to add to the risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This is a process which will not affect an identifiable group of people.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 The paper does not relate to the planning and development of health services.

8 Resource Implications

8.1 There are no further resource implications.

Alan Payne / Sean Morrison
Corporate Governance
18th March 2021
sean.morrison@nhslothian.scot.nhs.uk
alan.payne@nhslothian.scot.nhs.uk

Appendix 1: Draft Revised Scheme of Delegation

LOTHIAN NHS BOARD SCHEME OF DELEGATION

Category/Level/Type: 1- Policy and Procedure
Status: Draft as at 230321 to Board
Key Words: Delegation, Limits, Expenditure, authority, scheme
Page 1 of 44

Author S Morrison
Authorised by :
Version Final Draft 230321
Review Date :

INTRODUCTION

Lothian NHS Board (the "Board") has developed and approved this Scheme of Delegation. All of the Board's policies and other publications are available on the intranet. Instructions from the Scottish Government (HDL, CEL etc.) and other material relating to NHS Scotland can be found at SHOW - Scotland's Health On the Web

GLOSSARY

"**Executive Board Members**"
These are individuals whom the Scottish Government have formally appointed to the Board, and for clarity the term does apply to every executive director. Within this Scheme of Delegation there are certain higher value transactions which require the approval of one or more of the executive Board members. You can confirm who the executive Board members are at any point in time by contacting the Board secretariat.
"Budget Holders" and "**Employees**"
~~As a consequence of the Public Bodies (Joint Working) (Scotland) Act 2014, and the subsequent integration of functions of services, there have been significant changes to the management structure. I~~It is quite possible that this Scheme of Delegation identifies a post which may be filled by an individual who is an employee of a local authority rather than the NHS Board. ~~In order to make these new arrangements work, w~~When applying this Scheme, the following definitions for "budget holder" and "employee", which are drawn from the Standing Financial Instructions, are to be used: " **Budget Holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation. A Budget Holder may also be a Local Authority Employee, as defined below." "**Employee**" means an employee of the Board. Additionally 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 (as defined in the Board's Standing Financial Instructions) when acting on behalf of the Health Board, e.g. agency staff, locums, employees of service providers. "**Local Authority Employee**" means an employee of a local authority which is a party to an Integration Scheme (as defined in the Board's Standing Financial Instructions) with ~~Lothian NHS~~the Board, in circumstances where that employee carries out Directed Functions. "**Directed Functions**" means a function which an Integration Joint Board as defined in the Board's Standing Financial Instructions) has directed the Board to carry out under s.26 (1) of the Public Bodies (Joint Working) (Scotland) Act 2014.

"Category A" Approvers

There are certain matters which require to be approved by the relevant person who is included in a defined list of individuals ("Category A" approvers). Rather than repeat this extensive list throughout ~~the~~ this Scheme of Delegation, the list of Category A approvers is set out below:

- Chief Executive
- Deputy Chief Executive
- Chief Officer, Acute Services
- Director of Finance
- Medical Director
- Director of Public Health & Health Policy
- Director of Strategic Planning
- Deputy Director of Public Health & Health Policy
- Executive Director for Nursing, Midwifery, & Allied Health Professionals
- Director of Human Resources & Organisational Development
- Director of Primary Care Transformation
- Director of Health and Social Care – Edinburgh
- Director of Health and Social Care – West Lothian
- Director of Health and Social Care – East Lothian
- Director of Health and Social Care – Midlothian
- Director of Operations (Estates & Facilities)
- Director of Digital
- Hospital Site Director
- Service Director (Royal Edinburgh & Associated Services)
- Service Director (Diagnostics, Theatres, Anaesthetics & Critical Care)
- Service Director (Women & Children's Services)
- Service Director (Outpatients & Associated Services)
- Nurse Director (Acute & Support Services)
- Director of Allied Health Professionals
- Medical Director (Acute)
- Director of Operations (Edinburgh)
- ~~Head of Older People and Access & Chief Nurse (East Lothian);~~
- ~~Head of Children's Wellbeing Services (East Lothian)~~
- Head of Operations (East Lothian)
- Head of Primary Care and Older People (Midlothian)
- Head of Adults (Midlothian)

- Head of Health (West Lothian)

GENERAL PRINCIPLES TO APPLYING THIS SCHEME OF DELEGATION

a) This Scheme of Delegation should be implemented together with the requirements of the Board's Standing Financial Instructions and all other policies and procedures.

b) All ~~budget~~ Budget ~~holders~~ 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. Officers must ensure that there is available budget in place before taking any decisions in line with their delegated authority.

c) Where an employee of a local authority is to be either a ~~budget~~ Budget ~~holder~~ Holder or someone with delegated authority to approve expenditure of any type, it is the responsibility of the relevant Director of Health & Social Care (Chief Officer) to ensure that the individual has the necessary access to the Board's policies & procedures and the relevant IT systems (e.g. procurement, payroll & expenses), and the capability to competently implement the Board's policies and procedures.

d) This Scheme of Delegation identifies certain positions in the management structure. The holders of those positions are allowed to delegate authority to approve transactions to other employees and this is usually done through the Authorised Signatory Database process. Nevertheless the holders of the positions identified in the Scheme of Delegation remain personally accountable for all transactions in their area of responsibility, and the actions of the individuals to whom they delegate financial authority to.

e) This general provision ~~for~~ which allows post holders to delegate their authority (as described in paragraph d)) ~~further delegation of authority~~ does not apply to ~~revenue~~ expenditure that is described at Sections 6, and 9-14 of this Scheme of Delegation. ~~In those sections, t~~The officers identified in the~~o~~se sections must approve the proposed transaction.

~~d)~~f) If a position identified in the Scheme of Delegation is vacant, or an officer with delegated authority is ~~If those officers are~~ not available, then the matter should referred up to the next level of authority as described in the relevant section of this Scheme of Delegation. ~~, then the matter should be referred up to the next level of authority.~~

~~If any individual leaves a position, then any delegated authority that the individual had will revert back up the route of line management to the next appropriate position that is identified in the Scheme. The more senior officer is responsible for approving all transactions, but can elect to re-delegate the authority to someone else. This general provision for further delegation of authority does not apply to revenue expenditure~~

~~that is described at Sections 6, and 9-14 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.~~

~~•~~

g) All figures in the Scheme are inclusive of VAT.

~~e)~~h) If for any reason an item of business has not been approved as described in this Scheme of Delegation, the Board may directly approve the item itself.

~~f)~~i) The Board has delegated authority to the Director of Finance to approve amendments relating to job titles in this Scheme of Delegation, so as to keep it up-to-date with any changes to the organisation's management structure.

STRUCTURE OF THIS SCHEME OF DELEGATION

There are two broad categories of financial business – revenue and capital. The diagram below illustrates which sections of the Scheme of Delegation to refer to under these broad headings, and for different types of transactions. The vast majority of transactions will be in the Revenue column.

Section 7 of the Standing Financial Instructions relates to Non-Pay Expenditure for both capital and revenue, and sets out the arrangements for:

- Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services
- Tendering and Contracting

~~Lothian NHS~~The Board does use nationally agreed procurement frameworks and supplier contracts, as well as locally agreed contracts. All employees are required to follow the systems and procedures put in place by the Procurement function, and use the Board's approved suppliers for the supply of approved products and services.

<table>
<tr><th>REVENUE</th><th></th><th>CAPITAL</th></tr>
<tr><td rowspan="3">The Board will make use of national contracts or put in place local contracts with approved suppliers, to secure the supply of goods & services.

Where a contract is not already in place for the supply, then this will need to be addressed through market testing (and possibly tendering) which leads to a contract being put in place.</td><td rowspan="3"></td><td>1. Approval of items to be included in the NHS Lothian Capital Programme – Funding of the Initial Development of the Concept.</td></tr>
<tr><td>2. Approval of items to be included in the NHS Lothian Capital Programme – Business Cases</td></tr>
<tr><td>3. Approval of items to be included in the NHS Lothian Capital Programme – Use of Frameworks such as Frameworks Scotland 2 or HUB</td></tr>
<tr><td colspan="3">4. Requirements for Market Testing (Capital and Revenue)</td></tr>
<tr><td>6. Revenue Expenditure – Contracts and Service Agreements for Healthcare Services and other specified services.</td><td></td><td>5. Award of Capital Tenders</td></tr>
<tr><td>8. Revenue Expenditure – General Arrangements</td><td></td><td>7. Capital Expenditure – Delegation of Authority and Approval of</td></tr>
</table>

REVENUE		CAPITAL
		Expenditure
9. Revenue – Use of Management Consultants		
10. Revenue – Travel and Reimbursement of Expenses		
11. Revenue – Private Finance Initiative / Public Private Partnership Payments		
12. Revenue - Payroll		
13. Revenue - Virement		
14. Revenue – Losses & Special Payments		
15. Asset Transactions (Capital and Revenue)		
16. Financial Services (Capital and Revenue)		
17. Signing of Contractual Documentation (Capital and Revenue)		

Within this Scheme of Delegation, there are references to certain roles in the context of the Board's capital programme.

The meanings of these roles are set out below. For simplicity the term 'project' is used, and applies to both programmes and projects:

SENIOR RESPONSIBLE OFFICER
The **Senior Responsible Officer** for the project needs to be a senior person within the organisation with the status and authority to provide the necessary leadership and clear accountability for the project's success. Success is when a project meets its objectives and delivers its intended benefits. The Senior Responsible Officer owns the overall service change which the project is supporting or enabling. The Senior Responsible Officer chairs the Project Board, and ensures that the project remains focused on success, and has the resources to deliver it. The Director of Finance is the executive lead for the overall systems of capital planning, financial planning, and budgetary control. Consequently in the interests of respecting the principle of segregation of duties, and the ownership of services within the management structure, the Director of Finance may not be the designated Senior Responsible Officer for any project. The Senior Responsible Officer may be any other officer who is in a position to carry out the role for the project. If the Senior Responsible Officer is not an executive Board member or an executive director, then there should be an identified executive Board member or executive director who will provide accountability to a Board committee or the Board itself if and when required. Any individual who intends to take on the role of Senior Responsible Officer will be required sign an agreement which confirms his or her understanding

of what the role requires and agreement to carry out the role.

PROJECT DIRECTOR

The Project Director will be an individual who has adequate knowledge and information about the organisation and its functions and services to make informed decisions on behalf of the Senior Responsible Officer.

The Project Director is responsible for the ongoing day-to-day management and decision-making on behalf of the Senior Responsible Officer to ensure success.

The Project Director is also responsible for the development, maintenance, progress, and reporting ~~of the business case~~ to the Senior Responsible Officer.

Both the Senior Responsible Officer and the Director of Capital Planning & Projects will jointly determine who the Project Director is. If the Director of Capital Planning & Projects is unavailable (e.g. vacancy or long-term absence) then the Director of Finance may jointly determine who the Project Director is (with the Senior Responsible Officer).

PROJECT MANAGER

The Project Director or the Senior Responsible Officer will assign an individual or individuals to the role of Project Manager. Larger projects may have more than one Project Manager.

Those individuals should have the necessary knowledge, skills and experience to carry out the role.

The Project Manager will lead, manage and co-ordinate the project activities and the project team (if one exists) on a day-to-day basis. The Project Manager will be responsible and accountable to the Project Director for the successful day-to-day delivery of the project.

DIRECTOR OF CAPITAL PLANNING AND PROJECTS

This individual is responsible for the implementation of the Board's overall capital plan through;

- delivery of individual projects~~, and~~;
- applying project management resource and practices~~.~~;
- jointly determining with the Senior Responsible Officer who should be the Project Director for the project;
- providing oversight of capital project technical assurance reporting; and
- providing oversight of appointment and performance of advisers and contractors.

The individual is responsible and accountable to the Director of Finance.

1. Approval of Items to be included in the NHS Lothian Capital Programme – Funding of Initial Development of Concept	
What does this section cover?	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 2 of this Scheme of Delegation).
Which ~~budget~~ Budget ~~holders'~~ Holders are likely to incur revenue expenditure developing a future capital scheme?	➢ Director of Capital Planning & Projects ➢ Director of Operations (Estates & Facilities) ➢ Associate Director of Operations (Estates & Facilities) ➢ Director of Digital ➢ The lead service director / manager for the area that will be the beneficiary of the capital scheme. ➢ The Senior Responsible Officer of major capital projects
Delegated authority of ~~budget~~ Budget ~~holder~~Holder.	The ~~budget~~ Budget ~~holder~~ Holder is only limited by his or her available budget and his or her individual delegated authority (see Section 7 of this Scheme of Delegation). The ~~budget~~ Budget ~~holder~~ 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.

2. Approval of Items to be included in the NHS Lothian Capital Programme – Business Cases

Overview of Process

1) Defining the Board's requirements

The Board has to develop and submit to the Scottish Government a capital plan and a Property & Asset Management Strategy. Both of these documents are informed by a 'strategic assessment' which has to be prepared before any capital project is started. This section relates to the processes that are to be followed after the 'strategic assessment' has been approved.

2) The scope of the Board's authority

a) For all capital projects, the Board has to comply with the Scottish Capital Investment Manual, which sets out the business case process. If land and property transactions are involved the Board also has to comply with the Scottish Government's Property Transactions Handbook concurrently with the business case process. The effect of this is that the Scottish Government has to approve certain matters before a transaction can proceed.

b) The Scottish Government defines the level of authority of the Board to approve capital schemes. The Scottish Government can change the Board's level of authority at any time. If the Scottish Government publishes changes to these limits before this Scheme of Delegation is amended, the latest Scottish Government publication takes precedence. The Scottish Government also has the authority to take direct control of a capital project. If either of these events happen, then the Board and/or the Scottish Government may apply a different process to capital projects than what is described in this section. Where the Scottish Government has control of a project, the Board and the groups in this section may have a role in reaching a view on whether the Board supports any proposals.

c) The Board's delegated limits for the approval of capital schemes is **£10m** for non-Information Management &Technology (non-IM&T) schemes and **£2m** for IM&T schemes. This section of the Scheme of Delegation sets out how the Board has delegated this authority within the organisation.

d) Where the value of a capital scheme is greater than the Board's delegated limits, the Board must review any business case material before referring it to the Scottish Government.

e) Any group (whether the Board, a committee, or other group) in this Section 2 of the Scheme of Delegation which has the authority to approve business case material can do so up to the value set out in the table below. Any such group can do so without any other group reviewing it first, or any other group expressing support or approval of the business case material. The Board may directly approve any item itself.

f) The relevant management team for the service to which the capital project relates should agree the business case material before submitting it into the approval process set out in this Section 2 of the Scheme of Delegation. Where an initial agreement is being prepared, the NHS Lothian Corporate Management Team is the relevant management team.

g) The approving groups (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 Lothian 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 3 of this Scheme of Delegation)

h) The Board shall be entitled, with the agreement of the Scottish Government, to proceed with a combined business case (Outline Business Case and Full Business Case), rather than considering and approving an Outline Business Case and a Full Business Case.in turn as discrete items. The Board shall be entitled, with the agreement of Scottish Government to waive the requirement to prepare any of the business case material which is prescribed in the Scottish Capital Investment Manual.

i) When an approving group (below) approves a capital scheme, 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 to expenditure for a capital scheme until a capital budget has been formally allocated by this process.

- ~~For schemes within the Board's delegated limit, a Strategic Assessment, 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).~~

- ~~The Board's delegated limits for the approval of capital schemes is **£10m** for non- Information Management &Technology (IM&T) schemes and **£2m** for IM&T schemes. (SCIM).~~

- ~~For projects beyond these delegated limits a Strategic Assessment (SA), 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.~~

- ~~Business cases should be prepared in accordance with the Scottish Capital Investment Manual (SCIM). 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 3).~~

- ~~For the avoidance of doubt, the Board shall be entitled to, with the agreement of the Scottish Government, waive the requirement for an OBC and FBC to be produced and taken in turn through the approval groups identified in this section and to simply proceed on the basis of approving a combined business case. 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 the Scottish Government shall have to approve certain matters before a~~

transaction can proceed.

- 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. You can find further information on Finance Online.

2. Approval of Items to be included in the NHS Lothian Capital Programme – Business Cases	
Schemes over the Board's delegated limit (£10m for non-IM&T, £2m for IM&T)	Following review by the Planning, Performance and Development Committee (for any Initial Agreement) or the Finance & Resources Committee (for any Outline Business Care and/or Full Business Case as applicable), the business case item must be referred to the Board. The Board must approve the item, and provide confirmation of the Board's approval when formally submitting the item to the Scottish Government for its approval. ~~Following review by the Finance & 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 (unless it has been agreed to have a combined business case), and provide confirmation of its support prior to formally submitting the item the Scottish Government for approval.~~
Schemes from ~~above~~over £1m and up to (a) £10m for non-IM&T schemes and (b) £2m for IM&T schemes.	~~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 Digital senior management team.~~ ~~2. Lothian Capital Investment Group.~~ ~~Finance & Resources Committee.~~ For Initial Agreements: 1. Lothian Capital Investment Group (review) 2. Lothian Corporate Management Team (review) 3. Planning, Performance & Development Committee (approval) For Standard Business Cases: 1. Lothian Capital Investment Group (review) 2. Finance & Resources Committee (approval)
Schemes from over £250k and up to £1m	Schemes within this range are typically local service developments, or perhaps the routine replacement of major medical equipment or investment in IT. As such they are typically concerned with the continuous development and maintenance of operational matters, rather than having a bearing on the Board's strategic approach. The expenditure does however draw from the Board's limited capital resources. Management may present proposals to secure the agreement on what the expenditure is to be spent on either through: - The Board's Property & Asset Management Strategy or the Board's Capital Plan, or - Discrete initial agreements. For the Property & Asset Management Strategy or Capital Plan: 1. Lothian Capital Investment Group (review) 2. Lothian Corporate Management Team (review) 3. Finance & Resources Committee (review)

2. Approval of Items to be included in the NHS Lothian Capital Programme – Business Cases	
	4. Board (approval) For initial agreements: 1. Lothian Capital Investment Group (review) 2. Lothian Corporate Management Team (review) 3. Planning, Performance & Development Committee (approval) For Standard Business Cases: a) Where the need for investment was agreed through the Property & Asset Management Strategy or Capital Plan. 1 Lothian Capital Investment Group (approval) b) Where the need for investment was agreed through an initial agreement. 1 Lothian Capital Investment Group (review) 2 Finance & Resources Committee (approval)' ~~The item should be reviewed and approved by the Lothian Capital Investment Group.~~

2. Approval of Items to be included in the NHS Lothian Capital Programme – Business Cases	
Schemes up to and including £250k	**MEDICAL EQUIPMENT** For NEW medical equipment under £250k, the first and second stage of the Capital Steering Group Pipeline documentation must be completed. ~~There is no requirement for a Strategic Assessment, Initial Agreement, or 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 Lothian Capital Investment Group (LCIG) must agree the annual budget for replacement medical equipment. Thereafter the Lothian Medical Equipment Review Group (LMERG) must approve the schemes, including review and approval by the finance directorate. **ALL OTHER SCHEMES** The first and second stage of the Capital Steering Group Pipeline documentation 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 Digital senior management team (for schemes related to Digital).

3. Approval of Items to be included in the NHS Lothian Capital Programme – Use of Frameworks such as Frameworks Scotland 2 or HUB	
What does this section cover?	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 (as defined in the NHS Lothian Standing Financial Instructions) with delegated authority to make decisions at each stage. However the same principles should be applied to any other framework.
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.	This will be determined by the NHS Lothian Capital Investment Group (see Section 2 of this Scheme of Delegation). If a project is within the scope of Frameworks Scotland, then Frameworks Scotland must be used. ~~Lothian NHS~~The Board must approve any decision to depart from this process (per paragraph 7.7 of the Standing Financial Instructions).
Appointment to the position of Project Director and Project Manager for capital construction projects.	• Director of Capital Planning and Projects in conjunction with the Appointed Senior Responsible Officer. The posts must be in the funded establishment, or for external appointments, affordable within the project budget. The Senior Responsible Officer shall formally communicate any delegated budgetary responsibilities to the Project Director and Project Manager(s). The nominees or holders of the position of Project Director and Project Manager(s) (if different individuals) and other members of the project team and project delivery resources (as appropriate given the scale of the project) must be clearly documented in the Initial Agreement documentation, and subsequently the Outline Business Case 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 Senior Responsible Officer shall assign appropriate delegated authority to the Project Director and the Project Manager 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.

3. Approval of Items to be included in the NHS Lothian Capital Programme – Use of Frameworks such as Frameworks Scotland 2 or HUB	
Approval of Project Initiation Document	• Appointed Senior Responsible Officer The Project Director should prepare the PID for approval by the Senior Responsible Officer, and this should identify the resources available to the Project Director.
Awarding of Professional Services Contracts (PSCs)	➢ Director of Capital Planning & Projects ➢ Director of Operations (Estates & Facilities) (for projects with a capital value up to £500k) ➢ 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 2** of this Scheme of Delegation. The estimated financial value should be included in the Initial Agreement documentation (when required), and presented ~~to the~~for approval ~~approving group (s~~) as stipulated in **Section 2**.
Selection and appointment of Principal Supply Chain Partners (PSCP)	• Appointed Senior Responsible Officer 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 ➢ Director of Operations (Estates & Facilities) (for projects with a capital value up to £500k) ➢ 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 2** of this Scheme of Delegation. It is expected that the target price should be incorporated within the Final Business Case (where required) as detailed in **section 2** of this Scheme of Delegation. 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 or Board as applicable) shall specify what officer will implement its decisions, e.g., signing the Framework contract with the agreed details identified.

3. Approval of Items to be included in the NHS Lothian Capital Programme – Use of Frameworks such as Frameworks Scotland 2 or HUB	
Approval of project variations (time, quality and resources) within the agreed target price.	• Project Director or Capital Project Manager named in the contract. • Programme Director (Estates & Facilities) 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 2** of this Scheme of Delegation. Following approval of the proposed change, the approving body or Board as applicable) 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.

4. 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 2, NHS National Procurement), 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 other market testing (where appropriate) must be conducted in accordance with the provisions below. • The Director of Finance has delegated authority to waive the tendering requirements for the supply of goods and services over £49,999 in certain circumstances. Section 7 of the Standing Financial Instructions sets out these circumstances and the process of approval. Managers should contact the Procurement department in the first instance. • For all supplies under £25,000, in the event that it is not possible to satisfy the requirements expressed below (e.g. it is not possible to get two quotations), the Procurement function may waive the requirements. The lead senior officer (procurement) shall establish procedures to be followed by the Procurement function in these cases, with due regard the circumstances used for the waiver of competitive tendering (as described in the Standing Financial Instructions).
Supply of goods and services over £49,999	This supply falls into the scope of the Public Contracts (Scotland) Regulations 2015 (and any subsequent amendments) and the Procurement (Reform) (Scotland) Act 2014 and will require to be managed in accordance with these legal requirements. Managers should contact the Procurement function for advice as to how to proceed.
Supply of goods and services over £25,000 and up to £49,999	Please contact the Procurement function which shall determine the most appropriate procurement process for the supply.
Supply of goods and services from over £10,000 and up to £25,000	Competitive quotation - At least 2 written quotations should be considered.
Supply of goods and services from £2,501 - £10,000	One written quotation should be considered.
Supply of goods and services up to £2,500	There is no requirement for a quotation.

5. 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 3**), 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). • 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 2**) for an increase to the scheme's budget to cover the cost. • Following the decision to award a capital tender, please refer to **Section 17** to determine which officers can sign the associated documentation required to form a contract.	
Any tender award of a value from £1m	Two executive board members must approve the award.
Any tender award of a value under £1m	The relevant lead for the service or function to which the project relates, from the following list; ➢ Chief Executive ➢ Deputy Chief Executive ➢ Chief Officer – Acute Services~~(University Hospitals & Support Services)~~ ➢ Director of Finance ➢ Medical Director ➢ Director of Public Health & Health Policy ➢ Executive Director for Nursing, Midwifery, & AHPs ➢ Director of Human Resources & Organisational Development ➢ Director of Health and Social Care – Edinburgh ➢ Director of Health and Social Care – West Lothian ➢ Director of Health and Social Care – East Lothian ➢ Director of Health and Social Care – Midlothian ➢ Director of Capital Planning & Projects ➢ Deputy Director of Finance **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:-

5. Award of Capital Tenders	
	➢ Director of Operations (Estates & Facilities) ➢ Director of Digital ➢ Hospital Site Director ➢ Service Director (Diagnostics, Theatres, Anaesthetics & Critical Care) ➢ Service Director (Women & Children's Services) ➢ Service Director (Outpatients & Associated Services) ➢ Nurse Director (Acute & Support Services) ➢ Director of Allied Health Professionals ➢ Medical Director (Acute) ➢ ~~Head of Older People and Access & Chief Nurse (East Lothian)~~ ➢ ~~Head of Children's Wellbeing Services (East Lothian)~~ ➢ Head of Operations (East Lothian) ➢ Head of Operations (Edinburgh) ➢ Head of Primary Care and Older People (Midlothian) ➢ Head of Adults (Midlothian) ➢ Head of Health (West Lothian).

6. Revenue Expenditure - Contracts and Service Agreements for Healthcare Services and other specified services

Overview of process

What does this section cover?

Income

- Contracts for Research and Development income and expenditure.
- Income from other bodies for the provision of services by the Board.
- National Services Division Contracts
- Other specified contracts and service agreements

Expenditure

- Expenditure on NHS contracts and NHS service agreements, unscheduled activity with other NHS bodies.
- Purchase of healthcare from non NHS organisations, e.g. private sector, voluntary organisations.
- Resource transfer.
- Other specified contracts and service agreements

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 **Section 4** of this Scheme of Delegation apply. All expenditure should be directed through the Board's ordering systems as described in **Section 8**.

6. Revenue Expenditure - Contracts and Service Agreements for Healthcare Services and other specified services
Contracts and Agreements for Expenditure on Healthcare Services
Any amount over £1.5m per annum
Three executive Board members
£0.5m to £1.5m per annum
Any **two** from the following list (one of whom should be the budget holder); ➢ Chief Executive ➢ Deputy Chief Executive ➢ Chief Officer – Acute Services~~(University Hospitals & Support Services)~~ ➢ Director of Finance ➢ Medical Director ➢ Director of Public Health & Health Policy ➢ Executive Director for Nursing, Midwifery, & Allied Health Professionals ➢ Director of Human Resources & Organisational Development ➢ Deputy Director of Finance.
Up to £0.5m per annum
➢ Research & Development Director ➢ Director of Digital ➢ Director of Health and Social Care – Edinburgh ➢ Director of Health and Social Care – West Lothian ➢ Director of Health and Social Care – East Lothian ➢ Director of Health and Social Care – Midlothian ➢ Director of Operations (Estates & Facilities) ➢ Director of Operations (Royal Edinburgh Hospital & Associated Services) ➢ Hospital Site Director ➢ Service Director (Diagnostics, Theatres, Anaesthetics & Critical Care) ➢ Service Director (Women & Children's Services) ➢ Service Director (Outpatients & Associated Services) ➢ Nurse Director (Acute & Support Services) ➢ Director of Allied Health Professionals ➢ Medical Director (Acute) ➢ ~~Head of Older People and Access & Chief Nurse (East Lothian)~~

6. Revenue Expenditure - Contracts and Service Agreements for Healthcare Services and other specified services
Contracts and Agreements for Expenditure on Healthcare Services
➢ ~~Head of Children's Wellbeing Services (East Lothian)~~ ➢ Head of Operations (East Lothian) ➢ Head of Operations (Edinburgh) ➢ Head of Primary Care and Older People (Midlothian) ➢ Head of Adults (Midlothian) ➢ Head of Health (West Lothian)

6. Revenue Expenditure - Contracts and Service Agreements for Healthcare Services and other specified services

Occupational Health & Safety / Library Services / Regional NHS Education for Scotland Initiatives

Any amount over £250k per annum

- Three executive board members

£150k to £250k per annum

- Director of Human Resources & Organisational Development

Up to £150k per annum

- Director of Occupational Health & Safety (for occupational health & safety)
- Head of Education and Employee Development (for library services and regional NHS Education for Scotland initiatives)

Maintenance Contracts / Utilities

Any maintenance / utilities expenditure that is required to be directed through National Procurement must be contracted through that route. For expenditure out of the scope of National Procurement, the following officers have delegated authority to agree contracts and service agreements. This section does not relate to maintenance contracts for medical equipment. Those types of contracts should be considered as part of the procurement process for the equipment itself, and the expenditure subject to Section 8 – "Revenue Expenditure – General Arrangements

Any amount over £250k per annum

- Three executive Board members

£150k to £250k per annum

- Executive Director for Nursing, Midwifery, & Allied Health Professionals (for Digital)

Up to £150k per annum

- Director of Capital Planning & Projects
- Director of Operations (Estates & Facilities)
- Associate Director of Operations (Estates & Facilities)
- Programme Director (Estate & Facilities)
- Director of Digital

Any Other Income Contract or Agreement not covered by the above

The value of the contract or agreement is over £250k per annum

Three executive Board members

The value of the contract or agreement (per annum) is over £150k and up to £250k

Two people have to approve the transaction, one of whom should be the budget holder.

- Any executive Board member PLUS
- Another individual who has been given delegated authority to approve revenue expenditure up to £250,000. This person may be a Category A approver, or someone to whom a Category A approver has (though the authorised signatory process) delegated authority to approve expenditure up to £250,000.

The value of the contract or agreement is up to £150k per annum

Please refer to the list of Category A approvers.

6. Revenue Expenditure - Contracts and Service Agreements for Healthcare Services and other specified services

Management Consultants

Section 9 of this Scheme of Delegation sets out in detail the process that is to be followed when management are considering the use of management consultants. This highlights that either the Chief Executive or the Director of Finance must approve a “pre-engagement review form” before going to market.

7. Capital 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 2-5**).

- Capital schemes or projects can be made up of several smaller pieces of work. The approval process (**Sections 2-3**) 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 2**) will determine his or her delegated authority to approve expenditure for that code only. **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 individual's established delegated authority for his or her revenue budget (**Section 8**) 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 (for the capital code) to approve the transaction**.

- The budget holder may delegate authority to others to approve expenditure against the code. 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 2**), 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. The total value of an order should be recognised when determining who the appropriate signatory is for the order.

- Officers must establish systems to ensure that all ordered goods & 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.

- 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.

8. Revenue Expenditure – General Arrangements

General Provisions for the delegation of authority and approval of expenditure

- 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.

- All expenditure must be processed on official orders through the approved procurement channels for that type of expenditure. **The necessary approvals must be given before placing the order**.

- 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 **Section 4**. All procurement activity should be in accordance with the Standing Financial Instructions, and administered through the systems that the Board establishes for that purpose.

- 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.

- Officers must establish systems to ensure that all goods & 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.

- This section sets out the required authority levels for general ordering of goods and services. **However employees should refer to Sections 6 and 10-14 for the specific requirements for certain types of revenue expenditure**.

8. Revenue Expenditure – General Arrangements	
Any item over £2m	Three executive Board members
Any item over £250,000 but under £2m	Two people have to approve the transaction, one of whom should be the budget holder. ➢ Any executive Board member PLUS ➢ Another individual who has been given delegated authority to approve revenue expenditure up to £250,000. This person may be a Category A approver, or someone to whom a Category A approver has (though the authorised signatory process) delegated authority to approve expenditure up to £250,000.
Officers with a delegated authority up to £250,000	➢ Any category A approver. ➢ ~~Director of Operations (Royal Edinburgh Hospital & Associated Services)~~ ➢ Head of Operations (East Lothian) ➢ Head of Operations (Edinburgh) ➢ Chief Strategy & Performance Officer (Edinburgh) ➢ Chief Nurse (Edinburgh)
Officers with a delegated authority up to £150,000	➢ Director of Capital Planning & Projects ➢ Associate Director of Operations (Estates & Facilities) ➢ Programme Director (Estates & Facilties) ➢ Deputy Director of Finance
Officers with a delegated authority up to £100,000	➢ Director of Pharmacy ➢ Chief Quality Officer ➢ Deputy Director (Corporate Nursing) ➢ Consultant in Public Health (finance lead) ➢ Associate Director of Pharmacy ➢ General Manager (ATCC)
Officers with a delegated authority up to £75,000	➢ General Manager (Mediciine – WGH) ➢ General Manager (Surgery – WGH) ➢ General Manager (Cancer – WGH) ➢ Associate Nurse Director (WGH)

8. Revenue Expenditure – General Arrangements	
	➢ General Manager (Medicine – RIE/ Liberton) ➢ General Manager (Surgery – RIE/ Liberton) ➢ Associate Nurse Director (RIE/ Liberton) ➢ Operational Manager (RIE/Liberton) ➢ General Manager – Scheduled Care (St John's) ➢ General Manager – Unscheduled Care (St John's) ➢ Associate Nurse Director (St John's)
Officers with a delegated authority up to £50,000	➢ Director of Nursing, Primary/Community Care ➢ Site Chief Pharmacist ➢ Deputy Director of Human Resources ➢ Health Promotion Manager ➢ Smokefree Lothian Service Manager ➢ Research & Development Director ➢ Locality Manager (Edinburgh) ➢ Hospital and Hosted Services Manager (Edinburgh) ➢ Service Manager for Laboratories
Officers with a delegate of authority up to £20,000	➢ General Manager (Primary Care Contracting Organisation) ➢ Associate Medical Director ➢ Clinical Director ➢ Clinical Service Manager ➢ Clinical Nurse Manager ➢ Chief Midwife ➢ Chief Professional ➢ Director of Communications, Engagement and Public Affairs ➢ Head of Medical Physics ➢ Service Manager for Radiology

9. Revenue – Use of Management Consultants	
What does this section cover?	• 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. • This section sets out the process and the key controls to be followed with respect to the engagement of management consultants. All expenditure should be directed through the Board's ordering systems as described in **Section 8**.
Key Definitions	**MANAGEMENT CONSULTANTS** Management Consultants have two characteristics: 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. 2. The responsibility for the final outcome of the project largely rests with Lothian NHS Board. **PROFESSIONAL ADVISORS** Professional Advisors have two characteristics: 1. They are engaged on work that is an extended arm of the work done in-house. 2. They provide an independent check. An example of professional advice is the engagement of VAT advisors on the accounting treatment of VAT in relation to the Board's activities. Professional Advisors are commonly engaged in major capital projects, e.g. architects, quantity surveyors, structural engineers. **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.**

9. Revenue – Use of Management Consultants	
Step 1 – Clearly define what the assignment is.	This is a task for the ~~Project Lead~~Senior Responsible Officer – 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?
Step 2 – 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.	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~~Senior Responsible Officer 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 **Step 3.** The Senior Responsible Officer ~~Project Lead~~ should prompt a review of how capacity and capability can be put in place for future assignments.
Step 3 – Contact Procurement and document your requirements.	1. The Senior Responsible Officer ~~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 & 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 Senior Responsible Officer ~~Project Lead~~ should be different people). **Procurement will not proceed unless this**

	authorisation is in place.

9. Revenue – Use of Management Consultants	
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.

9. Revenue – Use of Management Consultants	
Step 5 – Client Evaluation of the Performance of the Management Consultants at the conclusion of the assignment.	The Senior Responsible Officer ~~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 Senior Responsible Officer ~~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.

10. Revenue - Travel and Reimbursement of Expenses	
What does this section cover?	The Finance Directorate provides services for all Travel and Accommodation that can be pre-booked. A dedicated Travel Team works directly with the Scottish Government National Procurement travel provider, through online facilities. The booking method ensures that NHS Lothian Standing Financial Instructions (SFIs) are complied with and the best secure price can be achieved. Employees can find further information on Travel, as well as making bookings for external courses and conferences on the intranet at: Corporate> A-Z>Finance Online > Ordering & Paying for Goods & Services including travel Employees can also find advice on the process for claiming expenses, including mileage and information on car leasing on the intranet at: Corporate>A-Z>Finance Online > Staff Pay and Expenses
Approval of any amount for an event in or journey made within the UK	➢ The relevant budget holder
Approval of any amount for an event in or journey made to an overseas destination	➢ The relevant budget holder from the list of Category A approvers. ➢ Deputy Director of Finance

11. Revenue – Private Finance Initiative / Public Private Partnership Payments	
What does this section cover?	
This refers to the expenditure that arises from PFI/PPP contracts, following the completion of the build phase and during the operational phase.	
Any contractual payments: – fixed and variable (e.g. patient meals).	**Approval of the order** – Budget holder for the contract (or his or her delegate). **Confirmation of Receipt of goods or services** – To be provided by the Director of Operations (Estates & Facilities) or Associate Director of Operations (Estates & Facilities) or their nominated officers.
Ad-hoc – minor works/ service changes	**Approval of the order** –The relevant budget holder must approve a minor works form. **Confirmation of Receipt of goods or services** – To be provided by the Director of Operations (Estates & Facilities) or Associate Director of Operations (Estates & Facilities) or their nominated officers.
Additional Works	
These are likely to be of a value higher than £5,000 and shall be directed through the capital approval route (**see Section 2**).	

12. Revenue -Payroll	
What does this section cover?	This section describes the processes in place to delegate authority to compile and approve data that is required to make payments through the payroll system.
Payment of Hours through SSTS	
SSTS is an electronic time and attendance system accessed through NHS Lothian's intranet, in which all attendance (absence and overtime) is recorded for staff with a NHS pay number in Lothian. Relevant absence data, e.g. sickness and overtime, is uploaded to SSPS (Payroll system) electronically prior to each weekly and monthly payroll run. I Users are set up on SSTS with access rights appropriate to their role: • Compiler – can enter data into the system • Approver – ability to approve the data for processing (and consequently the payment that it leads to) The individuals selected to perform these roles will depend on the structure of the department concerned. The Pay Office shall only set up users on SSTS following receipt of an instruction from the person who has responsibility for the budget from the following list, and after confirming that the proposed approver has been given the authority on the authorised signatory database: ➢ Any post identified in Section 8 of this Scheme of Delegation.	
Other Payments that cannot be processed via SSTS, e.g. allowance codes, waiting time initiatives payments per consultant contract	
Payroll Administration and Information Services has issued a form that must be used in these circumstances, and this is available on Finance Online.Payroll Helpdesk The individual giving the final approval to make these payments must be the relevant person from the above list for the budget concerned. The Pay Office will check the authorised signatory database to confirm the person can approve the payments. Additionally the relevant Associate Medical Director must approve waiting time initiative payments (as defined in the Consultant Contract) to medical staff.	

13. Revenue- 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: "5.17 The Chief Executive may agree a virement procedure that would allow budget holders to transfer resources from one budget heading to another. 5.18 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." The following officers are permitted to approve virement transactions for their budgets.
Any Amount	➢ Please refer to the list of Category A approvers. ➢ Deputy Director of Finance.
Up to £100,000	➢ Director of Capital Planning & Projects ➢ Associate Director of Operations (Estates & Facilities) ➢ Programme Director (Estate & Facilities) ➢ Director of Pharmacy ➢ General Manager (Cancer – WGH) ➢ General Manager (Medicine - WGH) ➢ General Manager (Surgery – WGH) ➢ Associate Nurse Director (WGH) ➢ General Manager (Medicine – RIE/ Liberton) ➢ General Manager (Surgery – RIE/ Liberton) ➢ Associate Nurse Director (RIE/ Liberton) ➢ Operational Manager (RIE/Liberton) ➢ General Manager – Scheduled Care (St John's) ➢ General Manager – Unscheduled Care (St John's) ➢ Associate Nurse Director (St John's) ➢ Director of Operations (Royal Edinburgh Hospital & Associated Services) ➢ Site Chief Pharmacist

13. Revenue- Virement	
Up to £20,000	➢ General Manager (Primary Care Contracting Organisation); ➢ Associate Medical Director; ➢ Clinical Director; ➢ Clinical Service Manager; ➢ Clinical Nurse Manager; ➢ Chief Midwife; ➢ Chief Professional; ➢ Director of Communications, Engagement and Public Affairs ➢ Operational Manager (RIE/ Liberton) ➢ Associate Director of Human Resources. ➢ Head of Medical Physics

14. Revenue- Losses and Special Payments	
What does this section cover?	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 & Risk Committee. For any type of losses or special payments, the responsible budget holder has delegated authority to approve them up to the value £10,000 provided that they have budgetary authority for the value of the loss or special payment. All losses and special payments must be reviewed and counter-signed by one of; the Director of Finance; the Deputy Director of Finance; or the Head of Management Accounting~~;~~. For losses and special payments up to £10,000 the following finance officers can also counter-sign them: the Head of Financial Control; the Deputy Head of Financial Control, or the Finance Manager (Order to Cash). ~~The responsible budget holder a delegated limit of at least £10khave delegated authority to approve losses to be written off and special payments from their budgets up.~~ For proposed losses to be written off and proposed special payments that are above the delegated limits, management must refer these items to the Audit & Risk Committee before seeking authorisation from the Scottish Government Health Directorate.
Theft / Arson/ Wilful Damage	The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve the write-off of losses up to the following amounts: 1. Cash £20,000 2. Stores/ Procurement £40,000 3. Equipment £20,000 4. Contracts £20,000 5. Payroll £20,000 6. Buildings/ Fixtures £40,000 7. Other £20,000
Fraud, embezzlement & other irregularities (including attempted fraud)	The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve the write-off of losses up to the following amounts: 8. Cash £20,000 9. Stores/ Procurement £40,000 10. Equipment £20,000 11. Contracts £20,000 12. Payroll £20,000 13. Other £20,000

14. Revenue- Losses and Special Payments	
Nugatory and Fruitless Payments	A "fruitless payment" 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 Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve the write-off of losses up to £20,000.
Claims Abandoned	The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve the write-off of losses up to the following amounts: a) Private Accommodation - £20,000 b) Road Traffic Acts - £40,000 c) Other - £20,000
Stores Losses	The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve the write-off of losses up to £40,000 in the following categories: 16. Incidents of the Service – Fire, Flood, Accident 17. Deterioration in Store. 18. Stocktaking Discrepancies. 19. Other causes.
Losses of Furniture & Equipment and Bedding & Linen in Circulation	The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve the write-off of losses up to £40,000 in the following categories: 20. Incidents of the Service – Fire, Flood, Accident 21. Stocktaking Discrepancies. 22. Other causes.

14. Revenue- Losses and Special Payments	
Compensation Payments – Legal Obligation - Clinical	NHS Lothian is a member of the Clinical Negligence & Other Risks Indemnity Scheme (CNORIS). CNORIS provides indemnity to members in relation to clinical and non clinical negligence compensation payments. The Scottish Government via the Central Legal Office gives the approval to settle claims under this scheme . The following officers can approve payments up to £250,000 • The relevant budget holder from the list of Category A approvers For amounts over £250,000 - Two people have to approve the transaction, one of whom should be the budget holder. ➢ Any executive Board member PLUS ➢ Another individual who has been given delegated authority to approve revenue expenditure up to £250,000. This person may be a Category A approver, or someone to whom a Category A approver has (though the authorised signatory process) delegated authority to approve expenditure up to £250,000.
Compensation Payments – Legal Obligation – Non-Clinical	The following officers can approve payments up to £100,000: • The relevant budget holder from the list of Category A approvers. For amounts above £100,000 – Two people have to approve the transaction, one of whom should be the budget holder. ➢ Any executive Board member PLUS ➢ Another individual who has been given delegated authority to approve revenue expenditure up to £250,000. This person may be a Category A approver, or someone to whom a Category A approver has (though the authorised signatory process) delegated authority to approve expenditure up to £250,000.

14. Revenue- Losses and Special Payments	
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.
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. If the Board has any reason to suspect that the ultimate total will exceed its delegated powers it should consult the Scottish Government. The delegated limit for this category is **£20,000**.

14. Revenue- Losses and Special Payments	
Compensation Payments – Ex Gratia – Clinical	The delegated limit for this category is **£250,000**.
Compensation Payments – Ex Gratia – Non-Clinical	The delegated limit for this category is **£100,000**.
Compensation Payments – Ex Gratia – Financial Loss	The delegated limit for this category is **£25,000**.
Compensation Payments – Ex Gratia – Other Payments	The delegated limit for this category is **£2,500**. 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.
Damage to Buildings and Fixtures – Incidents of the Service – Fire, Flood, Accident, Other Causes	The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve the write-off of losses up to **£40,000**.
Extra-Statutory & Extra-regulatory 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 Scottish Government 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 Scottish Government 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 regulatory payments must not be classified as ex gratia. **The Board has no delegated authority to approve these payments**.

14. Revenue- Losses and Special Payments	
Gifts in cash or kind	The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve payments up to **£20,000**.
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”. Note: There is a distinct process to be followed for overpayment of salaries. Please contact the Head of Financial Control. The Director of Finance or the Deputy Director of Finance or the Head of Management Accounting can approve payments up to **£20,000**.

15. Asset Transactions	
What does this section cover?	This section relates to miscellaneous asset transactions.
Disposal of fixed assets (other than land and buildings)	All transactions to be referred to the Director of Finance. The Director of Finance shall establish a procedure to approve these disposals and this may include delegating the approval of some disposals to other officers.
Land & Property and Equipment Leases	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. In such circumstances the **Director of Operations (Estates & Facilities), Associate Director of Operations (Estates Facilities) or other 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: <u>Land & Property Leases:</u> Chief Executive or Director of Finance <u>Equipment Leases</u> • The relevant budget holder from the list of Category A approvers. • Deputy Director of Finance.
Notification and Certification of Property Transactions (per Property Transactions Handbook)	Chief Executive

16. Financial Services	
What does this section cover?	This section relates to financial functions and controls administered by Financial Services.
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: Deputy Director of Finance; Head of Financial Control; ~~D~~eputy Head of Financial Control or the Finance Manager (Order to Cash) ~~Finance Manager – Corporate Reporting & Governance or the Financial Controller (Financial Accounting)~~
Establishment of a cash float (any amount)	The Head of Financi al Control, Deputy Head of Financial Control~~Finance Manager – Corporate Reporting & Governance~~ or the Financial Manager (Order to Cash)~~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 the Deputy 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. £25,001 - £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 ➢ Deputy Director of Finance ➢ Deputy Chief Executive ➢ Medical Director ➢ Executive Director for Nursing, Midwifery, & Allied Health Professionals ➢ Director of Public Health & Health Policy For cheques to the Central Legal Office only: ➢ Head of Financial Control ➢ Head of Management Accounting

16. Financial Services	
Cheque Signatories – Level 2	➢ Head of Management Accounting ➢ Head of Financial Control ➢ Financial Controller (Financial Accounting) ➢ Finance Manager (Corporate Reporting and Governance)_
Cheque Signatories – Level 3	➢ Any Business Partner ➢ Senior Finance Manager - Performance ➢ Financial Controller (Accounts Payable) ➢ Financial Accountant
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. The Deputy 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)~~(Order to Cash) 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 Control; Deputy Head of Financial Services: Finance Manager (Order to Cash): ~~Head of Finance (PCCO); Financial Controller (Financial Accounting);~~ Financial Controller (Accounts Payable); Financial Accountant.; ~~Finance Manager (Corporate Reporting and Governance).~~ **Administrator** - Head of Financial Control; Deputy Head of Financial Control: Financial Manager (Order to Cash)~~Controller (Financial Accounting); Financial Controller (Corporate Reporting);~~ 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.

16. Financial Services	
Electronic Banking – Government Banking Service	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 Control; Deputy Head of Finance Control (Order to Cash) ~~(PCCO); Financial Controller (Financial Accounting);~~ Financial Controller (Accounts Payable); Financial Accountant.~~; Finance Manager (Corporate Reporting and Governance).~~ N.B. HM Treasury administer this system.

16. Financial Services	
Electronic Banking – BACS	The system profiles are granted to each of the following officers: **Preparer** –Senior Treasury Assistant; Treasury Assistant. **Authoriser** –Head of Financial Control; Head of Finance (PCCO); Financial Controller (Financial Accounting); Financial Controller (Accounts Payable); Financial Accountant; Treasury Team Leader; Finance Manager (Corporate Reporting and Governance). **Administrator** - Head of Financial Control; Financial Controller (Financial Accounting); Finance Manager (Corporate Reporting and Governance). 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.
Electronic Banking – Bankline	A project Bank Account is an internet banking facility provided by a commercial bank to allow a commissioning body to pay the main contractor and supply chain firms which are named as beneficiaries of the trust deed. The system profiles are granted to each of the following officers: **Read only –** Treasury Assistant, Main Contractor nominated staff **Preparer** – Main Contractor nominated staff **1ST Authoriser** Main Contractor nominated staff **2nd Authoriser** - Head of Financial Control; Deputy Head of Financial Services: Finance Manager (Order to Cash): Finance Controller (Accounts Payable); Financial Accountant **Administrator –** Head of Financial Control; Deputy Head of Financial Control: Finance Manager (Order to Cash) Treasury Team Leader. N.B. Bankline enforces segregation of duties between the preparer and the payment Authoriser. There is a systematic control that requires the approval of two administrators to authorize any administrative changes to the system.

17. 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.
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 2** 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: <u>All Acquisitions</u> • Chief Executive • Director of Finance <u>Disposals where the subjects of sale or lease would **not** continue to be used for NHS purposes by another party</u> • Chief Executive • Director of Finance <u>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</u> • 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. ➢ The relevant budget holder from the list of Category A approvers. ➢ Deputy Director of Finance ➢ Director of Capital Planning & Projects ➢ Associate Director of Operations (Estates & Facilities) ➢ Associate Director of Procurement

NHS LOTHIAN

NHS Lothian Board
Date: 7th April 2021.

Medical Director

NHS LOTHIAN BOARD
NHS LOTHIAN HEALTH AND SAFETY POLICY

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with an update on the progress of the review of NHS Lothian Health and Safety Policy and present the updated version for consideration, perusal and if appropriate final approval.

1.2 Any additional information should be requested in advance of the meeting by contacting the Health and Safety Team.

2 Recommendations

2.1 The Board is recommended to review the document and agree any actions for implementation within the organisation.

3 Discussion of Key Issues

3.1 NHS Lothian have a statutory duty to produce and maintain the Health and Safety Policy as a commitment to high standards of health and safety management and a summary of the responsibilities and arrangements for achieving this is line with the Health and Safety at Work etc Act 1974.

3.2 The approval of the Health and Safety Policy is a matter of the NHS Lothian Board.

3.2. The current version is due to be reviewed and this report provides a summary of the actions that have been taken to produce the new version of the policy.

.

4 Key Risks:

4.1 A negative impact on the implementation of the Health and Safety Management System if the Health and Safety Policy is not updated.

4.2 A negative impact on Health and Safety staff awareness if the Health and Safety Policy is not updated.

4.3 The potential for enforcement action by the HSE.

4.4 The potential for future civil litigation claims against NHS Lothian.

5 Risk Register

5.1 The Health and Safety Risk (ID3455) is currently graded in the Corporate Risk Register as “High” due to the number of reported Violence and Aggression adverse events.

6 Impact on Health Inequalities

6.1 N/A.

7 Impact on Inequalities

7.1 No impact.

8 Involving People

8.1 The approval of the Health and Safety Policy is a matter of the NHS Lothian Board.

8.2 The Policy statement has been already signed by the Chief Executive.

8.3 The document has been placed in the Consultation Zone for 4 weeks in October 2020 for all staff to be able to comment it. No comments were received.

8.4 The Policy was presented in the NHS Lothian Health and Safety Committee in November 2020.

8.5 A Policy Implementation and Communication Plan has been produced to ensure that the Policy is published and disseminated for action through the organisation.

9 Resource Implications

9.1 The need to have in place suitable management systems to mitigate any HSE concerns regarding NHS Lothian’s ability to fully comply with Health & Safety legislation. The Health and Safety Team are not in a position to quantify the financial implications at this time.

Angeles Mendoza
Lead Health and Safety Adviser
7th April 2021.

Appendix 1: Draft Health and Safety Policy (version 5)
Appendix 2: Health and Safety Implementation and Communication Plan

Policy Implementation and Communications Plan

Policy title: Health and Safety Policy

Version: v5.0

This policy is: New ☐ Review ☒ Technical Update ☐

Executive Lead:	*NHS Lothian Executive Medical Director*
Policy Owner:	*NHS Lothian Head of Health and Safety*
Author or Implementation Lead:	*NHS Lothian Lead Health and Safety Adviser*
Purpose statement:	The purpose of the Policy is to set out the NHS Lothian approach to health and safety in order to establish the responsibilities and the arrangements to manage the health and safety within the organisation. The specific objectives of the Policy are: – To define the health and safety responsibilities and organisational arrangements. – To develop a health and safety culture which secures the full participation of all staff within NHS Lothian. – To ensure an effective closed loop health and safety management system operates based on the plan, do, check and act principle which provides continuous improvement in risk control. – To implement measures which will systematically identify hazards and control risks that arise from the work activities and the work environment. – To commit management and staff at all levels to promote healthy and safe ways of working and set personal examples in safe behaviour. – To ensure all persons working within NHS Lothian are responsible for making working safely a key objective in order to protect themselves, their colleagues, patients, visitors and the interests of NHS Lothian. – To provide and maintain safe systems of work and healthy working conditions in compliance with all relevant statutory requirements.

	– To provide where appropriate personal protective equipment (PPE) in accordance with legislation. – To have in place systems of communication to ensure the effective dissemination of both external and internal information on health and safety matters. – To ensure the highest levels of consultation on health and safety matters in accordance with the principles of Partnership working. – To provide resources, by way of facilities, information, education, training, instruction and supervision. – To co-operate and co-ordinate with other employers/ agencies such as the Health and Social Care Partnership(s) where they share premises or workplaces, tasks and care provision. – To commit NHS Lothian to implement and abide by relevant health and safety legislation. This may include working with the Enforcing Authorities to ensure compliance such as the Health & Safety Executive (HSE), Environmental Health Officers, Scottish Fire and Rescue Service, Scottish Environmental Protection Agency. – To ensure a formal link to NHS Lothian Quality and Clinical Governance structures and arrangements and NHS Quality Improvement Scotland. – To ensure compliance with the Staff Governance Standard 'to provide an improved and safe working environment.' – To have in place effective specific structures, policies and procedures, to ensure that NHS Lothian meets its legal obligations with regard to other key risk areas.
Are there any associated documents for this policy?	– NHS Lothian Adverse Event Management Policy and Operational Procedure. – NHS Lothian Risk Management Policy and Risk Register Operational Management Procedure – NHS Lothian Health Surveillance Policy – NHS Lothian Control of Contractors Policy. – NHS Lothian Waste Management Policy. – NHS Lothian First Aid Policy. – NHS Lothian Fire Safety Policy.

	– NHS Lothian Records Management Policy. – NHS Lothian Whistleblowing Policy. – NHS Lothian Policy for the Implementation of the Ionising Radiation (Medical Exposure) regulations 2017.
Is there an impact from this policy on other policies?	*None*

Stakeholder Consultation

Engaging staff and developing strong working relationships will provide a solid foundation for any changes to be made. All stakeholder representatives should be informed and appropriately engaged to facilitate the implementation and sustainability of the policy.

Who are your stakeholders?	This policy applies to all staff working for and/or on behalf of NHS Lothian. Temporary and agency staff, volunteers, contractors, students and work experience personnel will also be expected to follow the requirements contained within this Policy.
What steps have been taken to consult with them?	*This policy was placed on the NHS Lothian Consultation Zone for a 4-week period for all NHS Lothian staff to comment on.* *The Policy was presented in the NHS Lothian Health and Safety Committee.* *The Policy statement has been signed by the Chief Executive.*
Please list any service users, carers, representatives or local organisations who could contribute to the implementation.	*All staff who work for and/or on behalf of NHS Lothian.*
Is there a need to provide information to service users and carers regarding this policy? If so, how do you intend to do this?	*No requirement*

Implications

Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy.

Does this policy have implications for IT systems?	*No*
Does this policy have implications for administrative systems?	*No*
Does this policy have implications for practice?	*No-existing Policy in place*
Please outline the nature of any other implications and how they are to be managed	*None*
If your policy will bring about change, what barriers are there to this change?	*Policy has been in existence since 2012. The main change introduced in version 5.0 is the requirement for the Local Health and Safety Committees to provide level of assurance for the 12 key topics but this requirement has been in place within the organisation since 2018.*
How will you overcome these barriers?	*Health and Safety Team already conducting assurance level visits and workshops.*
Who needs to change and how do you plan to approach them?	*Managers responsible for implementing the Healh and Safety Policy. Training and support visits*
Education and Training	
Will the implementation of this policy require any education and training?	*Yes-NHS Lothian Health and Safety Management System Module within Health and Safety Training for Managers*
What format will your education/training take?	*Face to face (when COVID-19 circumstances permitting so) and working on preparing an online version .*
Who will do the training?	*Health and Safety team*
What tools/resources will be required to carry out the training?	*This training is already in place, running regularly five times a year. Health and Safety team will update the information to include the new version of the Health and Safety Policy*
How long do you anticipate this training will take?	*4 hours*
When do you intend to start this training?	*Already in place, running regularly five times a year (face to face sessions currently cancelled due to COVID-19 pandemic but working on preparing an online version)*
Have arrangements been made with service managers to enable staff to attend any briefing and training sessions? If so, what arrangements have been made?	*It can be booked through eESS.*

Are arrangements in place to ensure the induction of new staff reflects the policy?	*Yes, as part of the Quarterly Report System*
Are there any barriers to providing this training? And if so, how will you overcome these barriers?	*Face to face session cancelled due to COVID-19 pandemic.* *Health and Safety Team working on an online vesion.* *If any barrier this should be escalated as part of the Quarterly Report System*
How will you measure, and record, the effectiveness of this training?	*Satisfaction of the Health and safety training for managers is monitored by feedback of attendees and information to staff is monitored annually through the health and safety management system quarterly review system*
Where will you keep any data that you record regarding your training and educations?	*Locally in the Health and Safety Folder*

Monitoring and Evaluation

Being able to evaluate and demonstrate the benefits of a policy is essential to promote the achievements of those involved and justifying changes that have been made.

How will you monitor the effectiveness of this policy?	*Annually through the Health and Safety Management System Quarterly review System*
If any, what are the main changes in practice that you would expect to see from the implementation of this policy?	*To improve the awareness of the staff about their Health and Safety responsiblities.* *To promote health and safety culture within the organisation.*
How might these changes be evaluated?	*Through the Health and Safety Management System Quarterly review System.* *As part of the Plan, Do, Check, Act (PDCA) System.* *Review of DATIX Adverse Events* *Carrying out Audits.*
How will lessons learnt from the implementation of this policy be fed back into the organisation?	*Local Health and Safety Committees will provide level of assurance of the 12 key topics at the end of each Quarter to NHS Lothian Health and Safety Committee and the NHS Lothian Staff Governance Committee*

Policy Communication Plan

Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.

- What are the key messages to communicate to the different stakeholders?
- How will these messages be communicated?

There are a variety of communication methods/channels. Listed below are just some of the ways that could be used to support implementation and to distribute the messages to stakeholders. This list is by no means exhaustive and is only intended to stimulate discussion.

- Email, intranet, posters on staff noticeboards
- Meetings – management meetings, team meetings, and briefings
- Presentations – Toolbox talks, presentations to target audiences
- Competency assessments, local training sessions, NHS Lothian e-Learning

Policy title: Health and Safety Policy

Key Messages	Details	Channels	Responsibility	Indicative timescale
The Health and Safety at Work etc Act 1974 is the primary piece of legislation covering occupational health and safety. It sets out the general duties which employers have towards employees and members of the public and which employees have to	The policy establishes a clear direction for NHS Lothian to follow and aims to reflect the organisation values and beliefs. It provides the framework in which the statutory requirement to manage for health and safety is integrated into everyday business and becomes core to the service NHS Lothian provides. The arrangements to achieve this include the following: – NHS Lothian has in place a health and	Communication of the Health and Safety Policy and related documents through Toolbox Talks, Safety Briefs and Team meetings. Records of this communication should be kept through the "Record	Managers	Post Policy approval

themselves and to each other. Employers have the duty to ensure, so far is reasonably practicable, the health, safety and welfare at work of all their employees. The Management of Health and Safety Regulations 1999 provide a legal framework to establish how to manage health and safety. Employers must make arrangements to cover the effective planning, organisation, control, monitoring and review of the preventive and protective measures and these details must be recorded in writing as part of the Health and Safety Policy.	safety management system. – NHS Lothian has identified 12 key health and safety hazards to staff and patients. – Health and Safety related policies are in place. – An Annual Health and Safety Plan is in place and it is monitored on a quarterly basis. – Members of staff are provided with information, education, instruction and training. – NHS Lothian has in place a framework of Health and Safety Committees that promotes consultation and governance. The Committee also assists with supporting the risk management system to help ensure the health, safety and welfare at work of staff.	of Undesrtanding" Form (available in the Health and Safety website).		

NHS Lothian

Title: Health & Safety Policy			
Date effective from:		**Review date:**	
Approved by:	Lothian Health Board		
Approval Date:			
Author/s:	NHS Lothian Lead Health & Safety Adviser		
Policy Owner:	Head of Health and Safety		
Executive Lead:	NHS Lothian Executive Medical Director		
Target Audience:	All employees of NHS Lothian and other employees working on behalf of NHS Lothian		
Supersedes:	NHS Lothian Health and Safety Policy v4		
Keywords (min. 5):	Health and Safety Management System, Planning, Organisation, Control, Monitoring, Review		

Health and Safety Policy

NHS Lothian

Version Control

Date	Author	Version/Page	Reason for change
July 2012	Health and Safety Team	1.0	Approved
April 2014	Health and Safety Team	2.0	Reviewed and approved
August 2015	Health and Safety Team	3.0	Reviewed and approved
May 2017	Health and Safety Team	4.0	Reviewed and approved
August 2020	Health and Safety Team	5.0	Under review/New Format

Executive Summary

The Health and Safety at Work etc Act 1974 is the primary piece of legislation covering occupational health and safety. It sets out the general duties which employers have towards employees and members of the public and which employees have to themselves and to each other. Employers have the duty to ensure, so far is reasonably practicable, the health, safety and welfare at work of all their employees. The Management of Health and Safety Regulations 1999 provide a legal framework to establish how to manage health and safety. Employers must make arrangements to cover the effective planning, organisation, control, monitoring and review of the preventive and protective measures and these details must be recorded in writing as part of the Health and Safety Policy.

The policy establishes a clear direction for NHS Lothian to follow and aims to reflect the organisation values and beliefs. It provides the framework in which the statutory requirement to manage for health and safety is integrated into everyday business and becomes core to the service NHS Lothian provides. The arrangements to achieve this include the following:

- NHS Lothian has in place a health and safety management system.
- NHS Lothian has identified 12 key health and safety hazards to staff and patients.
- Health and Safety related policies are in place.
- An Annual Health and Safety Plan is in place and it is monitored on a quarterly basis.
- Members of staff are provided with information, education, instruction and training.
- NHS Lothian has in place a framework of Health and Safety Committees that promotes consultation and governance. The Committee also assists with supporting the risk management system to help ensure the health, safety and welfare at work of staff.

Health and Safety Policy

NHS Lothian

Contents

1.0 Purpose

The purpose of the Policy is to set out the NHS Lothian approach to health and safety in order to establish the responsibilities and the arrangements to manage the health and safety within the organisation.

The specific objectives of the Policy are:

- To define the health and safety responsibilities and organisational arrangements.
- To develop a health and safety culture which secures the full participation of all staff within NHS Lothian.
- To ensure an effective closed loop health and safety management system operates based on the plan, do, check and act principle which provides continuous improvement in risk control.
- To implement measures which will systematically identify hazards and control risks that arise from the work activities and the work environment.
- To commit management and staff at all levels to promote healthy and safe ways of working and set personal examples in safe behaviour.
- To ensure all persons working within NHS Lothian are responsible for making working safely a key objective in order to protect themselves, their colleagues, patients, visitors and the interests of NHS Lothian.
- To provide and maintain safe systems of work and healthy working conditions in compliance with all relevant statutory requirements.
- To provide where appropriate personal protective equipment (PPE) in accordance with legislation.
- To have in place systems of communication to ensure the effective dissemination of both external and internal information on health and safety matters.
- To ensure the highest levels of consultation on health and safety matters in accordance with the principles of Partnership working.
- To provide resources, by way of facilities, information, education, training, instruction and supervision.
- To co-operate and co-ordinate with other employers/ agencies such as the Health and Social Care Partnership(s) where they share premises or workplaces, tasks and care provision.
- To commit NHS Lothian to implement and abide by relevant health and safety legislation. This may include working with the Enforcing Authorities to ensure compliance such as the Health & Safety Executive (HSE), Environmental Health Officers, Scottish Fire and Rescue Service, Scottish Environmental Protection Agency.
- To ensure a formal link to NHS Lothian Quality and Clinical Governance structures and arrangements and NHS Quality Improvement Scotland.

- To ensure compliance with the Staff Governance Standard 'to provide an improved and safe working environment.'
- To have in place effective specific structures, policies and procedures, to ensure that NHS Lothian meets its legal obligations with regard to other key risk areas.

2.0 Policy statement

NHS Lothian exists to provide healthcare services of high quality to the people of Lothian. We recognise that we cannot provide these services unless we ensure, as far as is reasonably practicable, that we will reduce the risks to the health, safety and welfare of staff, and others affected by our work activities.

The minimum acceptable standards for health and safety are those contained in legislation. It is our obligation to meet these standards as a minimum and strive for continual improvement. NHS Lothian will ensure that the statutory requirement to manage for health and safety is therefore integrated into everyday business and that is not seen as a bolt on and becomes core to the service NHS Lothian provides.

We recognise that the prime responsibility for health and safety rests with our managers. This principle extends from the Chief Executive to first line supervisors.

Managers and supervisors are directly accountable for the prevention of incidents, accidents and occupational illness, as well as damage or loss to NHS Lothian property and the environment within their area of responsibility. All persons within NHS Lothian are responsible for making working safely everyone's business in order to protect themselves, their colleagues, patients, visitors and the interests of NHS Lothian.

Health and Safety and other specialist Advisors are appointed as competent persons under the current Management of Health and Safety at Work Regulations. They are responsible for advising managers and staff about their legal obligations and to provide advice and support to enable managers to manage health and safety in their area of responsibility.

NHS Lothian is required to co-operate and co-ordinate health and safety arrangements where more than one organisation or group share or visit premises. NHS Lothian will therefore work in conjunction with the Health and Social Care Partnerships and others on all aspects of managing for health and safety.

The Chief Executive has overall responsibility for health and safety in NHS Lothian. The Chief Executive has delegated to the Executive Medical Director the responsibility to lead on health and safety matters. The implementation of this policy will be reviewed as part of the requirements of the Health and Safety Management System.

This policy statement is supplemented by additional policies giving detailed arrangements for health, safety, welfare and related issues. Managers are responsible for bringing these policies to the attention of their staff.

Chief Executive

3.0 Scope

This policy applies to all staff working for or on behalf of NHS Lothian. Temporary and agency staff, volunteers, contractors, students and work experience personnel will also be expected to follow the requirements contained within this Policy.

The Health and Safety Policy covers three areas to set out the approach to health and safety:

- Statement of intent
- Responsibilities for health and safety
- Arrangements for health and safety

4.0 Definitions

4.1 Health and Safety Management System

It is the section of the Organisation's management system that covers the Health and Safety Policy, responsibilities, arrangements and the practices, procedures and resources for developing and implementing, reviewing and maintaining the health and safety within the organisation. The health and safety management system currently used in NHS Lothian is the "Plan, Do, Check, Act" approach recommended by the Health and Safety Executive (HSE) as treats health and safety management as an integral part of good management rather than as a stand-alone system.

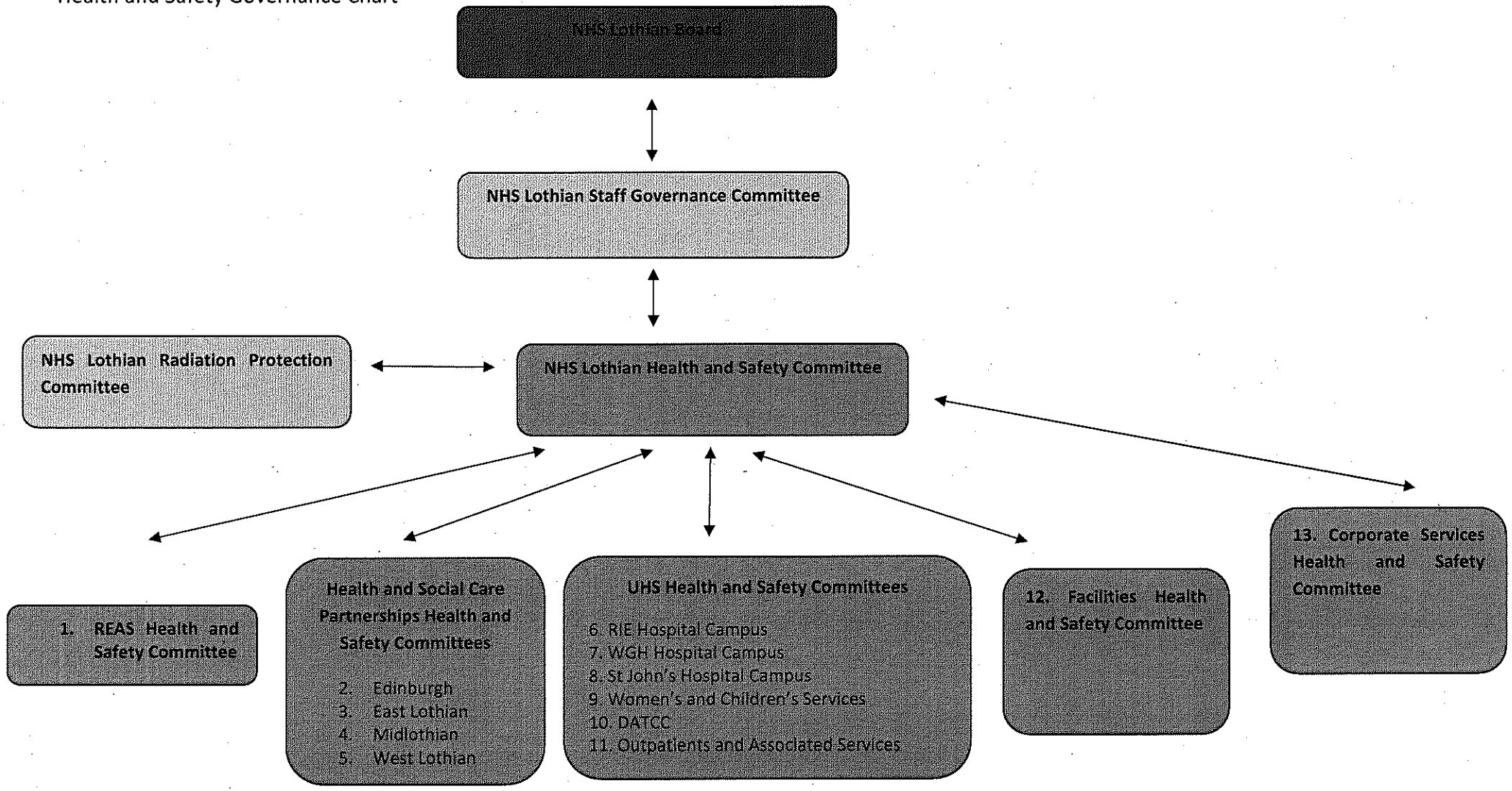
4.2 Assurance Levels

Documented information to evidence how the Health and Safety Management System is implemented within the organisation. Assurance Levels for NHS Lothian are currently:

- Significant: Fully compliant. The Board can take reasonable assurance that the system of control achieves or will achieve the purpose that is designed to deliver. There may be an insignificant amount of residual risk or none at all.
- Moderate: Mostly compliant. The Board can take reasonable assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.
- Limited: Some compliant. The Board can take some assurance from the systems of control in place to manage risk(s), but there remains a significant amount of residual risk which requires action to be taken.
- None: Limited compliant. The Board cannot take any assurance from the information that has been provided and urgent action must be taken.

5.0 Implementation roles, responsibilities and arrangements

Health and Safety Governance Chart



5.1. Implementation roles and responsibilities

5.1.1. Chief Executive

- This policy is authorised by the Chief Executive as the officer responsible for the duties of the employer under legislation relating to the health and safety of employees, patients and others who may be affected by the activities of NHS Lothian Health Board.

- The Chief Executive has overall responsibility for ensuring that an organisational structure and effective arrangements exist to ensure the health, safety and welfare of staff employed within NHS Lothian and all persons (e.g. patients, visitors, contractors) liable to be affected by the activities carried out within NHS Lothian premises.

  This will include responsibility for:

  a) The staff employed within NHS Lothian
  b) The work processes, activities and systems performed within NHS Lothian
  c) The specific accommodation within which NHS Lothian activities are carried out.
  d) The property in the form of equipment, supplies, furnishings etc. which is used in the performance of these activities.

  In practice the Chief Executive will discharge this direct responsibility by delegation to the Executive Medical and Senior Management Teams.

- The Chief Executive through the line management structures will ensure that there are systems in place to monitor regularly the arrangements for managing the health and safety. The details of those arrangements will be agreed in Partnership.

- It is the responsibility of the Chief Executive to ensure that sufficient resources are available to ensure so far as is reasonably practicable, the health and safety of NHS Lothian staff.

- The Chief Executive shall ensure that there is an effective consultation and governance system in place for the health and safety of staff and others. This will be facilitated through the NHS Lothian Health and Safety Committee(s) and the NHS Lothian Staff Governance Committee framework.

5.1.2 Executive Medical Director

The Executive Medical Director is responsible for the following:

- Ensuring that the provisions of this policy are implemented throughout the organisation.

- Ensuring through the various line management structures and the NHS Lothian Staff Governance Committee that the NHS Lothian Board is meeting all its health and safety statutory requirements in order to provide a continuously improving healthy and safe working environment for staff and others.

- Reporting annually to the Chief Executive and advising the Chief Executive of any serious breaches of the duties of the employer under legislation relating to the health and safety of employees, patients and others who may be affected by the activities of NHS Lothian Board.

- Taking a visible and active lead in health and safety matters.

- Ensuring that arrangements are made to enable NHS Lothian to comply with statutory regulations and codes of practice which particularly affect clinical staff for example the Ionising Radiations Regulations, Ionising Radiation Medical Exposure Regulations, and reports of the HSE Advisory Committee on Dangerous Pathogens.

- Ensuring where possible that there is Medical Staff representation and attendance at the NHS Lothian Health and Safety Committee and other local Health and Safety Committees/Groups as required.

5.1.3 Senior Management and their teams

Senior Management and their teams are responsible for ensuring the following:

- Full compliance with the requirements of the NHS Lothian Health and Safety Policy and its supporting Management System.

- That NHS Lothian Health and Safety related Policies are being implemented and that where applicable local rules and procedures are prepared to comply with them.

- That so far as is reasonably practicable there are in place:

  a) Safe systems of work, safe procedures and safe processes and that are devised, observed, monitored and maintained.

  b) Arrangements to ensure that all staff based on the risk that they may be exposed to are provided with the necessary information, instruction and supervision to enable them to carry out their duties safely. This should include comprehensive and relevant information on health and safety risks identified by any risk assessment and the protective and preventative measures in place. Any training/ assessment must be

repeated when appropriate to take into account any new or changed risks to the staff concerned and must take place during working hours.

c) The provision of information on any special skills required for safe working and any health surveillance required, before work starts to any person they employ on a fixed term contract or secondment, or through an employment agency.

d) Assurance that plant and equipment provided for use is maintained to a standard which is safe and without risks to health when used, and is cleaned and maintained.

e) Accommodation(s) that is maintained in a manner which constitutes a safe and healthy environment.

f) Arrangements to ensure the transport of personnel and the transport, handling, use and storage of articles and substances are carried out in a manner which is without risk to health.

g) Effective procedures that are set up to be followed in the event of serious and imminent danger to persons working in NHS Lothian premises and other locations, including the nomination of competent persons to implement any evacuation procedures and restrict access to areas of danger.

- That where NHS Lothian shares a workplace with another employer or employers (e.g. Health and Social Care Partnerships), there is a mutual co-operation to enable the relevant statutory duties to be complied with and all reasonable steps to be taken to inform other employers of risks arising out of the NHS Lothian undertaking.

- The provision to any self employed persons or employees of other employers working on NHS Lothian premises, of comprehensive information concerning any risks from the undertaking, including procedures to be followed in the event of serious or imminent danger.

- That all staff are fully aware of their delegated health and safety duties and that these responsibilities are where required documented and given to the individuals concerned, and ensuring, by effective monitoring, that the duties are being carried out and corrective action is taken if they are not.

- That work related incidents, accidents, diseases and dangerous occurrences are reported and recorded in accordance with the NHS Lothian Adverse Event Management Policy and Procedure and the appropriate follow-up action taken.

- That Staff Side Health and Safety Representatives are consulted in good time in respect of the staff they represent concerning:

a) The introduction of any measure within NHS Lothian, which may substantially affect health and safety.

b) Any health and safety information that NHS Lothian is required to provide to employees.

c) Planning and organisation of any health and safety training the organisation is required to provide.

d) The health and safety consequences of the introduction of new technologies into the workplace.

5.1.4 Line Managers and their teams

Line managers and their teams are responsible for the following:

- Taking a visible and active lead in health and safety matters.
- Ensuring that this Policy is communicated and implemented and that staff to which specific responsibilities are delegated, are fully aware of and discharge these Health and Safety responsibilities. Where they do not have the authority to deal with such matters they should escalate them to more senior management.
- Taking appropriate action on matters concerning Health and Safety, which are brought to their attention including providing a level supervision that is commensurate with the risk. E.g. higher risk tasks would require a greater level of supervision.
- Ensuring that all staff are aware, understand and have access to this Policy and that they are also made aware of any health and safety related policies and procedures. All policies and procedures should be easily accessible. Policies must be effectively implemented, share with staff and monitored by the management teams.
- Preparing and updating any local health and safety risk assessments and procedures for their department, liaising with managers of similar departments in other locations of NHS Lothian. This will assist with functional consistency of practice, and ensure that all staff for which they are responsible receive and understand any departmental health and safety risk assessment and procedures. This should be undertaken by seeking advice from Health and Safety Advisors/specialists where appropriate.
- Developing and implementing safe working practices and systems by risk assessment, education, training, supervision and provision of information within the department, particularly in the case of young or inexperienced staff, to ensure maximum safety for all personnel involved.

- Identifying the level of knowledge required for all staff under their control and providing the necessary training where this is possible. Training needs which cannot be met should be reported to the next higher authority, and training records should be clearly documented. Training should be commensurate with the level of identified risk. This should be undertaken seeking advice from Health and Safety Advisors/specialists when required.

- Undertaking hazard spotting exercises, leading to risk assessments, along with compliance monitoring, and safety inspections to ensure that machinery and equipment is maintained in a safe condition, that safety devices are fitted, maintained and operated, and that safety rules and procedures are observed, and safety equipment utilised.

- Reporting and investigating all accidents, incidents (near misses), diseases and dangerous occurrences in accordance with the NHS Lothian Adverse Event Management Policy and Procedure.

- Providing Trade Union and employee appointed Health and Safety representatives with facilities to carry out their prescribed functions in accordance with the Safety Representatives and Safety Committee Regulations and the Health and Safety (Consultation with Employees) Regulations.

- Liaising with safety representatives for the department on all matters concerning safety.

- Keeping up-to-date with developments in their field of work and responding to change as necessary.

- Responding to specific safety technical information notified.

- Ensuring that any visitors to the department are segregated from foreseeable hazards, or are advised of any hazards they may encounter, so far as is reasonably practicable. Where departmental activities take place out with the department, to ensure similar care is taken.

- Ensuring the department is kept tidy, with safe access and egress, and safe storage, use and disposal of materials.

- Ensuring that new equipment is inspected by a competent person and staff trained in its use, before it is brought into operation.

- Ensuring that fire procedures are brought to the attention of all their staff and that staff attend training, in accordance with the NHS Lothian Fire Safety Policy.

- Maintaining appropriate safety records. E.g. risk assessments, training records, significant adverse event report forms in line with the NHS Lothian Records Management Policy.

- Making proposals to the relevant Directors for improvements to safety policies and contributing towards the preparation of safety polices, where appropriate.

- Co-operating and consulting with the Facilities Department and where applicable other external providers to ensure that all statutory examinations are carried out at the appropriate time and records are maintained.

- Seeking specialist advice when necessary by bringing matters to the attention of the appropriate Director and/or Specialist Adviser.

- Ensuring that requirements under the NHS Lothian Control of Contractors Policy are met.

5.1.5 Staff

Every member of staff working on NHS Lothian premises or elsewhere on its behalf has a legal duty to take all reasonable care of their own health and safety as well as that of others, e.g. patients, who may be affected by their acts or omissions. Students, volunteers and placements will be treated as staff (employees) for the purposes of this Policy.

NHS Lothian requires its staff to:

- Take all reasonable care of their own health and safety and that of others who may be affected by their acts or omissions.

- Co-operate with any provision made towards achieving the Health and Safety Policy objectives and complying with statutory duties.

- Notify immediately to their manager/supervisor all health and safety hazards that they identify. (Note: Where an employee believes it is inappropriate for any reason to raise a legitimate concern with their manager that is in the public interest they may wish to raise it with a Senior Manager within the NHS Lothian Whistleblowing Policy and Procedure).

- Make full and proper use of any control measure, personal protective equipment or other facility provided to eliminate or reduce risk to health and safety.

- Report all work related adverse events (incidents, accidents, dangerous occurrences or diseases) to the appropriate manager/supervisor as soon as possible, in accordance with NHS Lothian Adverse Event Management Policy and Procedure.

- Use all machinery, equipment, any dangerous substances, transport equipment, means of production or safety devices in accordance with any relevant training and instructions.

- Make themselves familiar with all relevant Health and Safety related Policies and local procedures.

- Report any defect in plant or equipment, or shortcomings in the existing safety arrangements to their supervisor or manager without delay.

- Be aware that if they feel that a job or activity is inherently unsafe, they should report to their supervisor before attempting to undertake the job or activity. **If in doubt ask.**

- Not undertake any task for which authorisation and training has not been given. **If in doubt ask.**

- Attend health and safety training when requested to do so.

Staff are encouraged to improve standards of health and safety and constructive suggestions made by them will be welcomed. Such suggestions should be passed to the appropriate line manager and safety representative.

5.1.6 Occupational Health and Safety Service

The Occupational Health and Safety Service (OHSS) is responsible for the following:

- To develop and prepare health and safety policies and procedures on behalf of the Chief Executive to aid compliance with current legislation.

- To advise the Chief Executive and all Management Teams on health and safety issues including notification of any changes to current legislation.

- To monitor the implementation of health and safety policies and procedures on behalf of the Chief Executive through use of recognised performance management systems.

- To offer practical support and guidance to Managers and their staff, on the assurance and risk assessment process. To assist with devising and implementing initiatives in response assurance levels and to identified risks.

- To investigate potential hazards associated with work practices and or the environment and to recommend action for their elimination to local management.

- To assist in ensuring that NHS Lothian premises are safe for patients, employees and visitors.

- To provide health and safety related training e.g. adverse events, health and safety management, COSHH, risk assessment.

- To act in an ex-officio capacity at health and safety committee/group meetings within each Site or Service and Health and Social Care Partnership, advising the committee on its remit and activities and assisting managers in promoting the effectiveness of the committee.

- To collect and disseminate statistics and other data on health and safety matters to assist with the control of risk, and to highlight areas of concern either locally or for NHS Lothian Board.

- To liaise with and respond to correspondence from the Health and Safety Executive.

- To prepare regular reports on health and safety performance to the Health and Safety Committees/Groups as required.

- To support managers and others to undertake adverse events including RIDDOR (Reporting Incidents, Diseases and Dangerous Occurrence Regulations) investigations in line with the requirements of the NHS Lothian Adverse Management Policy and Procedure.

- To coordinate activities carried out by the NHS Lothian Respiratory Protective Equipment (RPE) Service.

- To provide a wide range of service such as: pre-employment screening, immunisation, health surveillance, 24 hour on call sharp adverse events advice, hand skin surveillance, workplace advice, management referrals and advice to employees and managers on fitness for work.

- To provide an Annual report to the Chief Executive regarding relevant Occupational Health and Safety information.

5.1.7 Other Specialist Advisers

Specialist Advisers e.g. Infection Prevention and Control, Radiation Protection and Manual Handling, have been appointed to comply with the general requirements of Regulation 7 of the Management of Health and Safety at Work Regulations 1999. The Advisors for these disciplines will be able to:

- Provide a proactive source of competent advice within their particular specialism and experience.

- Prepare and issue appropriate Polices and Guidelines within their sphere of expertise on which managers require advice.

- Be available to meet with and consult with department heads, Health and Safety Committees and staff appointed safety representatives.

- Have the right to attend Health and Safety Committee meetings and to propose agenda items where relevant.

- Assist management and staff to interpret national Occupational Health and Safety standards.

- Advise on local procedures, training and risk assessment.

- To make available appropriate training to meet Health and Safety requirements.

- Give guidance on the preparation and amendment of NHS Lothian policies and procedures.

5.1.8 Head of Fire Safety and Fire Safety Advisors

- To assist the Director of Facilities to develop and prepare the NHS Lothian Fire Safety Policy and any associated Procedures, on behalf of the Chief Executive, to ensure compliance with current fire safety legislation and other mandatory requirements e.g. any current Scottish Health Technical Memorandum.

- Advise the Chief Executive and Line Management on fire safety issues including the notification of any changes to current legislation.

- To provide both general and specific fire training, and an advisory service, for all staff relevant to specific areas of work. This should include use of fire fighting equipment and evacuation techniques.

- To carry out an ongoing review of fire risk assessments of all premises and prepare reports, prioritising findings with recommendations for action to the management team. Copies of any Fire Risk assessments must be provided to the ward/department managers to inform of the findings and what if any action(s) is required.

- To ensure close liaison and co-operation with the Scottish Fire and Rescue Service and external agencies in fire related matters.

- To investigate all fire related adverse events and prepare reports with recommendations for action.

- Prepare and submit quarterly reports to the NHS Lothian Health and Safety Committee.

5.1.9 Contractors

NHS Lothian requires all contractors to comply with all health, safety and environmental legislation and must be adhered to the NHS Lothian Control of Contractor Policy that is available and regularly revised and reviewed.

5.2. Arrangements

5.2.1 Health and Safety Policy and related Policies

The Health and Safety Policy will be revised and reviewed every 3 years. All Services within NHS Lothian will establish arrangements (systems and procedures) for carrying out this policy objectives.

These arrangements will include adoption and implementation of health and safety related policies and procedures issued by NHS Lothian on specific issues e.g. Manual Handling, Prevention of Sharps Injuries, Preventing Employee Slips, Trips and Falls, Lone Working, Waste Management, Management of Aggression, Control of Substances Hazardous to Health (COSHH), Driving at Work, Risk Management/Assessment, Radiation Safety etc. This list is not exhaustive.

All the health and safety related policies and procedures are available on the health and safety homepage of the intranet and will be updated without complete revision of the Health and Safety Policy.

5.2.2 Health and Safety Management System

NHS Lothian uses a closed loop Health and Safety Management System. The system follows the principles of the HSE (G) 65 revised guidance on Plan, Do, Check and Act and will comprise of the following interrelated components: policy, organisation, planning and implementation, performance measurement and a review of performance. The Annual Health and Safety Plan which is central to the system and each of its elements will be reviewed annually and reports submitted quarterly to the NHS Lothian Health and Safety Committee.

Health and Safety education/training and awareness for managers and staff will form part of the management system requirements. All the information on Health and Safety Management System is available on the NHS Lothian Intranet Site.

5.2.3 Key Hazards

The management of these hazards will help to improve health and safety performance. These are detailed below:

1. Management of Violence and Aggression
2. Safe Bathing, Showering and Surface Temperatures
3. COSHH Review including Face Fit Testing and Skin Health Surveillance
4. Manual Handling
5. Environmental Ligature Points
6. Workplace Inspections
7. Prevention of Falls from Windows and Balconies
8. Clinical Sharps
9. Fire Safety Arrangements
10. Slips, Trips and Falls
11. Work related Stress
12. Adverse Events Management including RIDDORs

These hazards will be reviewed and updated annually by the NHS Lothian Health and Safety Committee in line with the outcomes of the previous year. Most of the common hazards which affect the majority of the Services (12 key hazards as listed above) can be found in the Health and Safety Plan which is monitored by the local Health and Safety Committees and the NHS Lothian Health and Safety Committee.

Not all of the hazards are included in the health and safety plan, some may be very Service specific such as working in Confined Spaces or Radiation Safety and these risks should be identified and controlled by the Service.

As part of the Health and Safety Management System, reports are provided on a quarterly basis to update on the individual topics under focus for that period. The information reported at each level is reviewed and summarised by each of the Local Health and Safety Committees/Groups to determine local levels of assurance. This is again reviewed by the NHS Lothian Health and Safety Committee to determine the overall Assurance Level as part of the Corporate Governance process.

5.2.4 Health and Safety Plan

The Annual Health & Safety Plan identifies key hazard topics that are expected to be controlled within the ward/department. Progress against the control requirements of the plan are monitored on a quarterly basis and those that are not effectively controlled during the year will be discussed at the NHS Lothian Health and Safety Committee and highlighted to the Staff Governance Committee, as necessary.

5.2.5 Partnership Working

NHS Lothian is committed to the principles of partnership working and the NHS Lothian Partnership Forum is the main vehicle to take this forward. Staff-side Health and Safety Representatives will be an integral part of the NHS Lothian Health and Safety Committee arrangements and can act as Co-Chairs of those Committees.

5.2.6 Health and Social Care Partnerships

Health and Social Care Partnerships within NHS Lothian, involve both NHS Healthcare staff and staff from local Councils. Both groups of staff may be working on premises controlled by either NHS Lothian or the Local Council. Consequently, mutual co-operation and communication of risk is required between both employers to ensure that all statutory provisions are met and risks are controlled.

Managers managing multi disciplinary teams will ensure that the policy requirements from the respective employer organisations are being followed and complied with. When common shared risks are identified appropriate, joint local procedures may be devised to manage and control those risks.

5.2.7 Health and Safety Committees

- The NHS Lothian Health and Safety Committee is chaired by the Executive Medical Director and meet at on a quarterly basis. The co-Chair of the NHS Lothian Health and Safety Committee will be the NHS Lothian Employee Director. The Committee will oversee organisation-wide health and safety issues. The Term of Reference (TOR) is published as follows:

NHS Lothian HS Committee Terms of Reference (TOR)

Committee Overview

The Health and Safety Committee is established in compliance with the Health and Safety at Work Act 1974, Safety Representatives and Safety Committees Regulations.

The Health and Safety Committee is a consultative Committee and reports to the NHS Lothian Staff Governance Committee.

The Staff Governance Committee is a standing committee of the NHS Lothian Board and together with the Healthcare Governance Committee and the Audit and Risk Committee form the full governance framework for the Board.

The Staff Governance Committee shall receive reports from the NHS Lothian Health and Safety Committee on assurances that the risks to staff health and safety are identified and are being controlled and or reduced.

It is also recognised that the remit of the Health and Safety Committee extends beyond staff into health and safety issues affecting patients, visitors and contractors and links will therefore need to be made with other Committees as appropriate.

Purpose of the Health and Safety Committee

- To develop, endorse, promote and review the NHS Lothian Health and Safety Policy aims and objectives and to oversee implementation.
- To ensure that health and safety risks are identified and managed and that the NHS Lothian Board meets both its organisational and legislative requirements.
- To promote the ownership of health and safety as an integral part of the provision of high quality health care and health care services.
- To ensure the organisation meets the Staff Governance Standard that entitles staff to an *"improved and safe working environment"*.
- To ensure that the appropriate level of competence in health and safety is identified, supported and maintained.
- To monitor health and safety performance and strive for continual improvement, both in the operational service and at a corporate level.
- To provided assurance to the NHS Lothian Board that effective systems are in place to manage for health and safety.

These working arrangements have been developed to ensure that the committee functions efficiently, effectively and achieves its purpose.

Specific responsibilities

The specific responsibilities of the Health and Safety Committee are to:

- To improve health and safety leadership, management commitment and employee participation.
- To endorse Health and Safety Policies and recommend them to the Staff Governance Committee and NHS Lothian Board as appropriate.
- To supervise the commissioning of health and safety policy development and consultation.
- To monitor the dissemination and implementation of health and safety related policies across the organisation.
- To inform and influence health and safety planning, developments and budgeting.
- To consider the impact of significant change / service management processes on health and safety risks.
- To consider and act upon enforcement representations, reports and factual information provided by Health and Safety Executive inspectors.
- To monitor performance from Health and Safety internal audit reports, adverse event statistics and trends and provide direction for corrective action.
- To monitor and oversee action planning arising from health and safety inspections, audits, and adverse event data.
- Consideration of reports which staff-side health and safety representatives may wish to submit.
- To communicate health and safety information and advice to the organisation.
- To translate statutory and best practice requirements into operational targets for use by NHS Lothian.
- To review and approve health and safety information reporting requirements.
- To consider UK / Scottish Government proposals for new/amending legislation and recommend NHS Lothian responses.
- To establish 'Short Life Working Groups' as it deems necessary to fulfil its operational and statutory obligations.
- To support Local Health and Safety Committees/Groups adhering to the NHS Lothian Partnership Agreement.

Committee Membership

The membership of the Committee includes:

- Medical Director – Chair
- Employee Director – Co-Chair
- Interim Human Resources Director
- Partnership Health and Safety representatives
- Chair or deputy from the Site/ Services, REAS and the Health and Social Care Partnership Health & Safety Committees/Groups
- Director of Facilities
- Nurse Director representative
- Director of Occupational Health and Safety
- Head of Health and Safety
- Associate Director of Clinical Governance and Risk Management
- Other specialist advisers nominated by the Chair

Staff Side Representatives

Each Trade Union/Professional Organisation will be invited to nominate one staff side health and safety representative to sit on the Committee. However in specific circumstances more than one representative may attend the Committee as appropriate and necessary.

Advisors

Advisors will attend the Committee but not be formal members. This should facilitate them providing independent advice. Membership can be supplemented by co-opted attendees to provide additional knowledge or expertise:

- Health and Safety Advisors
- Radiation Protection Advisors

Frequency of Meetings

Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. In any event, meetings shall normally be held as a minimum four times a year.

Quorum

No business shall be transacted at a meeting of the Committee unless at least six members are present of which there will be one Executive Member of NHS Lothian Board. Any member must be represented by a Deputy at any meeting if unable to attend in person.

Reporting Arrangements

The Health and Safety Committee will report to the Staff Governance Committee by means of submission of minutes to the next available meeting along with a summary report highlighting the key risks discussed and also any that will be required to be addressed in the future or that require escalating to the NHS Lothian Board.

The Chair of the Health and Safety Committee will also provide assurance on the work of the Committee on an ongoing basis to the Staff Governance Committee.

An Annual Report will also be prepared for presentation to the Staff Governance Committee describing the outcomes from the Health and Safety Committee during the year in order to provide assurance that it has met its remit during that year.

- The chairperson of the NHS Lothian Health and Safety Committee shall report annually to the Chief Executive via the Staff Governance Committee and, in addition, shall advise the Chief Executive of any serious breaches of the duties of the employer under legislation relating to the health and safety of employees, patients, and members of the public who might be affected by the activities of Lothian NHS Board.

- The NHS Lothian Health and Safety Committee shall approve the Health and Safety Annual Plan.

- All Acute Hospital Sites and other Services along with the Health and Social Care Partnership(s) have their own Local Health and Safety Committees/Groups in place to ensure that health and safety arrangements/risks for operational matters are discussed communicated with and to staff. As a result of these discussions proportionate action must be taken. These Committees/Groups will be chaired by a senior manager and will provide evidence and assurance on a quarterly basis to the NHS Lothian Health and Safety Committee.

5.2.8 Radiation Safety

Radiation safety will be managed in accordance with the provisions of the NHS Lothian Radiation Protection and the Policy for the implementation of the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER).

In conjunction with advice from the Radiation Protection Advisor, the Executive Medical Director shall be responsible for providing and maintaining relevant policies and for ensuring that the provisions of these policies are implemented throughout the organisation.

These Policies shall include details of how the Radiation Protection Committee members shall be appointed, the staff position held by these members, the frequency of meetings, and the arrangements for reporting to the NHS Lothian Health and Safety Committee on Radiation Protection Committee matters.

There shall be an NHS Lothian Radiation Protection Committee, the chairperson of which shall be the Executive Medical Director.

There shall be an IRMER Committee, the chairperson of which, who will also act as the IRMER Policy Lead, shall be appointed by the Executive Medical Director.

5.2.9 Health and Safety Advice

The Occupational Health and Safety Service will provide advice on health and safety matters. The Occupational Health and Safety staff will serve as a source of 'competent advice' as required by the Management of Health and Safety at Work Regulations.

All managers and employees are encouraged to contact the Occupational Health and Safety Service for advice on any health and safety issues.

The Health and Safety Advisors have access to both the Chief Executive and the Executive Medical Director regarding health and safety issues. The Health and Safety Advisors have delegated authority, by the Chief Executive, to stop any work which has an immediate serious risk to employees, patients, visitors, contractors, or members of the public, or which could result in Enforcement Action (e.g. Prohibition / Improvement Notice) from any of the Enforcing Authorities.

Other specialist Advisors such as: Radiation Protection, Infection Prevention and Control, Manual Handling, Violence and Aggression, Fire Safety are also available within NHS Lothian to provide advice.

5.2.10 Communication

NHS Lothian will ensure that a mechanism for communicating all information regarding health and safety risks is established throughout the organisation. This will take the form of both written and verbal communication including the use of I.T. systems.

5.2.11 Resources

NHS Lothian will consider the allocation of resources to support the implementation of this policy along with any other supporting health and safety related policy requirements based on the information provided by the Staff Governance Committee This allocation will be determined by the level of risk tolerance.

5.2.12 Monitoring

The requirements and the arrangements of the policy will be monitored by the NHS Lothian Health and Safety Committee.

5.2.13 Equality and Diversity

Health and Safety issues are a concern for all staff and groups of users of NHS Lothian's services and premises. The equality & diversity page on the intranet includes a wide range of information about the issues and how these might be addressed. Previous similar versions of this policy were subject to an impact assessment and no concerns were identified.

6.0 Associated materials

- NHS Lothian Adverse Event Management Policy and Operational Procedure.
- NHS Lothian Risk Management Policy and Risk Register Operational Management Procedure
- NHS Lothian Health Surveillance Policy
- NHS Lothian Control of Contractors Policy.
- NHS Lothian Waste Management Policy.
- NHS Lothian First Aid Policy.
- NHS Lothian Fire Safety Policy.
- NHS Lothian Records Management Policy.
- NHS Lothian Whistleblowing Policy.
- NHS Lothian Policy for the Implementation of the Ionising Radiation (Medical Exposure) regulations 2017.

7.0 Evidence base

Health and Safety at Work etc. Act 1974.

Management of Health and Safety at Work Regulations 1999.

The Health and Safety (Consultation with Employees) Regulations 1996.

Safety Representatives and Safety Committees regulations 1977.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

The Ionising Radiation (Medical Exposure) Regulations 2017.

Ionising Radiation Regulations 2017.

Managing for health and Safety, HSE, HSG65, 2013.

8.0 Stakeholder consultation

This policy was placed on the NHS Lothian Consultation Zone for a 4-week period for all NHS Lothian staff to comment on.

The policy was presented in the NHS Lothian Health and Safety Committee.

9.0 Monitoring and review

9.1 Proactive management

The implementation of the Health and Safety Management System is reviewed and reported on annually as part of the Health and Safety Management Quarterly Reporting System. Documented information is gathered at ward/department level and then provided to the Service(s)/HSCP Management Teams. Reports are then provided to the respective Health and Safety Committees. This information is then gathered by the NHS Lothian Health and Safety Committee with the risk assurance level and provided to the Staff Governance Committee.

9.2 Reactive management

All adverse events must be reported using the DATIX system and investigated in line with the NHS Lothian Adverse Event Management Policy and Operational Procedure.

9.3 Review

This policy will be revised and reviewed every three years or as a result of any changes in level of risk and/or in legislation which may occur before this. This policy may also be subject to review if new guidance or legal opinion is issued or NHS Lothian identifies a need for revision as the result of inspection, audit or following investigation of an adverse event.

NHS LOTHIAN

NHS Lothian Board
7th April 2021

Deputy Chief Executive

WGH ENERGY INFRASTRUCTURE – PHASE 2

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with an overview of the Energy Infrastructure Phase 2 Enabling Works Outline Business Case (OBC) and recommend that the Board approve the OBC.

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

2 Recommendations

2.1 The Board is recommended to approve this Outline Business Case (OBC) for submission to the Scottish Government Capital Investment Group (CIG). The Board is assured that the Finance and Resources Committee reviewed the OBC at the meeting on 10 March 2021 and supports its submission to the Scottish Government CIG.

2.2 In line with Finance and Resources Committee, the Board supports the principle of a proposal to develop a methodology and cost assessment for demolition of the unoccupied laundry building, to be included within Full Business Case or addendum to the FBC. Works to include relocation of existing service needs adjacent to the building.

3 Discussion of Key Issues

3.1 Heat and power infrastructure at WGH is recognised as NHS Lothian's #1 priority in the forward looking 5 year Property and Asset Management Investment plan from 2017/18, due to condition and age of the systems.

3.2 The ageing steam infrastructure for heat in particular is impacting the ability to maintain operations in a safe, resilient and effective manner. Additionally the system is inefficient in terms of cost and carbon, and does not align with requirements to reduce carbon emissions for the site within the legislation of the Climate Change Act (Scotland) 2009.

3.3 An Initial Agreement for WGH site wide energy infrastructure was approved by NHS Lothian Finance and Resources Committee in July 2018 and subsequently by the Scottish Government Capital Investment Group in October 2018.

3.4 This Initial Agreement set out the need for an initial phase (Phase 1) energy infrastructure works in order to meet the energy requirements of the Oncology Enabling works. The works commenced December 2019 are due for completion March 2021.

3.5 In this context, the project team continue to progress with the plans for site wide energy infrastructure congruent with the IA and providing a pathway to net zero carbon by 2045 and addressing the critical site resilience issue of the HV network- through the development proposals for Phase 2 Energy Infrastructure. .

3.6 The overall approach to the pathway to net zero has highlighted the following synergies:

- New build and refurbishment projects are required to meet higher sustainable standards, and must be designed to incorporate the highest levels of energy

efficiency through fabric specification, building systems designs and operational performance to minimise the energy demands and carbon impact. The developing ECC case must make its contribution by realising positive, deliverable and innovative energy and sustainability solutions but achievement of net-zero carbon is reliant on the site infrastructure.

- Removal of the ageing steam network has other benefits, including removal of large volumes of asbestos from site within the steam ducts, safer working environment and increased site resilience due to steam replacement for phase 1 and 2, which also releases steam capacity on the already overloaded system.

Phase 2 Heat

3.7 The phase 1 heat plant and network was designed to supply DCO and Cyclotron, as part of the initial steam replacement, but was not included within phase 1 due to the complexity and time constraints of the Linac and Renal developments. DCO and Cyclotron account for 70% of the installed heat capacity so the newly installed plant is currently delivering only 20 % of capacity.

3.8 The scope of works in Phase 2 is to extend the heat network established in Phase 1, utilise the full capacity of the plant and continue the de-steaming programme by converting the DCO and Cyclotron heat stations from steam to Low Temperature Hot Water.

3.9 This comprises replacement of current steam heating interfaces, installation of a new section of underground heat network connecting the Phase 1 heating plant to Cyclotron and connection to pipework installed adjacent to DCO in phase 1.

3.10 The extension of the heat network and further de-steaming will improve site energy efficiency of the connected existing buildings compared with the existing steam system through reduced losses and high efficiency specification. The plant is fuelled by natural gas, with oil back up, and therefore does not focus on providing a low carbon solution, but increases the overall resilience and future-proofs buildings for connection to the future site wide solution.

Phase 1 Power

3.11 When the IA for energy infrastructure was submitted, this identified the need to upgrade all power networks across the site. It set out the need for upgrade to the HV network and assumed that these works would also need to be part of the Phase 1 works to support additional power requirements of the Oncology enabling works.

3.12 During the development of the Phase 1 OBC, it was determined that upgrade works were not on the critical path for the Oncology Enabling Works programme. Sufficient capacity was identified from the existing infrastructure in the Department of Clinical Oncology (DCO).

3.13 While the works were omitted from phase 1 due to interdependent project programmes, the risk and need to replace and upgrade these critical systems remains.

3.14 Works involve a Scottish Power main incomer relocation from existing laundry, construction of new Intake Building west of Estates Building and diversion of existing HV cables.

3.15 Site High Voltage electrical works, comprising new HV cables from the incomer to new secondary Sub Station (adjacent to Ward 1).

Other considerations to be addressed in Phase 2

3.16 Phase 2 constitutes a key element of the overall infrastructure programme, specifically in terms of the HV power systems, but the wider programme of replacing the energy centre and remaining infrastructure, is dependent on preparing the new location.

3.17 Through workshops involving stakeholders across facilities, estates and capital planning the area occupied by the redundant laundry has been determined as the preferred location, due to existing infrastructure arrangements, separation from clinical areas, spatial requirements and logistics.

3.18 Removal and clearance of the site is on the critical path for delivery of the site-wide Energy Infrastructure, but the current level of risk associated with the building is of significant importance due to high levels of asbestos and fire response strategy further supporting the case for removal.

3.19 While not included within the scope at this time, further investigations and associated costs are being sought in connection with demolition of the redundant laundry building. Dependent on timing for completion of the assessment, costs will be presented at FBC stage if available or advised under a FBC addendum for consideration.

Phase 2: Summary

3.20 Phase 2 capital cost estimates are circa £10.72M, including professional fees, engineering works, mark-ups and 15% design risk allowance.

Capital Cost (£m)	Preferred Option – Costs at OBC
Construction	6.71
Professional Fees	1.00
Estates Charges	0.20
Other fees and charges	0.08
Risk Allowance	1.05
Project Team Costs	0.04
Total Cost (excl VAT)	**9.08**
VAT	1.64
Total Capital Cost	**£10.72m**

3.21 Cost information to date is based on a well-developed design and delivery plan and framework supplier input with the majority of proposed works having been fully costed and market tested. The current risk allowance is 15% of contractor budget construction costs including professional fees. Assessment of risk and allocation is ongoing and will be updated at FBC.

3.22 It is assumed that the preferred solution will not result in any recurring revenue cost increase. Further investigation to be undertaken during the FBC process.

3.23 Interrelated studies and projects running in parallel, in particular Flood Phase 2 and the new Landscape Strategy have not been considered due to timing. Final designs for some elements will likely not be complete for FBC submission. To ensure projects are not impacted by delays, design risk allowances will remain. Works are ongoing to minimise the unknown elements.

Next Steps

3.24 The critical step in the timetable for producing the FBC is in relation to the details and costs of Laundry demolition. The development of the FBC is on track for consideration at the Finance and Resources Committee Meeting on the 2nd June.

4 Key Risks

4.1 Delays in Energy Infrastructure impacting site development, connected build and refurbishment works programme.

4.2 Funding for the delivery of the Site Wide Energy Infrastructure (Heat Network and HV Electrical Network) is not in place. Development of proposals and business case ongoing.

4.3 Planning requirements and Wayleave rights for new SPEN Incomer location.

4.4 Co-ordination and disruption of existing underground services and Hospital Main Drive access, due to final position of new District Heat network pipe route. Locations to be determined.

4.5 Proximity of works to UofE BRF building during HV works and possible laundry demolition.

5 Risk Register

5.1 Energy Infrastructure previously identified within NHS Lothian Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 Not considered relevant due to scope of works.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 Not considered relevant due to scope of works.

8 Resource Implications

8.1 The resource implications are; Current capital cost estimates are £10.8M (subject to confirmation) including professional fees, engineering works, mark-ups and 15% design risk allowance. Phase 2 previously estimated at £7m.

8.2 The scale of additional cost identified since the IA estimates for phase 1 and 2 is notable in relation to the site wide Energy Infrastructure works. The full scheme was estimated at £56.7M at IA. Significant elements of the scope in Phase 1 & 2 relate to enabling works for adjacent projects and non-energy infrastructure.

8.3 The resource implications are programme management through Capital Planning with external input from advisers.

8.4 Project support resources to be finalised, but links to wider infrastructure project.

Jane Hopton
Programme Director Facilities
jane.hopton@nhslothian.scot.nhs.uk
24 March 2021

Daniel Mill
Senior Project Manager Sustainable & Technical Development
daniel.mill@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: WGH Energy Infrastructure OBC phase 2 v5

WGH Energy Infrastructure – Phase 2

NHS Lothian

Outline Business Case

Project Owner: Daniel Mill, Energy & Technical Sustainability – Facilities Directorate

Project Sponsor: Jim Crombie – Deputy Chief Executive - Executive Office

Date: 18/02/2021

Version: 5

Version History

Version	Date	Author(s)	Comments
1	12/10/2020	Daniel Mill	SCIM Template
2	24/01/21	Jane Hopton	Review and revision
3	26/01/21	Daniel Mill	General revisions
4	10/02/21	Daniel Mill	General revisions
5	16/02/21	Daniel Mill / Emma Amor	General revisions and updated cost information
6			
7			

Contents

1 Executive Summary

The purpose of this Outline Business Case (OBC) is to seek approval for a second phase of investment (Phase 2 EI) in the energy infrastructure at the Western General Hospital (WGH). This phase of investment in energy infrastructure is required to maximise the reach of the investment in the new boiler and District Heat (DH) network installed in Phase 1 of the Energy Infrastructure Works and secure the power supply to the site in the context of the Phase 1 Masterplanning Works.

The works proposed in this OBC align with the long-term site energy strategy as set out in the IA approved by CIG in December 2018.

Strategic Context

The IA for site wide energy infrastructure explicitly recognised imminent needs for heat and power to the buildings in development as part of the WGH Masterplan and resilience of current infrastructure. Phase 1 of the masterplan, referred to collectively as the Oncology Enabling Works includes:

The development of a renal satellite unit (due for completion 2021) the development of two additional linear accelerator bunkers together with changes to the existing haematology and cancer clinical accommodation to improve standards of accommodation required urgently (and in advance of a new regional cancer centre being operational).

Recognising the impact on clinical services due to potential failures of the existing energy infrastructure and requirement to accommodate growth and development in relation to clinical services, the WGH Energy Infrastructure (EI) was identified as NHS Lothian's #1 priority in the forward looking 5 year Property and Asset Management Investment plan from 2017/18.

One of the key components for the energy infrastructure upgrade is switch from steam distribution to low temperature hot water. Current systems are unreliable, costly and labour intensive to maintain. Maintenance of key systems requires staff to work in confined spaces and in high temperature conditions. The preferred option in the IA was to provide a site (district) Low Temperature Hot Water (LTHW) piped distribution and upgraded power network from a new energy centre.

Secondly is re-provision of ageing infrastructure, beyond normal operating life-expectancy, thereby building resilience and modernising essential critical services.

This project seeks to replace the existing site-wide steam and electrical infrastructure systems with a solution based on a low temperature district heating network which can utilise renewable and low carbon solutions to provide increased resilience, increased efficiency and lower associated carbon impact.

There is the opportunity for the proposed ECC to benefit from this new energy infrastructure by being based on the site.

It is important to recognise the energy / carbon challenge and opportunity at the WGH. The work to date on the Energy Infrastructure Project has highlighted that a development pathway approach is required that combines infrastructure, energy generation and demand reduction from building refurbishment/replacement across the remainder of the site to move to low or zero carbon technologies suitable for a city-centre location. Without a holistic approach to the site, the opportunity for wider net-zero carbon commitments will be reduced.

The new Cancer Centre must be designed to incorporate the highest levels of energy efficiency through fabric specification, building systems designs and operational performance tools to minimise the energy demands and carbon impact of the building. ECC must make its contribution by realising positive,

deliverable and innovative energy and sustainability solutions but achievement of net-zero carbon is reliant on the site infrastructure.

The proposals in the IA sought to align the ambition of Scottish Government policies on Climate Change with NHS Lothian's proposals for the site by basing the proposals on the following principles;

- Reduce energy consumption and carbon emissions from existing and new building stock;
- Phase out of fossil fuels for heating with renewable energy solutions;
- Development of intelligent local electric grid - demand side response, flexible use of CHP plant and local standby electrical generators;
- Installation of major electric vehicle charging points recognising phase out of internal combustion engines;
- Development of district LTHW heating to future proof the site so that it can take full advantage of low and zero carbon technology;
- Incorporation of heat and power storage units to more closely align site demand and renewable supply and therefore reduce fossil fuel required and increase use of renewables; and
- Smarter management of heat and power to reduce costs, energy, emissions and supply to local community where it can be used to help tackle fuel poverty.

In January 2020 a business case was approved for Phase 1 infrastructure works which were required by the timescales for delivery of the renal unit and the critical path for the wider Oncology enabling works. The site-wide infrastructure IA reported a total budget of circa £60M, with capital cost of phase 1 at £9.7M. It is of note that substantial elements of enabling for connected projects and other infrastructure have been included in Phase 1 and 2, for example; steam alterations, site-clearance, IT infrastructure upgrades, medical gas alterations, structural retaining walls, back-up generation and localised improvements.

In order to achieve the objectives of the Energy Infrastructure IA and Oncology Enabling Projects, works commenced in February 2020, the key technical aspects of the preferred solution were;

- Provision of a 3MW Low Temperature Hot Water (LTHW) boiler plant within the SHSC undercroft, comprising 3 No. new 1MWth dual fuel gas/oil boilers and ancillary plant.
- New underground District Heating pipework to connect plant and buildings.
- New electrical supplies from existing location in DCO for power requirements.
- Alterations to existing steam route, to maintain supplies to DCO and proposed position of Linac.
- Diversion and re-provision of non-energy infrastructure for Linac enabling works

This effectively started de-steaming of the WGH, by utilising Low Temperature Hot Water (LTHW) distribution that is safer, more efficient, simpler to maintain and capable of low carbon heating technology integration.

Due to programme alignment some works which had been scoped in the initial phase of the energy infrastructure IA were omitted in phase 1 - these were activities not on the critical path but remaining necessary as part of the Oncology Projects and Energy Infrastructure development.

As was the case with Phase 1 Energy Infrastructure, this Business Case for Phase 2 works aims to deliver immediate needs of the Oncology Enabling Works and site wide resilience whilst aligning with plans for the site as a whole. Those objectives relevant to this Business Case are;

- Phase 1 and Phase 2 solution will be capable of integration into a site energy scheme, by future-proofing the infrastructure and not introducing barriers to a 2045 carbon zero pathway.

- Considers and minimises sunk costs and any future revisiting of completed areas of the site.
- Provides the increased heat and power demands of the new and refurbished buildings.
- Aligns timescales with the Oncology projects.
- Resolves resilience issues of critical site services infrastructure.

Note: since starting the review amendments to the Climate Change Bill have been lodged to set a legally binding target of net-zero greenhouse gas emissions by 2045 at the latest with Scotland becoming carbon neutral by 2040.

The Project

Phase 2 progresses the programme of re-providing, modernising and developing the infrastructure at the WGH. The scope of works being considered aims to extend and fully utilise the new heat plant installed in phase 1 and commence with critical HV power upgrades.

While assessment continues on the wider scheme these works should be considered for progression based on; immediate needs, delivery efficiency, enabling for future solution and works omitted from phase 1 due to interdependent project programmes. All works were identified during site wide IA.

- Scottish Power main incomer relocation from existing laundry, construction of new Intake Building west of Estates Building, diversion of existing HV cables. Works required due to aged equipment and enabling of laundry demolition.
- High Voltage electrical works. Comprising new HV cables from incomer to new secondary Sub Station (adjacent to Ward 1). Works were not considered critical during phase 1 though were identified as necessary in the short-term.
- Conversion of DCO and Cyclotron heating from existing steam plant to the District Heat Network (DHN) pipework infrastructure installed in phase 1.

The phase 1 heat plant and network was designed to supply DCO and Cyclotron, as part of the initial steam replacement, but was not included within phase 1 due to the complexity and time constraints of the Linac and Renal developments. DCO and Cyclotron account for 70% of the installed capacity.

Laundry Building Demolition

Phase 2 constitutes a key element of the overall infrastructure programme, specifically in terms of the HV power systems, but the wider programme of replacing the current energy centre and remaining infrastructure, is dependent on preparing the new location.

Through workshops involving stakeholders across facilities, estates and capital planning the area occupied by the redundant laundry has been selected as the preferred location, due to existing infrastructure arrangements, separation from clinical areas, spatial requirements and logistics.

Removal and clearance of the site is on the critical path for delivery of the site-wide Energy Infrastructure, but the current level of risk associated with the building is of significant importance due to high levels of asbestos and fire response strategy further supporting the case for removal.

While not included within the scope at this time, further investigations and associated costs are being sought in connection with demolition of the redundant laundry building. Dependent on timing for completion of the assessment, costs will be presented at FBC stage if available or advised under a FBC addendum for consideration.

Economic & Financial Case

Conclusion of Phase 2 of the Energy Infrastructure project is essential to the programme of increased site resilience, carbon pathway development and realisation of Phase 1 value. In development of this OBC, assessment of viable solutions was undertaken by the project team. This included consideration of the site wide energy infrastructure objectives, to include a No Regrets objective whereby works are future-proofed for connection to the site-wide scheme with minimal disruption and sunk-costs.

The options assessed considered a range of solutions to provide heat and power, which were investigated and appraised against the described objectives. The table below gives a summary of the project costs;

Capital Cost (£m)	Preferred Option – Costs at OBC
Construction	6.71
Professional Fees	1.00
Estates Charges	0.20
Other Fees and Charges	0.08
Risk Allowance	1.05
Project Team Costs	0.04
Total Cost (excl VAT)	**9.08**
VAT	1.64
Total Capital Cost	**10.72**

Cost information to date is based on a well-developed design and framework supplier input, with the majority of proposed works having been fully costed and market tested. The current risk allowance is 15% of contractor budget construction costs including professional fees. Assessment of risks and allocation is ongoing and will be updated at FBC.

While the focus is reliable infrastructure, the decommissioning of the steam leads to more efficient heat generation. Due to the increased demand and continued use of steam on the majority of the site, there is no expectation of demonstrable energy and carbon savings, yet this project initiates the site-wide de-steaming strategy being developed.

Impacts on revenue, except for depreciation, have been considered as cost neutral, due to reduced reliance on costly steam infrastructure but will be further investigated at FBC. Annual depreciation has been estimated at £1.07m and will be funded by the existing NHSL depreciation budget.

Commercial Route

To deliver the project in accordance with current NHS Scotland construction procurement policy, it was decided that Frameworks Scotland 2 would be the preferred option via traditional capital funding.

RMF were appointed as the Principle Supply Chain Partner (PSCP) in December 2018. Since then, RMF and their supply chain have engaged with NHS Lothian to develop a concept design for the full Infrastructure Works and have undertaken the Phase 1 Works. This includes surveys and investigations of the site conditions, to better inform the developing design and the construction cost estimates.

The same team were engaged to develop the outline design, based on direct site knowledge, experience and value. Utilising the same team has significant benefits in terms of technical and cost implications.

Risk & Management

As the key objective is to facilitate the immediate needs of Oncology Enabling, it is important to recognise the relationship between the connected projects. Failure to align the energy infrastructure development and Oncology Enabling could result in potential impacts on the clinical requirements.

Engagement with the clinical groups, master-planning group, Capital Planning and Estates is critical to the success. There has been dialogue throughout the development to date, and there is commitment to ensure robust governance and communications is maintained.

The commercial route recognises this important issue, by utilising the same delivery partners to give continuity and understanding of the related aspects.

Governance

Governance and assurance arrangements set out in the project are in line with NHS Lothian Capital Projects Assurance and Resources Framework setting out clear roles, responsibilities and accountabilities within NHS Lothian via defined roles of Project Owner, Project Manager, HV Appointed Person (AP) and programme board.

The roles and responsibilities of external contractors are defined are delivered through Framework Scotland 2 procurement programme under NEC3 Contract processes, principally Lead Advisor roles (Project Management, Cost Advisor and Technical Advisors) and Project Delivery PSPC (including Technical and Design Development). The PSCP have been procured to deliver a wider programme of work at the Western General Hospital.

The Project Board, Project Director, Project Manager and Stakeholders will be internal resources, whilst the Contract Project Manager, Cost Advisor, PSCP (Contractor) and Design Team will be provided by external organisations who have already

The Board has used this blend of resource successfully on other projects and feels that it creates a good balance between control, risk transfer, capability and availability. The Board is experienced in delivering projects of this nature within the selected procurement route and is ready to move the project forward to the next stage upon approval of the OBC.

Governance arrangements are designed to be consistent with providing assurance utilising the range of internal and external resources allocated. A detailed Project Execution Plan (PEP) will be developed prior to commencement and presented for endorsement to the Programme Board.

Recommendations

The Capital Investment Group is asked to approve the OBC to proceed with development of the project to complete the detailed assessment and design of new heat infrastructure, power systems alterations and services diversions to align with the requirements of the Oncology Enabling projects.

Consideration of future inclusion of the laundry demolition is recommended, following further surveys, due diligence and determination of costs in order to remove this element on the critical path for the site wide infrastructure development and WGH Masterplan.

1 The Strategic Case

1.1 Existing Arrangements

1.1.1 Strategic Context for Clinical Services

The Western General Hospital (WGH) site is NHS Lothian's largest carbon producing site and one of the highest in Scotland which currently has an area of 153,000m2 comprising of 67 buildings with a net area of 109,000m2.

NHS Lothian's Strategy 2014 to 2024 Our Health Our Care Our Future, sets out its commitment to develop the WGH site, one of four major sites which are "stakes in the ground" in order to ensure that its services delivered to Lothian, the South East Region of Scotland and National Services are configured for the future. The Edinburgh Cancer Centre is located on the WGH site and provides specialist cancer services across the South East Region (60% of patients from Lothian and 40% from out with Lothian).

In line with this strategy NHS Lothian commissioned a redevelopment master plan for the WGH which has 10 phases (over 15-30 years).

Phase	Description	Status
Phase 1	Enabling, Haematology, Oncology including 2 additional Linaccs, Renal Satellite, HV transformer relocation and connection	Oncology Enabling OBC submitted Haematology OBC approved Renal IA approved NHSL Energy IA submitted CIG
Phase 2	Demolitions – old boiler house, Laundry	
Phase 3	**Build new energy centre** and Infrastructure including road realignment (and University of Edinburgh BRF)	Energy IA submitted CIG
Phase 4	Demolitions, DCN, Library, Residences, CC Enabling works including road	
Phase 5	Edinburgh Cancer Centre and Car Park	IA in development with anticipated submission to CIG late 2021
Phase 6	Demolitions, Old Energy Centre, RIDU, CJD ECC Radiotherapy	
Phase 7	New Block 1 CP and Block 2 Clinical Block Demolitions Kitchen, Labs , Minor injuries	
Phase 8	Major refurbishment of Alexander Donald Building and OPD	
Phase 9	Refurbishment of Clock Tower Building and Part-demolitions, and refurbishment of Ann Ferguson Building	
Phase 10	Final landscaping and site consolidation	

The masterplan for the WGH sets a framework for sustainable development of the site through to circa 2040-50 through phased replacement and modernisation.

This project seeks to replace the existing site-wide steam and electrical infrastructure systems with a solution based on a low temperature district heating network which can utilise renewable and low carbon solutions to provide increased resilience, increased efficiency and lower associated carbon impact.

It is important to recognise the energy / carbon challenge and opportunity at the WGH. The work to date on the Energy Infrastructure Project has highlighted that a development pathway approach is required that combines infrastructure, energy generation and demand reduction from building refurbishment/replacement across the remainder of the site to move to low or zero carbon technologies suitable for a city-centre location. Without a holistic approach to the site, the opportunity for wider net-zero carbon commitments will be reduced.

The new Cancer Centre must be designed to incorporate the highest levels of energy efficiency through fabric specification, building systems designs and operational performance tools to minimise the energy demands and carbon impact of the building. ECC must make its contribution by realising positive, deliverable and innovative energy and sustainability solutions but achievement of net-zero carbon is reliant on the site infrastructure.

There is the opportunity for the proposed ECC to benefit from this new energy infrastructure by being based on the site.

In January 2020 a business case was approved for Phase 1 infrastructure works which were required by the timescales for delivery of the renal unit and the critical path for the wider Oncology enabling works. The site-wide infrastructure IA reported a total budget of circa £60M, with capital cost of phase 1 at £9.7M. It is of note that substantial elements of enabling for connected projects and other infrastructure have been included in Phase 1 and 2, for example; steam alterations, site-clearance, IT infrastructure upgrades, medical gas alterations, structural retaining walls, back-up generation and localised improvements.

The major clinical priority for the services on the WGH is the works to urgently improve the clinical environment for cancer and haematology patients and to provide additional radiotherapy treatment capacity in the form of two additional Linacs' (Phase 1 of the Masterplan set out above) in advance of the development of the regional Edinburgh Cancer Centre as part of the overall site master plan.

A Business Case was approved and construction of the enabling works at the WGH are underway which will ensure sustainable cancer services and other clinical service provision on the site while the future model for the Edinburgh Cancer Centre is considered.

1.1.2 WGH Energy Infrastructure

Annual energy consumption at the Western General Hospital in the financial year 2019-20 amounted to 98,756 MWh per annum, equating to 13,677 tonnes of CO_2 emissions and around £3.9m in energy costs per annum. The WGH represents over 22% of NHSL buildings related carbon emissions.

Heat

The majority of the Western General Hospital site is currently served from a central Energy Centre (dating from 1968) on the North-West boundary of the site. The energy centre contains three steam boilers, a gas fired combined heat and power (CHP) engine and back-up diesel generators. The majority of plant has or will shortly go beyond expected operating life cycle. The CHP engine will reach end of normal operating life (15 years) in 2021.

Scottish and Southern Energy (SSE) have been responsible for operation and maintenance of the plant over the last 20 years. Originally contracted as an Energy Supply Agreement (ESA), whereby the original coal fired heating plant was replaced via a financed initiative, and capital costs recovered through reduced energy costs and operational contract. Capital costs repayments are now fully concluded and the assets transferred into NHSL ownership, but SSE have been retained to provide the specialist expertise, management and system knowledge to operate and maintain the plant.

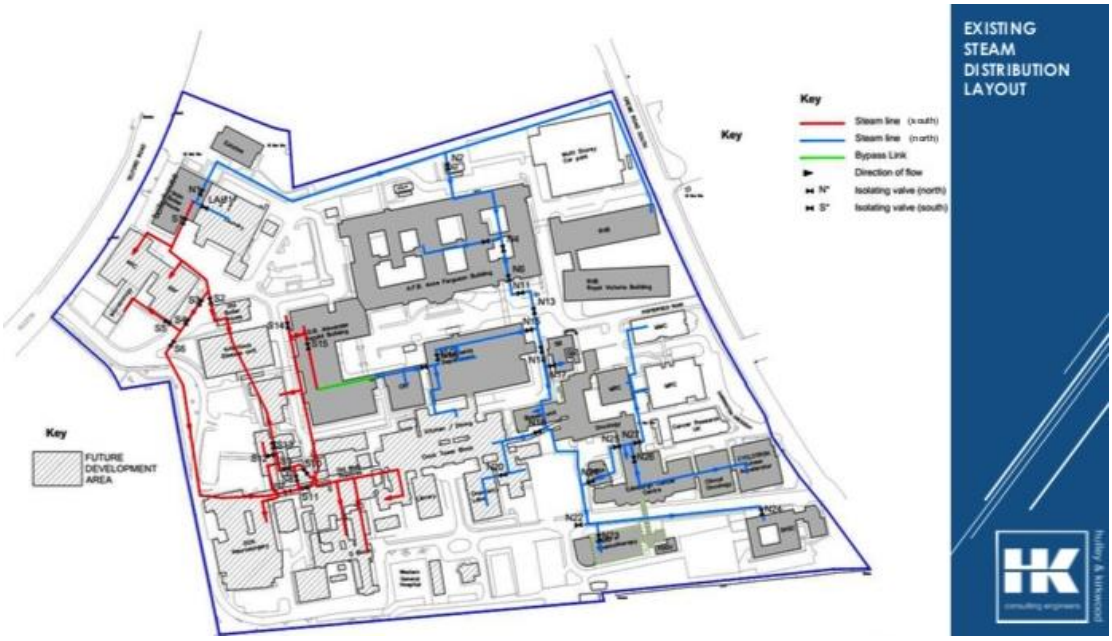
The energy centre building can be described as industrial in character and is generally suitable for its current purpose but does not have the flexibility to deal with the scale of equipment upgrades and network reconfiguration required in the relatively near future.

The Energy Centre (Boiler House) is joined to the former laundry building which is now redundant and is due for demolition, due to various risks and spatial demands on the site. The laundry site has been identified as the most suitable location for a replacement energy centre.

Figure 1: Existing energy centre shaded red

The majority of heat at the WGH site is provided by an inefficient, carbon intensive and increasingly hard to maintain steam heating network. Steam is commonly being phased out across the UK due to high losses compared with alternative technologies, high operational costs and specialist technical requirements.

The existing site steam distribution pipework network has also been in place since the late 1960s. The service continues to be maintained but it is becoming more difficult due to condition and Health and Safety issues as well as lack of trained in-house staff because of limited use of steam elsewhere in general industry. Eight service shutdowns are planned annually and this can only increase as emergency repairs take precedence over maintenance. The system has a limited lifespan and it can be argued that recent failures of the steam main are evidence that it has already expired. The image below shows the extent of the existing network.



Power

A power network, supplied by the national grid, provides electricity at High Voltage (HV) with localised step down Low Voltage (LV) supplies throughout. The incoming Scottish Power Network incomer and HV substation is within the basement of the laundry building.

The existing Scottish Power 11kV intake is located within the laundry building and comprises a joint owned 11kV switchboard. It is proposed to demolish the laundry as part of the site masterplan development proposals so it is necessary to relocate the intake switchboard as part of these works in advance of the demolition commencing.

The Scottish Power incoming cables terminate within oil insulated circuit breakers on the WGH's main 11kV switchboard. The 11kV switchboard supplies several ring mains on the site including two 11000/400V transformers in the laundry HV switchroom and it is also the point of connection for the CHP machine.

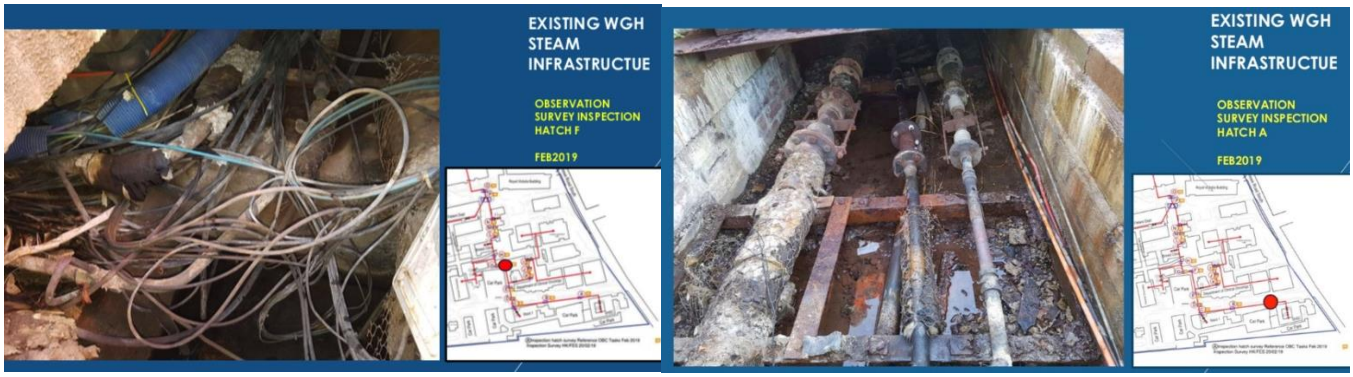
There is a high risk to the site operations as while there are two grid supplies, both feed the one incomer location. Fire Officers have advised this as a key risk due to the known asbestos and vacated use, which could lead to a limited defence only response should a fire occur.

The agreed site capacity that Scottish Power allows is 3.7 MVA. Site maximum electricity demand at 3.3MVA is close to the agreed capacity and which means any further development of the site,

as described in the Masterplan, requires a new connection agreement with Scottish Power to service additional load. The capacity can be increased to 5.4MVA without any upgrade to the supply network.

The energy infrastructure is not in line with legal requirements: NHS Lothian (NHSL) is required to have a low carbon plan for the site within the legislation of the Climate Change Act (Scotland) 2009.

Both of these critical networks, steam and HV electricity, have reached the end of normal serviceable life and require to be replaced. The image below highlights the condition of steam lines at the south-east which is indicative of the site as a whole.



The Energy Centre and primary energy supplies are managed through an Energy Supply Agreement (EPA) by a 3rd party contractor - Scottish and Southern Energy (SSE), and they also maintain and operate significant elements of the Heating, Ventilation and Air Conditioning (HVAC) services in the Anne Ferguson Building (AFB).

Recognising the impact on clinical services due to potential failures of the existing energy infrastructure and requirement to accommodate growth and development in relation to clinical services, the WGH Energy Infrastructure was identified as NHS Lothian's #1 priority in the forward looking 5 year Property and Asset Management Investment plan from 2017/18.

The IA for investment in the Energy Infrastructure at WGH was approved by CIG in December 2018. The proposals in the IA sought to align the ambition of Scottish Government policies on Climate Change with NHS Lothian's proposals for the site by basing the proposals on the following principles;

- Reduce energy consumption and carbon emissions from existing and new building stock;
- Phase out of fossil fuels for heating with renewable energy solutions;
- Development of intelligent local electric grid - demand side response, flexible use of CHP plant and local standby electrical generators;
- Installation of major electric vehicle charging points recognising phase out of internal combustion engines;
- Development of district LTHW heating to future proof the site so that it can take full advantage of low and zero carbon technology;
- Incorporation of heat and power storage units to more closely align site demand and renewable supply and therefore reduce fossil fuel required and increase use of renewables; and
- Smarter management of heat and power to reduce costs, energy, emissions and supply to local community where it can be used to help tackle fuel poverty.

The preferred option in the IA was to replace the existing system with a site (district) low temperature heat network served from a new energy centre including a combination of Waste Water Heat Recovery (WWHR), Gas Combined Heat and Power (CHP) and Gas/Oil dual fuel boilers with Diesel

Standby Power generation plant. The existing steam would be replaced with a Low Temperature Hot Water (LTHW) piped distribution and upgraded power network.

It was proposed that this would allow initial urgent and essential requirements for the site development to be met, yet future-proof for subsequent proposed development phases and potential to be linked to a City of Edinburgh district heat network, maximising potential low carbon energy sources and increasing overall economic benefit to the area.

The proposed centralised energy centre and distribution network solution creates a flexible “plug and play” structure for the introduction of innovative new technologies as they may become available along with the addition of new facilities and should ensure that the site can reach a point of carbon reduction and grid balance as soon as possible in the development strategy and therefore maximising the potential of the investment in early and ongoing savings (and avoidance of significant future carbon penalties).

The IA included plans for the electrical infrastructure to be upgraded to suit the proposed phasing strategy for the site and also offer “plug in” flexibility for new requirements.

Through the proposed phases of the overall site redevelopment, the site electrical load will vary and reliable Grid supplied HV capacity is required to deal with the additional loads from proposed increased use of high tech diagnostic and treatment equipment for imaging services and radiotherapy cancer treatment.

At IA, the preferred option of a centralised energy centre had an estimated capital cost of £56.7m but would deliver carbon savings of around 65% and energy cost savings of around 28% or £930k per annum once fully operational, based on current prices.

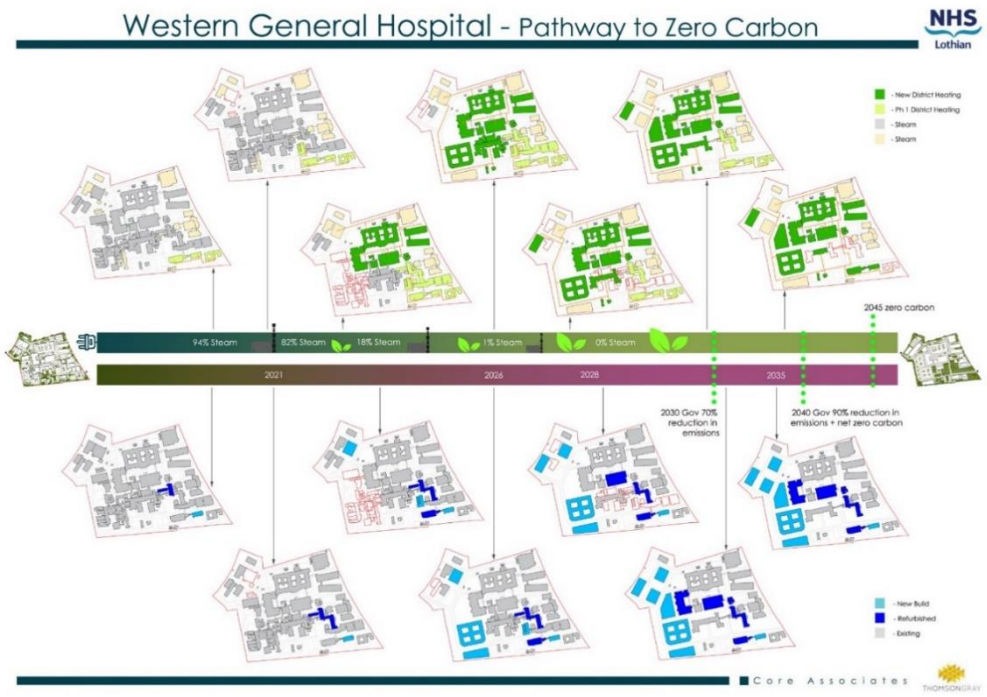
1.1.3 Strategic and Technical Review of IA for WGH Energy Infrastructure as a whole

Subsequent to the approval of the IA, following consultation with SG along with associated technical and procurement workshops, there have been adjustments to the overall strategy informing the energy infrastructure plans for the site as a whole. Those relevant to the Business Case for Phase 1 are still relevant;

- There needed to be a clear pathway to net zero carbon (as opposed to low carbon) by 2050 for the site in line with The Scottish Government’s Climate Change Strategy.
- Scottish Government, through Zero Waste Scotland, have commissioned additional support to peer review the energy infrastructure studies.
- Related to the above, the possibility of a future all electric solution for the heating networks (based on low carbon electricity being available in the future) should be reviewed and discussed with Scottish Power to determine what would be required to provide the demand both on and off site. This would determine the replacement plant requirement which would be provided during the relocation of HV Switchgear / transformer from the laundry building, or at least allowance made for the increased capacity at a future date when the site demand would require it.
- Any solution for phase 1 should be capable of being integrated into a site energy scheme to minimise sunk costs and any future revisiting of completed areas of the site.
- The de-steaming of the site as a whole should have greater and earlier priority for the energy infrastructure proposals than following the phasing of the masterplan works.

Note: since starting the review amendments to the Climate Change Bill have been lodged to set a legally binding target of net-zero greenhouse gas emissions by 2045 at the latest with Scotland becoming carbon neutral by 2040.

The image below shows the developing energy strategy overlaid against the site masterplan.



1.1.4 Initial Phases of Energy Infrastructure to meet the needs of Phase 1 Masterplanning : Oncology Enabling Works

The IA for site wide energy infrastructure explicitly recognised the imminent need to consider an early phase of energy infrastructure works in order that the Oncology Enabling Works (works located in south-east of the site) could progress to timescale.

Upgrades of the site power network are required due to life-cycle of the equipment and increasing demands expected. The increased electrical demands on the site by the Phase 1 projects including the addition of Linac bunkers and the Renal extension were expected to require the HV network capacity to be increased to allow these projects to commence. Through development of the OBC, and detailed investigations, it was identified that existing capacity can be utilised, thereby minimising disruption and project scope in the short-term.

The capacity limits on the site are able to be increased by requesting additional agreed capacity with the network operator, Scottish Power. The feeder network is capable of an increase to approximately 5.4MVA from the current 3.7MVA limit. This would not require any additional works or replacement of plant though there would be an increase to standing charges.

Specifically: in order to achieve optimal design of the enabling works and avoid future costs a priority was to decommission the steam main on this section of the site and provide a new heat solution in line with the overall strategy for the site set out in the IA.

At the time of preparing the IA it was assumed that the early phase of energy infrastructure would also require a new HV substation and ring as the additional load from the additional linear accelerators expected to exceed the agreed site capacity.

As detailed design work on the early phases of energy infrastructure works required by the Oncology Enabling Works it became clear that;

- Existing power infrastructure could cover short-term additional demand from cancer enabling works.
- To meet the timescales of the Oncology enabling works the priority for Energy Infrastructure needed to be de-steaming and re-provision on that sector of the site.
- Required detailed design work required to address both the requirements to de-steam that sector of the site, provide a new heat source and undertake the works on the power supply would extend the business case process and delay the commencement of essential works.

In the context of the above it became clear that the optimal approach was to consider the immediate requirements early of the energy infrastructure works in two phases.

1.1.5 Phase 1 Energy Infrastructure Works

The key aspects of the Phase 1 Energy Infrastructure:

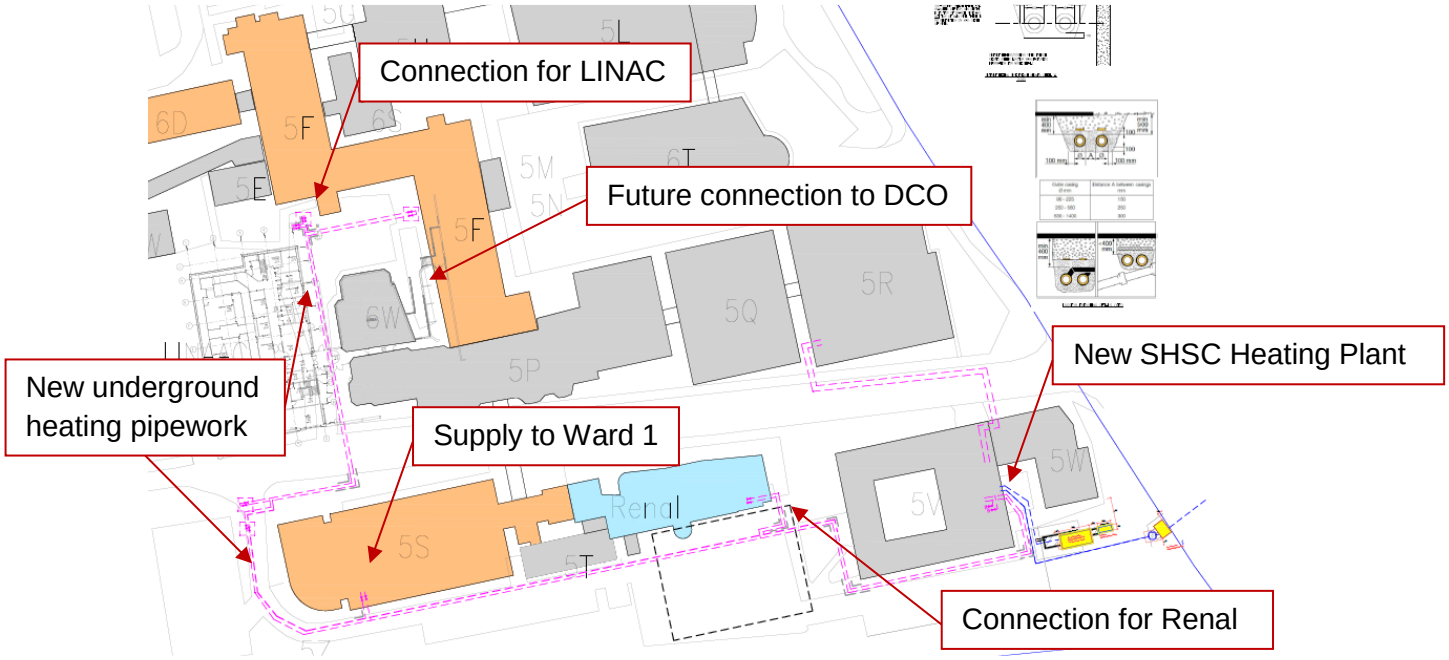
- Steam distribution in this zone was already beyond capacity with limited resilience. By not providing an alternative solution there would be increased loads to the existing steam and therefore increased risk, carbon, cost etc.
- The agreed location of the new LINAC bunkers required the steam main to be diverted. De-commissioning and removal fits with the site wide de-steaming strategy.
- Opportunity to remove several existing buildings off the steam network as part of Phase 1 works – improving resilience and reducing risk to the wider site.
- Longer term solution possible for this area of the site which would mitigate any delays to later phases. The interim solution could potentially be functional for 15-20 years and supports the energy centre transition pathway to zero carbon 2045.
- Earlier improved local heat/power provision driving improved fabric for new build areas and suitability to connect to the future site wide network.
- Wider area served by the interim plant solution allows for an increased period of efficiency.
- Reduction in risk of existing system failure by removing steam loads.
- Reduction in ongoing maintenance costs and H&S concerns by reducing steam network length.
- First steps for the site on carbon reduction following a proposed pathway to zero carbon.

In order to achieve the objectives of the Energy Infrastructure IA and Oncology Enabling Projects, works commenced in December 2019, the key technical aspects of the preferred solution were;

- Provision of a 3MW Low Temperature Hot Water (LTHW) boiler plant within the SHSC undercroft, comprising 3 No. new 1MWth dual fuel gas/oil boilers and ancillary plant.
- New underground District Heating pipework to connect plant and buildings.
- New electrical supplies from existing location in DCO for power requirements.
- Alterations to existing steam route, to maintain supplies to DCO and proposed position of Linac.
- Diversion and re-provision of non-energy infrastructure for Linac enabling works

This effectively started the de-steaming of the WGH, by utilising Low Temperature Hot Water (LTHW) distribution that is safer, more efficient, simpler to maintain and capable of low carbon heating technology integration.

The image below shows the extent of the heat network provided in phase 1.



As noted above, some elements were removed from the scope due to programme constraints, namely the existing DCO and Cyclotron heating plant-rooms. Provision for these works was included, whereby the new heating plant has sufficient capacity and connections points have been prepared in suitable locations in order to minimise future disruption.

Construction activities for the phase 1 works commenced on-site in December 2019, with completion expected March 2021. Throughout the challenges encountered in 2020, the project has been successful in safely continuing construction and delivery against the specification.

1.1.6 Phase 2 Energy Infrastructure Strategy

Power: A new intake switchroom is to be created for Scottish Power. It is proposed that the intake switchroom is part of a new building that can accommodate a new primary 11kV switchboard, transformers and LV switchgear. The proposed location for the new building is to the west of the Estates Building adjacent to Telford Road due to the close proximity of the Scottish Power cables and the WGH's private 11kV cables outside the laundry.

The buildings that are currently supplied from the laundry's main low-voltage switchboard will require new low-voltage supplies from the LV switchboard within the new intake building. This will include the Estates Building, Boiler House and Microbiology. It is also proposed to install an LV supply to the existing laundry main switchboard to maintain certain supplies that will remain in use until the building is demolished. It is proposed that the essential supplies from the existing generator remain in place for the Boiler House and Microbiology.

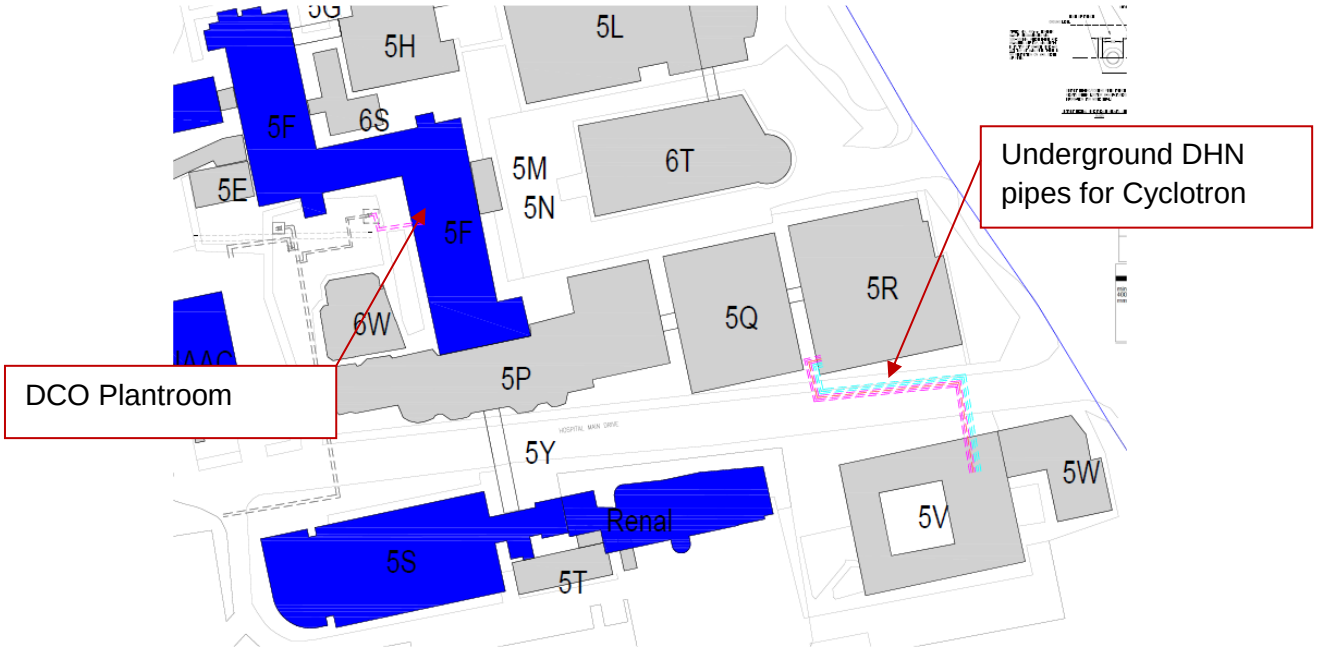
All 11kV cables will need to be cut outside the laundry building footprint and jointed to new sections of cable which will be extended to the new intake building.

In addition to the works required in and around the laundry, it is proposed that a new substation is established in the south of the site close to the Phase 1 PoW buildings and connected directly to the new primary 11kV switchboard. This sub-station is to be located in the car park to the west of Ward 1 and will initially supply Ward 1, Renal and the Linac/Admin building but it will have the capacity to supply other buildings in this area which will be affected by the removal of existing sub-stations in the future. It is proposed that a new emergency stand-by generator is provided in this area in the short term.

Heat

Proposed works comprises the decommissioning and replacement of all existing steam/Low Temperature Hot Water (LTHW) and steam/Domestic Hot Water (DHW) heat exchange (HX) plant within the following buildings/areas, as well as new connections from the District Heat Network (DHN) pipework infrastructure:

- Department for Clinical Oncology (DCO) plantroom (5F), including Simulator Suite plant
- Cyclotron Plantroom (5R)



Heat: Cyclotron Plantroom Steam to LTHW DHN Conversion; comprises the decommissioning and replacement of all existing steam to LTHW and steam to Domestic Hot Water heat exchanger plant within the Cyclotron plantroom (5R).

This includes the decommissioning and removal of all existing steam pipelines associated with;

- Steam sub-mains in the corridor floor trench of the Cancer Care Unit (Linac Reception Areas) from DCO plantroom to Cyclotron plantroom.
- Steam sub-mains to a number of currently un-used AHU humidifiers located on the DCO Cyclotron Roof, Cancer Care Unit Roof, as well as main DCO Plantroom.
- Existing un-used steam infrastructure pipework previously serving site buildings 5L, 5H and 6B.
- Temporary steam distribution pipework installed within ground trough to serve DCO plantroom between Chambers G and I.

New heat exchangers plant shall be located within SHSC undercroft plantroom to minimise downtime during change-over of the live LTHW and DHW systems of the Cyclotron plantroom.

New secondary LTHW and DHW F&R pipework shall be routed across Hospital Main Drive into the existing Cyclotron plantroom. The existing steam HX plant within shall be removed, in a staged manner, once new plant connections are made and operational.

Redundant steam infrastructure pipelines and ancillary plant internally within the Cyclotron Plantroom and externally shall be stripped out as far as is safely practicable without causing disruption to the operational functionality of the facility.

Building Management System (BMS) auto controls scope shall include new mechanical control panels (MCP's) for each new LTHW and DHW HX plant, as well as cold water booster pumps, pressurisation plant and new system pumps where necessary. This will capture temperature monitoring, pressure monitoring, fault alarming, control valve field wiring, control/alarm signalling to new outstations, all linked to the existing NHSL BMS communications IT Network. BMS dynamic graphics shall be required to be installed at the head end.

Heat metering shall be provided on the primary side of all LTHW & DHW plant and secondary metering to each existing sub-circuit.

New primary pumpset and DHWR pumpsets shall be installed as necessary. Any secondary pumpsets shall be replaced as necessary but it is the intention to utilise the existing secondary pumpsets where suitable based on condition.

Heat: DCO Plantroom Steam to LTHW DHN Conversion; this comprises the decommissioning and replacement of all existing steam/LTHW and steam/DHW HX plant within the DCO plantroom (5F), including Simulator Suite plant.

It also comprises the decommissioning and removal of all existing steam pipelines associated with this:

- Steam sub-mains within the corridor floor trench of the Cancer Care Unit (Linac Reception Areas) from DCO plantroom to Cyclotron plantroom
- Steam sub-mains to a number of currently un-used AHU humidifiers located on the DCO Cyclotron Roof, Cancer Care Unit Roof, as well as within the main DCO Plantroom.
- Existing un-used steam infrastructure pipework previously serving site buildings 5L, 5H and 6B
- Temporary steam distribution pipework installed within ground trough to serve DCO plantroom between Chambers G and I.
- New LTHW DHN pipelines are to be extended into the DCO plantroom from the adjacent Phase 1 infrastructure termination point.

Redundant steam infrastructure pipelines and ancillary plant internally within the DCO Plantroom (UoEd MMC and MRC facilities already redundant and capped off), Cancer Care Unit and Cyclotron Unit shall be stripped out as far as is safely practicable without causing disruption to operations.

Building Management System (BMS) auto controls scope shall include new mechanical control panels (MCP's) for each new LTHW and DHW HX plant, as well as cold water booster pumps, pressurisation plant and new system pumps where necessary. This will capture temperature monitoring, pressure monitoring, fault alarming, 2 port control valve field wiring, control/alarm signalling to new outstations.

Heat metering shall be provided to be on a stand-alone NHSL IT energy metering/monitoring network. Heat metering shall be provided on the primary side of all LTHW &DHW duty/standby HX plant. Secondary metering is being proposed to be installed to each existing sub-circuit, potentially in the form of 'clamp-on' type.

New primary pumpset and DHWR pumpsets shall be installed as necessary. New secondary pumpsets (minimum of 3 No.) shall be replaced as necessary as some of these existing pumpsets are at the end of their useful life.

Admin corridor AHU ductwork (fresh air intake) will be required to be altered to enable the LTHW DHN pipework entry into the DCO plantroom.

Phase 2 constitutes completion of the local heating network and electrical network upgrades, identified as critical in the IA but postponed from Phase 1 Energy Infrastructure to ensure that the works could meet the critical path for early Oncology Enabling Works.

In the context of the above, the key aspects of the Phase 2 Energy Infrastructure requirements are:

- New plant-room and boiler capacity in SHSC, installed in phase 1, sized to provide demands of buildings connected in phase 1 plus the DCO and Cyclotron. DCO & Cyclotron were removed from phase 1 scope due to programme implications based on complexity and scale of design work. Phase 2 proposes completion of the local heat network to include the de-steaming and connection of the DCO and Cyclotron. **Phase 2 represents around 70% of the installed plant capacity**.
- High Voltage electrical works were removed from Phase 1. Comprising new HV cables from HV incomer (currently within the Laundry) to new secondary Sub-Station (adjacent to Ward 1). Works were not considered critical during phase 1 though were identified as necessary in the short-term. Additional capacity and resilience is critical for the new Linac and any future expansion.
- Relocation of Scottish Power Energy Network (SPEN) main incomer from existing laundry, to comprise construction of new Intake Building west of Estates Building. Diversion of existing HV cables from Laundry Intake Room to new SPEN Intake Building. Critical works required due to aged equipment, high risk of current location and enabling of laundry demolition.
- Continuation of site de-steaming by removing several existing buildings off the steam network as part of Phase 2 works – improving resilience and reducing risk across the site.
- The solution will be functional for up to 15-20 years and aligns with the pathway to zero carbon 2045, by extending the low temperature network.
- Wider area served by the interim plant solution allows for an increased period of efficiency.
- Reduction in risk of existing system failure by removing steam loads.
- Reduction in ongoing maintenance costs and H&S concerns by reducing steam network length.
- Individual plant room requirements are to be determined but it is expected a level of asbestos removal will be required as part of any works. This removal will reduce the asbestos on the site and in turn the risk of that asbestos becoming more of an issue in the future.

The image below shows the extent of the proposed HV/LV network, with the new incomer at the top-right with the new cable route shown in red following the site boundary to the south-east.

Laundry Building Demolition

Phase 2 constitutes a key element of the overall programme, specifically in terms of the HV power systems, but the wider programme of replacing the current energy centre and remaining infrastructure, is dependent on preparing the new location.

The implications of not progressing these works

The building is also a known high risk due to the significant volume of asbestos. This creates further site risks due to the restrictions on fire fighters entering the building should a fire occur. Our understanding is that SFRS would protect neighbouring buildings from the spread of fire but due to the asbestos would undertake dynamic risk assessment that could involve limited activities in relation to the laundry itself.

Phase 2 scope will remove the key site-wide electrical systems but a high risk will remain as the building is connected to the existing energy centre.

While not included within the scope at this time, further investigations and associated costs are being sought in connection with demolition of the redundant laundry building. Removal and clearance of the site is on the critical path for delivery of the overall site-wide Energy Infrastructure as this location has been determined through workshops involving stakeholders across facilities, estates and capital planning the preferred location is the current position of the redundant laundry building.

1.2 Drivers for Change

The table below summarises the need for change, the impact it is having on present service delivery and why this needs to be actioned now:

Table 1: Summary of the Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
Site developments requiring increased capacity and future ready systems and networks	Need for sufficient and robust heat and power supplies to match demands of new and refurbished buildings. Inability to provide capacity to developing projects (i.e. expanded Linac provision).	Fit for purpose new energy infrastructure to support projects in development and prevent building new and connecting to old systems and networks and associated potential sunk costs.
High Carbon Footprint of WGH and need to meet Scottish Government Carbon reduction targets.	Limited capacity of existing systems and ability to achieve relevant energy and carbon legislation	To support a long-term strategy for a low carbon energy infrastructure on an acute hospital site and in alignment with developing projects
Poor reliability and lack of operational resilience in systems and networks	System failures, with increasing frequency, that severely impact on site operationally	The risks are growing in line with the systems and network's age and lack of major investment
Increasing legislation and policy requirements in relation to reducing Energy and Carbon emissions.	Potential future penalties and failure to meet national and local policy and legislation.	Mitigation of ongoing risks and associated financial impacts including the opportunity to deliver a low carbon energy solution that aligns with Scottish Government climate change targets
Age of equipment requires large investment and direct replacement does not align with Low Carbon pathway	Current energy contract beyond original agreed term and investment in new equipment aligned with low energy distribution network	To have an energy infrastructure arrangement in place that doesn't require NHSL to tie into an extended contract arrangement with 3rd parties on long-term basis.
High energy infrastructure running costs	Increased running costs due to aging systems and associated maintenance and repair Increasing costs relating to high energy consumption and rising fuel costs.	Existing generation and distribution systems are inefficient and carbon intensive. Investment in failing infrastructure would reduce the increasing energy and carbon cost burden.
Health and Safety risks due to working in excessive high temperatures in limited access environments and potential exposure to asbestos	Health and Safety risks are difficult to manage and there are limited numbers of contractors with the specialist skill set and experience to deal with repair and maintenance	To mitigate impacts of increased system and network deterioration and increasing requirements for relevant maintenance and repair.

1.3 Investment Objectives

The assessment of the existing situation and the drivers for change were used to identify the investment objectives in the Initial Agreement. This have been revisited and reassessed by the project team as part of the OBC for the phase 2 works.

Table 2: Investment Objectives

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)
Need for sufficient and robust heat and power supplies to match demands of new and refurbished buildings. Inability to provide capacity to projects in development (i.e. expanded Linear Accelerator demand and provision).	That the energy infrastructure is addressed in the context of the phase 1 & 2 works. Resilient heat and power supplies in place of existing steam network.
Limited capacity of existing systems and ability to achieve relevant energy and carbon legislation.	To improve site flexibility and be more future proof, Phase 2 works continue the progression of WGH de-steaming and provide infrastructure ready for low carbon pathway.
System failures, with increasing frequency, that severely impact on site operationally	Replacement of failing steam infrastructure and plant
Potential future penalties and failure to meet national and local policy and legislation.	Reduce Carbon emissions by investing in high efficiency, lower energy and lower carbon technologies.
Current energy contract beyond original agreed term and investment in new equipment aligned with low energy distribution network	To ensure a future ready arrangement is in place at the end of the existing energy supply contract extended to August 2021. Further extension is being investigated.
Increased running costs due to aging systems and networks from associated maintenance, repair and rising fuel costs	Improve future financial performance, optimise energy usage costs and support a reduction in maintenance costs through higher efficiency network and generation plant.
Health and Safety risks are difficult to manage and there are limited numbers of contractors with the specialist skill set and experience to deal with repair and maintenance	To improve safety of staff maintaining systems.

The proposal contributes to and satisfies the site wide energy investment objectives identified:

1. That the energy infrastructure is addressed in the context of the site masterplan development framework.
2. To improve site flexibility and be more future proof.
3. To improve the site users' experience.
4. To improve site operational resilience.
5. Reduce Carbon emissions by investing in low energy/ low carbon technologies.

6. To ensure a future ready arrangement is in place at the end of the existing energy supply contract now extended to August 2021.
7. To improve future financial performance, optimise energy usage costs and support a reduction in maintenance costs.
8. To improve safety of staff maintaining systems.

Further detail on each of the objectives is contained in Appendix 7: Investment Objectives.

1.4 Is the preferred strategic solution still valid?

The fundamental goal of the project is to meet the investment objectives of the site wide Energy Infrastructure improvements, in relation to the phase 1 master-planning programme for the Oncology Enabling Works and identified resilience issues of the existing steam and electrical systems.

The overall strategy to decommission the existing steam power plant and associated infrastructure by creating a new energy centre providing low carbon heat and electrical power to buildings as a pathway to achieving the Scottish Government Zero carbon target for 2045 is still valid and continues in parallel.

The Energy Infrastructure IA described the site wide arrangements which includes the supplies for the south-east area, referred to as phase 1 in the site development masterplan. Due to the new build and refurbishment works in this area a Phase 1 of Energy Infrastructure works commenced to supply heating and power to match the increased demands and building locations.

Phase 1 Energy Infrastructure Works aligned the need for de-steaming and provision of resilient heat and power to the New Linac, New Renal, SHSC and Ward 1 by providing a local heating solution in the SHSC undercroft, comprising dual fuel oil/gas boilers, flues, pumps and controls with heat mains distributed underground to serve the new and existing buildings within this vicinity. This facilitated the disconnection of each of these existing buildings from the North Steam network and the removal of the steam & condensate mains and associated steam duct infrastructure in the ground.

The localised heating solution includes a new mains gas infrastructure supply, water supply and power supply as well as separate oil storage (for resilience) and will remain in place until the phased site wide infrastructure and new energy centre are operational. Phase 2 scope on heating, extends the network to supply the DCO and Cyclotron heat stations utilising the capacity installed in phase 1.

Electrical HV re-provision, was identified as critical in the IA. The works were removed from the phase 1 scope but remain a critical service requiring upgrade and re-provision due to age and location of existing plant within the laundry building.

Fulfils the agreed Phase 2 infrastructure benefits:

1. Improves the safety of patients and public by improving system resilience and reducing the risk of system failure.
2. Improves financial performance, optimises energy usage costs and supports a reduction in maintenance costs.
3. Improves environmental performance of the site and reduces CO_2 emissions in line with Scottish Government policy and also reduces energy consumption.
4. Optimisation of phased delivery to the future operational benefit of site users / stakeholders ie. Minimises future disruption to Phase 1 site zone.
5. Phase 2 solution does not prejudice future site wide flexibility to respond to future developments / improvements / advancements in clinical services and also emerging Scottish Government policies on management of utilities infrastructure, for example renewables, electric cars.
6. Supports the pathway to the 2045 Carbon Reduction Target.
7. Improves safety of staff maintaining systems by eliminating confined spaces & high temperature conditions.
8. Future ready arrangements to replace SSE Contract.
9. Minimises sunk costs for wider site infrastructure.
10. Minimise environmental impact regarding sound and emission production for adjacent clinical areas and neighbours.

2 Economic Case

As described in section 1.2, the Phase 2 OBC proposal to support clinical priorities is required due to the immediate need for resilient energy infrastructure and building locations for the Oncology Enabling Works projects due for completion prior to the full assessment and submission of the site wide strategy.

Phase 2 expands and continues the site de-steaming, critical HV re-provision and maximises the benefit of the new plant installed during phase 1. Conclusion of Phase 2 of the Energy Infrastructure project is essential to the resilient and efficient delivery of the Oncology Enabling, Renal and Haematology projects through new electrical HV infrastructure.

Definition of the Do Minimum is based on the following key requirements, set out in the IA update that forms the scope of the Phase 2 works;

- Re-provision of HV Electrical Incomer and protection systems
- Improves the safety of patients and public by improving system resilience and reducing the risk of system failure.

The critical nature, equipment age, availability of spares and location within a disused building highlights the immediate needs to undertake the electrical HV incomer.

To maximise the value of provided solutions for the Phase 1 Works, there needs to be agreement to commence with Phase 2 which will fully utilise the heat capacity and higher efficiency heating system.

This would allow initial requirements to be met, with further phases to follow to meet the requirements of the site-wide IA. Subsequent phases would be identified as project costs for future business cases.

2.1 Do Minimum

A summary the “Do Minimum” option is set out below for ease of reference and to enable a comparison with other feasible options.

Table 3: Do Minimum

Strategic Scope of Option	Do Minimum
Service provision	Energy infrastructure is provided to the site from an energy centre with a primary steam distribution network and associated high voltage and step down low voltage electrical power network. The current HV incomer is situated within the decommissioned laundry building, due to the age of the plant and critical protection systems replacement is required. An alternative location of incoming supply and equipment is critical due to the fire & asbestos risks associated with the laundry building and future need to demolish the building for siting of a new energy centre.
Service arrangements	Provision of the HV incomer sub-station, new HV supply to south-east zone and new sub-station serving Oncology buildings in zone 1.
Service provider and workforce arrangements	The remainder of the site infrastructure network is managed by NHS Lothian estates staff. The new build elements of the works and new equipment would replace existing high risk and high maintenance items.
Supporting assets	New Energy Network transformers and protection equipment.
Public & service user expectations	Increased resilience of power supply to the entire site.

2.2 Short-list of Implementation Options

In development of this OBC, the assessment of viable solutions undertaken by the project team and evaluated during the phase 1 Business Case development was revisited and considered against the objectives set out in section 1.2 for phase 2. This included consideration of the site wide energy infrastructure objectives, to include a No Regrets objective whereby the phase 2 works are future-proofed for connection to the site-wide scheme with minimal disruption and sunk-costs.

The options considered are limited in scope, as phase 2 seeks to fulfil the resilience needs, critical plant replacement and completion of the heat network installed in phase 1. The options assessed in phase 1 considered a range of solutions to provide heat and power, which were investigated and appraised against the described objectives. The option implemented in Phase 1 is still valid and phase 2 seeks to fulfil the preferred option.

The options considered can be viewed in terms of the two key critical systems; heating and power.

Power - Electrical HV - From the assessment, only one option has been considered suitable in relation to the investment objectives described. The option identified is to re-locate the site incomer and ancillary protection equipment from the laundry building to a new position adjacent to the estates building. Enhancement of the site-wide system is included, where a new sub-station is required to supply buildings on the south-west zone due to increased demands, resilience, flexibility and efficiency.

Heat – Extension of the heating infrastructure to supply the DCO and Cyclotron heat stations from the network and plant installed in phase 1.

Overall there is only a marginal difference in scope to the Do Minimum, due to the fixed key infrastructure requirements of alternative heat supply, increased energy loads and critical replacement of the HV power.

2.3 Monetary Costs and Benefits of Options

The table below summarises the costs associated with each of the shortlisted implementation options. Further detail on calculation of costs including assumptions made can be found in the Financial Case.

Table 4: Indicative Costs of Shortlisted Options

Cost (£m)	Option 1 Do Minimum	Option 2 Preferred Solution
Capital Cost	9.09	10.72
Recurring Revenue Costs	0.91	1.07

2.4 Non-monetary Costs and Benefits of Options

Each of the short-listed options was assessed against the benefits included in the register in Apendix 2: Benefits Register and Realisation plan. Each of the identified benefits was weighted and options was scored against its ability to deliver the required benefits. The full assessment is contained in Appendix 4: Non-Financial benefits Assessment. The results of the benefits assessment are summarised below:

Table 5: Results of Non-Financial Benefits Assessment

#	Benefit	Weight (%)	Option 1	Option 2
1	Improves safety of patients and public by improving system resilience and reducing the risk of system failure.	15	8	10
2	Improves financial performance, optimises energy usage costs and supports a reduction in maintenance costs.	12	7	9
3	Improves environmental performance of site and reduces CO_2 emissions in line with Scottish Government policy and also reduces energy consumption	10	1	7
4	Optimisation of phased delivery to future operational benefit of site users / stakeholders ie. Minimise future disruption to phase 1 zone	10	6	8
5	Phase 2 solution does not prejudice future site wide flexibility to respond to future developments / improvements / advancements in clinical services and emerging Government policies on management of utilities infrastructure, for example renewables, electric cars	10	8	8
6	Provides a pathway to 2045 Carbon Reduction Target	10	7	8
7	Improves safety of staff maintaining systems by eliminating confined spaces & high temperature conditions.	10	6	8
8	Future ready arrangements to replace SSE Contract	1	1	1
9	Minimises sunk costs for wider site infrastructure	8	8	8
10	Minimise environmental impact regarding sound and emission production for adjacent clinical areas and neighbours	14	5	8
Total Weighted Benefits Points			**619**	**825**

The result show option 2, HV and Heat tasks, is the preferred solution scoring 817 points. Option 2 achieves a higher score due to the high utilisation of the Phase 1 heating plant and associated reduction in aged steam infrastructure.

2.5 Non-monetary Risk Appraisal

This section provides an assessment of the non-financial risks associated with each of the implementation options (financial risks are quantified in the financial options appraisal). A risk workshop was undertaken, with internal and external attendees from the project team and key stakeholders. Representatives included facilities, capital planning, finance, design team, CDM expert, contractors' commercial lead, contractors' project lead, Lead Advisor PM and Cost Advisor.

A follow-up workshop will be undertaken to review mitigation measures and evaluate associated risk costs which would inform the final risk allowance, risk allocation and contract sums prior to FBC.

Table 6: Non-financial risk analysis

Risk	Impact Score	Risk Score (Impact x Probability) Option 1		Option 2	
		Prob	Score	Prob	Score
Client changes to Brief or design after the project has started	3	3	9	3	9
Access to part of the site delayed. PSCP not given access to part of the site in line with contract.	4	2	8	2	8
The employer does not approve RAMS, access requirements or other similar items in time	4	2	8	2	8
Instruction given to stop / not start the work. Risk that out of hours work will be required to progress some works.	4	2	8	3	12
The PSCP encounters physical conditions which they could not have foreseen.	5	3	15	3	15
Asbestos is encountered other than in the steam ducts or laundry building or cyclotron DCO.	5	3	15	3	15
Issues leading to design development.	3	2	6	3	9
Clashes in different project coordination/design leading to design development.	4	2	8	2	8
Poor sub-contractor performance leading to poor quality and or delay.	4	2	8	2	8
Traffic issues including public safety / interface	3	4	12	5	15
Adverse publicity, lack of communication with all involved parties	4	2	8	2	8
Delay in handover due to number of defects.	5	1	5	1	5
Problems with contractor's access/deliveries to site.	3	2	6	2	6
Delay in building warrant and planning	4	2	8	2	8
HAI SCRIBE Issues	3	3	9	3	9
Supply chain bankruptcy/insolvency	5	2	10	2	10
Long lead in periods for materials	4	2	8	2	8
Health and safety issues leading to delays.	5	2	10	2	10
Risk of services strike/mistakenly cut cable	5	3	15	4	20
NHSL staff not available to isolate services to meet programme.	3	4	12	4	12
Damage/delaps caused through work	4	2	8	3	12

Risk	Impact Score	Risk Score (Impact x Probability) Option 1		Option 2	
		Prob	Score	Prob	Score
Business continuity risk caused through security issues - i.e. unauthorised people accessing plantrooms.	5	2	10	2	10
Logistics of working adjacent to live areas and fire escapes.	5	2	10	2	10
Incorrect time and cost estimate for commissioning	3	2	6	2	6
Critical programme dates are unrealistic	5	1	5	1	5
Construction noise and vibration to adjacent areas	4	2	8	3	12
Adjacent Contractors and/or developments may result in disruption to construction works.	4	3	12	4	16
Unknown existing services or other unknown obstructions (other than rock) in the ground	4	5	20	5	20
Other on site construction constraints i.e. cars parked in the way of access routes causing disruption/delay.	3	3	9	3	9
Security of people accessing the construction site and causing damage/disruption/delay.	3	2	6	2	6
Delay in/issues with switch over of plant in plant rooms	3	2	6	2	6
Building infrastructure fails following switch over.	4	3	12	3	12
Programme risk to other projects	5	3	15	3	15
Utility providers fall behind programme	5	3	15	3	15
Service diversion routes are not achievable, new routes are required or additional works	4	2	8	2	8
Changes in the construction market	3	2	6	2	6
Brexit implications (e.g. delay in procurement, additional cost)	4	4	16	4	16
Access to hospital plantrooms which will include working with live services and pipework.	3	2	6	2	6
Ground contamination - NW of site (boundary of Telford Road, Laundry building, Estates)	4	4	16	4	16
Scottish Power availability	5	1	5	1	5
HV fails following switchover	5	1	5	1	5
Impact on BRF compliance	4	5	20	5	20
Further Covid restrictions impact the programme	5	3	15	3	15
Covid impacting on key personnel (e.g. self-isolation requirements)	5	3	15	3	15
Total Risk Score:			**486**		**513**
Rank:			**1**		**2**

2.6 Net Present Value

The table below details the indicative whole life costs associated with each of the shortlisted options. For further detail around the determination of the costs see the Financial Case.

The additional assumptions associated with the calculation of the NPV of costs are:

- A discount rate of 3.5% has been used in line with Government guidelines
- The base date for the proposal is 2021.
- VAT and inflation have been excluded in line with Green Book guidance.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.
- No impact on the recurring revenue costs.

Table 7: NPV of Shortlisted Options

Cost (£m)	Option 1 Do Minimum	Option 2 Preferred Solution
NBV whole life capital costs	7.64	8.95
Estimated Net Present Value (NPV) of Costs	**7.64**	**8.95**

2.7 Overall economic assessment and preferred way forward

The table below show the weighted benefit points for each shortlisted option, the NPV of costs and the calculated cost per benefit point. This calculated cost per benefit point has been used to rank the options and identified the preferred way forward.

Table 8: Economic Assessment Summary

Option Appraisal	Option 1	Option 2
Weighted benefits points	619	825
NPV of Costs (£m)	7.64	8.95
Cost per benefits point (£m)	0.012	0.011
Rank	**2**	**1**

The result show option 2, HV re-provision and heating infrastructure extension, is the preferred solution scoring 817 points. Option 2 achieves a higher score due to the high utilisation of the Phase 1 heating plant and associated reduction in aged steam infrastructure.

Table 9: Summary of economic assessment and risk assessment

Evaluation Results	Option 1 Rank	Option 2 Rank
Economic Appraisal	2	1
Risk Appraisal	1	2

Option 2 is the preferred solution, although there are marginally higher associated risk. The higher risk is due to option 2 covering the entirety of the option 1 scope, with inclusion of additional works.

3 The Commercial Case

This Commercial Case outlines the proposed commercial arrangements and implications for the Phase 2 Infrastructure Works at the Western General Hospital, by responding to a series of questions set out in the SCIM Outline Business Case guidance.

3.1 Procurement Strategy

3.1.1 Procurement route

To deliver the project in accordance with current NHS Scotland construction procurement policy, it was decided that **Frameworks Scotland 2** would be the preferred option via traditional capital funding. The criteria for selecting this route is that the project is a health project with an investment greater than £1m.

This procurement route appoints a single contractor to act as sole point of responsibility for the management and delivery of an integrated design and construction project on time, within budget and fit for purpose. The Framework is procured and managed by Health Facilities Scotland (HFS) on behalf of NHS Scotland Health Boards.

Frameworks Scotland has been used successfully by NHS Lothian on several projects in recent years and there is a clear organisational understanding of the process for appointment of the Principal Supply Chain Partner (PSCP).

To undertake the process of appointing a PSCP, a 'High Level Information Pack' (HLIP) was issued by NHS Lothian to the HFS PSCP Framework inviting expressions of interest. Four expressions of interest were received by the appointed deadline. An evaluation undertaken after which each of the PSCP's were invited to a presentation and interview. The evaluation and interview panel were made up of representatives from NHS Lothian and Health Facilities Scotland.

A Single Stage bid (Quality / Cost evaluation) was undertaken following which the highest scoring PSCP, which was RMF was appointed. The PSCP provide pre-construction and supply chain expertise through the Outline and Full Business Case Stages to develop a detailed design for the proposed investment, which utilises their construction delivery expertise, and optimises programming to achieve best value from the process.

Phase 1 is being delivered by RMF. The delivery, quality and expertise RMF have brought to the project have been instrumental in the success of the project to date. Significant experience and understanding of site operations, stakeholder relations and work proposed in scope 2 places significant value on maintaining the same team to undertake fulfilment of the heating infrastructure and electrical upgrades.

3.1.2 Procurement plan and timescales

RMF were appointed as the PSCP in December 2018. Since then, RMF and their supply chain have engaged with NHS Lothian to develop a concept design for the full Infrastructure Works and Phase 1 Works. This includes surveys and investigations of the site conditions for the proposed site, to better inform the developing design and the construction cost estimates.

Thomson Gray Partnership has been appointed as the Project Managers and Cost Advisors under the auspices of the Lead Advisor appointment for the WGH Master-planning

3.2 Scope of works and services

The scope of the commercial arrangement with RMF is for the design and construction of the Phase 2 Infrastructure Works to support the Oncology Enabling Works, Renal Projects and Site-wide Energy Infrastructure programme.

The details of the commercial arrangement were clearly set out in the High-Level Information Pack (HLIP) which was issued as part of the procurement competition bid documents, which essentially sets out the Employers Requirements.

RMF have appointed a design team including an architect, principal designer, civil and structural engineer, and a mechanical and electrical engineer. Activity Schedules which list the activities of each member of the Design Team were submitted as part of the procurement competition and formed part of the commercial evaluation.

The scope of works is detailed within the executive summary of the Design Report which is included as Appendix 5. The following items were established in relation to the limitation of what the project is to deliver:

- Scottish Power main incomer relocation from existing laundry, to comprise construction of new SPEN Intake Building west of Estates Building , diversion of existing HV cables from Laundry Intake Room to new SPEN Intake Building. Works required due to aged equipment and enabling of laundry demolition.
- High Voltage electrical works removed from Phase 1. Comprising new HV cables from HV incomer (currently within the Laundry) to new secondary Sub Station (adjacent to Ward 1). Works were not considered critical during phase 1 though were identified as necessary in the short-term.
- The phase 1 heat network was designed to supply DCO and Cyclotron, as part of the initial steam replacement, but was not included within phase 1 due to the complexity and time constraints of the Linac and Renal developments. Utilising the same team has significant benefits in terms of technical and cost implications.
- Steam distribution works to facilitate future alterations and local disconnections in a safe manner that minimises disruptive impacts and large scale shut-downs.

Laundry Demolition

With the demolition of the laundry being considered, the scope could be amended to include these works, but further technical and commercial considerations are required based on;

- Demolition methodology and cost,
- Alternative commercial routes and value,
- Risk level and allocation.

An addendum FBC will be presented following the investigations and appraisal for wider consideration.

3.2.1 Design Quality Objectives/ Design Assessment Process

Due to the project scope of energy infrastructure the NDAP & AEDAT are not considered relevant. We are assessing the design in relation to the connected buildings and relevant policy, including the Scottish Government Climate Change Policy.

There are no relevant standards, but the proposed solution is designed to match the needs and assessments required at a building level of the connected sites.

3.3 Risk allocation

Risk will be allocated to the party best able to manage it, subject to the relative cost, and the degree to which risk transfer optimises value for money. A priced risk register has been developed and this will continue to be developed through development of the RIBA Stage 4 design and Full Business Case. This will include construction stage risks following Risk Review workshops by the project team.

An appropriate allocation of risk will be made to both the PSCP and NHS Lothian (as the Employer) based on the ability to manage each individual risk. The process of risk apportionment will be completed in advance of agreeing a Target Price contract with RMF. Where risks are allocated to the PSCP, a priced risk allocation will be included within the target price. A PERT analysis will be used to derive risk values for the risk register.

Project risks will be managed by the project team using the processes and Contract Administration Toolkit as set out in the NEC contract documents. Consideration of the NEC contract option is expected, phase 1 was originally priced using an Option C Target Price Contract, a proposal was submitted from the PSCP to undertake the works under an Option A contract which placed greater risk on the contractor and provided an upfront £150,000 saving. The project Lead Assessors, Thomson Gray, supported the assessment and through discussion with Capital Finance and Capital Planning members of the programme board the Option A contract was agreed.

Any such proposals will be reviewed and considered as and when appropriate.

Table 10: Risk allocation

	Potential allocation of risk		
Risk Category	Public	Private	Shared
Client / Business risks	100%	0%	
Design	0%	100%	
Development and Construction	25%	75%	V
Transition and Implementation	60%	40%	V
Availability and Performance	0%	100%	
Operating	100%	0%	
Revenue	100%	0%	
Termination	100%	0%	
Technology and Obsolescence	50%	50%	V
Financing	100%	0%	
Legislative	50%	50%	
Other Project risks	100%	0%	

3.4 Payment structure

The payment structure is dictated by the terms of the chosen contract, which under Frameworks Scotland 2 is the NEC contract. The Project Manager is accountable, and the Joint Cost Advisor is responsible for determining via assessment, the amount due for payment at monthly intervals. The monthly assessment process will be undertaken in line with the NEC3 process. The Stage 2 contract between NHS Lothian and RMF will be an Option C Target Price contract. Option C is a target price paid monthly up to the target cap (adjusted for Compensation Events).

The following overview of the process is based on the Monthly Assessment Process for an Option C Target Price contract.

The Cost Advisor will review the PSCP's application and prepare a recommendation for the payment based upon the Project Manager's assessment of completion and the Supervisor's review of defects. This should be undertaken within 5 days of receipt of the application. The validated application requires to be certified by the Project Manager within 3 days of receipt of the validated application. Once certified the Project Director must within 2 days approve the certified valuation and forward to NHS accounts. NHS accounts will make payment to the PSCP within 14 days of the approved, certified valuation. The overall payment period should be within 21 days of the PSCP's application for payment. The Cost Advisor will:

- Perform assessment duties including, assess the price of work done to date (PWDD) through the validation of records of Defined Cost submitted by the Contractor and compliance with the Schedule of Cost components, take site particulars as necessary; assess progress against programme and liaise with the Project Manager to determine any disallowed costs that may apply.
- Agree with the contractor the amount due and report same to the Project Manager.
- Review the PSCP's assessment application
- Prepare assessment documents and certification for issue by the Project Manager.
- In addition to the above, NHS Lothian have requested that as part of the main application and assessment process, the PSCP tracks and reports on payment to sub-contractors (including timescales of payment).

3.5 Contractual arrangements

Frameworks Scotland 2 embraces the principles of 'collaborative working' to ensure that teams within and between the public and private sectors work together effectively. Collaborative working is defined as a relationship between purchasers and providers of goods and services throughout the supply chain, based on mutual objectives, maximising the effectiveness of each participant resource while continually seeking continuous improvement. This approach is designed to deliver ongoing tangible performance improvements due to repeat work being undertaken by the supply chains.

3.6 Type of Contract

To achieve the objectives outlined above, the Framework adopts an NEC3 form of contract. The principle objective of an NEC3 contract is to engender a collaborative working approach by creating an open, cooperative, non-adversarial team approach to managing the contract.

It is anticipated that the PSCP and Employer will agree to utilise an 'Option C: Target Price' contract for Stage 2 Construction. This contract has been successfully utilised by NHS Lothian on projects under both Frameworks Scotland 1 and Frameworks Scotland 2.

NEC3 encourages the use of the contract as a management tool, and this is facilitated through the use of the Health Facilities Scotland Contract Administration Toolkit (CAT), which is a series of pro-forma which if used effectively enable contract parties to comply with contract clauses. Key features of the NEC contract include:

- The contracting parties are encouraged to 'work together in a 'spirt of mutual trust and harmony', as partners in an open and transparent approach,

- To ensure this partnering approach is maintained, there is a 'Gain/Pain share' mechanism to incentivise the delivery team, by rewarding good performance and penalising poor performance
- A clear and transparent process is in place to enable negotiation and agreement of cost
- A level of 'price certainty' is determined
- All price thresholds are set using quantitative risk analysis

A key principle of the NEC3 Option C contract is the payment of 'Defined Cost' and an open book accounting philosophy. These require a robust, reliable and transparent system to record staff time and manage the invoicing process.

3.7 Key Contractual Issues

As outlined previously, NHS Lothian and RMF are entering into an NEC Option C Target Price contract for the design and construction of the Centre for Health Sciences 2. NHS Lothian experience with managing construction projects under the HFS Frameworks Scotland 2 will enable the management of the construction risks through proactive management of the NEC contract.

The contract duration is set out in the master programme, key milestones are tabled below.

Table 11: Contract Milestones

Milestone	Date
Conclude Phase 1 RIBA Stage 4 design	January 2021
Issue Target Price Report	March 2021
Construction Start	May 2021
Construction Complete	June 2022

The key roles and responsibilities under this contractual arrangement are set out in Table 12 below.

Table 12: Contractual Roles and Responsibilities

Name	Role	Responsibilities
Jane Hopton	Employer - NHS Lothian (Project Director)	Project oversight and lead on governance.
Daniel Mill	Employer – NHS Lothian (Project Manager)	Lead role for communicating with the Contractor and Project Manager, reporting to the NHS Lothian project board.
Anna Daley	Contractor – RMF (Framework Manager)	Delivery of the construction project on behalf of the Contractor.
Andy Somerville	Contractor – RMF (Project Lead)	Delivery of the Construction Project on behalf of the Contractor.
Ian McGregor	Project Manager – Thomson Gray	NEC Contract Administration on behalf of NHS Lothian.

Rod Shaw	Joint Cost Advisor – Thomson Gray	Assessment of payment applications and construction costs relating to Compensation Events. Working with the Contractor to finalise the Target Price.

The NEC Contract includes standard clauses to deal with any disputes that may arise in the event of failure of any of the parties to the contract.

3.8 Personnel Implications

NHS Lothian have involved a wide cohort of stakeholders throughout the development of this project, including attendance at Design Review, Progress and Steering Group Meetings. There are no contractually based personnel implications arising from the proposed investment.

4 The Financial Case

The Financial Case considers the affordability of the scheme. This section sets out all associated capital and revenue costs, assesses the affordability of the preferred option and considers the impact on NHS Lothian's finances.

4.1 Capital Affordability

The estimated capital cost associated with the preferred option(s) is detailed in the table below. Construction costs were provided by independent quantity surveyors.

Table 7: Capital Costs

Capital Cost (£m)	Preferred Option – Costs at OBC
Construction	6.71
Professional Fees	1.00
Estates Charges	0.20
Other fees and charges	0.08
Risk Allowance	1.05
Project Team Costs	0.04
Total Cost (excl VAT)	**9.08**
VAT	1.64
Total Capital Cost	**10.72**

The key assumptions made in the calculation of the capital costs are:

- Optimism bias (risk allowances) included at 15% of construction and professional fees' costs
- Preliminaries have been included at 15%
- No inflation allowance has been included as construction timeline assumed on site 2021 to 2022
- VAT has been included at 20% on all costs. Some VAT recovery has been assumed on PSCP Mark-up & Professional Fees to be confirmed with VAT advisors.

Capital costs are proposed to be funded from the specific allocation from the Scottish Government.

4.2 Revenue Affordability

The estimated recurring incremental revenue costs associated with the preferred option(s) are detailed in the table below. These represent the additional revenue costs when compared to the 'Do Nothing' option.

Table 17: Incremental Revenue Costs

Incremental Revenue Cost/Year (£m)	Preferred Option
Depreciation	1.07
Total Annual Revenue Cost	**1.07**

The assumptions made in the calculation of the revenue costs are:

- Depreciation is based on a useful life of 10 years and assumed to be funded from the existing NHS Lothian Depreciation funding allocation
- A reduction in maintenance and reactive costs for local steam system
- Increased efficiency of new heating system
- Reduction in backlog maintenance

Further investigation to be undertaken prior to FBC.

4.3 Overall Affordability

The capital costs detailed above are anticipated to be funded through traditional capital funding and it is anticipated this will be provided by a specific allocation from the Scottish Government.

Funding has been identified for the additional revenue costs from the existing NHSL depreciation budget and this has been reviewed and agreed by the Finance Business Partner.

This project has been prioritised by NHS Lothian and the estimated costs noted above will be included in the NHS Lothian Property and Asset Five Year Investment Plan. All costs will continue to be refined through the FBC process.

4.4 Confirmation of stakeholder support

The costs include in this proposal and the funding noted have been supported by the relevant finance business partner. In addition the works proposed in this OBC will continue to be reviewed and approval requested by the NHS Lothian governance structure including:

- WGH Masterplanning Group
- WGH Hospital Management Group
- Acute Senior Management Team
- NHS Lothian Capital Investment Group
- NHS Lothian Finance and Resources Committee

5 The Management Case

5.1 Project Management

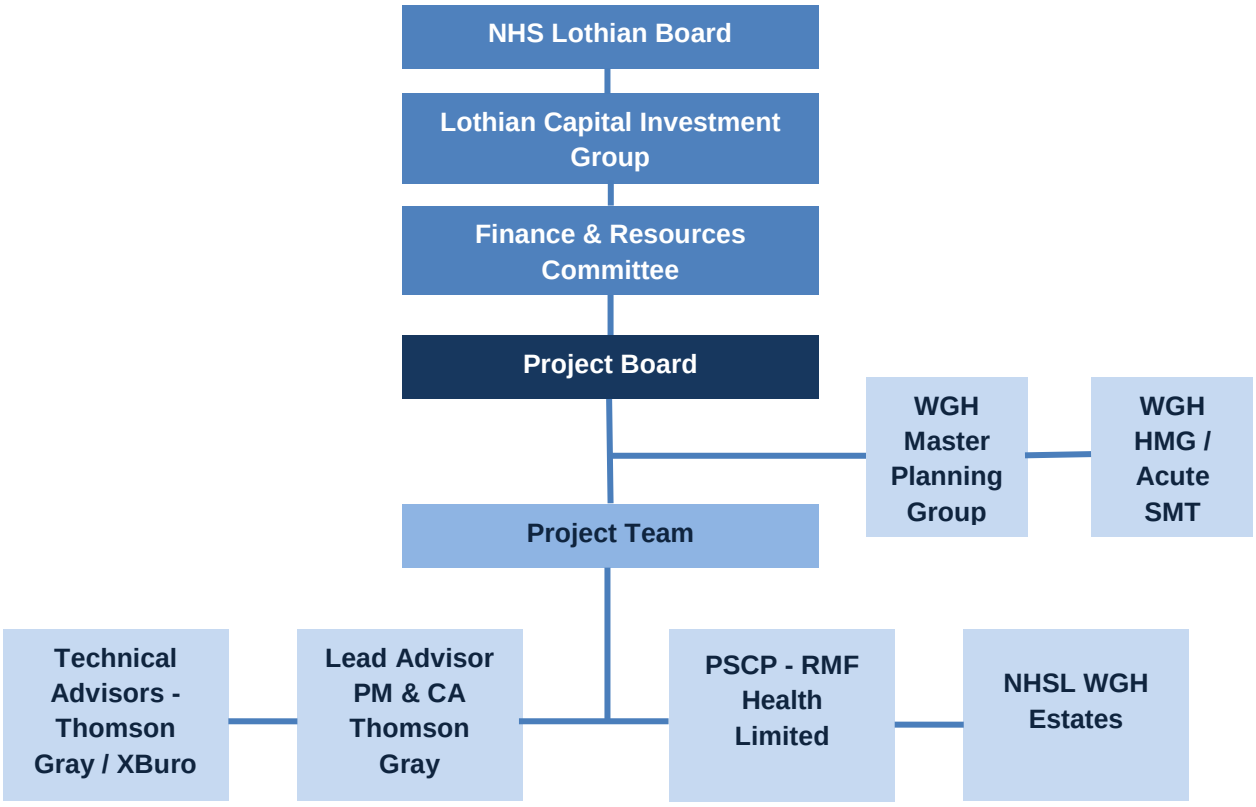
5.1.1 Governance arrangements

The proposed project organisation and governance arrangements are set out in the diagram below. The diagram currently includes Framework Scotland team, where much of the team including external suppliers are already in place.

Those individuals identified within the governance diagram outlined below have been involved in developing this OBC and they will continue to be involved in leading the project through subsequent stages of the project providing continuity and a stable environment for the project to achieve its objectives.

A blend of resources will be utilised to deliver this project. The Project Board, Project Director and Stakeholders will be internal resources, whilst the Project Manager, Cost Advisor, PSCP (Contractor) and Design Team will be provided by external organisations who have already been procured to deliver a wider programme of work at the Western General Hospital. The Board has used this blend of resource successfully on other projects and feels that it creates a good balance between control, risk transfer, capability and availability. The Board is experienced in delivering projects of this nature within the selected procurement route and is ready to move the project forward to the next stage upon approval of the OBC.

The diagram below shows the organisational governance and reporting structure that will be in place to take forward the proposed solution.



Prior to project commencement a detailed Project Execution Plan (PEP) will be developed.

It will describe who does what and how, defining the policies, procedures and priorities that will be adopted. The PEP will be produced by the Lead Advisor project manager in collaboration with the NHSL Lead and Project Owner. In the first instance, it will be based on information contained in the project business case and the strategic brief, but will be developed to consider and include (where relevant):

- Project definition and a summary of the strategic brief or later the project brief.
- Drawings insofar as they are developed at this stage.
- Project programme
- Cost plan, cost management and accounting procedures.
- Contracting and procurement strategy
- Roles, responsibilities and authorities
- Monitoring and reporting strategies
- Potential consultations / stakeholder management
- Communications strategy and standards
- Risk assessment and risk allocation
- Strategy for obtaining planning permission and other permissions.
- Health and safety strategy.
- Environmental / Sustainability strategy.
- Quality assurance strategy
- Soft landings strategy, including business change and staff training requirements, commissioning, handover, migration, aftercare and post occupation evaluation strategy.
- Operational strategy
- Equipment requirements (inside or outside of the building contract)
- Unusual or long-lead items.

As described above the Project Reporting will be developed within the PEP, but as a minimum will include the Project Owner will provide regular reporting to the following relevant groups;

Group	Timescale
Energy Infrastructure Board	Electronic report submission – Monthly Formal meeting – Monthly / Quarterly as required.
WGH Masterplanning Group	Attendance and update at quarterly meetings
LCIG	Quarterly update
Cancer Capital Programme Board	Quarterly update

Reports will provide updates for the following sections:

- Executive summary headlines for the following key issues
- Health and safety issues
- List of keys activities past/next month
- Programme and performance
- Financial issues
- Risk and issues requiring escalation

5.1.2 Key roles and responsibilities

This section sets out the framework for decision making, reporting, change-management and resources to provide the NHS Board and executives with sufficient assurance.

The table below notes the project Board that will be responsible for taking the project forward including details of the capabilities and previous experience.

Table 8: Programme Board

Role	Individual	Capability and Experience
Senior Responsible Officer	Jim Crombie	Senior executive with significant experience in the delivery of complex projects.
Client Director	George Curley	Director of Operations - Facilities
Project Director	**Jane Hopton**	Programme Director, with experience of leading transformational projects within NHSL
Project Owner	**Daniel Mill**	NHSL lead on energy and technical sustainability. Over 15 years of building engineering experience and knowledge of energy systems.
Campus Leadership Representative	TBC	
NHSS Sustainable Lead	Kate Dapre	National NHSS lead on sustainability.
Capital Planning	Iain Graham	Director of Capital Planning and Projects
Capital Planning (WGH)	**Colin Adam**	Senior Project Manager leading the WGH Masterplan
Capital Finance Support	**Immy Tricker**	Capital Finance Manager responsible for finance support and advice for capital projects.
Finance Business Partner	Nick Bradbury	Finance professional with over 10 years of experience. Background in analysis and evaluation of large projects.
Estates WGH Area Manager	**Jamie Ramsay**	Sector Estates Manager with years of experience and expert knowledge of WGH
Strategic Planning	Catherine Kelly	Strategic Programme Manager with experience of supporting the delivery of capital and strategic programmes

The programme board will provide guidance, undertake key decision making (such as dispute, derogations, approvals of scope change and review of progress) in support of the main project members. The following table provides detail of the core project team including internal and external resources.

In recognition of the scale and needs of phase 2 in the context of the site-wide infrastructure programme of works, it is proposed that attendance of the programme board needs to reflect the level of governance required in relation to the activities. The full board will be required for key milestone events, significant programme issues and site-wide development, but a smaller core group is considered pertinent to the intermediate needs during project delivery of phase 2. All members will be issued with regular update reports to maintain awareness and assurance.

Table 9: Project Team

Capacity	Individual	Role	Capability and Experience
Lead Project Manager (internal)	Role to be appointed		Requirement for project manager with relevant engineering experience and delivery experience
NHSL Estates	David Williamson	HV AP	Expert subject and site knowledge. Responsibility for the control, operation or maintenance of installed high voltage systems.
NHSL Estates	Chris Whitecross	Sector Estates Manager	Operational manager for estates, provides key role in facilitating on-site support through-out project and taking operational ownership.
Lead Advisor - Thomson Gray (External) - PM	Ian MacGregor	NEC3 Contract Project Management	15 years' experience in delivering complex projects and leads Thomson Gray's Project Management Team. PM for Phase 1
Lead Advisor - Thomson Gray (External) - CA	Rod Shaw	NEC3 Contract Cost Advisor	Over 30 years' experience in the Construction industry in Quantity Surveying.
Primary Supply Chain Partner - RMF (External)	Andy Somerville	PSCP – Lead Contractor	A highly experienced project expert with a proven track record of success and delivery within Construction
Consultant - Hulley & Kirkwood (External)	Michael O'Donnell	Lead mechanical building services design expert	Director of Edinburgh office and has been Team Leader for a number of major high profile projects with extensive experience in Health Care.
Consultant - Hulley & Kirkwood (External)	David Stewart	Lead electrical building services design expert	Director of Edinburgh office with 30 years' experience. Team Leader with responsibility for the design and specification of electrical services, including high-voltage and low-voltage distribution systems
Technical Advisor – Xburo (External)	Tom Brady	Technical Assurance for M&E design, delivery and commissioning	Tom has 35 years of design experience and provides assurance services throughout the design, construction and commissioning stages to ensure quality and compliance delivery.
Technical Advisor – Thomson Gray (External)	Ged Gowan	Technical Assurance for Civil engineering design, delivery and commissioning	Director responsible for Building Surveying and Health and Safety services with over fifteen years' experience. Accredited NEC Project Manager & Supervisor
Technical Advisor – RMG (External)	Ian McGregor	Asbestos Expert	Asbestos management expert consultant used by NHSL.

5.1.3 Project plan and milestones

The table below includes a summary of the key project milestones and dates. A full project plan is included in Appendix 6: Project Programme.

Table 15: Project Timetable

Key Milestone	Date
Initial Agreement approved (Site wide Energy Infrastructure)	December 2018
Appointment of Principal Supply Chain Partner (PCSP)	December 2018
Agreement to develop OBC at LCIG	May 2020
Submission of OBC to LCIG	February 2021
Submission of OBC to F&R*	March 2021
Programme Board – FBC Review*	April 2021
Submission of FBC to LCIG*	April 2021
Submission of FBC to F&R*	March 2021
Full Business Case approval*	April 2021
Construction starts*	May 2021
Construction complete*	June 2022

* *Pending approval to proceed from previous milestone*

5.2 Change Management

The works undertaken as part of the phase 2 energy and infrastructure project will alleviate pressure on the existing steam network. This should reduce the operational requirement and risk of this section of the network. The reduction in the steam system which currently requires specialist technical knowledge and support will reduce the overall site pressure on reactive maintenance to this system.

Re-provision of the Electrical HV incomer and new sub-station will reduce risk of failure and risks associated with current equipment located with the laundry building.

A management plan will be prepared for the ongoing maintenance and repair of the proposed plant and distribution network installed as part of this phase including the integration with the site wide infrastructure replacement in the future.

5.2.1 Engagement with Stakeholders

The table below summarises the stakeholders impacted by this proposal and the details of the engagement that has taken place with them to date. This is followed by the stakeholder engagement and communication plan.

Table 16: Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
WGH Masterplanning Group	Attendance at Master-planning Group, with presentation of scope and impacts planned for next meeting. Masterplan Project Manager included in monthly project meetings throughout design stages.	Endorsement of proposals on an incremental basis and included in meeting minutes including further actions required and relevant ownership.
WGH Energy Infrastructure Board	Meetings including presentations and updates of phase 1 construction.	Scope endorsed.
Staff / Resources	Staff potentially affected by this proposal include clinical, non-clinical support, Estates, FM, Capital Planning, Finance and also volunteers working on site. The impact the proposal has on them varies depending on job function. There are not likely to be implications for the structure and design of the Hard FM workforce.	A partnership representative will be invited to join the project board. There will be appropriate consultation with staff during the development of the business case when the potential impact on staffing and roles is better defined.
General public	The general public will be affected by this proposal. Due to the nature of ongoing projects and the requirements to develop a contextual statutory planning framework for the site, there have been wide ranging consultation and community engagement events both on the site with stakeholders and off site with the wider public and community.	Support statement to be confirmed based on outcomes from proposed engagement at OBC stage. A Place brief has been developed further to public consultation events and has been adopted by the council as non-statutory guidance for the site development.
Other key stakeholders and partners	University of Edinburgh as a strategic site partner have been involved in various meetings and including the WGH Masterplan Group	Confirmed support for this proposal has been gained through the masterplan PM, further meetings will be arranged prior to FBC.
WGH Energy Infrastructure Group and wider stakeholder group	Overall energy infrastructure proposals discussed, reviewed and challenged as part of the wider engagement. The enabling phase works were reviewed in the context of the pathway to carbon neutrality for the overall site.	The participants agreed on the solutions being developed and further development of the options will be undertaken in conjunction with procurement issues.

NHS Lothian's strategic plan - Our Health, Our Care, Our Future – 2014-2025 was widely consulted on across the communities of Lothian in 2014 with the Western General Hospital a main part of that vision for health service delivery.

A detailed site masterplan has been developed over the past four years and an associated energy infrastructure feasibility study is now in place. This strategic development framework proposal for the site is currently supporting NHS Lothian's early dialogue with the City of Edinburgh Council Department of Planning. A Place Brief (flexible development brief) is being prepared to inform the context for forthcoming planning applications. Integral to the brief has been the local community and stakeholder engagement public events.

NHS Lothian are developing a consultation and stakeholder engagement plan, with the Council and other stakeholders, and this will also form the basis of both statutory community engagement and ongoing consultation protocols.

Engagement will seek to reflect Scottish Government Good Practice. As part of the 150th Anniversary of the WGH, several initiatives are running to promote the hospital generally which will also be used for community engagement around its future development. Clearly the Energy Centre and associated infrastructure play a huge part in that and as such will be included in that process.

Implementation of the masterplan has commenced with a contractor taking forward a number of early projects which will include infrastructure works. Community engagement, as part of the planning application process for these projects, will also take place promoting the benefits to the community of the wider site proposals.

The WGH Master planning group comprises a wide range of over 40 NHS Lothian key staff including clinical leads, services managers, Capital Planning, Facilities Management (FM) and Estates staff. In addition, there is representation from the University of Edinburgh and other site users such as the Maggie's Centre.

This group have been fully involved through meetings and briefing papers in the evolution of the masterplan site development framework including the energy infrastructure strategies and feasibility study development to align with the masterplan.

There has also been a smaller infrastructure group comprising of NHS Lothian Estates and FM staff, Capital Planning, Finance and external supporting consultants involved in further refinement of the energy infrastructure strategy and associated options for the site and including more detailed work supporting this OBC.

A range of key issues have been raised through involvement of all these stakeholders and these are reflected in this OBC and particularly in respect of current service arrangements and the facilities assets that support them.

5.3 Benefits Register and Realisation Plan

The investment objectives and the Strategic Assessment (see Appendix 1: Strategic Assessment) have informed the development of a Benefits Register (see Apendix 2: Benefits Register and Realisation plan).

Per the Scottish Capital Investment Manual guidance on `Benefits Realisation`, this register is intended to record all the main benefits of the proposal and also includes a full Benefits Realisation Plan detailing how the benefits will be realised and measured.

5.4 Risk Management

Risks are managed consistently across the project via a risk management strategy that is in line with the HFS Framework requirements, industry best practice and learning from recent and ongoing projects.

NHS Lothian and the project team recognises that all projects involve risk that needs to be identified and pro-actively managed to ensure that the project successfully meets its objectives, and that these risks are heightened when undertaking works within a live acute hospital environment.

Project risk is managed within the project team and led by the Project Owner. A project risk register is used to record and manage all risks associated with the project and it is a key part of the project's control processes. It is maintained as a live document which is referred to by all members of the project team and continually updated. The Risk Register is consistent with the HFS guidance and adopts a "traffic light scoring system".

The project Risk Register will be developed as the project progresses through the design stages. It will be appended to FBC before final approval by LCIG. The risk highlighted have been developed against the three following themes;

- Finance - Capital and revenue funding related risks
- Delivery - Risks associated with the deliverability of the project
- Technical - Risks with the technical aspects of solutions proposed

The table below highlights key strategic risks that may undermine the realisation of benefits and the achievement of the investment objectives. These are described thematically and potential safeguards and actions in place to prevent these.

A full risk register is included in Appendix 3: Risk Register.

Table 17: Strategic Risks

Theme	Risk	Safeguard
Finance	Failure to meet the SG requirements for funding through the business case process	Manage the business case process and dialogue with SG CIG
Finance	Funding restrictions from two sources may constrain the ability to realise the full potential of the Investment Objectives.	Alignment of dialogue regarding funding and business case development with SG and other acceptable providers / enablers / frameworks

Theme	Risk	Safeguard
Delivery	Phasing the programme may cause operational issues in terms of parking, pedestrian routes and traffic management.	Create realistic phasing steps and demonstrate temporary operational solutions.
Delivery	Risks associated with working in a live environment.	Create realistic phasing steps in respect of each part of the programme. Ensure relevant surveys are carried out and existing data is made available.
Delivery	The facilities do not have flexibility to respond to future changes in technology.	Ensure that this Investment Objective is realised through the design development and acceptance process.
Delivery	Limited capacity in respect of site utility supplies.	Through prior engagement the indication is that there is sufficient capacity in the network to serve demand at the site. Maintain an ongoing dialogue with the suppliers. Technical proposals will reduce grid demand.
Technical	Inadequate / inappropriate planning of design development and delivery approach.	PSCP contractor on board to support early planning and continuity of suitable engineering design consultants on that team.
Technical	Limited renewable technologies that can be effectively installed impacting ability to meet energy consumption and carbon reduction targets.	Identified and developed Low Carbon Option already developed limits the risks with a sustainable and available resource together with proven innovative technology to extract.

5.5 Commissioning

Commissioning of the works is predominately a technical function to set the new plant into operation, as defined by the designers' requirements, and relevant technical standards. A project specific commissioning plan will be developed by the contractors commissioning manager, which will be made available to the project team.

Technical Advisors, XBuro, have been appointed at project commencement to carry out an initial design review and will support the project through construction, commissioning and handover. This role is appointed directly and provides technical assurance to the Board, with specific tasks to; monitor, review, witness and collate all commissioning documentation.

In accordance with NEC3 contract requirements formal handover is reliant on acceptance by the Technical Advisor.

Additionally the local estates team, including relevant Appointed Person's (AP's), and engineering teams are invited for regular site inspections throughout construction and any witnessing, demonstrations and handover documentation will be made available.

5.5.1 Reporting Structure

The commissioning process will be treated as a distinct work stream, but fully integrated into the overall project to enable a smooth transition to the new working arrangements and realisation of the anticipated benefits.

Technical Advisor's (TA) role will sit between the Project Manager and PSCP. This will allow the TA to engage with the PSCP and their supply chain members whilst providing a reporting and escalation route to the Project Manager. Refer to Section 5.1.1 where this structure is set out within the organogram.

The TA will also form separate links with relevant NHS Lothian Stakeholders. This will enable Client direct commissioning tasks to be planned and managed. Such tasks will relate to post-handover commissioning.

5.5.2 Appointed Person

The TA has been appointed at the project outset, to undertake technical review of all stages. Thomas Brady, of XBuro, has over 35 years of building services engineering experience, and provides services to a range of Healthcare projects across NHS Lothian and other Scottish Boards. His experience and knowledge covers; Buildings Standards, Health Technical Memorandums (HTM's), Scottish Health Technical Memorandums (SHTM's) and sector specific guides.

5.5.3 Key Stages

Key stages in respect to the commissioning process are noted below together with approximate timescales (subject to OBC approval).

Full Business Case	
Appoint Technical Advisor	November 2020
Develop a Commissioning Requirement Brief	December 2021
Develop a full Commissioning Master Plan	January 2022
Construction and Handover	
Oversee commissioning in respect to the contract works	June 2022
Oversee commissioning in respect to client direct activities (post-handover)	July 2022

5.5.4 Resource Requirements

As noted earlier there is a requirement to identify a suitable resource via an internal appointment. This may be one individual or two individuals to support technical and clinical commissioning activities.

5.6 Project Evaluation

The Project Owner will be supported by the Project Team in managing and monitoring the project's progress against the agreed programme, quality of the works against the agreed specification and plans and delivery of the project to the approved Business case target cost and overall budget.

The project will be subject to robust arrangements for the measurement and verification of benefits. Remedies for underperformance will be included in the contract. Integration with the enabling projects programme of works will be key to the evaluation of the project. The evaluation measures and methodology will be developed in conjunction with the enabling programme of works and detailed in the

Full Business Case. Any role required for the evaluation will be fulfilled from within the existing team profiled in section 5.1.2.

A final report and presentation will be submitted to all relevant governance groups on completion of the project. The report will provide the sections:

- Executive summary headlines for the following key issues
- Health and safety issues
- List of keys activities past/next month
- Programme and performance
- Financial issues
- Risk and issues requiring escalation

A full Project Evaluation Plan will be presented in the Full Business Case.

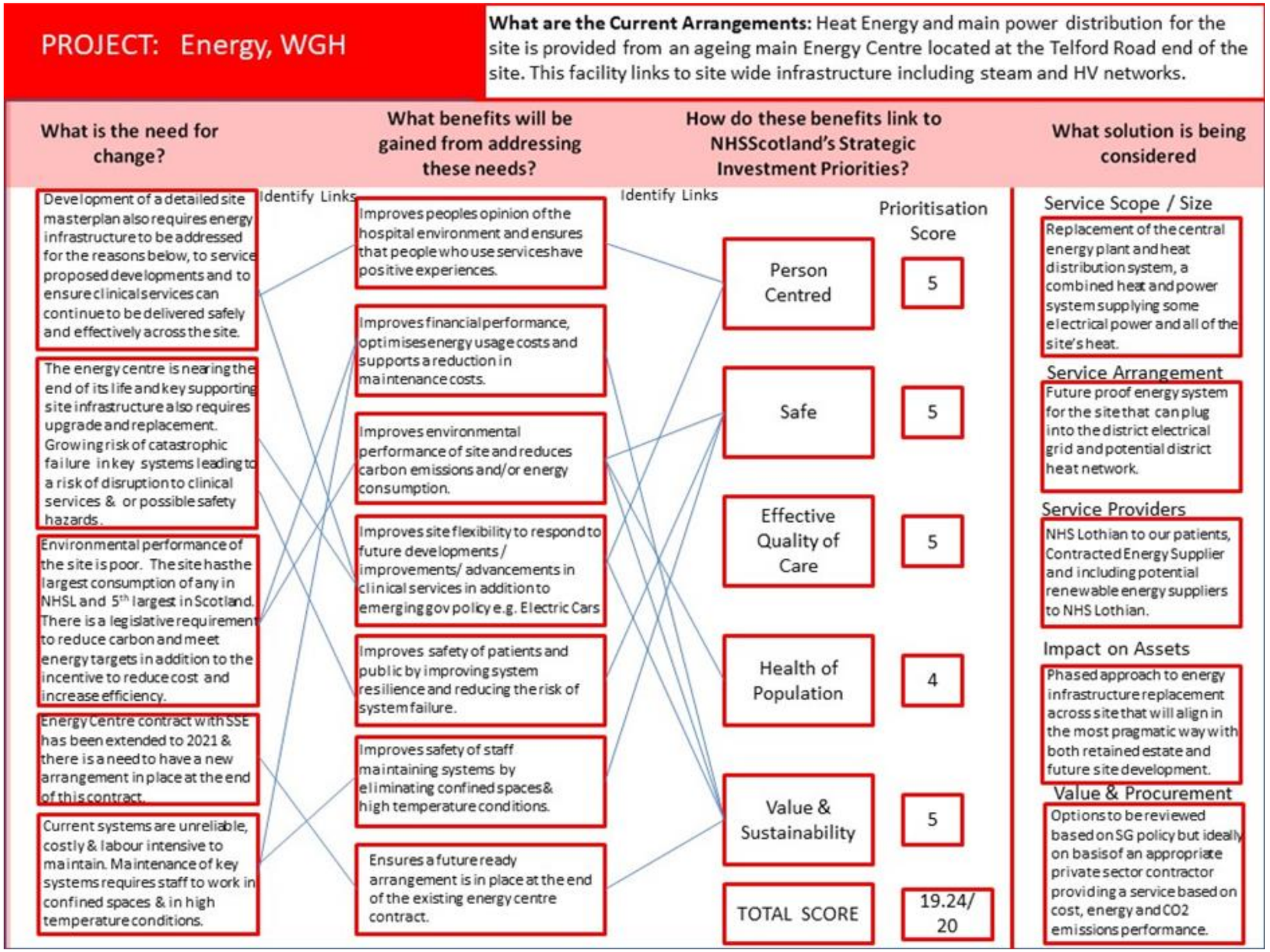
6 Conclusion

The Strategic Assessment for the site-wide energy infrastructure has a 19.24/20 priority score. There has been no alterations necessary from the evidence gathered in the production of this complementary OBC.

The works detailed in this document, entirely relate to the immediate clinical needs requiring the Oncology Enabling projects. Based on the objectives identified, the following key points should be recognised;

1. This phase in the energy infrastructure is required to maximise the reach of the investment in the new boiler and District Heat (DH) network installed in Phase 1 of the Energy Infrastructure Works and secure the power supply to the site in the context of the Phase 1 Masterplanning Works
2. Aligns with Oncology Enabling Works programme to provide heat and power to new and refurbished buildings, by matching increased loads and altering existing service routes.
3. Improves the safety of patients and public by increasing resilience and reducing the risk of failure associated with steam and power systems.
4. Minimises future disruption to Phase 2 zone, the proposed solution has considered the site wide strategy and is designed ready for future integration.
5. Phase 2 solution does not prejudice future site flexibility to future developments and emerging Scottish Government policies.
6. Improves safety by eliminating confined spaces & high temperature conditions for maintenance.

Appendix 1: Strategic Assessment



Apendix 2: Benefits Register and Realisation plan

Project Name												
1. Benefits Register						*2. Prioritisation*	*3. Realisation*					
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
1	Improves safety of patients and public by improving system resilience and reducing the risk of system failure.	Qualitatively	Facility monitoring and reporting that addresses operational impacts on facilities, staff, patients and visitors - i.e. availability, etc. Align with staff, patient and public questionnaires.	Minimal system shutdown	No system shutdown through planned maintenance and improved resilience	5 - Vital	Public/Patients /Staff	Project team	To improve site operational resilience.	Reduction of existing steam network	Continued maintenance and replacement plan	
2	Improves financial performance, optimises energy usage costs and supports a reduction in maintenance costs.	Quantitatively	Monitoring of energy usage through metering and BMS. Monitoring and evaluation of ongoing costs including backlog reduction through new infrastructure investment.	Minimal system shutdown Current energy use	No system shutdown through planned maintenance and improved resilience Reduction in energy use	4 - Important	NHSL	Project board	To ensure a future ready arrangement is in place at the end of the existing energy supply contract now extended to August 2021.	Procurement options	Discussions with Scottish Government on alternative procurement routes	
3	Improves environmental performance of site and reduces CO2 emissions in line with Scottish Government policy and also reduces energy consumption	Quantitatively	Energy reporting through metering and associated empirical evaluation	Current energy use	Reduction in energy use	4 - Important	NHSL	Project team	Reduce Carbon emissions by investing in low energy/low carbon technologies.	Improvements to building fabric	Adoption of 'spend to save' philosophy with investment in greater than standard specification	
4	Optimisation of phased delivery to the future operational benefit of site users / stakeholders i.e.. Minimise future disruption to phase 1 site zone	Qualitatively	Managed process via PSCP across enabling projects	Minimal disruption to ongoing site operations	Minimal disruption to ongoing site operations	4 - Important	NHSL	Project board	To improve site flexibility and be more future proof.	Projects are briefed to suit future systems	Suitably designed systems to allow expansion and replacement	
5	Phase 1 solution does not prejudice future site wide flexibility to respond to future developments / improvements / advancements in clinical services and also emerging Government policies on management of utilities infrastructure, for example renewables, electric cars	Qualitatively	Use of NHSL project prioritisation process. Capital Planning and reporting and alignment of masterplan with 5 year plans.	Backlog and reactive maintenance and development	Planned development	4 - Important	NHSL	Project board	To improve site flexibility and be more future proof.	Projects are briefed to suit future systems	Suitably designed systems to allow expansion and replacement	
6	Provides a pathway to 2045 Carbon Reduction Target	Quantitatively	Carbon use	Current energy use	Reduction in energy use	4 - Important	NHSL	Project team	Reduce Carbon emissions by investing in low energy/low carbon technologies.	Improvements to building fabric	Adoption of 'spend to save' philosophy with investment in greater than standard specification	
7	Improves safety of staff maintaining systems by eliminating confined spaces & high temperature conditions.	Qualitatively	Staff and contractor surveys of working practices and operational arrangements through contracts. Health and Safety reporting and record keeping.	Mitigate against dangerous working conditions	Remove dangerous working conditions	4 - Important	Staff	Project team	To improve safety of staff maintaining systems	Phasing of projects to allow de-steam	Integrated site development team	
8	Future ready arrangements to replace SSE Contract	Qualitatively	Contractual arrangements and associated performance measurement to KPIs.	Current service contract	Extension of contract or provision of new contract	1 - Fairly insignificant	NHSL	Project board	To ensure a future ready arrangement is in place at the end of the existing energy supply contract now extended to August 2021.	Procurement options	Discussions with Scottish Government on alternative procurement routes	
9	Minimises sunk costs for wider site infrastructure	Quantitatively	Lifecycle of plant maximised via phasing to ensure maximum use	Reactive repairs and service outages	Planned maintenance and replacement programme and no unplanned service outage	3 - Moderately important	Public/Patients /Staff	Project team	To improve site operational resilience.	Reduction of existing steam network	Continued maintenance and replacement plan	
10	Minimise environmental impact regarding sound and emission production for adjacent clinical areas and neighbours	Quantitatively	Environmental monitoring as required by local authority	Current background value	Limit any increase to below the required threshold defined by the local authority	5 - Vital	Public/Patients /Staff	Project board	To improve the site users' experience.	Development of proposals to minimise plant	Discussions with local authority on acceptable levels	

Appendix 3: Risk Register

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
D1	Delivery		Client changes to Brief or design after the project has started	3	3	9	Ensure that the brief is solid to begin with. Ensure appropriate governance is in place to control change through an agreed process. Secondary substation location to be agreed.	3	2	6	NHSL		Feb-21
D2	Delivery		Access to part of the site delayed. PSCP not given access to part of the site in line with contract.	2	4	8	Regular meetings with appropriate stakeholders. Micro-programming of key areas.	2	3	6	NHSL		Ongoing
D3	Delivery		The employer does not approve RAMS, access requirements or other similar items in time	2	4	8	Regular meetings with estates and look ahead programmes. Early submission of RAMS to allow ample time for review.	1	4	4	NHSL	PSCP	Ongoing
D4	Delivery		Instruction given to stop / not start the work. Hours of work will be circa 07:30 to 17:00 - risk that out of hours work will be required to progress some works.	3	4	12	Could be due to noise etc. Construction strategy and communication strategy to continue to be reviewed as required (particularly with adjacent buildings to planned works e.g. theatres, BRF).	2	4	8	NHSL		Ongoing
D5	Delivery		The PSCP encounters physical conditions which they could not have foreseen.	3	5	15	All relevant surveys and investigations to be undertaken during preconstruction and construction phases. Additional trial digs to be undertaken where appropriate.	2	5	10	NHSL	PSCP	Feb-21
D6	Delivery		Asbestos is encountered other than in the steam ducts or laundry building or cyclotron DCO.	3	5	15	Early identification and testing of suspect pipework.	3	5	15	NHSL	PSCP	Feb-21
D7	Delivery		Issues leading to design development.	3	3	9	Ongoing coordination. Regular design team meetings ongoing. Xburo appointed earlier within the process to help ensure design is mature.	2	3	6	PSCP	-	Ongoing
D8	Delivery		Clashes in different project coordination/design leading to design development.	2	4	8	RMF leading on all projects (including common design team). Ongoing coordination. Regular design team meetings ongoing.	2	3	6	PSCP		Ongoing

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
D9	Delivery		Poor sub-contractor performance leading to poor quality and or delay.	2	4	8	PSCP to select suitable subcontractors from their supply chain. PSCP appointed same team as used on Phase 1.	1	4	4	PSCP		Ongoing
D10	Delivery		Traffic issues including public safety / interface	5	3	15	Plans to be agreed in advance of specific construction elements. Engagement with NHSL Traffic Management Group and Gordon Fender ongoing and regular updates to be provided. Methodology workshops to be arranged if required. Mini-programmes to be created for certain tasks for clarity.	2	3	6	NHSL	PSCP	Mar-21
D11	Delivery		Adverse publicity, lack of communication with all involved parties	2	4	8	Project is unlikely to involve much external publicity/communication. Internal communication to be managed. NHSL PR Plan/Storyboarding being prepared. Internal Logistics meetings/workshops. Information to be issued to surrounding neighbours to continue engagement.	1	3	3	NHSL	PSCP	Mar-21
D12	Delivery		Delay in handover due to number of defects.	1	5	5	Ensure that quality control is in place including an NEC3 Supervisor. Regular site walkarounds with NEC3 Supervisor and NHS Estates ongoing. RMF are conducting internals checks and sign offs.	1	5	5	PSCP		Ongoing
D13	Delivery		Problems with contractor's access/deliveries to site.	2	3	6	Construction phase plan to be developed. Traffic management plan and Covid mitigation actions forwarded to suppliers.	1	3	3	PSCP		Mar-21
D14	Delivery		Delay in building warrant and planning	2	4	8	Oberlanders have applied for building warrant and planning - outstanding clarification responded to, with CEC to approve. CEC to be invited to site to review the works and sign off. RMF to continue with works which do not require a warrant or planning application to be approved.	1	2	2	PSCP		Apr-21

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
D15	Delivery		HAI SCRIBE Issues	3	3	9	Project wide HAI SCRIBE has been agreed. Individual areas which required specific HAI SCRIBEs to be agreed in advance.	2	3	6	NHSL	PSCP	May-21
D16	Delivery		Supply chain bankruptcy/insolvency	2	5	10	PSCP to select a robust supply chain and ensure that quality is a factor in selection.	2	5	10	PSCP		Ongoing
D17	Delivery		Long lead in periods for materials	2	4	8	To be reflected within the construction programme. Order in advance where possible (e.g. pipework from Denmark ordered and HV switchgear panels). Noted that this should be low risk given the scope of the project. RMF to compile a procurement schedule.	2	4	8	PSCP		Apr-21
D18	Delivery		Health and safety issues leading to delays.	2	5	10	Robust construction phase plan, good site manager and regular H&S audits.	1	5	5	PSCP		Apr-21
D19	Delivery		Risk of services strike/mistakenly cut cable	4	5	20	GPR surveys, hand digs, tracing and protection of cables. Materials available on site to repair damaged services to ensure business continuity.	3	5	15	PSCP		Ongoing
D20	Delivery		NHSL staff not available to isolate services to meet programme.	4	3	12	Procedure and notice periods to be confirmed and established. Isolation protocol to be established between NHSL and PSCP and UoE/SHSC. Micro-programming of switchovers in DCO Cyclotron, HV changeover and other key areas. To liaise with Estates and Scottish Power where required.	2	3	6	NHSL	PSCP	Ongoing
D21	Delivery		Damage/delaps caused through work	3	4	12	PSCP to undertake delap survey and make good as required.	1	4	4	PSCP		Apr-21
D22	Delivery		Business continuity risk caused through security issues - i.e. unauthorised people accessing plantrooms.	2	5	10	Access protocol to be established.	1	5	5	NHSL	PSCP	May-21

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
D23	Delivery		Logistics of working adjacent to live areas and fire escapes.	2	5	10	Construction phase plan to consider and resolve. Ongoing review of changing escape routes and ensuring these are communicated to building users.	2	4	8	PSCP		May-21
D24	Delivery		Incorrect time and cost estimate for commissioning	2	3	6	Commissioning programmes have been issued.	1	3	3	PSCP		Aug-21
D25	Delivery		Critical programme dates are unrealistic	1	5	5	A realistic project programme should be developed from FBC stage onwards which is regularly monitored and reviewed.	1	5	5	PSCP		Feb-21
D26	Delivery		Construction noise and vibration to adjacent areas	3	4	12	Early dialogue required with departments affected to discuss way forward (particularly BRF / UoE).	3	3	9	PSCP	NHSL	Mar-21
D27	Delivery		Adjacent Contractors and/or developments may result in disruption to construction works.	4	4	16	RMF to ensure ongoing communication and coordination. Engage with BRF and UoE to ensure early notice of any planned projects.	2	4	8	NHSL		Ongoing
D28	Delivery		Unknown existing services or other unknown obstructions (other than rock) in the ground	5	4	20	GPR survey completed to route of services. Trial pits completed where known issues may be present.	3	5	15	NHSL	PSCP	Mar-21
D29	Delivery		Other on site construction constraints i.e. cars parked in the way of access routes causing disruption/delay.	3	3	9	Ongoing communication and signage.	2	2	4	NHSL		Ongoing
D30	Delivery		Security of people accessing the construction site and causing damage/disruption/delay.	2	3	6	Precautions must be taken to ensure no unauthorised access. Robust fencing / access controls etc.	2	2	4	PSCP		May-21
D31	Delivery		Delay in/issues with switch over of plant in plant rooms	2	3	6	Micro programming and communication. Advanced surveys of plant rooms.	1	3	3	PSCP		Apr-22
D32	Delivery		Building infrastructure fails following switch over.	3	4	12	Water samples taken to identify any potential issues in secondary system. Systems to be monitored for a period after switch over.	3	4	12	NHSL		Jun-22

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
D33	Delivery		Programme risk to other projects	3	5	15	Other projects to ensure this risk is listed. Robust programme. Possibility of second LINAC machine being brought into LINAC building - would only be able to be powered once Phase 2 works complete. Early engagement with LINAC department and project team.	2	5	10	NHSL		Ongoing
D34	Delivery		Utility providers fall behind programme	3	5	15	Early engagement with providers and regular communication with both providers and critical action holders (i.e. Legal)	2	5	10	PSCP		Ongoing
D35	Delivery		Service diversion routes are not achievable, new routes are required or additional works	2	4	8	Early surveying of diversion routes.	2	3	6	PSCP		Apr-21
D36	Delivery		Changes in the construction market	2	3	6	Project Team to review any likely impacts on a regular basis and consider mitigating actions.	2	2	4	PSCP		Ongoing
D37	Delivery		Brexit implications (e.g. delay in procurement, additional cost)	4	4	16	Early ordering of materials and/or equipment from EU suppliers. RMF to produce a procurement schedule and provide a regular update to the Project Team.	3	3	9	PSCP		Ongoing
D38	Delivery		Access to hospital plantrooms which will include working with live services and pipework.	2	3	6	All operatives to be made aware of surrounding existing services as part of their site induction. Working areas to be adequately cordoned off (Permit to enter) to a standard required to protect hospital staff. Communciation between NHSL / Estates and RMF required to agree responsibilities between all parties and agree shared access approach.	1	3	3	NHSL		May-21
D39	Delivery		Laundry Building Demolition - Relocation & Reprovision of potential storage services adjacent to building.	2	5	10	Engagement with Estates & Maintenance ongoing.	1	5	5	NHSL		Apr-21

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
D40	Delivery		Laundry Building Demolition - Roadworks reducing staff parking spaces and general access.	5	3	15	Access to BRF, boiler, maintenance, deliveries and other support services to be confirmed and communicated to surrounding buildings in advance of works commencement.	5	2	10	NHSL		May-21
D41	Delivery		Ground contamination - NW of site (boundary of Telford Road, Laundry building, Estates)	4	4	16	Engage with Estates regarding oil tank storage near excavation areas. Understand historic usage for specific areas surrounding proposed energy centre site through NHSL Estates (e.g. clinical waste storage).	4	3	12	NHSL	PSCP	Mar-21
D42	Delivery		Scottish Power availability	1	5	5	Early notification to SP.	1	5	5	PSCP		Ongoing
D43	Delivery		HV fails following switchover	1	5	5	Staggered changeover approach to reduce risk of failure. Microprogramming required for switchover activities.	1	5	5	PSCP		Jun-22
D44	Delivery		Impact on BRF compliance	5	4	20	Early engagement with UoE. NHSL to communicate any restrictions in terms of noise or vibration required by UoE.	3	4	12	NHSL	PSCP	Apr-21
D45	Delivery		Laundry Building Demolition - adjacent buildings / infrastructure	3	5	15	Demolition methodology to include a strategy to prevent any impact to the adjacent oxygen tanks, buildings or other infrastructure.	2	5	10	PSCP		May-21
D46	Delivery		Further Covid restrictions impact the programme	3	5	15	Remote site accommodation to limit number of operators in each compound.	2	5	10	PSCP		Apr-21
D47	Delivery		Covid impacting on key personnel (e.g. self-isolation requirements)	3	5	15	Robust methodology in place to reduce spread of Covid. Contingency plan to be produced for a back-up office accommodation at an alternative location on site - to be regularly reviewed in line with government guidance and project progress.	2	5	10	PSCP		Apr-21
D48	Delivery		Extreme weather causing flooding on site - towards Ann Ferguson site entrance, may impact Laundry Building Demolition or BRF	1	4	4	Design for demolition should consider water / drainage management.	1	3	3	PSCP		May-21

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
F1	Finance	Affordability and funding	Suitable alternative funding routes not available within the required timescales	4	5	20	Pursue other funding and support options with other acceptable providers / enablers / frameworks			0	NHS L	Thomson Gray	tbc
F2	Finance	Availability of funding generally	Funding restrictions may constrain the ability to realise the full potential of the Investment Objectives.	4	5	20	Alignment of dialogue regarding funding and business case development with SG and other acceptable providers / enablers / frameworks			0	NHS L	Thomson Gray	tbc
F3	Finance	Scottish Government funding	Failure to meet the SG requirements for funding through the business case process	2	5	10	Manage the business case process and dialogue with SG CIG			0	NHS L	Thomson Gray	tbc
F4	Finance	Inability to deliver the project to budget	Failure to work within cost plan projected limits.	2	4	8	Accurate cost planning, forecasting and active monitoring with mitigation measures enacted as required.			0	NHS L	Thomson Gray	tbc
F5	Finance	The solution doesn't deliver the anticipated revenue savings	Failure to meet energy consumption reduction and carbon reduction targets.	3	3	9	Accurate development of forecasts based on available data and anticipated systems performance.			0	NHS L	Thomson Gray	tbc
F6	Finance	Funding and programme	Funding restrictions may constrain the ability to deliver the programme within optimal timescales.	4	3	12	Programme options to be presented with capital and revenue projections. Funding assessment and options can then be considered.			0	NHS L	Thomson Gray	tbc
F7	Finance	Existing site energy supply contract	Commercial arrangements associated with the current energy centre may affect the scope of any proposals.	3	3	9	Commercial arrangement of current provision to be reviewed and discussed with current provider.			0	NHS L	Thomson Gray	tbc

Ref No:	Risk Category	Risk Sub Category	Risk Description	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Mitigation and Management strategy	Probability (1-5)	Impact (1-5)	Risk Rating (1-25)	Risk Owner	Risk Manager (if not Risk Owner)	Action Date
F8	Finance	Cost Planning and contingency	Accuracy of the estimated option costs.	4	3	12	Factor in optimism bias.			0	NHS L	Thomson Gray	tbc
F9	Finance	Statutory Changes	VAT rules may change.	3	3	9	Monitor the environment.			0	NHS L	Thomson Gray	tbc
F10	Finance	Phased development on an operational site	The scope and costs associated with the replacement of existing site infrastructure may be considerably more than estimated.	4	3	12	Utilise existing reports/surveys to assess the likely requirement. Factor in optimism bias.			0	NHS L	Thomson Gray	tbc

Appendix 4: Non-Financial benefits Assessment

#	Benefit	Weighting (%)	Option 1 (Do Minimum)	Option 2
1	Improves safety of patients and public by improving system resilience and reducing the risk of system failure.	15%	10	10
2	Improves financial performance, optimises energy usage costs and supports a reduction in maintenance costs.	12%	9	7
3	Improves environmental performance of site and reduces CO2 emissions in line with Scottish Government policy and also reduces energy consumption	10%	7	7
4	Optimisation of phased delivery to the future operational benefit of site users / stakeholders ie. Minimise future disruption to phase 1 site zone	10%	8	7
5	Phase 1 solution does not prejudice future site wide flexibility to respond to future developments / improvements / advancements in clinical services and also emerging Government policies on management of utilities infrastructure, for example renewables, electric cars	10%	8	6
6	Provides a pathway to 2050 Carbon Reduction Target	10%	8	8
7	Improves safety of staff maintaining systems by eliminating confined spaces & high temperature conditions.	10%	8	8
8	Future ready arrangements to replace SSE Contract	1%	1	1
9	Minimises sunk costs for wider site infrastructure	8%	8	7
10	Minimise environmental impact regarding sound and emission production for adjacent clinical areas and neighbours	14%	5	6
	Total Weighted Benefits Points		**783**	**735**

NHS Lothian

Appendix 5: Design Report – Executive Summary

WGCC-H&K-XX-XX-RP-M-002_SC04 Infra

Appendix 6: Project Programme

Draft construction programme

WGH SCO-04 Infrastructure Phase

Appendix 7: Investment Objectives

Investment Objective 1: That the energy infrastructure is addressed in the context of the site masterplan development framework.

The masterplan has been developed through engagement with a wide range of stakeholders and includes flexible provision for the envisaged development of the site for clinical and non-clinical services over the next 25 years. The energy infrastructure needs to align with this flexible blueprint to allow for both the "here and now" issues and the longer-term inclusion of new development.

Investment Objective 2: To improve site flexibility and be more future proof.

Relatively detailed technical studies have been done to prove the feasibility of this integrated development strategy and to ensure that there is a viable solution that is flexible and future proof enough to align with key strategic drivers particularly in respect of climate change.

Investment Objective 3: To improve the site users' experience.

New energy infrastructure will address the issues of operational service risks and associated supply security to staff, patients and visitors to the site. The inconvenience factors of systems not operating correctly or at all, the disruption of closed off spaces – both inside and outside buildings - and including impacts on car parking, roads and footpaths will also be addressed.

Investment Objective 4: To improve site operational resilience.

The site energy infrastructure systems are unreliable and suffer frequent break downs that cause disruption to clinical and non-clinical services. New systems will provide greater operational resilience and associated site management confidence. New infrastructure will include better security for heat and power supply including back-up generation of power in case of main supply outages.

Investment Objective 5: Reduce Carbon emissions by investing in low energy/low carbon technologies.

The climate change targets that need to be met in the same time frame as the longer-term masterplan implementation will only be achieved through viable low carbon technologies. Opportunities for these sorts of strategies on sites of this nature is minimal. The technical feasibility study done has identified viable and sustainable low carbon technology for the site.

Investment Objective 6: To ensure a future ready arrangement is in place at the end of the existing energy supply contract now extended to August 2021.

The existing arrangements that are in place for energy supply and equipment maintenance will be extended from August 2018 for three years. It is important that a more future proof and sustainable arrangement and including both operational and commercial aspects is in place from August 2021 to provide the flexibility for the ongoing phased delivery of the infrastructure across the site.

Investment Objective 7: To improve future financial performance, optimise energy usage costs and support a reduction in maintenance costs.

The improvement of the energy infrastructure generally will provide an opportunity to address all these aspects. Financial performance along with operational reliability and resilience are probably the primary drivers. If there is little or no future investment then the financial impacts will increase. The opportunity

exists for significant operational revenue savings to be realised if there is the correct level of investment in the right type of systems and networks and including low carbon technologies.

Investment Objective 8: To improve safety of staff maintaining systems

There are significant health and safety issues associated with the maintenance of the existing networks and particularly the high temperature steam distribution through a duct system across the site. NHS Lothian staff and contractors must work in dangerous conditions where spaces are confined and working temperatures can be excessively high. There is also an issue in respect of suitably experienced and qualified contractors to carry out this work due to the growing obsolescence of the technology

Appendix 8: Detailed Options Appraisal

The proposed Phase 2 scope has been developed based on works that were previously omitted from phase 1 due to programme constraints, technical assessment and criticality of the works in relation to the Oncology Enabling programme of works.

As part of the Infrastructure review in phase 1 a detailed review of the provision and format of the energy infrastructure completed. This took into account current site conditions and restrictions as well as look forward to future site developments as per the site development plan. The proposals considered were evaluated to not compromise the future whole site energy infrastructure objectives for a pathway to zero carbon.

The long list was reviewed for suitability within the context of the phase 2 projects as well as the whole site energy infrastructure preferred option. The following short list of options were determined by this review as the most suitable, in terms of fulfilment of the needs determined in phase 1 and in support of the masterplan and site-wide energy infrastructure replacement:

- Option 1 - Do minimum – New SPEN HV incomer and zone 1 sub-station
- Option 2 – Proffered - New SPEN HV incomer and zone 1 sub-station and heating plant extension

Option 1 – Do Minimum	
Service provision	Service to be delivered as per the status quo, but key assets upgraded to latest standards and critical infrastructure resilience increased.
Service arrangements	As per current arrangement – Western General site (NHS Lothian, plus third parties as noted within IA)
Service provider and workforce arrangements	As per the current arrangements (hybrid between 3rd party and NHS Lothian)
Supporting assets	Existing steam and SHSC energy centre and existing site wide infrastructure, out with that proposed for replacement
Public & service user expectations	Public and service user expectations would be unchanged.

Strengths	**Weaknesses**
- Critical HV infrastructure complies with latest standards. - Increased resilience through equipment specification and functionality - Removal of critical assets from current high risk laundry location	- Disruption to site logistics, in particular parking due to proposed cabling route. - Potential loss of car park spaces due to spaces required for new sub-station and back-up generator
Opportunities	**Threats**
- Increased capacity for future development - Removal of live assets from Laundry allows demolition to progress	- Working within existing SHSC building with non-NHSL occupant - Possible planning issues with flues
Implications on whole site energy infrastructure preferred option	No detrimental impact on whole site proposals.

Option 2 – Proffered Option	
Service provision	Service to be delivered as per the status quo, but key assets upgraded to latest standards and critical infrastructure resilience increased.
Service arrangements	As per current arrangement – Western General site (NHS Lothian, plus third parties as noted within IA)
Service provider and workforce arrangements	As per the current arrangements (hybrid between 3rd party and NHS Lothian)
Supporting assets	Existing steam and SHSC energy centre and existing site wide infrastructure, out with that proposed for replacement
Public & service user expectations	Public and service user expectations would be unchanged.

Strengths	Weaknesses
- Critical HV infrastructure complies with latest standards. - Increased resilience through equipment specification and functionality - Removal of critical assets from current high risk laundry location. - Continuation of de-steaming, and maximises value of equipment installed in phase 1 - Releases capacity from existing steam, reducing risk across the site	- Disruption to site logistics, in particular parking due to proposed cabling route. - Potential loss of car park spaces due to spaces required for new sub-station and back-up generator
Opportunities	**Threats**
- Increased capacity for future development - Removal of live assets from Laundry allows demolition to progress	- Working within existing SHSC building with non-NHSL occupant - Possible planning issues with flues
Implications on whole site energy infrastructure preferred option	No detrimental impact on whole site proposals.

NHS LOTHIAN

Board Meeting
7 April 2021

Director of Primary Care Transformation

PHARMACY PRACTICES COMMITTEE TERMS OF REFERENCE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board accepts the Terms of Reference for the Pharmacy Practices Committee (PPC).

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

2 Recommendations

2.1 To review and approve the Terms of Reference as the authority delegated to the Pharmacy Practices Committee to consider applications for inclusion in the Pharmaceutical List of Lothian Health Board.

3 Discussion of Key Issues

3.1 Maintenance of a Pharmaceutical List is a requirement of the National Health Service (Pharmaceutical Services)(Scotland) Regulations 2009 as amended.

3.2 The functions of the Board in terms of consideration of applications for inclusion in the Pharmaceutical List are exercised by the PPC. The existing Terms of Reference were formally adopted at the Lothian NHS Board meeting on 3 April 2019 for a period of two years and are now due for review. These Terms of Reference appear alongside those of other Board Committees on the Board's website.

3.3 Schedule 4 of the Regulations sets out how the PPC on behalf of the Board will exercise the functions of the Board in terms of how the applications for inclusion in the Pharmaceutical List will be determined and granted. It also refers to membership, quorum, voting and other issues which are incorporated in the proposed Terms of Reference.

3.4 There are generally seven members of the PPC and the criteria for their appointments are set out under paragraph 3 of Appendix 1. The Chair and Vice-Chairs are appointed by the Board, pharmacist members are nominated by the Lothian Area Pharmaceutical Committee and appointed by the Board, and lay members are at present recruited through the Scottish Health Council and NHS Lothian Patient and Public Involvement and appointed by the Board. Other avenues continue to be explored for the recruitment of lay members. Training is arranged for new members.

3.5 The PPC currently has the required number of members on the Committee. The Terms of Reference recommends that members shall all be appointed for a term of three years, with an option for extension for a second three years, and that Lothian Health Board shall reserve the right to remove any member at any time.

3.6 The PPC is convened as and when there is an application ready to be heard.

4 Key Risks

4.1 There are no risks from the recommendations in this paper. The Board is required to establish a Pharmacy Practices Committee.

5 Risk Register

5.1 No change to the risk register

6 Impact on Inequality, Including Health Inequalities

6.1 No impact assessment was carried out.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 The creation of the Pharmacy Practice Committee is a statutory requirement placed on Health Boards. The publication of the Terms of Reference will ensure that interested parties have access to the process by which community pharmacies can operate in the Lothian Health Board area.

8 Resource Implications

8.1 The resource implications are minimal consisting of advice on the Regulations to Pharmacy Practice Committee members, travel and locum fee reimbursement for Committee members as appropriate and staff training.

David Small
Director of Primary Care Transformation
25 March 2021
David.A.Small@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Terms of Reference for the Pharmacy Practices Committee

APPENDIX 1

PHARMACY PRACTICES COMMITTEE
Terms of Reference

1. REMIT

The Pharmacy Practices Committee (PPC) has the delegated authority from Lothian Health Board to consider applications for inclusion in the Pharmaceutical List in accordance with the National Health Service (Pharmaceutical Services)(Scotland) Regulations 2009 as amended.

2. CORE FUNCTIONS

To consider applications for inclusion in the Pharmaceutical List of Lothian Health Board.

3. MEMBERSHIP

The Committee shall comprise seven Members appointed by Lothian Health Board of whom:

(a) one shall be the Chair appointed by NHS Lothian from the Non-Executive Members of the Board;

(b) three shall be pharmacists of whom:

(i) one shall be a pharmacist who is not included in any pharmaceutical list and who is not an employee of such person (known as “Non-Contractor Pharmacist”);

(ii) two shall be pharmacists each of whom is included in the Pharmaceutical List, or is an employee of a person who is so listed (known as “Contractor Pharmacists”);

(c) three shall be persons appointed by NHS Lothian, but not from the Members of the Board (known as “Lay Members”).

Lothian Health Board shall appoint deputies for the Members of the Committee.

In making appointments of Members and Deputies to the Committee NHS Lothian shall ensure that the eligibility criteria in paragraph 3 of Schedule 4 of the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 (as amended) are met.

Members shall all be appointed for a term of three years, with an option for extension for a second three years. Lothian Health Board shall reserve the right to remove any member at any time.

Provided a quorum is present at any meeting, the proceedings of the Committee shall not be invalidated by any vacancy in its membership, or any defect in a Member's appointment.

Where an application concerns premises that are located in the same neighbourhood as premises from which a dispensing doctor provides this service, the PPC shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

Administrative Support will be provided by officers of Lothian Health Board.

An independent legal assessor may be appointed to provide legal advice during PPC hearings.

4. QUORUM

The quorum for Meetings of the PPC shall be 5 members comprising:

Chair (or Deputy Chair)
One Non-Contractor Pharmacist Member
One Contractor Pharmacist Member
Two Lay Members

Voting provisions are set out in paragraph 5.

5. VOTING

Each application shall be discussed by all Members present at the meeting but shall be determined only by the Lay Members.

The Chair, or Deputy Chair acting as Chair shall not be allowed to vote, except in the case of an equality of votes, in which case he or she shall have a casting vote.

6. FREQUENCY OF MEETINGS

The PPC will meet as required on receipt of a competent application for inclusion in the Pharmaceutical List.

The agenda and supporting papers will be sent to the PPC members, at least ten days before the date of a meeting.

7. REPORTING ARRANGEMENTS

The PPC shall notify Lothian Health Board within ten days of its decision for each case providing full reasons for their decision.

8. DATE OF APPROVAL OF THESE TERMS OF REFERENCE

7 April 2021 (TBC)

9. REVIEW DATE

6 April 2023, or earlier if there is a relevant change in regulations or Scottish Government instructions.

LOTHIAN NHS BOARD

Board
7 April 2021

BOARD EXECUTIVE TEAM REPORT

Aim

The aim of this report is to update non – executive Board members on areas of activity within the Board Executive Team Director's portfolios. This report also includes contributions from Integration Joint Board Chief Officers. Directors have been invited to focus on key strategic / operational issues to bring to the attention of non – executive Board members, not otherwise covered in the Board papers.

1. Chief Executive

1.1 **Royal Hospital for Children, Young People/Child, Adolescent Mental Health Services, and Department of Clinical Neurosciences:** I am delighted to report that the new Hospital fully opened to patients on 23 March 2021. The opening received positive media coverage. The former Royal Hospital for Sick Children at Sciennes is now closed.

1.2 **Pay Negotiations:** I am the Chair of the employers negotiating side working with the Scottish Government and staff side on the Agenda for Change pay deal for 2021 -22. A proposal has been developed and offered to the staff side who will consult on it for 6 weeks. The basic outline of the deal is as follows:

1. The Scottish Government's aim is to deliver an agreed single year pay deal for NHS Scotland Agenda for Change staff for the financial year 1 April 2021 – 31 March 2022.

2. The pay deal will have an additional backdating to 1 December 2020, meaning any new pay rates are in place from 1 December 2020, and any arrears of pay related to the pay deal will be effective from this date.

3. In order to achieve this, the Scottish Government has committed an overall financial envelope of £323m to uplift Agenda for Change pay rates, with £76 million available for the additional 2020-21 costs, and £247 million for 2021-22. This includes the £20m payment on account that has already been applied.

1.3 **Remobilisation Plan:** On 18 March, a number of Executive Directors met with Scottish Government colleagues to agree the Remobilisation Plan. This will be reviewed in September when we have more clarity around the trajectory of the pandemic.

1.4 **Scottish Parliament Election 6 May 2021**- Board Members are reminded that the normal pre- election period arrangements are now in place in the run up to the Scottish Parliament election on 6 May 2021.

2. Deputy Chief Executive

2.1 **Car Parking:** Members are aware from previous briefings that parking capacity across our adult acute sites has been challenged since remobilisation began in summer 2020.

2.2 As reported the Pan Lothian Acute Car Parking Group has been monitoring the situation closely and have developed and implemented a series of mitigating actions focused on Traffic Safety. Members should note we now have planning permission for a temporary RIE expansion car park (250 spaces), this will be sited on Plot 1 of the EBQ (Edinburgh Bio Quarter). However we are unable to progress this development at this time due to protracted lease negotiations with University of Edinburgh. We are however optimistic at the time of submitting this report that these discussions should conclude shortly allowing construction to start. Construction will take 16 weeks to complete.

2.3 Whilst this will bring a level of relief to the capacity issues seen at the RIE site, members should note further expansion/control proposals are in development and will be brought through NHS Lothian governance in the coming weeks.

2.4` WGH, SJH and REH sites have all implemented bespoke temporary controls including; offering car parking facilities at nearby unused commercial and educational sites and increasing the number of car parking staff to physically monitor and control traffic.

2.5 **Estates and Facilities Strategic Review:** A review is currently underway which aims to further develop an E&F Function which effectively assures the Executive Leadership Team and NHS Board that the provision of critical systems are compliant with all relevant standards across our whole system. This is being led by a Strategic Review Board with members who have the appropriate management responsibility, knowledge, competence and experience for participation. The meeting is chaired by the Deputy Chief Executive and includes partnership colleagues and a peer representative from another Scottish Health Board. To date the HR and OD team have supported the facilitation of independent scoping exercises with senior management (SMT) and further sessions with direct reports of the SMT. The Strategic Review Board plan to present emerging recommendations and proposals to the Executive Leadership Team in late April 2021.

2.6 **Corporate Office Reconfiguration & Homeworking Guidance:** A working group is well established and review the operational measures required to support safe & effective working environments for staff working in Comely Bank and Waverley Gate buildings as lock down ends and increasing numbers of staff may require to return to office working.

2.7 This groups recommendations will also support similar work across all our campuses and buildings.

2.8 Whilst Health & Safety measures have already been deployed to support the very minimal numbers of our team currently using these buildings more detailed considerations and recommendations will be made in areas including; ventilation, augmented cleaning, physical distancing, mask wearing, equipment, wellbeing support, flow of movement and building capacity monitoring.

2.9 A wide range of stakeholders are involved in this work and coordinated by the group including Infection Control, Health & Safety, Facilities, Partnership, I.T, HR, Planning and Communications & Engagement. The group have now produced a pack of information and guidance, endorsed by Infection Control and Prevention ICP and the executive leadership team, which includes; cleaning SOPs, proposed floor plans and an internally designed desk booking system this information will support detailed discussion within functional teams and will support agreed working arrangements...

3. Executive Director of Nursing, Midwifery, & AHPs

3.1 For information the new Chief Nursing Officer took up post on the 22nd February (Prof Amanda Croft) and I have had several meetings with her already.

3.2 Nurse staffing continues to be pressured. At this stage sickness is not the issue it is filling gaps in vacancies whilst also looking to the future as well. We are taking a number of actions to address this which are both site/service specific but more generally we are looking at growing the band 4 role as an associate practitioner; working very closely with Edinburgh and West Lothian Colleges to provide placements for students studying at these colleagues and also getting them registered on the Staff Bank as a band 2 HCSW or indeed offering vacant posts. This will be a great pipeline for both community and hospital based services. We continue to look at recruitment, retention, and anything we can do to enhance or improve our process as well as advanced practice. Focus groups with students will continue so we can learn from them re what is good and bad about their experience as well as working with our own staff to understand what could retain them. Often the answer to the latter point is education, training, and career development opportunities. So we are looking at these to, and opportunities for rotation around different specialties and potentially sites. All of these actions aside we remain at very high in term of risk rating on the corporate register.

3.3 We are out to recruit for the additional infection control, tissue viability and improvement advisors to support care homes.

4. Medical Director

- I am pleased to have taken part in the appointment of new NHS Director of Research and Development and Professor Alasdair Gray has been appointed to take over from Professor Tim Walsh in April 2021. Alasdair established and

led the very successful EMERGE research consortium, has been the Lead on the RCEM research programme and is currently the co- chair of Acute Care Edinburgh based in the Usher Institute. He has worked as an NHS Consultant in Emergency Medicine in RIE since 2001 and brings a wealth of experience to the ACCORD office.

- Board members may be interested to know that NHS Lothian is the highest recruiting site in the UK wide SIREN study run by PHE, a real world study of Covid in health and social care staff. This is the study responsible for the generation of evidence about vaccine effectiveness in this population outside the more narrow confines of participants in vaccine trials
- Tim remains as part of the team in the NHS beyond his own clinical practice as Director of Innovation and we have recently submitted our regional priorities in this area which include community and mental health based areas as well as work in support of the new cancer centre and the opportunities to come as the Bioquarter develops
- Further growing areas of strength in regional working include radiology and cardiology, where we are pursuing a regional approach for physiologists to maximise training opportunities and career progression
- Assurance work on water safety through training and development of local Health and Safety committee chairs has been supported with a training session from our Authorised Engineer for water
- As we prepare for the next phase of robotically assisted surgery following National Planning Board and regional discussions, we are developing a supporting framework for safe and effective implementation
- National work in support of medical credentialling, forthcoming new contract discussions for SAS grade doctors and the next phase of recovery has continued.

5. Director of Finance

5.1 Over the last few weeks the focus of the Finance teams and the wider finance community has been the management of the year and the assessment of the financial position for 21/22. This has not been straightforward with multiple Covid work streams impacting on this, in addition to mobilisation plans. We have worked hard as a finance community across Scotland to try and tackle this in a consistent approach and to ensure that the flow of funds matches the expenditure profile over this year and next. This was part of a discussion at the national Director of Finance meeting, where we also met with the Workforce directorate within Scottish Government to consider how we align the need to develop a longer-term workforce and financial plan for the Test and protect, and vaccination programmes. We also considered the overall step up in workforce numbers and how this is matched with the redesign agenda.

5.2 At the same meeting we received a presentation from Audit Scotland on their Overview report and the key themes including PPE, Patient backlog and remobilisation, and the involvement of staff and the public in deciding priorities going forward. They highlighted the key actions for Health Boards of ensuring the health and well-being of our staff, the consideration of inequalities and outcomes, and performance in relation to waiting times.

5.3 Within our local finance team we have been continuing to work on proposals for a revised structure which builds on the work we did on the business partnering model. This is likely to be implemented on an incremental basis, ensuring we free up business partners to support and enable the various programme boards established to deliver performance improvement, and to support the Strategy development.

5.4 The work to enhance our PPP contract management capability has been reported separately to the Board and the Finance and Resources Committee. This has seen significant development recently as we have supported this with a Programme team until we reach steady state. Key elements of the programme team are now in place with options for procuring technical advice currently being finalised. Priorities include improved performance at the RIE and the full opening of the RHCYP/DCN. On this latter note the Project team are absolutely delighted at the move of the remaining services into the new hospital on the 23 March, and are working hard with Service colleagues to finalise commissioning.

5.5 Finally with the first deadline approaching for the submission of the initial response to information requests received from the Public Inquiry team there has been a significant amount of work involved in preparing for this. These cover 3 work streams: technical, project governance, and patients/families. Importantly we are also developing a document management system for the Board to deliver and manage the flow of information to the Inquiry team going forward and the resource requirements associated with both this and the ongoing management of the Board's response to the Inquiry. We are liaising closely with the CLO on this.

6. Director of Human Resources and Organisational Development

6.1 Preparations continue for the launch of the new National Whistleblowing Standards on 1 April 2021, with a series of briefings and 'lunch n learn' sessions for managers. The Datix systems has been updated to enable monitoring of all stage 1 (informal resolution) and stage 2 whistleblowing concerns and quarterly reporting to the Board will commence later this year. We are also in the process of extending our network of Speak Up Advocates. Communications are being issued to our primary care and other contractors regarding their responsibilities in relation to the new standards and the requirement to provide information to the Board on any stage 1 and stage 2 cases on a quarterly basis. Given the wider system pressures and priorities, the standards will not be fully embedded across our system and contractor services by the April 'go live' but we will continue to work this through in the coming months. This position has been flagged to both the INWO's team and the Scottish Government.

6.2 Partnering with DWP we were the first Health Board in NHS Scotland to launch the Kickstart programme during February. The aim of the programme is to support young people into paid employment for 6 months. During Scottish Apprenticeship Week 21 we were delighted that one of our modern apprentices was awarded the Scottish apprentice of the year (SCQF L6).

6.3 Work continues at pace on the final touches to our Wellbeing Strategy and the Staff Experience and Engagement Framework both of which are on target to be completed by the end of March.

6.4 Our four staff networks (BME, LGTB+, Youth and Disability) are in the process of developing action plans to inform our ambitions to improve diversity and inclusion and prevent discrimination in our organisation.

7. Interim Director of Public Health and Health Policy

7.1 **COVID:** With national restrictions in place, Lothian COVID rates declined through January 2021 until a brief upward swing in the second half of February. This has since improved and rates in Lothian are declining in keeping with Scottish trends. The 'UK' COVID Variant (B.1.1.7) is now well established as the dominant variant in Lothian and Scotland, responsible for more than 90% of PCR confirmed cases in both geographies. Additional surveillance is in place to identifying and limit the spread of other COVID variants.

7.2 **Health Protection response:** Early 2021 saw a further wave of outbreaks in Lothian's older-people's care homes associated with increases in community transmission (as in other Board areas). Outbreaks in care homes and social-care settings have now declined significantly and the focus of remaining clusters and outbreaks has tended to be in workplace settings with occasional cases in education settings. Over the coming weeks we will have a close focus on education settings in line with their phased reopening.

7.3 **Test and Protect:** The Test and Protect service has been expanding into more specialised elements of its service. This has included taking the lead in: contact tracing and management around cases in educational settings; conducting follow up in workplaces and care homes, enhanced contact tracing in occupational health settings and conducting surveillance around flight-related cases for Public Health Scotland. This has the benefit of freeing the resource of specialist services (Health Protection, Occupational Health, Infection Prevention and Control) to focus upon more complex investigations.

The performance of the service is consistently high against the three national metrics (as at 09/03/21):

1. Percentage of index cases interviewed within 24 hours – 92%
2. Percentage of contacts communicated with within 24 hours – 83%
3. Percentage of cases successfully closed within 72 hours – 100%

7.4 **Asymptomatic Community Testing programme:** The four Local Authorities and NHS Lothian have been working in partnership to expand asymptomatic testing across localities, employing an agile rapid response to target testing towards high prevalence Covid-19 area which reflects the need within local communities but is aligned, to government standard operating procedures.

Testing infrastructure is to be located at a network of venues across each council area. On the outcome of a positive test Local Authorities will make available wraparound support for individuals who will need to isolate.

Local Authority teams are taking the lead on the design, deployment, staffing and daily running of test sites. To support this work NHS Lothian Public Health is assisting with identification of potential high-risk communities, facilitating procurement of equipment via NSS, managing data flow and providing links to Test and Protect. Public Health will also lead on evaluations of the effectiveness of the programme.

7.5 Maternal and Infant Nutrition: Katie Dee and Alex McMahon presented at Corporate Management Team regarding the centralisation of the Infant Feeding Service within the Public Health Directorate of NHS Lothian. This has been approved and work is underway to deliver this change.

7.6 **Vitamin D supplements: The** new pathway for distribution of vitamin D supplements is now underway with a soft launch in each Local Authority area and across Family Nurse Partnership. Vitamin D supplement status will now be recorded at each Health Visitor development check. Scottish Government have started a national communication strategy which we will support as the full roll out occurs.

8. Chief Officer Acute Services

8.1 **Scheduled Care:** Within the Acute Division recent focus has been on how we will provide our planned services over the next 6 months and ensure as many patients as possible are seen and treated. We hope this will increase as winter and Covid associated clinical pressures start to subside although bed availability and staffing remain key challenges. We continue to see patients in line with agreed clinical prioritisation (urgent and urgent suspicion of cancer), and have reviewed our communication with patients and referrers to ensure they remain informed. Telephone or virtual consultations are in place for many clinical pathways and we continue to assess how we can increase these further. Work to look at how we provide maximum and protected elective capacity on all acute sites continues and includes looking at how we can provide procedures in alternative environments e.g. use of clinics for some procedures rather than theatres, where safe to do so. The SPiRE contract for 16 sessions per week will continue until the end of March 21.

8.2 **Cancer:** An additional temporary surgical robot became operational at SPiRE on 25th January 2021 to support prostatectomy procedures and release theatre capacity at the Western General Hospital for additional bladder cancer surgery. As a result, surgical waiting times for prostate and bladder cancer patients are reducing. Alongside this, the waiting time for prostate brachytherapy has been reduced from 6 months (mid 2020), to 8 weeks. It is anticipated that by May 2021 both of these developments will have contributed to improving NHS

Lothian's urology 62 day cancer performance and as one of the highest volume cancer sites, it will also improve overall 62 day performance.

8.3 **Unscheduled Care:** While total attendances continue to be significantly lower than pre-covid attendance levels, this reduction is mainly seen in the self-presenting cohort. Levels of attendances of patients referred by primary care or the ambulance service have returned to pre-covid levels. Therefore proportionately, patients at our acute front doors have a higher acuity than observed in the pre-covid period, and the number of admissions are at a similar level to the pre-covid period. Occupancy of our hospitals has continued to increase and wait for bed is one of the top breach reasons, reflecting the challenge of patient flow and available beds.

8.4 The Redesign of Urgent Care programme continues both across Lothian and nationally, and work is underway with our national partner NHS24 to improve the new route via 111 for the public to access scheduled same day care. Since 1 December 2020 the Lothian Flow Centre has been operating 24/7, managing this new urgent care referral pathway from NHS24, alongside managing the existing administrative function of the GP Out of Hours LUCS service, the Covid Triage Hub, and GP referrals to acute sites. The focus of the next phase of the Redesign of Urgent Care programme is improving professional (GP, SAS clinicians etc.), referral into same day community and secondary care services, that will provide care closer to home and reduce hospital attendances and admissions. Plans are being developed with our national partner SAS to open access to referral pathways to SAS clinicians via the Lothian Flow Centre.

8.5 **Laboratories**: Work and run-rates for laboratory testing at the RIE and Nodes sites remain steady at an average of 1,500 tests per day. Recruitment to RIE labs to provide sustainable staffing over winter is complete.

8.6 The regional 'hub' has been constructed at Lauriston Building – this was a significant project being carried out in conjunction with NHS National Services Scotland (NSS) and the Scottish Government. Certification for handover to NHS Lothian was received on 26th Feb 2021. A process of commissioning and testing has concluded, and the full operation of the laboratory is now commencing with the subsequent building up of capacity. This system went operationally live on the 21st Jan and is now regularly testing 2000 tests per day. All care homes in the east region are now tested via the NHS system and expansion to other asymptomatic groups is being considered.

9. Director of Improvement

9.1 Work continues to develop a programme of improvement work to support positive change in the light of Covid-19. However, increasingly the focus will return to recovery planning to address a number of the underlying performance challenges NHS Lothian face. In late February, a Performance Oversight Board was established to provide a forum for Senior Board Directors to help address and unblock performance issues, monitor recovery plans, and contribute to the development of the organisation strategy.

9.2 In relation to Scheduled Care a number of pieces of work are being taken forward to support performance, including reviewing theatre scheduling solutions to support improved efficiency, supporting the outpatient modernisation programme and maximising the potential of virtual working. In relation to the last point, a business case for further investment in end user devices (mainly laptops) was approved by LCIG and F&R paving the way for deployment of additional devices across the health and care system. A large proportion of these will support community, mental health and AHPs services switch to Teams, provide opportunities to use NearMe and reduce travel time.

9.3 From April, I will be taking a leadership role in two services with particularly long outpatient waits, Dermatology and Oral Health Services, and this month I have been meeting the respective teams to understand current challenges and future requirements.

9.4 The Unscheduled Care Programme continues to focus on access to urgent care, discharge and transfer of care pathways, and system capacity. The national and local implementation of the Redesign of Urgent Care programme is ongoing both across Lothian and nationally. Since 1 December 2020 the Lothian Flow Centre has been operating 24/7 managing this new urgent care referral pathway from NHS24. The focus of the next phase of the Redesign of Urgent Care programme is improving professional (GP, SAS clinicians etc.) referral into same day community and secondary care services. The programme portfolio will be broadening to address a number of other important issues across the unscheduled care pathway, with a project initiated to explore improving delivery and capacity of Hospital at Home across the four Lothian services with support from Healthcare Improvement Scotland. Additionally, initial exploratory discussions about the implementation of a Planned Date of Discharge model are underway to learn from the successes seen in NHS Lanarkshire and align with the new national work stream looking at whole system discharge planning.

9.5 The Mental Health Recovery Programme continues with the launch of a CAMHS 2021 Project to address continued performance challenges. The project has been developed with a dedicated project team and a governance structure which includes substantial clinical engagement and parent and staff representation. Work is ongoing reviewing the workforce, capacity expectations and operating practices. Liaison is also ongoing through the Children's Partnerships in relation to the ongoing investment in school counselling and community support for children and young people. In addition, support is also being received from the Scottish Government mental health advisers. Similar work is also progressing in Psychological Therapies.

10. Director of Strategic Planning

10.1 **Lothian Strategic Development Framework: Board** members will be aware that the work to date on the Lothian Strategic Development Framework was presented to the Planning, Performance, and Development Committee on 3rd March. A very successful discussion there allows us to move on to the next phase of development of the Framework. There will be updates to every PPDC

going forward on progress and we will engage the RSA in supporting the next phase.

10.2 **Remobilisation Plan 3:** Board members saw the final draft of Remobilisation Plan 3 ("RMP3"), covering the first six months of the coming financial year, in the papers for PPDC. This was submitted in its draft form to SGHSCD on 28th February and we anticipate discussions with SGHSCD colleagues during March. Once this feedback is received we will move to produce a final document for approval by the Board.

10.3 A reminder that the working assumption is that we will remain on an "emergency footing", with a focus on living with COVID-19, through the first six months of the year. At this point we will seek to produce "RMP4" for the second half of the year, which will hopefully be more about a return towards normality. My role in this has been two-fold, both leading the local delivery and, in my role as Chair of NHS Scotland's Directors of Planning, the national design of the next iterations of the RMP sequence.

10.4 **National prioritisation grid and extreme surge work :** On behalf of the Board Chief Executives Group, I've led work on how Boards should prioritise their activity during covid surges. This work has produced an illustrative grid of NHS services indicating which would be continued in extremis during emergency powers. This has led into a broader set of conversations regarding how the interface between Boards and government can and should work, in order to manage extreme surges move effectively and transparently across the country. This builds on earlier work led by our Medical Director on clinical prioritisation.

10.5 **Staff vaccination:** Since mid-January I've been leading the staff vaccination programme for the Lothian system. By 1st March we had provided more than 43,000 staff from across the health and care system with their first jab and moved the programme into two streams. Firstly, we have commenced second jabs for staff who are reaching the 12-week mark since their first jab, and to do so by the end of May. Secondly, we have opened a stream within the mass vaccination programme for staff to receive vaccinations. Criteria for entry to the programme is based on Joint Committee on Vaccination and Immunisation decisions to date and with an agreed interpretation of what constitutes "staff" within the broader programme across NHS Lothian and our four partner local authorities. As would be expected and is entirely understandable, staff awaiting a jab may well be anxious to receive this as early as possible. At the moment the assumptions around vaccine supply suggest a wait of up to 8 weeks for a first jab. There has been a concerted effort in conjunction with the Director of Communications to clarify messages for staff and for MPs, MSPs, local councillors, and local authority colleagues.

10.6 This work has also included general leadership support to the broader mass vaccination programme, and in total there are 8 other members of the Directorate temporarily seconded to the programme.

10.7 **Testing expansion:** I have continued to lead the testing expansion programme, covering the delivery of the new "mega-lab" at the Lauriston

Buildings, the staff testing programmes, community testing, and commissioning of external and internal pathways. This programme continues and is now considering how best to use the capacity we have given the fall in infection rates, while retaining contingency for possibly resurgences.

10.8 **Team moves :** Over the last year every member of the team has been temporarily seconded to a range of programmes and projects outside of the Strategic Planning space. We are beginning to repatriate team members as these programmes begin to move to more permanent footings, in order that the team can take forward the LSDF and provide support to operational teams in remobilisation clinical services. We are, however, losing two members of the team. Jess Davis, who joined us from NSS on a one-year secondment and who led the development of RMP3, is returning to NSS. Finally, Clare Cartwright, our Head of Implementation and the organisation's Programme Director for Scheduled Care Recovery, is to take a career break. Both will be sorely missed and arrangements are being put in place to cover Clare's roles during her absence. "

11. Director of Primary Care Transformation

11.1 **Covid Vaccination :** - see full Board report.

11.2 **Flu Vaccination :** The flu vaccination programme for 2020/21 ended on 31st March. Since January this has been in "mop up" mode with most activity through Community Pharmacy. Flu vaccination uptake has increased across all groups as shown below.

	2019/20 % Uptake	2020/21 % Uptake
Over 65	75.7	78.5
Under 65 At Risk	43.3	53.3
Primary School	66.7	79.9
2 to 5	56.2	61.5

11.3 2020/21 was the first year that elements of the adult programme were removed from general practice and models varied across HSCPs. Increases in uptake varied across HSCPs too. For 2021/22 flu vaccination programme all activity will be removed from general practice and the lessons from the models used in 2020/21 will be applied for 2021/22.

11.4 **GP Out of Hours:** Dr Sian Tucker, the Clinical Director, has moved on to take up post as Deputy Medical Director of NSS. Sian successfully steered the service through difficult times, maintaining the service to the population of Lothian and she will be greatly missed. Dr Hayley Harris has been appointed interim Clinical Director. Dr Harris has worked in LUCS as a GP and Associate Clinical Director for some time and is also a GP at Muirhouse Medical Practice.

11.5 **GP Contract:** Following announcements about revised timings for implementation of the contract as a result of the pandemic, the Primary Care Directorate, HSCPs and the GP Sub Committee will re-establish some of the

joint oversight arrangements for contract implementation. A key early target date to be achieved is the removal of all vaccinations from general practice by October 2021.

12. Director of Communications, Engagement and Public Affairs

12.1 **Covid Vaccination:** There is significant ongoing effort to support the staff and community vaccinations programmes, working with Local Authority and HSCP colleagues and contributing to planning and areas of communications focus at national level. There have been some areas of reputational challenge due to issues with vaccine supply, national messaging that does not apply locally and problems experienced by the national booking system. We are launching a local #StickWithIt campaign designed to encourage people to continue to follow the rules and take-up vaccination to enable a faster return to normal life. Nationally we are contributing to the development of materials to address inequalities and vaccine hesitancy among some groups.

12.2 We facilitated pooled media access at EICC, QMU drive through and Royal Highland Centre Showground to publicise their openings and issued media releases for the remainder generating widespread coverage for all the centres across TV, print, radio and online news.

12.3 We are current making a short film for Public Health Scotland on 'what to expect at your vaccination appointment'.

12.4 **Covid Testing:** We are supporting the drive to encourage staff to participate in Lateral Flow Testing. To date, this work has been aimed at all staff however a survey underway will generate the insight to enable this campaign to address specific reluctant staff groups. We are also supporting local authority comms colleagues on the roll out of community testing facilities and the introduction of LFT to schools.

12.5 **Covid 1 Year On:** There is considerable media interest in marking the first anniversary of the onset of the pandemic. BBC, STV and Evening News / Scotsman were invited to talk to our teams at the Regional Infectious Diseases Unit and the Western General Hospital (who received the first hospitalised patient in Scotland) and in Critical Care and at Royal Infirmary of Edinburgh. Further media opportunities are planned on the anniversary hook to reinforce the importance of continuing to adhere to Covid safety guidance.

12.6 **Capital Projects - Royal Hospital for Children and Young People:** On 10 March we held a media launch to announce the final migration to the new building would be on 23 March. , We have been implementing our communications plan to publicise the time and date of the A&E move in particular. This is a comprehensive campaign using media, social media, multichannel advertising spend and PR. We have also been collaborating with Edinburgh Children's Hospital Charity and their many partners to amplify our messages. I'd like to take this opportunity to put on record our thanks to them and to their Chief Executive, Roslyn Neely, for their tremendous support.

12.7 **Capital Projects - Edinburgh Cancer Centre:** An engagement plan has been developed to support progress through further development of the Initial Agreement. This was approved at the Cancer Capital Programme Board on 17 February.

12.8 **Scottish Hospitals Public Inquiry:** Meetings during February with the representatives of the Inquiry Team and with CLO have yielded more information about the focus, timelines and approach of the Inquiry. Work is underway to gather documents and information already requested.

12.9 **Elected Representatives –** two well attended meetings were held in February and one in March for MSPs and MPs with members of the Executive Leadership Team. Two meetings focused solely on the vaccination programme while the other was a broader update on performance. Briefings have also been shared with Cllrs in our four local authority areas. Elected representatives have been supportive in sharing briefing materials with constituents

13. Director/Chief Officer, Edinburgh Integration Joint Board Transformation

13.1 Our transformation programme continues to make good progress following some initial delays throughout 2020 due to Covid-19. The strategy underpinning the Bed Base Care project is under development following extensive engagement and consultation with key stakeholders and is due to be considered by the EIJB in June 2021. The strategy will set out our long-term vision and model for bed based services, with an initial focus on intermediate care, HBCCC, specialist rehabilitation beds and care homes. A draft version of our Edinburgh Wellbeing Pact has been developed and we are now moving into enactment of the Pact through the development and roll-out of our Community Mobilisation project. This will see the introduction of new, collaborative ways of supporting communities through the creation of community anchor organisations and community wealth building. A formal report will be presented to the EIJB in April 2021 setting out these plans in more detail. Home First remains one of our key strategic priorities and the project is currently developing an operating model and staffing structure to ensure the approach is embedded into our operational service delivery and can continue to drive improvements including reducing delayed discharge. Work also continues on our Home Based Care transformation. This project seeks to produce an improved, co-produced contract for care at home services, based on partnership working and collaboration with service providers. The project is on track to make contract awards in November 2021, with new services in place from Spring 2022. This project will also propose a new, improved model for our internal home care services.

13.2 **Roll out of care home and housebound vaccination programme: The** second dose of vaccinations have begun in care homes and is going well. The majority of housebound patients have been vaccinated.

14. Director/Chief Officer, East Lothian Integration Joint Board

14.1 **Winter Planning:** The partnership have successfully reduced and maintained Delayed Discharges to the pre April 2020 position of below 6 Social Care Delays reaching 0 social and 0 health delays on several occasions In March.

14.2 Available inpatient resource at East Lothian Community hospital continues to support system pressure.

14.3 **Primary Care:** One of our largest practices was reporting concern with their ability to respond to demand and has required significant partnership support which appears to be having desired results with fewer concerns raised and the practice reporting a less stressful working environment .

14.4 **Care Homes:** Governance arrangements for East Lothian continue under the oversight of the Chief Nurse with good relationships across services and care homes The existing East Lothian Care Home nursing team has been extended and restructured to support all care homes within East Lothian through education input, Nurse Practitioner support to anticipatory care and long-term conditions support and to respond to acute illness presentations in residents. The team are supported by lead GP practices and have also undertaken Covid Vaccinations of staff and residents in care Homes.

14.5 **Remobilisation 3**: Related work continues to:

- Support various COVID-19 related actions
- Provide high quality and responsive professional oversight and support to care homes and care at home services
- Provide enhanced community support to home care to avoid hospital admission
- Deliver a suite of rehabilitation and TEC Services
- Establish long-COVID support (and post-COVID rehabilitation) delivered through rehabilitation services
- Develop pain management approaches
- Fully remobilise social care packages

The ELHSCP vaccination team is managing the public COVID-19 vaccination programme and providing over 2,000 vaccinations per week within ELCH.

15. Director/Chief Officer, Midlothian Integration Joint Board

15.1 **Delayed Discharge:** Midlothian HSCP have made significant improvement in delayed discharge numbers. This is a result of the culmination of plans to expand and redesign our Home First model, though a Single point of Access (introduced in December 2021). Investment has been made to increase AHP and carer capacity within Discharge to Assess team, as well as adding senor decision making clinical expertise into out Flow team, who work within the RIE site to proactively identify and manage appropriate discharge for our residents. This has seen delays reduce to single figures.

15.2 **Vaccination programme and plan**: The Midlothian COVID Vaccination programme is progressing well. We are working in partnership with NHS Lothian Vaccination team and local GP practices to implement guidance from

the Joint Committee on Vaccinations and Immunisations (JCVI) based on direction from Scottish Government.

15.3 Care Home residents have received their first vaccine.

15.4 The Midlothian Community Hospital vaccination site has now increased coverage to 7/7 to improve access to local vaccination delivery. Discussions are ongoing with NHS Lothian vaccination team to consider a mass site within the county.

15.5 **Care Homes** : Midlothian currently has all Care Homes open to admission, with no current outbreaks. The Midlothian Care Home Support Team continue to work with local Care Homes to ensure a high-quality care experience for all residents. Two of our Local Authority Care Homes (Highbank Intermediate care facility and Newbyres Village Care Home) were recently inspected by the Care Inspectorate. Both services were inspected on standard 7 which focuses on infection control and how services have managed Covid. Both services received grade 4's which is classed as "Good" and were described as having good processes and communication in place to care for residents and support staff in their role. These grades have improved from previous inspections despite the pandemic. Plans are being developed to reopen care home visiting as per Scottish Government guidance.

15.6 **Care at Home:** Midlothian HSCP Care at Home service was also recently inspected on Standard 7, as well as additional areas for leadership and management, and care and support. All outstanding requirements were met, with improved grades of 4s. received. Further redesign has taken place to improve availability of care packages, with a significant impact on Delayed discharge numbers.

15.7 **Midlothian HSCP Chief Nurse**: Following the upcoming retirement of Caroline Myles in March, Fiona Stratton has been appointed to take up the role of Chief Nurse for Midlothian HSCP. Fiona has a wealth of experience across health and social care and will commence in post on 22nd March 2021.

15.8 **Midlothian Community Hospital**: As part of the HSCP plan to open additional beds at Midlothian Community Hospital (MCH), the bed model has been reviewed. A recently vacated ward was made available, providing an opportunity to open more beds and thereby support Midlothian residents to be cared for closer to home.

15.9 The hospital ward mode/configuration has been reviewed and reconfigured to meet current need. Recruitment of Medical, Nursing, Pharmacy and AHP staff was agreed and is being progressed. The new model for MCH will provide additional rehabilitation capacity whilst still providing vital care for continuing care patients, End of Life care, and those clinically stable patients awaiting care home placement. Currently 4 additional beds have been opened with plans to increase to up to 16 over the next 6 weeks.

15.10 **Scheme of Integration**: There is a legislative requirement for each Local Authority and Health Board to carry out a review of the IJB Scheme of Integration every 5 years. The current Midlothian Scheme of Integration was approved by Midlothian Council and NHS Lothian on 14 May 2015.

15.11 The plan to review of the Scheme in 2020 was delayed because of the pandemic. It is the intention of NHS Lothian to resume the review in summer 2021. Discussion with IJBs will also be arranged prior to the review. The draft updated Scheme will be returned to IJBs for approval in late Autumn 2021. The Midlothian Scheme of Integration was updated in 2019 specifically to incorporate amendments arising from the Carers (Scotland) Act.

15.12 **Strategic Commissioning Plan 2022-25:** Work to develop the Strategic Plan 2022-2025 is progressing. Building on from IJB agreement of the vision and values for the new plan in December 2020, work is underway with planning groups, including plans for consultation and engagement are in development. The intention is for the March IJB Development Session to focus on Strategic Plan priorities.

15.13 **Palliative Care Project :** This project, funded by the Scottish Government and Marie Curie, is part of a two-site project to explore ways to hear and learn from people's experiences of palliative and end of life care. In Midlothian, the project will follow Experience Based Co-design methodology and will focus on care provided by either the District Nursing service or at Midlothian Community Hospital. This involves gathering experiences from patients, carers and staff through in-depth interviewing, observations, and group discussions. The approach focuses on helping people tell the story of their own experience and using these experiences to understand not just the care journey, but the emotional journey people experience when they come into contact with the service.

This approach includes:

- Offering video as a method to capture patient and family member feedback and using the video to create an impactful resource for workshops.

- Holding workshops for staff and family members to come together, review the feedback, and identify opportunities for change and improvement that will offer patients a better experience of treatment and care.

The timescales for the project have been adjusted due to ongoing service pressures, however it is anticipated that the project will begin to collect data in March/April 2021 and will conclude in September 2022.

16. Director/Chief Officer, West Lothian Integration Joint Board

16.1 **Home First:** West Lothian HSCP and St John's Hospital co-hosted an online 'Home First' event on 18 Feb 2021. The purpose of the event was to share first hand experiences and provide case examples of how the discharge planning team are putting Home First principles into practice. This is achieved by

supporting assessments in the community and informing joint decisions on short and longer-term health care needs through a single discharge plan, that involves and focuses on what matters to patient, their family or carer. By concentrating the team's focus on the service user's home or recognised 'home' as the preferred discharge destination, we have seen significant discharge planning improvements.

16.3 The event was well attended by 48 people from across primary, secondary and community health partners present. The aim was for the breakout groups to share learning and lessons where improvements were made, and to also explore areas of opportunities for the future.

16.4 This noteworthy event establishes the foundation to build on the learning from Covid and new adopted ways of working while at the same time strengthening the short and medium term transformational work. We will continue to seek opportunities to join operational teams and pathways for the benefit of the patient, their family and/or carer.

16.5 **Digital Mental Health – Improving Feedback in IPCU** : The West Lothian Intensive Psychiatric Care Unit is undertaking work to develop the way in which feedback is gathered and used to improve patients' experiences and outcomes. Work is underway to develop an interactive tool which will gather information from patients electronically on arrival, as they progress with their treatment and on discharge. The three strands will be reportable in a simple format that will show comparisons, improvements and will allow teams to use the information to develop and improve service delivery.

17. The Board is asked to receive the report.

Policy/Strategy Implications	Policy/strategy implications will be addressed in the management of any actions resulting from these events, activities and issues.
Consultation	Board Executive Team
Consultation with Professional Committees	None
Risk Assessment	Risk assessment will be addressed in the management of any actions resulting from these events, activities and issues.
Compliance with Board Policy requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	Resource/staffing implications will be addressed in the management of any actions resulting from these events, activities and issues.

Approved by

Name	Designation
Calum Campbell	Chief Executive

Author(s)

Name	Designation	Name	Designation
Calum Campbell	Chief Executive	Katie Dee	Interim Director of Public Health and Health Policy
Jim Crombie	Deputy Chief Executive	Jacquie Campbell	Chief Officer Acute Services
Alex McMahon	Executive Director Nursing, Midwifery and Allied Healthcare Professionals	Pete Lock	Director of Improvement.
Tracey Gillies	Medical Director	Colin Briggs	Director of Strategic Planning
Susan Goldsmith	Director of Finance	David Small	Director of Primary Care Transformation
Janis Butler	Director of Human Resources and Organisational Development.	Judith Mackay	Director of Communications, Engagement and Public Affairs.
Morag Barrow	Director/Chief Officer Midlothian IJB/HSCP	Judith Proctor	Director/Chief Officer Edinburgh IJB/HSCP
Alison Macdonald	Director/Chief Officer East Lothian IJB/HSCP	Allister Short	Director/Chief Officer West Lothian IJB/HSCP

NHS LOTHIAN

Board Meeting
07 April 2021

Jim Crombie, Deputy Chief Executive

NHS LOTHIAN BOARD PERFORMANCE PAPER

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board discuss and review the current performance position of key metrics relevant to the Lothian Performance Recovery Programme and Remobilisation Plans.

The overall approach adopted is that performance management is integral to the delivery of quality and effective management, governance and accountability. The indicators included in this report are a high level set of performance standards which are supported by a comprehensive framework of measures reviewed across existing committees. These are reported to and monitored by the relevant responsible officers and their clinical and senior professional staff. A key vehicle for monitoring the wider performance metrics in our health and care system will be managed through the Planning, Performance and Development Committee (PPDC) which will report into the NHS Lothian Board. These metrics will be aligned with the NHS Lothian Board priorities:

- improving the health of the population,
- improving the quality of healthcare,
- achieving value and sustainability and,
- improving staff experience.

This categorisation of key metrics aligned to our board priorities will facilitate a greater visible connection to their performance. Local intelligence is gathered through quarterly performance reviews, existing committee structures and additional context sought from service areas, offering a robust and expansive set of indicators for review at PPDC. PPDC will also receive more detailed reports on issues or areas of strategic priority which have been escalated from subcommittees or via the performance review cycle. This reporting link to the Board will offer the opportunity for separate papers to be introduced to the board on specific escalated issues discussed by the PPDC.

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

2 Recommendations

2.1 The Board acknowledges the supporting performance infrastructure in place which provides formal assurance on a wider set of metrics aligned to Board priorities through existing committees.

2.2 The Board recognises the performance challenges detailed in this paper including; exacerbated pre-existing performance issues and dips in performance following the impact of Covid-19 and current measures.

2.3 The Board considers the clinical reprioritisation exercise undertaken on all inpatient and day case waiting list patients (circa. 14,500 patients) and the focus on maintaining and improving performance in order of clinical priority and longest routine waits.

2.4 To note this is the first iteration of a new performance reporting structure and the inclusion of dynamic performance targets (for metrics where Annual Operational Plan targets are not pre-set) whilst NHS Lothian moves through its remobilisation phase.

2.5 If further deeper dives are requested by the Board, these are addressed in separate reports to maintain the structure of the core performance report.

3 Discussion of Key Issues

3.1 There is a growing backlog of demand for secondary care and through remobilisation plans we have safely re-started the scheduled care portfolio and diagnostics to tackle the growing waiting times. These demand pressures have also extended to mental health services which also had pre-existing shortfalls in performance before the impact of Covid-19. Although less visible in national data and waiting lists, community and primary care are also likely facing a significant backlog. Whilst Covid-19 remains a risk, our unavoidable enhanced infection control measures will slow the pace at which patients can be treated, having an impact on waiting times, people's outcomes and experiences of care.

3.2 NHS Lothian is currently in its remobilisation phase with a plan produced to cover the first six months of financial year 2021/22. The fast-moving nature of the pandemic is such that there will be a increasing intelligence supporting capacity options as well as further understanding of demand curves post pandemic. Further plans will evolve from this covering the second half of 21/22.

3.3 We previously monitored performance through waiting list focused targets, although given our current position in remobilisation we are not yet clear how large the backlogs will be in terms of demand vs capacity and instead are tracking activity levels until September 2021. From this half way point in the financial year it may be appropriate to migrate to monthly position targets. The board will be updated on emerging thinking as this approaches.

3.4 At the time of drafting this paper, the migration of the Royal Hospital for Sick Children inpatient services has been completed.

3.5 The table below outlines the key performance metrics for the attention of the board:

Metric		Target	January 2021 Position	Dec-2020	2020/21 monthly average (to Jan-21)	2019/20 monthly average	2018/19 monthly average
4 Hour ED Target[1]		95%	**84.40%**	83.30%	92%	88%	88%
Outpatients (end of month breaches)[2]	➢ 12 weeks	-	**38,272**	36,810	36,905	22,414	20,777
	➢ 52 weeks		**8,426**	6,675	3,881	923	567
Delayed Discharges[3]	Health and social care / patient and family reasons	142*	**107**	122	111.4	217.7	303.4
	All census delays (above plus complex code 9s)	172*	**125**	148	130.1	247.2	331.4
TTG (end of month breaches)[4]	➢ 12 weeks	-	**9,206**	8,915	9,053	2,795	2,328
	➢ 52 weeks		**2,338**	1,680	888	49	73
Cancer Waiting Times[5]	31 Day Target	95%	**97.8%**	99.7%	97.5%	94.5%	94.3%
	62 Day Target		**87.4%**	87.3%	86.4%	79.2%	81.0%
CAMHS < 18 weeks target (seen within 18 weeks)[6]		90%	**69%**	67%	61%	54%	63%
Psychological Therapies < 18 weeks target (seen within 18 weeks)[7]		90%	**78.9%**	85.1%	78.4%	79.2%	72.3%
Mental health & learning disability bed occupancy[8]		85-90%	**93.8%**	94.6%	95.1%	-	-
HAI's per 100,000 bed days[9]	CDI	<11.8	**10.4**	7.9	13.3	12.0	12.6
	ECB	<29.6	**37.6**	31.8	31.3	35.2	35.5
	SAB	<12.6	**15.6**	11.9	13.4	12.6	13.5

[1] Data sourced from Lothian internal management system
[2] Data sourced from Lothian WT Monthly dashboard data
[3] Data sourced from PHS official statistics. *Targets are reportable census delays as projected for the 20/21 System Transformation Plan (and will be for 21/22 as projected in the 21/22 Remobilisation Plan)
[4] Data sourced from Lothian WT Monthly dashboard data
[5] Data sourced from Discovery
[6] Data sourced from Lothian internal management system
[7] Data sourced from PHS official statistics
[8] Data sourced from Lothian internal management system – average % Occupancy (inc. Pass) based on weekly data time points
[9] These rates represent overall rates for the year rather than monthly average: (sum of healthcare associated infections for the year / sum of total occupied bed days for the year)*100,000. Data sourced from Lothian internal management system.

Metric		Target	January 2021 Position	Dec-2020	2020/21 monthly average (to Jan-21)	2019/20 monthly average	2018/19 monthly average
Paediatrics and St Johns		7 days a week 24x7	**7 days a week 24x7**	7 days a week 24x7	-	-	N/A
8 key diagnostic procedures > 6 weeks target (end of month breaches)[10]	Upper GI endoscopy	-	**1813**	1792	1826	759	1308
	Lower Endoscopy (other than colonoscopy)		**612**	579	547	351	680
	Colonoscopy		**1136**	1154	1339	828	1508
	Cystoscopy		**1137**	1088	929	375	418
	Magnetic Resonance Imaging (MRI)		**890**	665	1000	342	304
	Computer Tomography (CT)		**670**	392	513	124	29
	Non-obstetric ultrasound		**622**	384	1134	7	10
	Barium Studies		**0**	0	16	0	0

[10] Data sourced from Lothian DMMI

3.6 The following table provides summary narrative on the performance demonstrated in the metrics above.

Board Performance Metrics

Areas of strong performance

Unscheduled Care

Delayed discharges remain significantly lower than previous years with performance exceeding forecasted trajectory; please note these was developed pre Covid-19. Forecasts for 2021/22 are now in place as reported in our Remobilisation Plan with an aim to maintain this momentum by further reducing delayed discharges. Please note, Code 100s (i.e. patients undergoing a change in care setting) are not published in the census data and are not included in performance papers. Code 9s have been highlighted in the below graph. Please see appendix 1 for a list of the delay codes considered in this metric.

Figure 1: PHS Delayed Discharge Census Publication

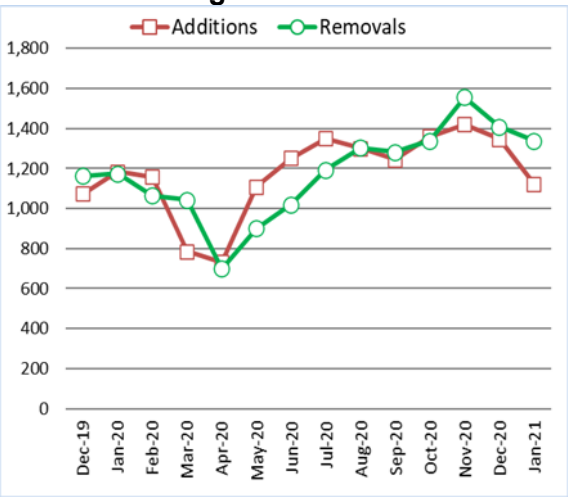
Across all adult acute sites there has been a focus on refreshing the discharge hub model and a focus on 'patient not delay' centred meetings which has improved joint working both across sites and with HSCPs.

A series of HSCP led initiatives are currently underway to focus on specific cohorts of delayed patients in each area. Community capacity is still limited by the workforce available and many of the initiatives involve bolstering existing community teams and services to provide the support and deliver the impact required. NHS Lothian internal management data from January 2021 suggested the key reasons for delays at this time included patient delays related to care required to live in their own home and care/residential home.

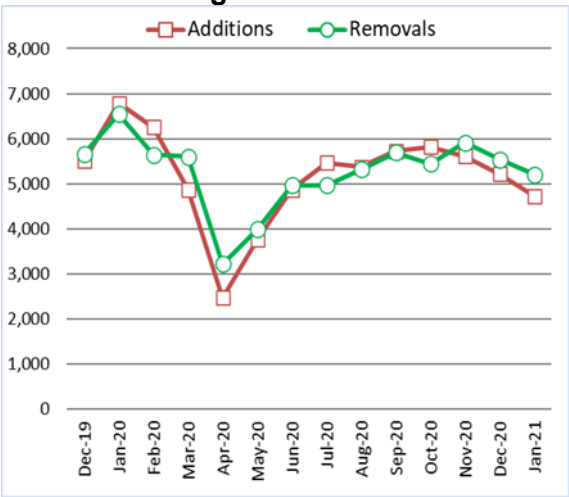
Outpatients & TTG

The Board should be aware that we continue to prioritise our available capacity to deliver urgent and cancer activity, as well as the longest waiting patients who have been reprioritised as needing urgent intervention.

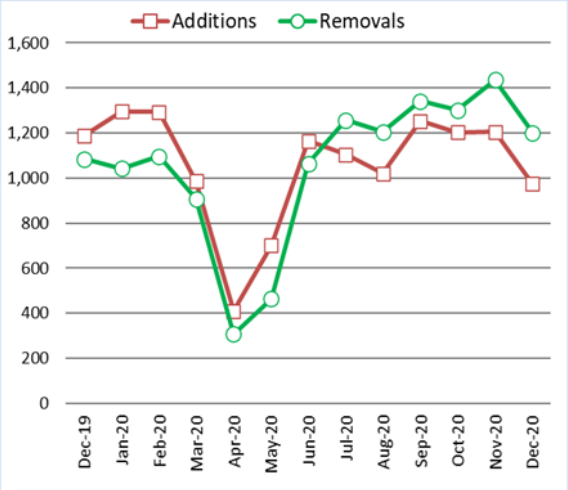
New Outpatient USoC Additions/Removals from the waiting list



New Outpatient Urgent Additions/Removals from the waiting list

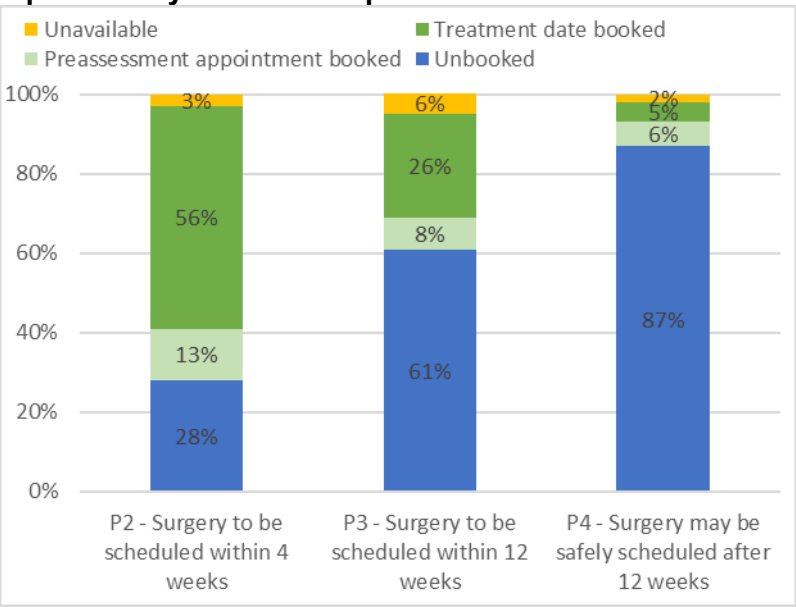


Inpatient/Daycase Urgent Additions/Removals from the waiting list



A clinically led review was conducted in January in an effort to reclassify all Inpatient and Daycase waiting list patients (circa 14,500 patients) in line with the new nationally agreed clinical categories (Priority 2 – 4). All patients who are now added to the Inpatient/Daycase waiting list will have the new priority applied and will receive the new 'Add To Inpatient Waiting List' letter informing them of their priority for transparency. Treatment is currently being booked according to clinical priority to improve clinical outcomes for patients at most risk.

Inpatient/Daycase clinical prioritisation



Diagnostics

Radiology continued to support acute services pathways despite the Covid-19 demand seen in our monthly 20/21 average data. Alongside this, they maintained USOC/Urgent work and have been progressively reducing the routine referral long waits. The graph below shows Radiology activity trends from April 2019 to January 2021. As Covid-19 demand reduced, available capacity was used to reduce long waits. Over recent months (November to January) the rise in demand is thought to be related to the further expansion of outpatient clinics.

Figure 2: Radiology activity (internal management data)

Radiology have taken several steps to increase capacity and are working with the Scottish Government to address the backlog and model the predicted, increasing demand as patients return to GP's and clinics. Radiology were able to create additional capacity internally and at the same time explore additional capacity out with NHS Lothian. Compared to previous years, our average monthly activity for 2020/21 is either similar or greater than 2019/20 and 2018/19. The table below also shows

that the number of patients waiting longer than 6 weeks has increased in 2020/21. This confirms the above rationale relating to increased referrals from clinics and GP's.

	Month Average 20/21	% < 6wks	% > 6wks	Month Average 19/20	% < 6wks	% > 6wks	Month Av 18/19	% < 6wks	% > 6wks
Barium	**52**	69%	31%	**42**	99%	1%	**-**	-	-
CT	**1950**	74%	26%	**1745**	93%	7%	**1360**	98%	2%
MRI	**2505**	60%	40%	**2614**	87%	13%	**2678**	89%	11%
US	**3798**	72%	28%	**3091**	100%	0%	**2512**	100%	0%

Mental Health

Psychological Therapies

There is ongoing improvement with the reduction of patients waiting over 18 weeks for psychological therapy in Adult Mental Health Services. For the quarter ending December 2020 within NHS Lothian 82% of patients were seen within 18 weeks, compared with 78% in the previous quarter. Although this is still below the target of 90%, the current national average for patients seen within 18 weeks is 80%. Trends continue to demonstrate a reduction in the total number of patients waiting for Psychological Therapies, both assessment and treatment into February 2021.

CAMHS

CAMHS performance continues to be a key priority within NHS Lothian and the service will continue to operate as near to normal levels as possible over the coming months and it should be noted that compared to pre Covid-19, there are 4.5% more treatment appointments offered by the service. Overall, the percentage of patients being seen within 18 weeks was 69% in January 2021 which is an increase from 67% in the previous quarter. However, activity levels overall were marginally reduced in January 2021 compared to the previous quarter, primarily due to staff absence at the start of the month associated with the holiday period.

Healthcare Acquired Inflections

The community associated SAB incidence across NHS Lothian for January 2021 (n=6) has seen a substantial decrease from the previous month's peak and is now below the current mean. None of the diagnoses were deemed to be associated with sources that were potentially preventable.

Areas requiring improvement and mitigating actions

Unscheduled Care

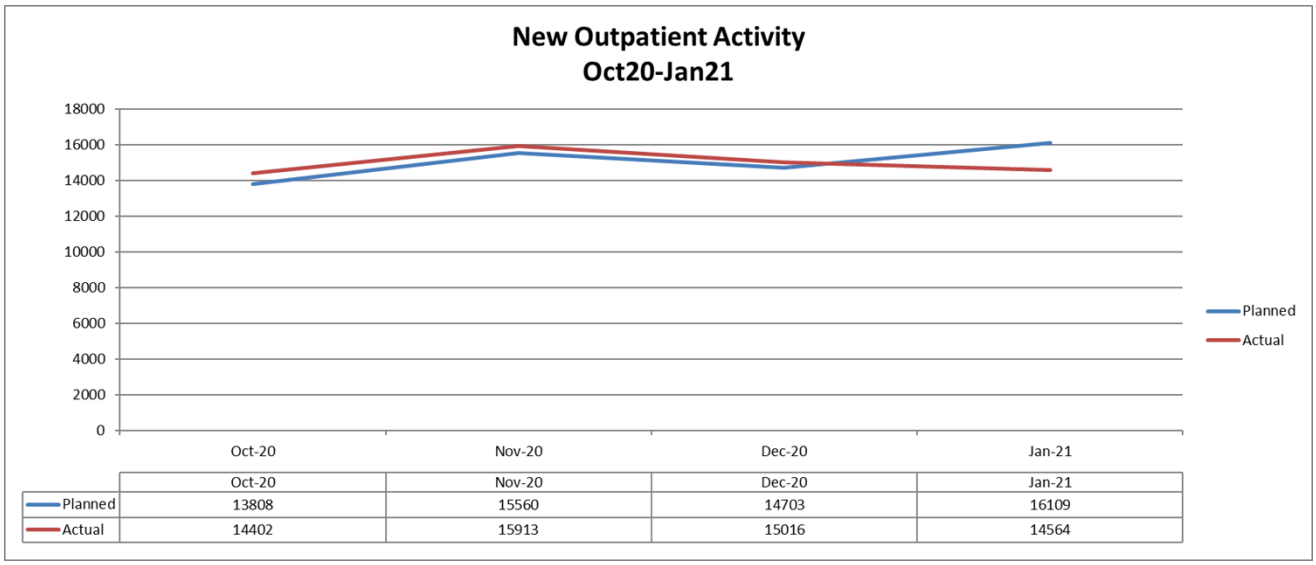
The 4 hour emergency access performance remains challenging across the adult acute sites with a deteriorating position since summer 2020. This follows a similar trend to that seen across Scotland. While self-presenter attendances remain significantly reduced compared to pre Covid-19, attendances following ambulance or GP referral are almost back to pre Covid-19 levels of attendance. These represent the cohort of more complex patients who are more likely to require admission than the self-presenting cohort. To support performance improvement the following areas are being progressed:

- Improving the reliability of front door processes including; reducing/maintaining time to triage, reducing/maintaining time to first assessment, reducing breaches due to first assessment, treatment, diagnostics
- Increasing the number of scheduled assessments; phase one of the Redesign of Urgent Care Programme established the pathway via 111 to the flow centre. This was implemented in December 2020 to support the scheduling of minor injury assessments (Call MIA – both scheduled Near Me and face-to-face assessments) as well as supporting increased sign-posting behaviour and redirection from flow centre and ED. Activity through this new pathway is currently low due to dependency on NHS24 workforce capacity to answer a higher volume of calls to 111.
- Increasing alternatives to unscheduled ED attendance; phase two of the Redesign of Urgent Care Programme aims to develop and improve professional referral to same day services (both community and secondary care) which should also prevent attendance at ED. Same day emergency care (SDEC) at WGH has been in place since November 2020 and a pan-Lothian SDEC approach is being developed to provide capacity for GP and Speciality and associate doctors (SAS) referrals that are suitable for ambulatory secondary care assessment with the aim to discharge home following assessment, diagnostics and treatment plan. A timeline to increase referral pathways for SAS clinicians to same day secondary and community care services via the Flow Centre is being developed and will be phased from April 2021.
- Improving reliable capacity to admit from ED, and improving reliable discharge planning and transfers of care by; reducing length of stay, refreshed focus on pre-12 discharges, reducing boarding, and improving effectiveness of joint working across acute and community teams to improve joint discharge planning and reduction of delays. A scoping exercise is currently underway via the Unscheduled Care Committee to identify a project framework to implement a Planned Date of Discharge model. This will also ensure we take a pan-Lothian approach.

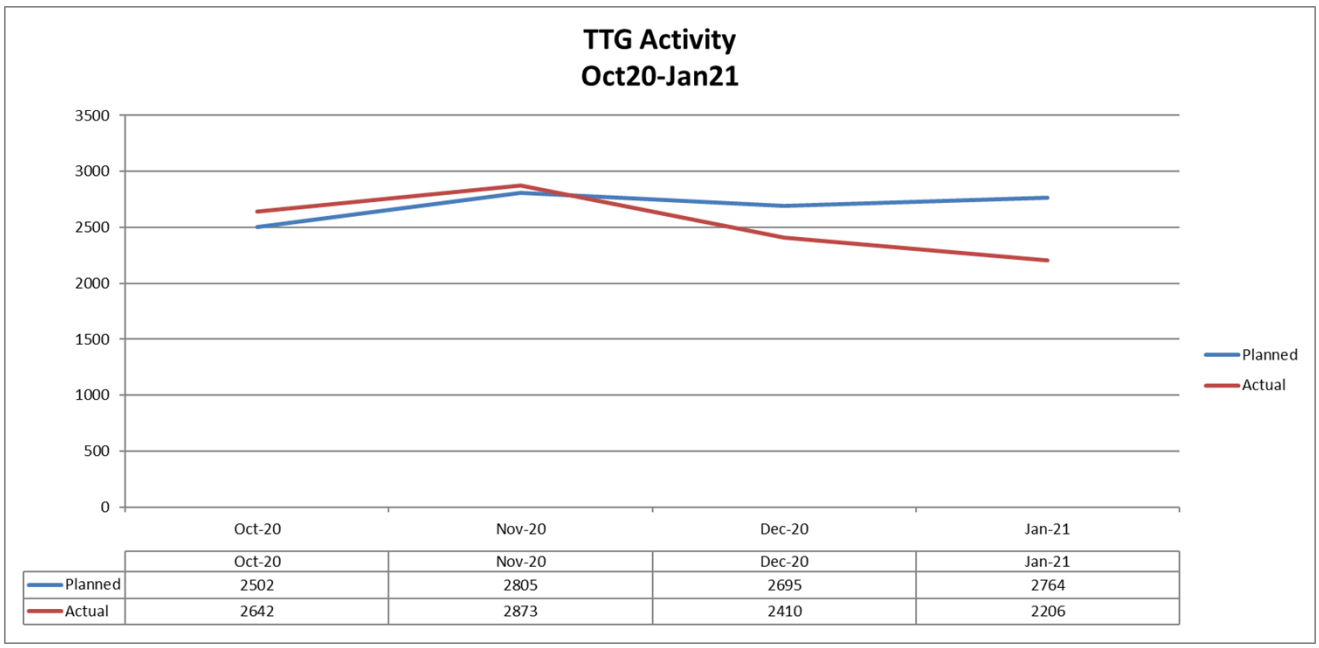
Figure 3: PHS data; NHS Lothian (RIE, WGH, SJH, and RHSC) and Scotland 4-hour emergency access performance

Outpatients and TTG

The impact of physical distancing and infection control measures has meant that capacity is below expected pre-Covid-19 levels. Routine referrals (additions) are unsurprisingly below pre Covid-19 levels but the backlog is steadily increasing, especially for long waiting routine patients as activity is prioritised for patients with the greatest clinical need. The activity levels in the graphs below demonstrate a drop in January for both OP and TTG activity. This is linked to the expected external provision which was included in the planned trajectories that subsequently could not take place due to the national lockdown.



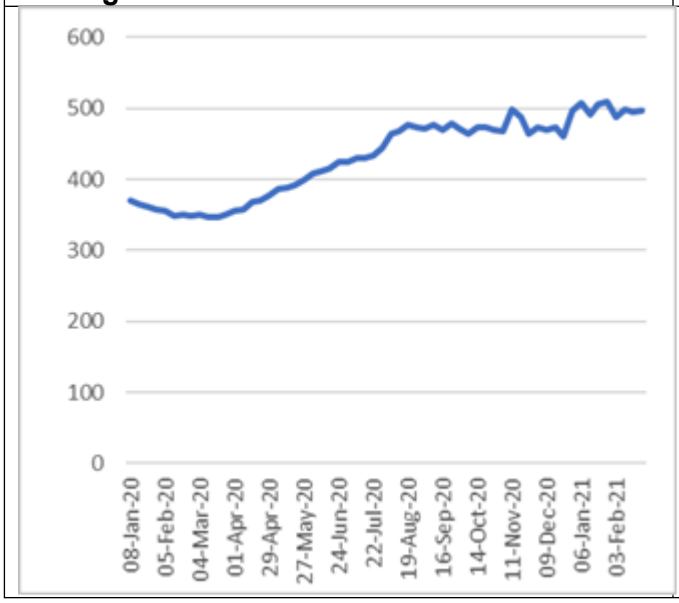
	Oct-20	Nov-20	Dec-20	Jan-21
Planned	13808	15560	14703	16109
Actual	14402	15913	15016	14564



	Oct-20	Nov-20	Dec-20	Jan-21
Planned	2502	2805	2695	2764
Actual	2642	2873	2410	2206

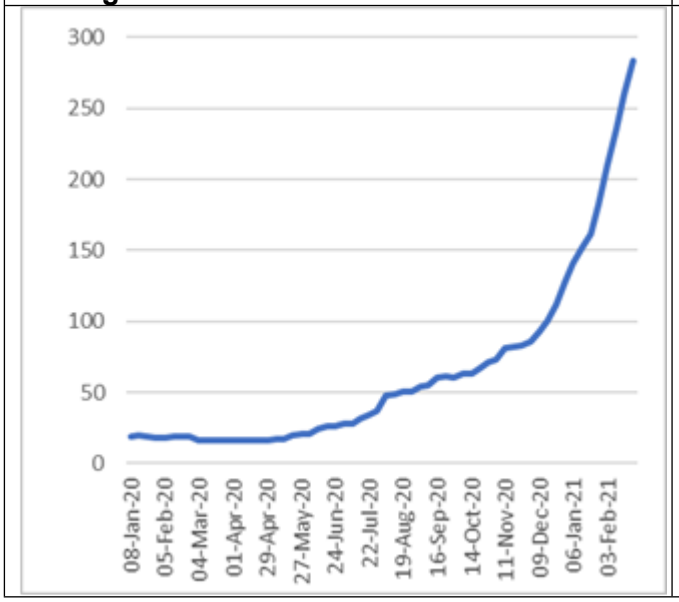
While services are focusing on the most urgent patients, there is also a focus on the longest waiting patients in order to manage the backlog of planned care to minimise harm. There has been a marked reduction in the number of Outpatients waiting over 104 weeks. A stepwise reduction will next focus on the number waiting over 78 weeks.

New Outpatient waiting list and patients waiting over 78 weeks

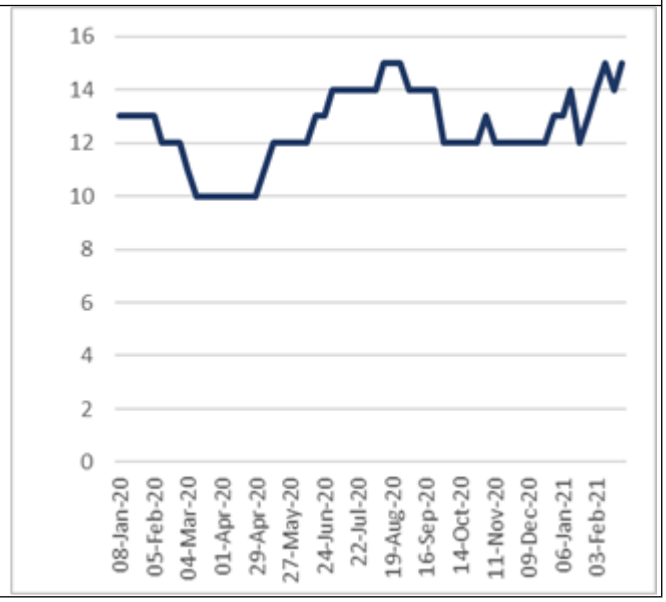


New Outpatient patients waiting over 104 weeks

Inpatient/Daycase waiting list and patients waiting over 78 weeks



Inpatient/Daycase patients waiting over 104 weeks



To manage and improve the performance position, each individual services' operational management team have a regular weekly oversight of the longest waiting patients in each clinical priority group. This includes active management of booking into the next available capacity and monitoring the keeping in touch pathway to ensure patients are fully informed.

Due to the ongoing performance challenges within both dermatology and the Edinburgh Dental Institute (EDI), an enhanced forensic review is required. To enable this, these services will move into the Director of Improvements portfolio from April 2021. Updates on improvement plans for EDI will be included in the next performance paper.

Dermatology

As mentioned, Dermatology is one of the key specialities with poor outpatient performance. The key drivers for this include:

- Prior to Covid-19 there was existing capacity issues and we have been reliant on external providers which stopped in March 2020 and has not yet restarted due to national lockdown.
- A return to pre Covid-19 referral rate (approximately 400 per week).
- A reduction in OP core capacity due to physical distancing and necessary infection control measures.
- Staffing issues; including maternity leave for key staff members and recruitment challenges.

To improve performance, waiting list initiatives (WLI) have been established until end of March 2021 in addition to the remobilisation of external provider contracts from April 2021. These actions and the resulting additional capacity are heavily reliant on adequate workforce and the sustainability of WLIs is uncertain due to this limitation. Multiple modernisation projects are also underway to support the efficiency and effectiveness of the service which may have varying degrees of impact on performance.

Strategic Transformation

Outpatient services have long been seen as an area amendable to transformation in the way services are delivered but until the Covid-19 pandemic the scale of these changes were relatively limited. The challenge for NHS Lothian now, is to look at the benefits from the way outpatient and allied services were delivered during the pandemic to deliver improved patient journeys and experience. Five priority outpatient redesign projects have been identified to be taken forward:

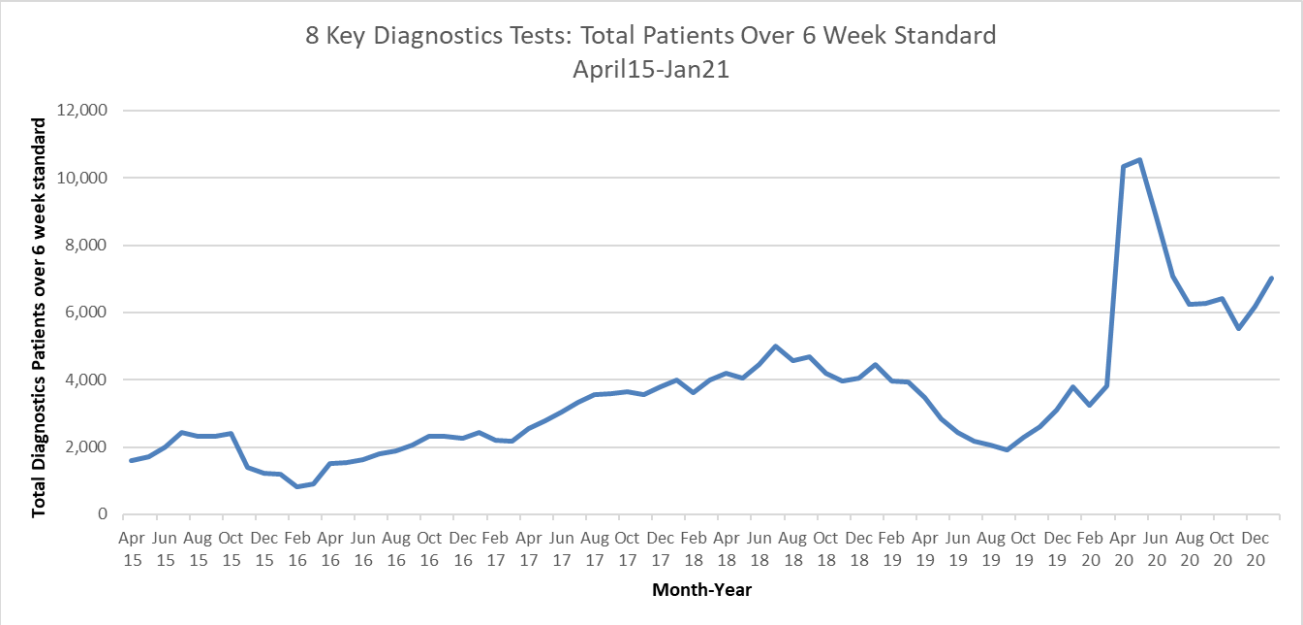
- Active Clinical Referral Triage (ACRT) (e.g. advice only, direct to diagnostics, direct to intervention/surgical waiting list, etc.);
- Virtual Clinics (Near Me & Telephone, asynchronous consultations);
- Monitoring Clinics;
- PIFU (Patient Initiated Follow-Up);
- PFB (Patient Focused Booking)

Cancer

The overall 62 day cancer performance remains below target throughout 2020/21, however has sustained a stable position from November 2020 through to January 2021. The majority of breaches which occurred are from colorectal and urology pathways, despite a significant reduction in urology and colorectal diagnostics waits since November. To address this, the following actions and plans are in place:

- The re-establishment of weekly cancer pathway huddles and national monitoring/escalation calls.
- External capacity for Robot Assisted Prostatectomy commenced at Spire in January 2021.
- Radiology services have also agreed to provide additional external capacity for MRI Prostate via the University of Edinburgh, the anticipated start date for this is April 2021.
- The prostate pathway stakeholders have been meeting weekly enhancing quicker decision making and communication, and this combined with actions from the Patient Tracking List meetings has demonstrated improved waiting times within the pathway. Actions have addressed PCC waits which are now down to an average of 15 days.
- For the colorectal pathway, CT colonography capacity at the Western General Hospital is now almost operating at pre Covid-19 capacity which has contributed to a slight recovery, although the service is exploring whether there is a requirement to increase this further.
- Ongoing work to embed the qFIT pathway to support colorectal pathway; this is the quantitative immunological test which will be used in symptomatic bowel disease patients.

Diagnostics



A significant factor in performance is due to the current Radiographic workforce being significantly depleted due to:

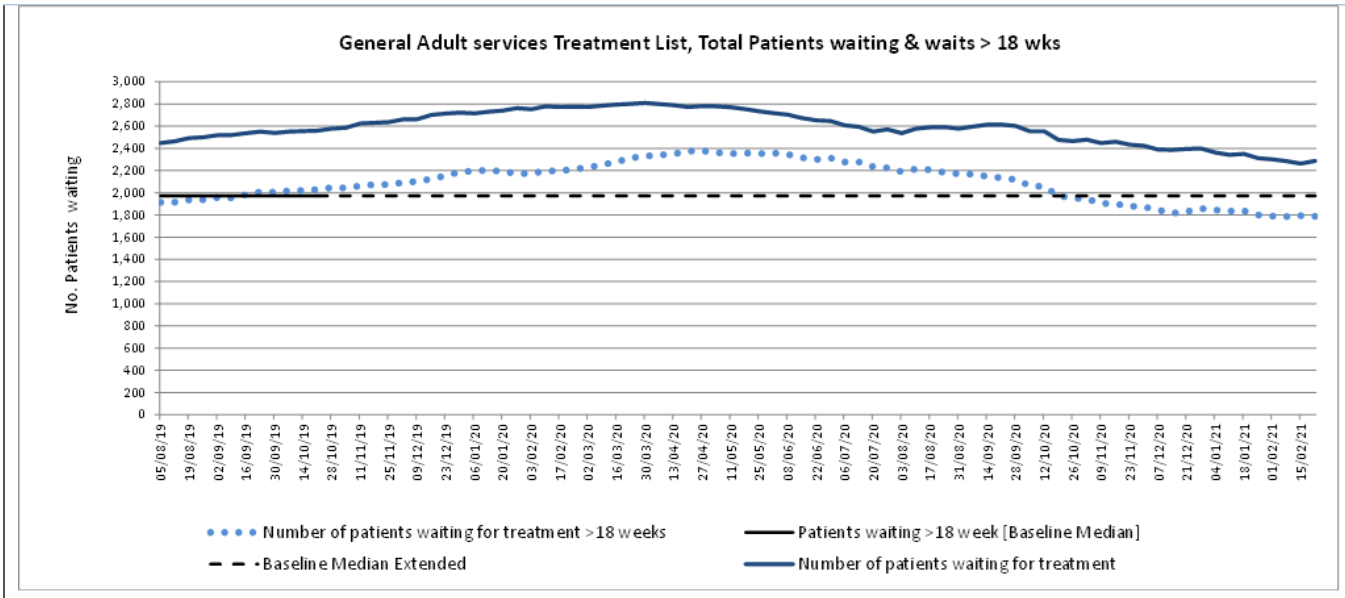
- Agency and bank are stagnant.
- Staff shielding
- Staff with limited flexibility due to family/children responsibilities. The impact on Ultrasound was significant in this regard. The service has recently recruited many new graduates (over establishing) who will start over the coming months

Social distancing in waiting areas and aerosol generated procedures (AGP) undertaken in Radiology have also reduced previous capacity. This has been mitigated as far as possible by contracting local external imaging providers for additional capacity. The requirement for suspicion of cancer referrals to be imaged within two weeks does impact on the capacity we require to reduce routine waits and improve our overall performance. An increase in USoC referrals is expected in the coming months as patients return to GPs or present through unscheduled care with progressively worse staging of disease.

Mental Health

Psychological Therapies

The trajectory for adult mental health services is dependent on the job planned capacity across primary care mental health teams (PCMHT's) and Psychological Therapy Teams and projected demand. Whilst estimates of capacity are reasonably robust demand is proving more difficult to predict with historic figures being of limited value under current circumstances and uncertainty about the longer-term impact of the pandemic. Given these uncertainties, the indication is that the number of patients waiting over 18 weeks will continue to go down albeit relatively gradually. The trajectory shown below assumes levels of demand broadly consistent with that seen over the last 6 months but this assumption is relatively fragile and will be monitored closely.



A cohort of patients have opted by preference for face to face treatment and as a result have extended waiting times due to reduced capacity in this access route. This cohort make up an increasing number of those waiting over 18 weeks.

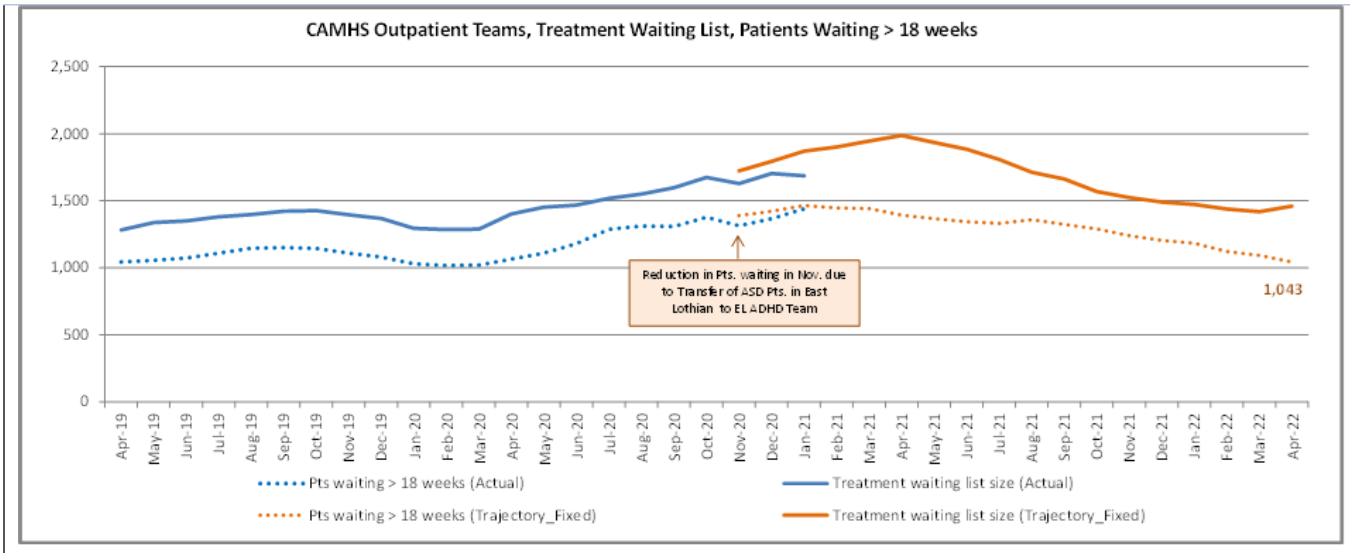
Patient Focused Booking is a key intervention within the Improvement plan and full referral to treatment time functionality is required for the non-manualised patient focused booking to be operational. This is contingent on eHealth supporting this change. The implementation of text reminders is also expected to improve DNA and CAN rates.

A digital group platform is currently being explored for the implementation of group work at greater scale. While face to face group work is being offered, the numbers are limited due to social distancing and other infection control measures. It is thought patient flow could be increased significantly if we were able to offer a range of group interventions using a digital platform. The use of video technology for group work is being approved at national level and it is expected this capability will be available in summer 2021. In order to reduce health inequalities, patients who are experiencing digital poverty would be offered face to face treatment.

CAMHS

Overall, CAMHS remains slightly below Trajectory at the end of January 2021 and remains below the standard. The total patients waiting was below trajectory as a result of a combination of less than predicted demand (105 vs 154) and more first treatment appointments being offered than expected (86 vs 70). The activity targets for February 2021 increased from 70 in January to 118. A risk to achieving this increased level of activity is the corresponding rate of discharge from caseloads. The service are mitigating this risk by renewing focus on supporting the concepts and practice of 'letting go' supervision and working with third sector partners to deliver post-diagnostic support. The number of patients waiting over 18 weeks has increased despite a small drop in the total number of children and young people waiting. This is due to the proportion of cases that are being seen on an urgent basis reducing the capacity to take from the waiting list. To mitigate the risk of urgent referrals absorbing capacity to offer New Patient appointments to patients waiting over 18 weeks, a number of key actions have been agreed:

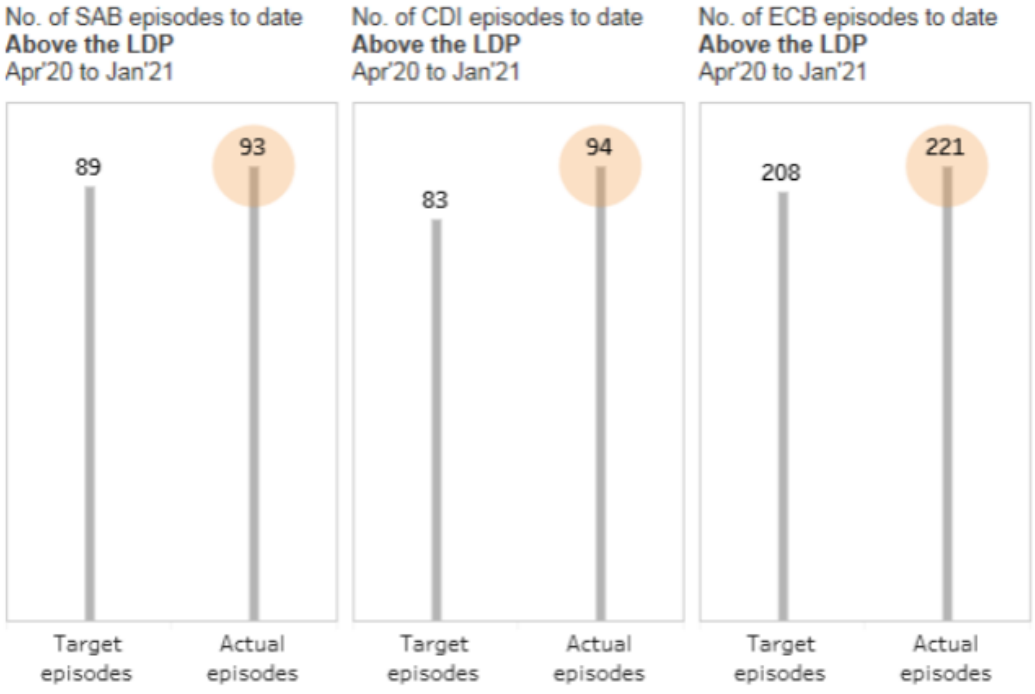
- provision of Unscheduled Care Service by Spring 2021 (41% of urgent demand could have been managed by an unscheduled care resource);
- adoption of a Brief Intervention standard operating procedure to provide time-limited (6 session) stabilisation support;
- adoption of single clinician delivered Family Based Therapy (an intervention that was previously delivered by two clinicians).



Autism Diagnostic Observation Schedule (ADOS) appointments have been suspended at present due to Covid-19 restrictions, however the service is engaging with partners in Community Child Health to adapt and restart the delivery of these assessments and expect these to resume from April 2021. The resumption of these specialist assessments is envisaged to positively recover the position on the number of patients waiting over 18 weeks, as the longest waiters in all teams are young people requiring an ADOS assessment.

Healthcare Acquired Infections

The average monthly data from April 2020 to January 2021, suggests we are currently exceeding our incidence target for all three standards in 2020/21.



The healthcare associated SAB incidence across NHS Lothian for January 2021 (n=12) has seen an increase from the previous month and is now above the current mean. A number of these were deemed to be associated with a source that was potentially preventable. In response to a review of these cases, local staff education was delivered on aseptic non-touch techniques (ANTT) to support the prevention of future incidences. This standard was met in 2019/20, with 5 fewer incidences that the target.

The ECB healthcare associated incidence across NHS Lothian has also increased to above the current

mean in January 2021 compared to previous month. In 2019/20 the target for this was not reached and we have already exceeded the target incidences for 2020/21. 34% of the healthcare associated incidences in January were from a source that was potentially preventable. Community cases have also increased and have remained above the current mean for the last 5 months. Recognising NHS Lothian's performance in this area and in line with refreshed NICE guidelines in December 2020, there will be a proposed change in the first line empirical therapy for certain patient cohorts at risk of antimicrobial resistance. This will seek to reduce ECB incidences related to urinary tract infections.

4 Key Risks

4.1 The risks associated with delivering the performance metrics relate to the need for recurring, longer term investment plans and availability of workforce to support delivery of access standard trajectories relating to outpatients, treatment time guarantee, diagnostic, cancer, child and adolescent mental health services and psychological therapies.

4.2 Implementation of some of the longer term ambitions to improve performance require an ambitious cultural change for patients and staff. The key risk to this is the potential for services to revert back to pre Covid-19 working practices.

4.3 That there will be an increased demand and backlog as a result of increased contact with GP and clinic.

4.4 There is limitations, due to infection control measures and national lockdowns on both internal and external capacity.

4.5 Some specialties have particular challenges with recruitment into key roles, ultimately impacting their capacity to support clinical services.

5 Risk Register

5.1 NHS Lothian's Risk Register already includes the risks associated with delivery of performance standards outlined in the 2019 - 20 Annual Operational Plan and Recovery Plans. The corporate risk register is subject to on-going review and update.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment associated with this grouping of performance metrics has not been undertaken. The directors for each service area are responsible for ensuring an integrated impact assessment is carried out where new services, redesign of services and new strategies/plans are referenced to allow NHS Lothian's Lead on Equalities and Humans Rights to follow up and review whether the necessary assessments have been completed as appropriate.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 NHS Lothian Directors, IJB Chief Officers and their teams have supported the development of the Remobilisation Plan which NHS Lothian is currently working to enact. Any public engagement and consultation relating to the contents of the plan remains with this programme of work.

8 Resource Implications

8.1 The resource implications are being clarified through our finance department. Any financial reporting will remain within the remit of the Director of Finance.

Wendy MacMillan
Business Manager, Deputy Chief Executive
26/03/2021

Wendy.macmillan@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Delayed Discharge Code Inclusion

Appendix 1: Delayed Discharge Code Inclusion

Health and social care reasons: Public Health Scotland		
	Assessment:	
		awaiting commencement of post-hospital social care assessment
		awaiting completion of post-hospital social care assessment
	Funding:	
		non-availability of statutory funding to purchase Care Home Place
		non-availability of statutory funding to purchase any Other Care Package
	Awaiting place availability:	
		in Local Authority Residential Home
		in Independent Residential Home
		in Nursing Home
		in Specialist Residential Facility for younger age groups (<65)
		in Specialist Residential Facility for older age groups (65+)
		in care home (Dementia bed required)
		Awaiting place availability in an Intermediate Care facility
	Awaiting completion of care arrangements:	
		for care home placement
		in order to live in their own home – awaiting social care support (non-availability of services)
		in order to live in their own home – awaiting procurement/delivery of equipment/adaptations fitted
		Re-housing provision (including sheltered housing and homeless patients)
	Transport:	
		awaiting availability of transport
Patient and family related reasons -		
	Legal/Financial:	
		legal issues (including intervention by patient's lawyer) e.g. informed consent and/or adult protection issues
		financial and personal assets problem - e.g. confirming financial assessment
	Disagreements:	
		internal family dispute issues (including dispute between patient and carer)

		disagreement between patient/carer/family and health and social care
	Other:	
		patient exercising statutory right of choice
		patient does not qualify for care
		family/relatives arranging care
		other patient/carer/family related reason
Code 9 reasons -		
	Patients delayed due to the Adults with Incapacity Act	
	Code 9 patients (excluding those delayed due to Adults with Incapacity Act):	
		awaiting completion of complex care arrangement - in order to live in own home
		awaiting place availability in specialist residential facility (under 65)
		awaiting place availability in specialist residential facility (65+)
		patient exercising statutory right of choice – where an interim placement is not possible or reasonable

NHS LOTHIAN

NHS Lothian Board
7th April 2021

Chief Officer, Acute Services

NHS LOTHIAN DID NOT ATTEND POLICY

1 Purpose of the Report

1.1 The purpose of this report is to reassure the NHS Lothian Board that NHS Lothian continues to follow the Scottish Government Waiting Times Guidance for patients who do not attend (DNA) for treatment.

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

2 Recommendations

It is recommended that Board members:

2.1 **Acknowledge** that NHS Lothian is in line with national guidance with regards to the management of patient who do not attend appointments.

2.2 **Take significant assurance** that NHS Lothian's Waiting Times Standard Operating Procedures are readily accessible to all staff and appropriate training is in place.

2.3 **Recognise** the Waiting Times Governance processes in place to provide assurance that the national and local guidance is being adhered to.

2.4 **Acknowledge** that the processes in place in CAMHS and Psychological Therapies services are in line with NHS Lothian and Scottish Government guidance.

3 Discussion of Key Issues

3.1 An appointment is defined as a Did Not Attend (DNA) if a patient did not attend and gave no prior warning of this.

3.2 The NHS Lothian Waiting Times Standard Operating Procedures and Local Access Policy have been developed in line with Scottish Government guidance and expanded to support staff in the operational application of these.

3.3 The relevant section from the NHS Lothian DNA guidance is attached in Appendix 1.

3.4 This guidance is available to all staff through the NHS Lothian intranet and all staff who undertake waiting list processes in their role are required to undertake annual face to face SOP training and completion of a LearnPro module.

3.5 The guidance in place in CAMHS and Psychological Therapies is in line with this and the service has recently worked to ensure staff are able to implement these locally with the different patient groups that they support.

3.6 There are some limited exceptions to the DNA policy, for example, in Infectious Diseases, Paediatrics and Oncology services patients will be offered more than one opportunity to attend before consideration for removal from the waiting list due.

3.7 The terminology used in Paediatric services is also different and focuses on the fact that the patient 'was not brought' to an appointment rather than 'did not attend'.

3.8 The use of the DNA policy is monitored by the Waiting Times Governance Team through monthly audits and Process Monitoring dashboards. The results of these audits/reviews and resulting action areas are shared with services and the Access, Assurance & Compliance Group.

4 Key Risks

4.1 None

5 Risk Register

5.1 None

6 Impact on Inequality, Including Health Inequalities

6.1 Impact assessments have been carried out on the NHS Lothian Local Access policy on several occasions. The main findings were to increase and improve communications with patients, particularly those with additional support needs. Communication with patients is continually under review locally and nationally.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 It is important that the NHS Lothian Local Access Policy is visible and accessible. To this end, the Waiting Times Governance & Data Quality Team ensures that it is appropriately updated on-line and incorporate all changes into the Waiting Times SOP website, training and all process monitoring tools.

8 Resource Implications

8.1 None

Anne Lavery
Head of Access, Scheduled Care
NHS Lothian.
19/03/2021

Appendix 1: NHS Lothian: Waiting Times Standard Operating Procedure (Scheduled Care)

Appendix 1

NHS Lothian: Waiting Times Standard Operating Procedure (Scheduled Care)

Did Not Attend (DNA)

NHS Lothian will not routinely offer a further outpatient appointment or admission date to a patient who does not attend (DNA) without prior notice.
When a patient does not attend, the appointment should be marked as a 'DNA' which will reset the patient's waiting time clock (regardless of clinical priority). The patient's notes should be presented to the responsible clinician to be reviewed. The clinician should decide whether a further appointment is to be offered. There must be a clear clinical reason for offering a further appointment.

If a further appointment is to be offered:

- The DNA should be recorded but the patient will remain on the waiting list to be booked at a future date. The waiting times clock will reset to zero as of the date the patient DNA'd.
- A further appointment should be booked for the patient, within the agreed waiting times guarantee from the date of the missed appointment.
- The only letter sent in this case would be the new appointment letter.

Return Patient: the patient should only be sent the new appointment letter.

If no further appointment is to be offered:

- The patient should be removed from the waiting list (using the date of the appointment that was DNA'd as the effective date).
- A Removal letter should be sent to the patient advising them that they have been removed from the waiting list due to DNA.
    - The letter should also inform the patient that if they contact the service within 4 weeks, they may be offered another appointment (regardless of original offer type, written or verbal).
    - A copy of the removal letter should also be sent to the GP, advising them that the patient has been removed from the waiting list and of the above process.

Return Patient: the patient should be sent the DNA letter and no further appointment should be booked.

NHS LOTHIAN

Board Meeting
07 April 2021

Director of Primary Care Transformation/Director of Nursing, Midwifery and Allied Health Professionals

COVID VACCINATION PROGRAMME

1. Purpose of the Report

1.1. The purpose of this report is to update the Board on the covid vaccination programme.

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

2. Recommendations

2.1. The Board is asked to:

2.2. Note the update on the covid vaccination programme performance.

2.3. Note that Lothian's reported performance against the whole eligible population is skewed by a number of issues and that Lothian's performance against the cohorts offered vaccination so far is better than reported.

3. Discussion of Key Issues

3.1. The Board has previously been updated in detail on the covid vaccination programme. This paper focuses on progress with the programme and issues around vaccine supply.

3.2. The table below summarises the cohorts eligible for covid vaccination by priority.

Table 1

Priority Group	Risk Group
1	Residents in a care home for older adults and their carers
2	All those 80 years of age and over Frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over Clinically extremely vulnerable individuals*
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

(once cohort 9 has been offered 1st dose vaccination, the programme will move on to vaccinate those aged 18 to 49)

3.3. There has been comment on how Lothian's progress with vaccination compares with Scotland.

3.4. The table below shows the % of the total eligible population vaccinated for all Health Boards at 22/03/21

Table 3: % of total eligible population vaccinated at 22/03/21

	Total 1st doses	Pop 16+	Percentage Coverage	Percentage of 16+ Scotland Population	Percentage Vaccine Share
NHS AYRSHIRE & ARRAN	163,984	308,231	53.2	6.8	6.7
NHS BORDERS	50,537	96,487	52.4	2.1	2.1
NHS DUMFRIES & GALLOWAY	72,938	125,617	58.1	2.8	2.7
NHS FIFE	161,544	308,998	52.3	6.8	6.8
NHS FORTH VALLEY	132,273	254,165	52.0	5.6	5.7
NHS GRAMPIAN	213,461	485,116	44.0	10.7	11.1
NHS GREATER GLASGOW & CLYDE	416,325	985,014	42.3	21.7	21.4
NHS HIGHLAND	141,816	269,758	52.6	5.9	5.9
NHS LANARKSHIRE	279,966	543,415	51.5	12.0	12.0
NHS LOTHIAN	316,867	755,366	41.9	16.6	16.6
NHS ORKNEY	11,568	18,688	61.9	0.4	0.4
NHS SHETLAND	12,002	18,722	64.1	0.4	0.4
NHS TAYSIDE	177,465	349,860	50.7	7.7	7.7
NHS WESTERN ISLES	15,316	22,466	68.2	0.5	0.5
Total	**2,166,062**	**4,541,903**	**47.7**	**100.0**	**100.0**

3.5. It appears that NHS Lothian is behind other Boards. However the denominator used is the whole eligible population down to age 16. Lothian's population is skewed to the under 50's. The initial stages of the vaccination programme focused on the over 50's.

3.6. The table below illustrates this.

Table 4: population shares by age:

NHS Board	All Ages		Population aged 50+		Population aged 16+	
Scotland	**5,463,300**		**2,183,051**	**40%**	**4,541,903**	**83%**
Ayrshire and Arran	369,360		168,012	45%	308,231	83%
Borders	115,510		56,176	49%	96,487	84%
Dumfries and Galloway	148,860		73,679	49%	125,617	84%
Fife	373,550		156,651	42%	308,998	83%
Forth Valley	306,640		125,077	41%	254,165	83%
Grampian	585,700		226,627	39%	485,116	83%
Greater Glasgow and Clyde	1,183,120		432,449	37%	985,014	83%
Highland	321,700		149,432	46%	269,758	84%
Lanarkshire	661,900		266,272	40%	543,415	82%
Lothian	**907,580**		**318,564**	**35%**	**755,366**	**83%**
Orkney	22,270		10,480	47%	18,688	84%
Shetland	22,920		9,615	42%	18,722	82%
Tayside	417,470		176,861	42%	349,860	84%
Western Isles	26,720		13,156	49%	22,466	84%

3.7. The impact of this on reported performance against the whole eligible population is shown in the table below.

Table 5: Performance in relation to population shares to 22/03/21

BOARD	% OF TOTAL ELIGIBLE POPULATION VACCINATED AT 22/03/21 (OVER 16)	% OF POPULATION OVER 50	% OF POPULATION OVER 50 VACCINATED AT 22/03/21
LOTHIAN	41.9	35.0	99.5
GG&C	42.3	37.0	96.3
GRAMPIAN	44.0	39.0	94.2
TAYSIDE	50.7	42.0	100.0
LANARKSHIRE	51.5	40.0	105.0
FVHB	52.0	41.0	106.0
FIFE	52.3	42.0	103.0
BORDERS	52.4	49.0	89.9
HIGHLAND	52.6	46.0	94.9
AYRSHIRE AND ARRAN	53.2	45.0	97.6
DUMFRIES AND GALLOWAY	58.1	49.0	99.0
ORKNEY	61.9	47.0	110.4
SHETLAND	64.1	42.0	124.8
WESTERN ISLES	68.2	49.0	116.4
SCOTLAND	47.7	45.0	97.6

3.8. This shows that Boards with larger proportions of population under 50 generally have lower % coverage of the entire eligible population. This is because these Boards have a larger proportion of their populations in groups that have not been offered vaccination. This creates a larger proportion of the denominator that is unvaccinated which distorts the apparent performance.

3.9. When all Boards total first dose vaccinations are compared against their over 50 population only, the picture is very different showing a much closer range of performance.

3.10. Another way to look at the same issue is to show what % of its total population a Board should have vaccinated on the assumption of 100% uptake. This is illustrated below.

Table 6: % of total population vaccinated up to cohort 9

Area name	All Ages	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90+
Scotland	5,463,300	347,456	382,255	369,463	352,522	319,432	361,458	401,090	393,123	344,693	299,444	278,856	195,951	142,807	83,429	43,658
		0.789932	0.726334	0.656366	0.58874	52.4%	46.6%	40.0%	32.6%	25.4%	19.1%	13.6%	8.5%	4.9%	2.3%	0.8%
NHS Board areas																
A N Other Board	321,700	16,442	16,492	17,092	18,437	17,665	21,220	25,198	25,550	23,386	21,610	20,379	14,443	10,014	5,886	2,966
		79.8%	74.7%	69.6%	64.3%	58.5%	53.0%	46.5%	38.6%	30.7%	23.4%	16.7%	10.4%	5.9%	2.8%	0.9%
Lothian	907,580	65,298	77,461	74,344	66,392	57,555	59,631	61,396	58,448	49,766	42,745	39,714	27,199	20,286	12,330	6,680
		79.2%	72.1%	63.5%	55.3%	48.0%	41.7%	35.1%	28.3%	21.9%	16.4%	11.7%	7.3%	4.3%	2.1%	0.7%

3.11. This shows that as a Board moves from right to left vaccinating priority cohorts down to age 50, Lothian ends up having vaccinated 35.1% of its population compared to another Board that has vaccinated 46.5%.

Vaccine Supply

3.12. Vaccine supply has continued to be problematic with short notice changes to timing and volumes occurring regularly. There have been well publicised variations nationally in vaccine supply that have affected Lothian as much as other Boards. Despite this Lothian has received sufficient supply overall to meet targets for completion of cohorts.

3.13. It does appear that Lothian has been a few days later than some other Boards in starting and finishing some cohorts and there has been speculation that this is due to inadequate vaccine supply to Lothian.

3.14. Vaccine supply up to cohort 9 has been calculated on the Board's share of the Scottish population over 50. Lothian has 14.59% of the Scottish population over 50 and has received this share of vaccine supply to date.

3.15. However, there are a number of factors that mean this has not been adequate to enable Lothian to perform as quickly as some other Boards, although Lothian has met the national targets for completing cohorts.

3.16. As shown in table 5, Lothian has the highest % of its population under 50 in Scotland. This means that where cohorts up to cohort 9 have an element of under 50's within them (Clinically Extremely Vulnerable, 16 to 64 At Risk, Staff), this will inflate the size of these cohorts disproportionately in Lothian against a supply calculation that excludes these patients.

3.17. Lothian has 18.8% of the Scottish Care Home population compared to a 14.59% share of the vaccine supply. This creates a proportionately bigger care home resident population and care home staff population.

3.18. Lothian has 8648 staff who have been vaccinated in Lothian using Lothian supply, but who appear in other Board's performance figures. With only 6392 Lothian resident staff vaccinated in other Boards. This is because of the high proportion of NHS Lothian staff who live outside Lothian. Whilst this will also be a factor for some other Boards it does not apply to all.

3.19. Lothian is also home to tertiary and national services and 4 Universities therefore Lothian has more staff and students who will qualify for staff vaccination because of their clinical commitments.

3.20. It is an accumulation of these issues that has resulted in a programme that appears to have tighter margins between vaccine supply and the size of cohorts.

3.21. These issues have been recognised by the national team and Lothian will receive 20,000 additional doses above previously planned deliveries to enable completion of cohort 9 by 18th April at the latest. In addition Lothian, Greater Glasgow and Clyde and Grampian have been selected to receive the new Moderna vaccine in early April without a negative impact on supply of AstraZeneca or Pfizer.

3.22. It has also been confirmed that Lothian's share of the national supply will increase to 18.89% for cohort 10 onwards to accurately reflect the larger proportion of Lothian's population that is under 50.

Venues, Workforce and Booking Systems

3.23. NHS Lothian capacity to vaccinate in terms of venues and staffing has not been a factor in performance.

3.24. In terms of venues, there has always been surplus capacity built into the system in order to deal with unforeseen events.

3.25. In terms of staffing there has not been an occasion where there were insufficient staff to vaccinate. There have been no unplanned closures of venues.

3.26. There has been an impact from issues with production of appointment letters through the national booking system in early March which resulted in several thousand letters not reaching patients in cohort 6 in time. This will have impacted on completion of that cohort.

3.27. There has been concern that high DNA levels were impacting on performance. Initial national data was showing DNA levels of around 30% for Lothian. Upon investigation this data was withdrawn by the national team. The revised methodology shows Lothian at 12.2% compared to Scotland level of 18.9% so this should not be affecting relative performance. The DNA level is still of concern and work is underway locally and nationally to improve this.

Governance and Management

3.28. As the programme has moved into a more clinically focused operational delivery the Director of Nursing, Midwifery and Allied Health Professions will chair the Programme Board going forward. The Director of Primary Care Transformation will focus on long term planning for vaccination.

4. Key Risks

4.1. Vaccine supply may continue to be fragile and this may impact on progress. This is a national issue and NHS Lothian is unable to control it.

4.2. Staffing may become more difficult as pandemic restrictions ease and there are greater competing demands for available staff.

5. Risk Register

5.1. This issue is included in the GMS Contract and Vaccination Transformation Risk Registers.

6. Impact on Health Inequalities

6.1. An impact assessment has been carried out. It will be important to support those with access difficulties to reach venues and for the local venues to provide access. A programme of targeted vaccination for hard to reach groups has been developed.

7. Impact on Inequalities

7.1. See above.

8. Involving People

8.1. There has been extensive involvement of stakeholders across the system and with external partners. However the programme has developed at pace and there have been limits on public involvement as a result. The programme is driven by national policy and involvement has focused on the detail of the programme and impact assessment.

9. Resource Implications

9.1. The programme cost estimate is around £23m. Government has given assurance that these costs will be funded.

Alex McMahon
Director of Nursing, Midwifery and Allied Health Professions
Alex.mcmahon@nhslothian.scot.nhs.uk

David Small
Director of Primary Care Transformation
david.a.small@nhslothian.scot.nhs.uk

31 March 2021

NHS LOTHIAN

Board Meeting
07 April 2021

Director Public Health and Health Policy

COVID-19 and Inequalities

1 Purpose of the Report

The purpose of this report is to brief the Board on the unequal impacts of COVID-19 across the Lothian population which have further exacerbated health inequalities. It focuses on emerging evidence about the social impacts of COVID-19 and the associated health impacts. It will highlight opportunities for the Board to address these inequalities as part of its COVID-19 remobilisation and recovery planning.

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

2 Recommendations

Board members are asked to note:

2.1 The findings of the COVID-19 and Inequalities in Lothian report

2.2 The development of an Anchor Institution approach for NHS Lothian

2.3 The development of Public Health locality work plans with particular focus on COVID-19 mitigation

2.4 The development of a Lothian wide survey during 2021 to measure the wider impacts that the pandemic has had on the health of the population.

3 Discussion of Key Issues

3.1 The COVID-19 pandemic has exacerbated existing health and social inequalities. Those in insecure employment, unable to work from home, lacking financial and other resources such as their own transport, are worst equipped to follow isolation and distancing guidelines. In turn, this means they are both more exposed to and more susceptible to the negative social and health impacts associated with COVID-19.

3.2 Age is a risk factor for severe COVID-19 illness along with a number of underlying health conditions. The risk of worse morbidity from COVID-19 increases with age from 50 years. People aged 70 years and older, people working in lower paid jobs and people from some ethnic minority groups are more likely to die from COVID-19 than other population groups. NHS Lothian's COVID-19 mortality rate is 1.8 times higher in the most deprived quintile compared to the least deprived quintile. When care home deaths in Lothian are excluded from the analysis, the rate of COVID-19 deaths in the most deprived quintile is 2.2 times higher than the rate in the least deprived quintile.

3.3 Across Lothian, more than 65,000 people, from a workforce of approximately 513,000 people have been placed on furlough during the pandemic. Between January 2020 and January 2021, the number of people claiming unemployment benefit more than doubled in Edinburgh and Midlothian and almost doubled in East Lothian and West Lothian. Approximately one in twenty of the Lothian workforce is actively seeking work while claiming benefits. There has been a 121% increase in Universal Credit claims in East Lothian, Edinburgh and Midlothian and an 82% increase in West Lothian between March 2020 and January 2021. Across Lothian, in ten months this equates to an additional 40,000 people claiming Universal Credit.

3.4 Scottish Welfare Fund crisis grant applications were 46% higher in the first quarter of 2020/21 than in the same quarter of the previous year. People can apply for grants if they are advised to self-isolate by Test and Protect. These grants are targeted at the most vulnerable in society and only 10% to 20% of applications are approved. Food banks have seen significant increases in demand.

3.5 NHS Lothian's contribution to addressing the causes of inequalities therefore should include engaging with wider public policy debates about the social determinants of health such as income, employment and housing. In response to the Edinburgh Poverty Commission recommendations, NHS Lothian has recognised the need for a Lothian wide approach to tackling poverty and inequalities exacerbated by COVID-19 and corporate objectives for 2021-22 include developing and defining an approach to inequalities and poverty and establishing an Anchor Institutions approach.

3.6 Work around Anchor Institutions has been piloted in England, notably in Wigan and Preston. The Scottish Government's Health and Social Care Directorate is currently working jointly with partners in COSLA, PHS and the Scottish Government Economy Directorate to identify what support NHS and

Social Care providers need to become Anchor Institutions within their local area. NHS Lothian is participating in a Scottish Government pathfinder workshop at the end of March 2021.

3.7 An NHS Lothian Anchor Institution Development Board, chaired by the Interim Director of Public Health, will meet for the first time in May.

3.8 Public Health will lead the development of a Lothian wide survey during 2021 to measure the wider impacts that the pandemic has had on the health of the population. Previous 'Lothian Health and Lifestyle Surveys' can be used to compare population health before and after the pandemic. This new survey will provide vital intelligence to inform future NHS Lothian locality plans for action pertaining to anchor work and health inequalities. The intention is for Public Health to develop this survey drawing upon the expertise of academic and other external partners as required.

4 Key Risks

There are significant long term implications on the health of the population of Lothian caused by the pandemic. This paper outlines the key approaches we will take to mitigate against these impacts.

5 Risk Register

No new risks are identified in this paper

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment was not required for this paper. The paper does show how COVID-19 infection rates were disproportionately higher in areas of multiple deprivation and care homes.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 Not applicable

8 Resource Implications

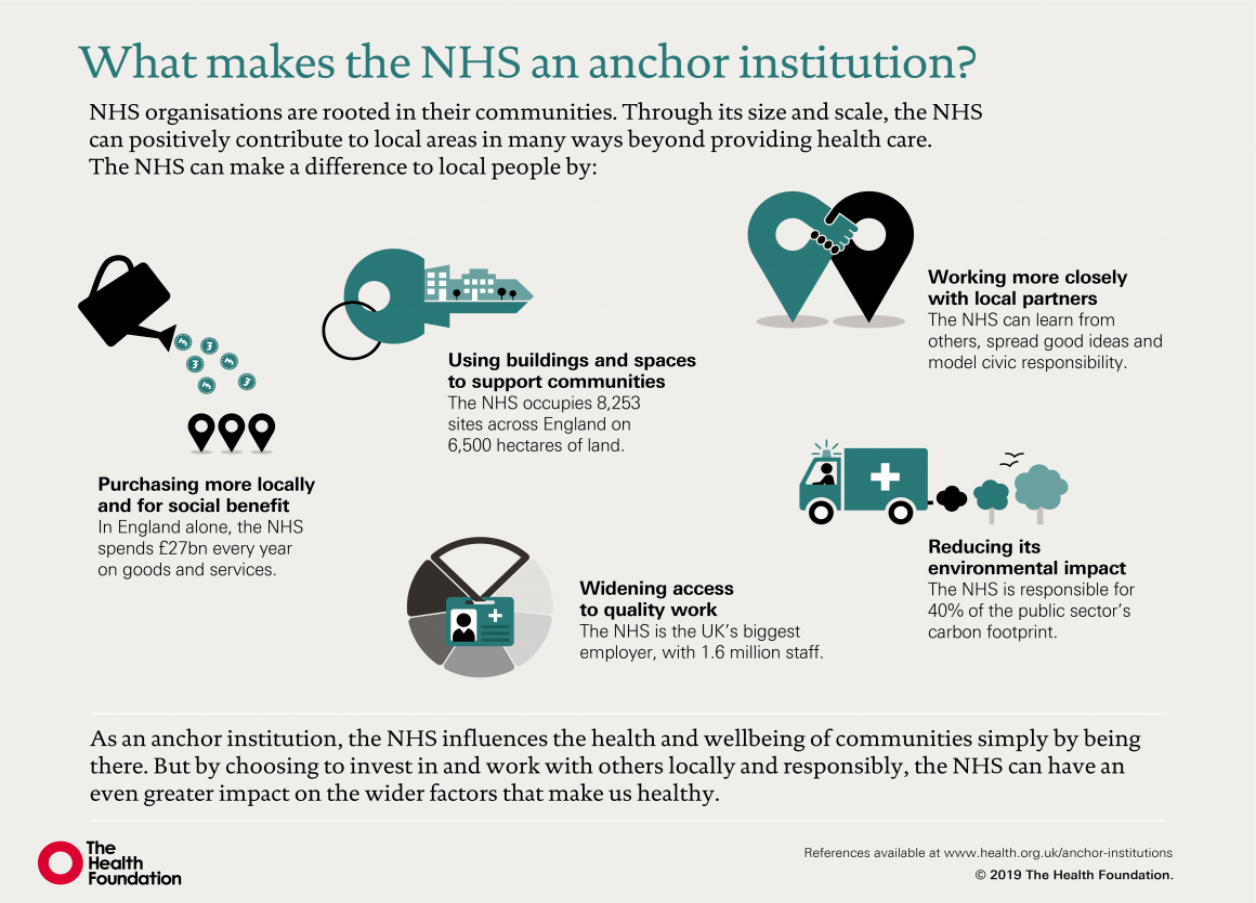
8.1 The resource implications are staff time from within Public Health and other departments to support a new Committee. New Public Health locality teams based in each Health and Social Care Partnership area will support this work as part of their annual work plan. Public Health budget will be used for the Lothian population health survey

Katie Dee
Interim Director of Public Health
25 March 2021
katie.dee@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Health Foundation Anchor Institutions graphic (below)
Appendix 2: COVID-19 and Inequalities in Lothian

Appendix 1: What makes the NHS an anchor institution?



Appendix 2: COVID-19 and Inequalities in Lothian

COVID-19 and Inequalities in Lothian

Introduction

This paper will outline the unequal impacts of COVID-19 across the Lothian population which have further exacerbated health inequalities. It will focus on emerging evidence about the social impacts of COVID-19 and the associated health impacts. It will highlight opportunities for the Board to address these inequalities as part of its COVID-19 remobilisation and recovery planning. This will include the development of a Lothian anchor institutions approach and plans for work within NHS Lothian and alongside partners to address inequalities and poverty.

> *"Inequalities in COVID-19 mortality rates follow a similar social gradient to that seen for all causes of death and the causes of inequalities in COVID-19 are similar to the causes of inequalities in health more generally. While health behaviours contribute to the causes of non-communicable diseases, it is the social determinants of health that cause inequalities in these health behaviours – the causes of the causes."[1]*
>
> *Professor Sir Michael Marmot, Build Back Fairer: The COVID-19 Marmot Review*

Key messages:

- The COVID-19 pandemic has exacerbated existing health and social inequalities. Those in insecure employment, unable to work from home, lacking financial and other resources such as their own transport, are worst equipped to follow isolation and distancing guidelines. In turn this means they are both more exposed to and more susceptible to the negative social and health impacts associated with COVID-19.
- Age is a risk factor for severe COVID-19 illness along with a number of underlying health conditions. The risk of worse morbidity from COVID-19 increases with age from 50 years.
- People aged 70 years and older, people from the most deprived communities, people working in lower paid jobs and people from some ethnic minority groups are more likely to die from COVID-19 than other population groups.
- NHS Lothian's contribution to addressing the causes of inequalities must focus on engaging with wider public policy debates about the social determinants of health such as income, employment and housing.

- The Board is asked to support development of an 'Anchor Institution' model to inform its approach to tackling inequalities and poverty.

Social, economic and health factors – explaining differential impacts of COVID-19 on the Lothian population

Age is the single biggest factor associated with severe illness or death from COVID-19. It is also evident that males have been more likely than females to experience serious illness or death as a result of COVID-19 while females are infected at higher rates. [3, 4] And there is evidence that people from ethnic minority populations, notably some South Asian people, are at higher risk of negative outcomes associated with COVID-19.[9] But the relationship between COVID-19 and age and especially sex and ethnicity is significantly shaped by social factors, which mean that the health and social impacts of COVID-19 have not been experienced equally across the population.[10] People's lives are shaped by multiple axes of social division – class, gender, ethnicity – and power structures that work together and influence each other. The poorest health outcomes have been experienced by those

Box 1: COVID-19 morbidity and mortality in Lothian

- Between July 2020 and January 2021 when testing was more widely available, COVID-19 incidence rates were 1.1 times higher in females compared to males. There was a small but significant difference in incidence rates between females (1,952/100,000) compared to males (1,712/100,000).
- People aged 60-69 years were among the groups with the highest number of admissions to ICU in Scotland during the peak of the COVID-19 pandemic.
- Males had a significantly higher age standardised admission rate than females and COVID admission rates increased with age.
- NHS Lothian COVID-19 age standardised mortality rates are significantly higher in males than females.
- The majority of all COVID-19 deaths occurred in people aged 65 years and older (95% of all COVID deaths in females and 90% of COVID deaths in males). There was a significantly higher death rate in the 80-84 year old age group in males compared to females.
- NRS report that Lothian deaths with COVID are predominantly among people with pre-existing conditions.[2] The most common 'main pre-existing condition' among those who died in Scotland during 2020 with COVID-19 was dementia and Alzheimer's disease (28%), followed by ischaemic heart disease (14%), chronic lower respiratory diseases (11%), cerebrovascular disease (6%) and influenza and pneumonia (5%).[5, 6] [7, 8]
- Scottish Analysis by PHS showed substantial excess all-cause mortality recorded across all deprivation quintiles for weeks 12-25 of 2020 (mid-March to mid-June) compared to the average for the same weeks in the previous 5 years. For this time period, deaths with an underlying cause of COVID-19 contributed most (82%) to the 32% excess in mortality rates.
- NHS Lothian's COVID-19 mortality rate is 1.8 times higher in the most deprived quintile compared to the least deprived quintile. When care home deaths in Lothian are excluded from the analysis, the rate of COVID-19 deaths in the most deprived quintile is 2.2 times higher than the rate in the least deprived quintile.

who are excluded through ‘multiple intersecting causes and multiple forms of morbidity’.[11, 12]
It is important to consider the different ways that risk applies to COVID-19. There are people at greater risk and environments and settings that are higher risk. The risks associated with COVID-19 can be broken down into three elements (see Box 2).

- Risks associated with exposure e.g. living conditions, occupation
- Risks associated with susceptibility e.g. socioeconomic gradient in health and pre-existing health risks
- Risks associated with consequences of COVID-19 e.g. wider social impacts such as unemployment or loss of income.[13]

In short, COVID-19 health outcomes are a complex interplay of age, sex and ethnicity with social risks associated with occupation, income, poverty and housing.

Box 2: Differential risk and COVID-19 [12]

Differential exposure leading to increased risk of infection with COVID-19

Limited material circumstances, such as crowded living conditions and multigenerational households, may increase the risk of being infected with SARS-CoV-2. The WHO housing and health guidelines from 2018 reports strong associations between crowding and airway infections, and there is reason to believe that COVID-19 is no exception. Work-related exposure is also increased for occupations that do not permit working from home and entail physical proximity to other people or direct contact with the public. These typically include low-income jobs in service sectors, such as health or social care, transportation, cleaning and hospitality. Use of public transportation to get to work and the lack of adequate personal protective equipment, or instructions on how to use them properly, may further increase the exposure risk. Precarious employments and a lack of social insurance are also more common among low-income earners and can limit their financial ability to stay at home during sickness.

Differential susceptibility leading to increased risk of severe COVID-19

The risk of severe disease and death in COVID-19 is increased among individuals with poor general health and nutritional status, and among those with underlying chronic conditions such as cardiovascular diseases, lung diseases, diabetes and cancer. The prevalence of these conditions is inversely associated with socioeconomic status. A socioeconomic gradient is also observed for smoking and obesity, which may further aggravate the disease. As health-seeking behaviors relate to health literacy and access to health care and are influenced by user fees, persons in disadvantaged socioeconomic groups may delay seeking care for COVID-19, potentially resulting in more severe disease and death.

Differential consequences of COVID-19

The social and economic consequences of the COVID-19 pandemic will affect the whole population but is expected to strike more severely in lower socioeconomic groups. The risk of unemployment is higher among those with atypical and precarious employment conditions, whose financial margins are already minimal. While unemployment is increasing overall, low-income earners more often serve in sectors that are hardest hit by the pandemic and have smaller economic buffers to sustain periods of lost income. The negative impact of unemployment on health is well known, and includes poor mental health, increased alcohol and substance use and family violence.

Adapted from Burstrom and Tao, 2020

These wider social factors and the public policy decisions that shape them need to be understood in order to comprehend fully the scale of inequalities associated with COVID-19.[14]

The Scottish Government's National Performance Framework's 2020 report describes the social impacts of the pandemic:

> *It has been estimated that employees in the lowest earnings group are seven times more likely than those in the top 10% of earners to work in a sector that was shut down during the pandemic, and women around a third more likely to do so than men. Single mothers with low qualifications are particularly concentrated in these sectors. Some ethnic minority groups, for example, Pakistanis and Bangladeshis, are also concentrated in some of the hardest hit sectors, such as the passenger transport and food and beverage sectors, while migrant workers are also more likely to work in the hospitality sector. People in low-paid jobs are also less likely to be able to work from home since their jobs are typically customer-facing or based on business premises (e.g. sales and customer service occupations), which puts them more at risk of job loss or being placed on furlough. Young people are also more likely than other workers to be in precarious forms of work (e.g. zero hours contracts) which have been more susceptible to job losses.*[15]

COVID-19 has also directly impacted the life circumstances of the Lothian population in differential fashion. Unemployment, loss of income and challenges associated with caring responsibilities are socially patterned. The burden of social impacts associated with COVID-19 has been disproportionately borne by women, notably in terms of loss of income and jobs and increased childcare and domestic responsibilities. There is some evidence of increased domestic violence and research shows that women's mental health has got worse during the pandemic.[16-19] The impacts of institutional racism – poorer housing conditions, lower paid jobs, more unemployment particularly for people from Bangladeshi and Pakistani communities – manifest themselves in terms of greater risk from COVID infection and a harder financial and social impact associated with loss of income and unemployment. Crucially, the higher mortality risk for people from ethnic minority groups is not explained by biological differences but social determinants.[1, 20-24]

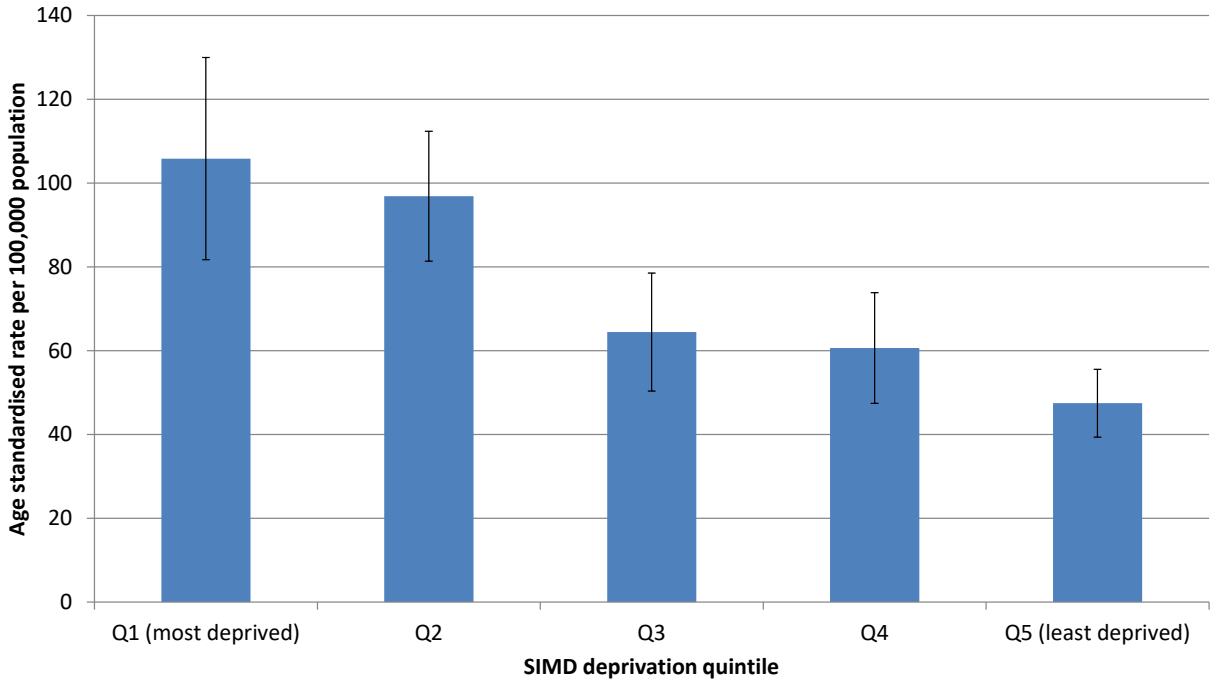
A detailed analysis of the most recent wave of responses to the UK Household Longitudinal Study highlighted five dimensions of 'household vulnerabilities': digital (access to internet, access to computer); financial (overcrowding, unemployment, low household income, payment arrears); employment (self-employed, part-time, and temporary employment); housing (living in flat and private renting); and health (COVID-19 health risk and long-term illness). The authors of the study describe how:

> *…different dimensions of vulnerabilities intersect. Among all household types and especially among working-age households, all dimensions of vulnerabilities intersect with financial and housing disadvantage. Among working-age households without children and among retirement-age households, severe health vulnerabilities intersect with severe digital disadvantage.*[25]

Socioeconomic Deprivation

Socioeconomic deprivation takes into account multiple influences such as income, employment education, health, access to services, crime and housing that interact to affect health and other outcomes. There is compelling evidence that health is directly correlated with socioeconomic position.[26] People from more socioeconomically deprived backgrounds in Lothian have been more likely to get infected, need hospital treatment and die. COVID admission rates were 2.5 times higher in the most deprived quintile compared to the least deprived quintile with an absolute difference of 212 admissions per 100,000 between these quintiles. [26] Excluding deaths that occurred in care homes[1], people in the most deprived communities in Lothian were twice as likely to die from COVID-19 as people from the least deprived communities

Figure 1: Scottish Index of Multiple Deprivation (SIMD) age standardised death rates for COVID-19, 1st March to 31st December 2020, excluding deaths in care homes
(95% confidence intervals; rates not annualised)

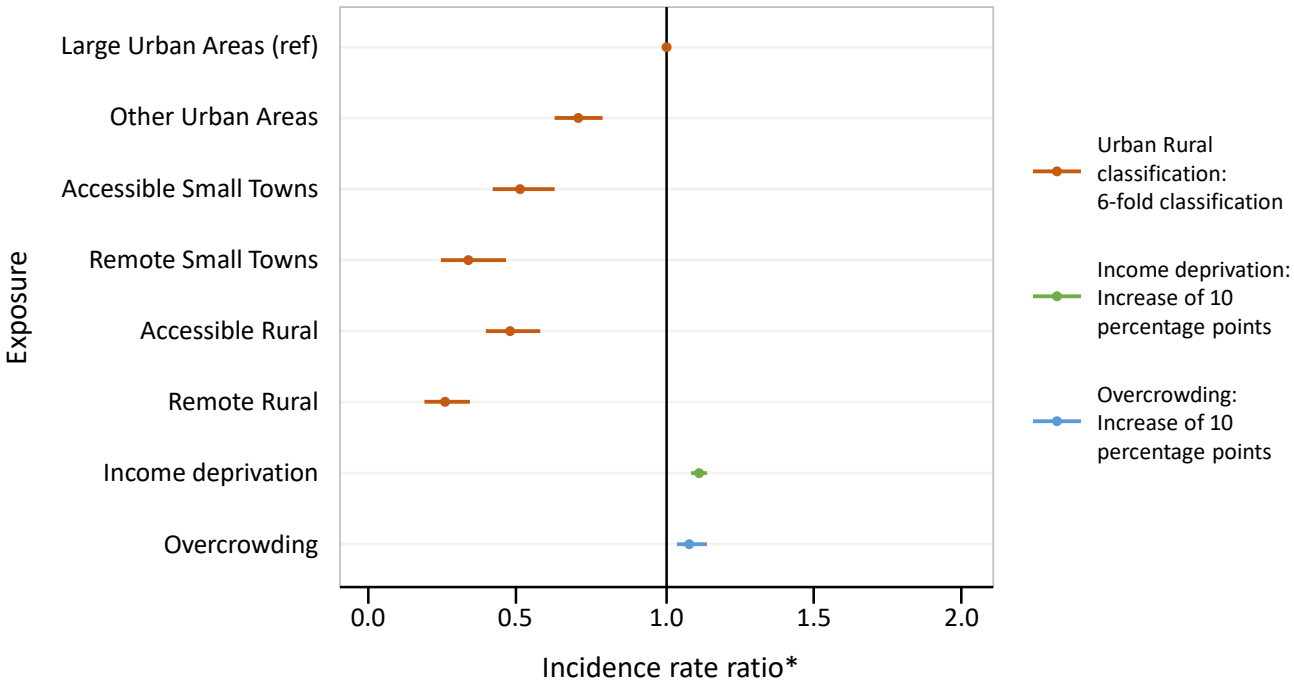


(106/100,000: 47/100,000), Figure 1.

Public Health Scotland has analysed COVID data between March and September 2020 and highlighted the extent to which some spatial factors have an influence on COVID deaths. The analysis suggests that income deprivation and household overcrowding present a measurable increased risk of COVID mortality above the risks these factors have for all-cause mortality, Figure 2.[27]

[1] Care homes are deliberately removed in this analysis, as the SIMD uses postcode of residence to estimate and rank multiple deprivation in each area (datazone). Care home locations are not distributed equitably across these areas, hence the inclusion of concentrations of individuals in these settings will distort analysis by SIMD.

Figure 2: Effect estimates of selected exposures on COVID-19 mortality (adapted from Public Health Scotland, 2020)



* The Incidence rate ratio, is the incidence rate in a group compared with the incidence rate in the reference group

The interaction between lower income, poorer housing, higher housing density, household occupancy and higher unemployment means that COVID-19 has a significant health and social impact on the poorest communities in Scotland. It should be noted that, bearing in mind the higher burden of COVID-19 infection and serious illness in more deprived communities, the impacts of Long COVID may also impact more heavily on these population groups.[28, 29]

Occupation and Employment[2]

People whose occupations were deemed essential during the pandemic have been at higher risk of infection.[30-32] But not all people in many essential jobs were afforded adequate protection from the virus. Research has highlighted the extent to which people in lower status and lower paid occupations have been at higher risk of infection and subsequent illness and death. These patterns of infection, illness and death reproduce the social gradient in health that existed pre-COVID-19.[1] National Records of Scotland report that age-standardised death rates are highest among people working in the lowest paid occupational groups (Process, Plant and Machinery Operatives and Elementary Occupations).[5] People working in low-paid, insecure jobs such as security guards, cleaners, personal care workers and restaurant workers were at higher risk of COVID-19 infection, illness and death as the Office of National Statistics review of deaths in England and Wales further highlights.[32] These occupations are where people from ethnic minority populations

[2] Routine labour market data is not produced for the Lothian area. ONS analysis uses local authority geographies. Skills Development Scotland group East Lothian, Edinburgh and Midlothian together and analyse West Lothian on its own.

are more likely to be over-represented. The Institute for Fiscal Studies noted that, in general, lower paid jobs are less amenable to home working, and since these are often occupations that involve close contact with customers or co-workers, risk of exposure while at work will increase, as well as exposure if travelling by public transport.[33]

But occupational risk is about more than exposure to COVID infection. There was a brief economic recovery during summer 2020 but lockdown has generally brought economic contraction. The impacts are slightly different when considering people who have stayed employed, even if furloughed, and those people who have been made newly unemployed during the pandemic. Research for the Resolution Foundation notes that:

> *Government policy has gone some way to protecting families from the sharpest income falls. We show, for example, that just one-in-seven (14 per cent) employees who were furloughed over the summer months experienced a severe drop in family income, compared to more than half (51 per cent) of those who have lost their job.[34]*

A social gradient applies to the ways in which people across the occupational spectrum have been supported through the pandemic. People with occupations in shutdown sectors or who are
self-employed have received relatively little government support but those who have lost jobs, find 'benefits are a far from adequate substitute for earnings for the many families newly reliant on the state for income support benefits.'[34]

Across Lothian, more than 65,000 from a workforce of approximately 513,000 people have been placed on furlough during the pandemic.

Table 1: Total people furloughed to date (rounding means total and sex numbers may not tally)
[35, 36]

	Females	Males	Total
East Lothian	4,300	3,500	7,800
Edinburgh	19,500	19,200	38,700
Midlothian	3,400	3,300	6,600
West Lothian	6,100	6,000	12,100
Lothian	33,300	32,000	65,200

Skills Development Scotland report that total jobs posted in the Lothian local authority areas have dropped by between 28% and 32% during the period from January 2020 and January 2021 with the biggest declines in jobs in lower paid occupations.[37] Although furlough has meant people have avoided unemployment, there are concerns that once the scheme ends, some companies will be unable to afford to retain employees if the economy does not rebound.

Between January 2020 and January 2021, the number of people claiming unemployment benefit more than doubled in Edinburgh and Midlothian and almost

doubled in East Lothian and West Lothian. The peak of unemployment claims was mid-Summer 2020.

Table 2: ONS claimant count January 2020-January 2021

	East Lothian	Edinburgh	Midlothian	West Lothian	Lothian
January 2020	1,750	6,910	1,410	3,260	13,330
February 2020	1,765	7,105	1,470	3,425	13,765
March 2020	1,720	7,285	1,495	3,450	13,950
April 2020	3,185	13,980	2,735	5,600	25,500
May 2020	3,680	17,775	3,160	6,645	31,260
June 2020	3,495	17,635	2,995	6,405	30,530
July 2020	3,620	18,290	3,060	6,800	31,770
August 2020	3,635	18,840	3,145	7,005	32,625
September 2020	3,400	18,280	3,050	6,675	31,405
October 2020	3,195	17,665	2,870	6,255	29,985
November 2020	3,255	18,170	2,950	6,325	30,700
December 2020	3,220	17,780	2,905	6,140	30,045
January 2021	3,295	17,600	2,940	6,190	30,025

Source: NOMIS (https://www.nomisweb.co.uk/reports/lmp/la/contents.aspx). Please note that the Lothian figure is a tally of local authority numbers. ONS does not produce routine data for the NHS Lothian Board area

Current unemployment rates are higher for males than females; overall approximately one in twenty of the Lothian workforce is actively seeking work while claiming benefits. Unemployment has more than doubled in 18-24 year olds: from 2,255 in January 2020 to 5,290 in January 2021.

Table 3: Claimant count percentage for Lothian council areas and Scotland, January 2021

	Females	Males	Total
East Lothian	4.1	6.0	5.0
Edinburgh	3.7	6.0	4.8
Midlothian	4.0	6.4	5.1
West Lothian	4.2	6.4	5.3
Scotland	6.1	8.6	7.4

Source: NOMIS (https://www.nomisweb.co.uk/reports/lmp/la/contents.aspx)

Skills Development Scotland reports a 121% increase in Universal Credit claims in East Lothian, Edinburgh and Midlothian and an 82% increase in West Lothian between March 2020 and January 2021. Across Lothian, in ten months this equates to an additional 40,000 people claiming Universal Credit.

Table 4: Total Universal Credit claimants January 2020-February 2021[35, 36]

	East Lothian, Edinburgh and Midlothian	West Lothian	Lothian
Jan-20	23,100	8,000	31,100
Feb-20	24,500	8,400	32,900
Mar-20	25,300	8,800	34,100
Apr-20	39,700	12,300	52,000
May-20	50,100	14,600	64,700
Jun-20	52,300	15,000	67,300
Jul-20	53,300	15,500	68,800
Aug-20	53,600	15,600	69,200
Sep-20	53,700	15,700	69,400
Oct-20	53,500	15,400	68,900
Nov-20	54,300	15,600	69,900
Dec-20	54,900	15,700	70,600
Jan-21	55,900	16,000	71,900

Income and Poverty

The economic fall-out from the pandemic has been disproportionate, with the most negative impact on people already on low income. People on a low income have been more likely than high earners to work in a sector shutdown during COVID-19 and to experience reduced hours, loss or earnings or be furloughed or lose their job. [1, 15, 38, 39] People who work in shutdown sectors such as retail and hospitality are more likely to be more precarious financially, and close to, if not living in, poverty.[38, 40] The Scottish Government National Performance team summarises the increase in people seeking social security support noting that both the overall number of claims has increased as well as the spectrum of people from across society who are making claims.

> *More people are now claiming benefits. … Scottish Welfare Fund crisis grant applications were 46% higher in the first quarter of 2020/21 than in the same quarter last year. While the caseload of Universal Credit has increased for each family type, the distribution between groups has changed during COVID-19 – with young people, men, and single people without children making up a larger proportion of the caseload than previously.[15]*

Around half of people in poverty live in a family which includes a disabled person. Poverty rates are higher in families with children and black and minority ethnic families. For many families this has resulted in using savings, borrowing money or missing bill payments.[41]

School closures have impacted on families whose children have free school meals and who need to work. The three key drivers that impact on child poverty – income from employment, costs of living, income from social security and benefits in kind – have all been affected by lockdown. Low income families can be affected in myriad and interconnected ways, for example an increase in living costs through adoption of expensive short term measures to cope with the consequences of job losses or greatly reduced income, at the same time as having to meet higher costs from staying at home such as heating, extra food provision, support for home schooling.[25, 33, 41, 42] There is ongoing concern about lockdown exacerbating educational inequalities. Surveys suggest that mental health concerns are likely to be among the most significant COVID impacts for children.[43, 44]

Across Lothian there has been a significant increase in the amount of Scottish Welfare Funding disbursed. For example, in West Lothian £1.6 million was awarded between late March and the end of December with a significant increase in crisis grants and, as the 2020-21 financial year has progressed and there has been movement in rented housing stock, a steady rise in community care grants. People can apply for grants if they are advised to self-isolate by Test and Protect. These grants are targeted at the most vulnerable in society. Yet successful applicants are low – between 10 and 20% on a monthly basis – mostly due to challenges in meeting all the Scottish Government's eligibility criteria.
Perhaps the most pronounced marker of poverty has been the increased use and need for food banks. West Lothian's Food Network has been supplying between 4,000 and 5,000 food packages on a weekly basis. Local feedback suggests that recently there has been a shift to people receiving packages due to destitution; in April and May 2020, food parcels were, in part, a function of people's inability to access shops rather than a lack of money to buy food. This echoes Resolution Foundation research which suggests that people's savings have been depleted and people who have lost jobs and income during the pandemic have reduced expenditure because they have no choice.

Summary

There is a social gradient to most of the inequalities associated with COVID-19 which reflect the trends that existed before the pandemic. The intersecting risks of exposure, susceptibility and consequences associated with COVID -19 mean that the most marginalised and vulnerable members of the community are most likely to be worst affected.
Increased inequalities from COVID-19 will have long-term consequences. Mitigating and reversing these inequalities cannot be confined to health care and health services, although it is essential that these are attuned to the challenges presented by COVID-19. One recent simple example of this is around ethnicity recording. COVID-19 analysis has identified a lack of detailed data about population-level ethnicity. Building on previous good practice, LAS Primary Care analysts are currently linking ethnicity recorded in TRAK and primary care systems to Lothian

Community Health Index (CHI) files. This will help ascertain how complete ethnicity recording is at population level.
However, NHS Lothian's contribution to addressing the causes of these inequalities must also focus on engaging with wider public policy debates about, for example, income, employment and housing. The Executive Leadership Team has agreed to establish a short-life working group, led by Public Health, to engage with the recommendations of the Edinburgh Poverty Commission and to take the findings and apply them in our work across Lothian. The Poverty Commission report provides a basis for a discussion of a wider Board approach to tackling inequalities and poverty. In particular the Board is asked to consider adopting an 'Anchor Institution' approach. Anchor Institutions are:

> *…large public sector organisations rooted in and connected to their local communities. They can improve health through their influence on local social and economic conditions by adapting the way they employ people, purchase goods and services, use buildings and spaces, reduce environmental impact, and work in partnership.[45]* See also Appendix 1.

As part of the implementation of the NHS Lothian Public Health Review, the Public Health and Health Policy Directorate is developing a work programme to support the corporate approach to Health in All Policies. Dedicated locality public health teams will work with NHS Lothian, local authority partners, Health and Social Care Partnerships and Community Planning partners to shape and influence policies including housing, income maximisation, anti-poverty and employability. Public Health also proposes the development of a Lothian wide survey during 2021 to measure the wider impacts that the pandemic has had on the health of the population. Previous 'Lothian Health and Lifestyle Surveys' can be used to compare population health before and after the pandemic. This new survey will provide vital intelligence to inform future NHS Lothian locality plans for action pertaining to anchor work and health inequalities. The intention is for Public Health to develop this survey drawing upon the expertise of academic and other external partners as required.

Recommendations

- NHS Lothian Board supports the development of an Anchor Institution approach to frame its inequalities and anti-poverty work.

- The Public Health teamwork with partners to develop locality plans with particular focus on COVID-19 mitigation.

- The development of a Lothian wide survey during 2021 to measure the wider impacts that the pandemic has had on the health of the population.

On behalf of the Public Health Intelligence Working Group: Gwen Bayne, Philip Conaglen (Chair), Annette Gallimore, Patrick Horgan, Martin Higgins, Naomi Honhold, Leonie Hunter, Katie Steel, Hannah Waite, Sheila Wilson.

References

1. Marmot, M., et al., *Build Back Fairer: The COVID-19 Marmot Review. The Pandemic, Socioeconomic and Health Inequalities in England*. 2020, Institute of Health Equity: London.
2. National Records of Scotland, *Deaths involving COVID-19 by pre-existing conditions, by Health Board of residence, March 2020 to January 2021*, NRS, Editor. 2020: Edinburgh.
3. Bwire, G.M., *Coronavirus: Why Men are More Vulnerable to Covid-19 Than Women?* SN comprehensive clinical medicine, 2020: p. 1-3.
4. Pradhan, A. and P.-E. Olsson, *Sex differences in severity and mortality from COVID-19: are males more vulnerable?* Biology of Sex Differences, 2020. **11**(1): p. 53.
5. National Records of Scotland, *Deaths involving coronavirus (COVID-19) in Scotland, Week 2 (11-17 January)*. 2021, NRS: Edinburgh.
6. Atkins, J.L., et al., *Preexisting Comorbidities Predicting COVID-19 and Mortality in the UK Biobank Community Cohort.* The Journals of Gerontology: Series A, 2020.
7. Mansfield, K.E., et al., *Indirect acute effects of the COVID-19 pandemic on physical and mental health in the UK: a population-based study.* The Lancet Digital Health.
8. Mansfield, K.E., et al., *COVID-19 collateral: Indirect acute effects of the pandemic on physical and mental health in the UK.* medRxiv, 2020: p. 2020.10.29.20222174.
9. Gruer, L.D., et al., *Complex differences in infection rates between ethnic groups in Scotland: a retrospective, national census-linked cohort study of 1.65 million cases.* Journal of Public Health, 2021.
10. Islam, N., et al., *COVID-19 mortality: a complex interplay of sex, gender and ethnicity.* European Journal of Public Health, 2020. **30**(5): p. 847-848.
11. Marmot, M. and J. Allen, *COVID-19: exposing and amplifying inequalities.* Journal of Epidemiology and Community Health, 2020. **74**(9): p. 681-682.
12. Marmot, M., *Inclusion health: addressing the causes of the causes.* The Lancet, 2018. **391**(10117): p. 186-188.
13. Burström, B. and W. Tao, *Social determinants of health and inequalities in COVID-19.* European Journal of Public Health, 2020.
14. Douglas, M., et al., *Mitigating the wider health effects of covid-19 pandemic response.* BMJ, 2020. **369**: p. m1557.
15. Scottish Government, *Scotland's Wellbeing: The Impact of COVID-19*, N.P. Framework, Editor. 2020: Edinburgh.
16. Jia, R., et al., *Mental health in the UK during the COVID-19 pandemic: cross-sectional analyses from a community cohort study.* BMJ Open, 2020. **10**(9): p. e040620.
17. Banks, J. and X. Xu, *The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK*, in *Working Papers*. 2020, Institute for Fiscal Studies: London.
18. Niedzwiedz, C.L., et al., *Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown: longitudinal analyses of the UK Household Longitudinal Study.* Journal of Epidemiology and Community Health, 2020: p. jech-2020-215060.
19. Pierce, M., et al., *Mental Health Before and During the COVID-19 Pandemic: A Longitudinal Probability Sample Survey of the UK Population.*
20. Aldridge, R., et al., *Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data [version 1; peer review: awaiting peer review].* Wellcome Open Research, 2020. **5**(88).
21. Harrison, E., et al., *Ethnicity and Outcomes from COVID-19: The ISARIC CCP-UK Prospective Observational Cohort Study of Hospitalised Patients.* SSRN Electronic Journal, 2020.

22. Raisi-Estabragh, Z., et al., *Greater risk of severe COVID-19 in Black, Asian and Minority Ethnic populations is not explained by cardiometabolic, socioeconomic or behavioural factors, or by 25(OH)-vitamin D status: study of 1326 cases from the UK Biobank.* Journal of Public Health, 2020.
23. Sze, S., et al., *Ethnicity and clinical outcomes in COVID-19: A systematic review and meta-analysis.* EClinicalMedicine.
24. Razai, M.S., et al., *Mitigating ethnic disparities in covid-19 and beyond.* BMJ, 2021. **372**: p. m4921.
25. Mikolai, J., K. Keenan, and H. Kulu, *Intersecting household-level health and socio-economic vulnerabilities and the COVID-19 crisis: An analysis from the UK.* SSM - Population Health, 2020. **12**: p. 100628.
26. Lone, N.I., et al., *Influence of socioeconomic deprivation on interventions and outcomes for patients admitted with COVID-19 to critical care units in Scotland: a national cohort study.* The Lancet Regional Health - Europe, 2020: p. 100005.
27. Public Health Scotland, *What explains the spatial variation in COVID-19 mortality across Scotland?*, in *A Management Information release for Scotland*. 2020, Public Health Scotland: Edinburgh.
28. Bliddal, S., et al., *Acute and persistent symptoms in non-hospitalized PCR-confirmed COVID-19 patients.* medRxiv, 2021: p. 2021.01.22.21249945.
29. Ayoubkhani, D., et al., *Epidemiology of post-COVID syndrome following hospitalisation with coronavirus: a retrospective cohort study.* medRxiv, 2021: p. 2021.01.15.21249885.
30. Williamson, E.J., et al., *Factors associated with COVID-19-related death using OpenSAFELY.* Nature, 2020. **584**(7821): p. 430-436.
31. Mutambudzi, M., et al., *Occupation and risk of severe COVID-19: prospective cohort study of 120,075 UK Biobank participants.* medRxiv, 2020: p. 2020.05.22.20109892.
32. Office for National Statistics, *Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 28 December 2020*. 2021, ONS: London.
33. Costa Dias, M., et al. *Getting People Back into Work*. Covid Economics, 2020.
34. Handscomb, K. and L. Judge, *Caught in a (Covid) trap: Incomes, savings and spending through the coronavirus crisis*, in *Resolution Foundation Briefing*. 2020, Resolution Foundation: London.
35. Skills Development Scotland. *Regional Skills Assessments: West Lothian, February 2021*. 2021 [cited 2021 06 March]; Available from: https://www.skillsdevelopmentscotland.co.uk/media/47103/rsa-infographic-west-lothian.pdf.
36. Skills Development Scotland. *Regional Skills Assessments: Edinburgh, East and Midlothian, February 2021*. 2021 [cited 2021 06 March]; Available from: https://www.skillsdevelopmentscotland.co.uk/media/47094/rsa-infographic-edinburgh-east-and-midlothian.pdf.
37. Skills Development Scotland. *COVID-19 Dashboard, February 2021*. 2021 [cited 2021 06 March]; Available from: https://www.skillsdevelopmentscotland.co.uk/media/47534/covid-19-dashboard-february-2021.pdf.
38. Wilson, T. and J. Buzzeo, *Laid low: The impacts of the Covid-19 crisis on low-paid and insecure workers*, in *ies Report*. 2021, Institute for Employment Studies: Brighton.
39. Buzzeo, J., et al., *The impact of COVID-19 on low income households: Interim findings*, in *ies Report*. 2020, Institute for Employment Studies: Brighton.
40. Scottish Government, *The impacts of COVID-19 on equality in Scotland*. 2020, Scottish Government: Edinburgh.
41. Brewer, M. and R. Patrick, *Pandemic Pressures. Why families on a low income are spending more during Covid-19*, in *Resolution Foundation Briefing*. 2021, Resolution Foundation: London.

42. Blundell, R., et al., *COVID-19 and inequalities*, in *The IFS Deaton Review*. 2020, The Institute for Fiscal Studies: London.
43. Cowie, H. and C.-A. Myers, *The impact of the COVID-19 pandemic on the mental health and well-being of children and young people.* Children & Society, 2021. **35**(1): p. 62-74.
44. Public Health Scotland, *COVID-19 Early Years Resilience and Impact Survey (CEYRIS): Report 4 – full findings.* 2020, Public Health Scotland: Edinburgh.
45. Allen, M., et al., *Anchors in a storm: Lessons from anchor action during COVID-19*. 2021, The Health Foundation: London.

NHS LOTHIAN

Board Meeting
7 April 2021

Director of Strategic Planning

LOTHIAN STRATEGIC DEVELOPMENT FRAMEWORK ARCHITECTURE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board agrees the architecture that will underpin the approach toward the development of the NHS Lothian Strategic Development Framework outlined at the Planning, Performance, and Development Committee of 3rd March 2021.

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 agreement of the Planning, Performance, and Development Committee to the broad direction and themes of the NHS Lothian Strategic Development Framework;

2.2 Note the governance arrangements, which build on existing governance rather than a new design;

2.3 Agree to seek formal agreement from our partner Integration Joint Boards to their support of and collaboration in this process;

2.4 Agree to commission external support for public engagement and consultation

3 Discussion of Key Issues

Background

3.1 The impacts of the COVID-19 pandemic have been well-rehearsed in various discussions. At one end of the spectrum, there are challenges around inequalities and around the effective provision of healthcare services, and at the other, significant opportunities for redesign. NHS Lothian needs to refresh its strategy to focus on these elements and reflect the changed landscape.

3.2 The NHS Lothian Strategic Development Framework (LSDF) concept was presented to the Planning, Performance, and Development Committee on 3rd March and was positively received, with helpful comments received from non-executive Board members and Directors of the Health & Social Care Partnerships in attendance. The draft framework is appended to this paper. This new strategic framework will supersede Our Health, Our Care, Our Future when complete.

3.3 Going forward, the approach will:

3.3.1 Continue work with an external partner, subject to formal commissioning through our procurement processes, in both the public square and working across communities to improve our shared understanding across service users and service providers of the challenge we are facing, and to envisage new models of care, ensuring that this work is coordinated with our partners, including local authorities.

3.3.2 Create three scenarios to test ideas and approaches, which will come forward as part of this work;

3.3.3 Create a "next generation" of leaders, building on the concept of "public entrepreneurs";

3.3.4 Use revised principles and assumptions for how the system may work going forward, and apply them to current workstreams to ensure that the one, three, and five-year proposals coming from these workstreams are aligned to organisational direction, and Our Priorities for Continuous Improvement.

3.4 The outline project plan to date shows a timescale for public consultation on the draft strategic framework towards the end of the first quarter of the calendar year 2022. In order to support this, it is proposed that the draft strategic framework should be subject to a public consultation that is externally-facilitated with feedback from the consultation being reported to the Board in advance of them being asked to consider and approve the new organisational strategy. Should this recommendation be supported, a tender document will therefore be drawn up to seek this support.

Enablers and Constraints

3.5 The key enablers for an effective strategy are, in this context, also constraints for us. The way in which we allocate our resources – workforce, revenue, capital – can allow us to take key pieces of work forward. Equally, the limits placed on our resources force us, as a system, to make choices about how we utilise these going forward. To this list we would add digital capability, environmental sustainability, and quality as givens which will also influence the choices we make.

3.6 As explained in the presentation to PPDC, finance, workforce, and planning will build three scenarios to "road-test" plans brought forward by the individual workstreams and ensure that the organisation is sighted on the challenges and consequent choices plans will bring forward.

Key assumptions and principles

3.7 The full magnitude of the challenges presented following the pandemic is not yet known, as indicated in the assumptions set out below. These assumptions lead to emerging principles, which outline how services and decision-making may need to change in future:

Figure 1: Challenges & Principles

Assumptions	Principles
We will honour legally committed investment to date. We will test fully approved investment (not yet legally committed) against the principles to the right before legally committing. We accept that there will be significant financial constraints We will start with large waiting lists and work through these according to clinical prioritisation Workforce availability will be a key consideration, and all models will need to reflect this. The pandemic has and will continue to change our models of care (how significantly is uncertain) There will be a requirement for redesign capacity to support change There will be an evolving context and narrative.	All cases and actions need to be clear on the question they seek to answer All cases and actions need to be able to demonstrate that they advance the organisational strategy All facilities will be flexible and multi-use We will work to reduce "on-site" attendances wherever we can We will separate emergency and elective activity where possible and maximise the use of "single-day" pathways We will align actions and facilities with our public and third-sector partners Non-clinical space will be minimised Our actions and facilities will align with the Climate Change (Scotland) Act which outlines a requirement for the public sector to achieve net-zero by 2045 at the latest.

Engagement with Key Partners

3.8 Engagement with IJBs will be key in taking forward this agenda and ensuring that we have a seamless strategic framework. We are currently seeking the views of our IJB planning partners on this approach, and seeking confirmation from our 4 IJB partners that they wish to continue collaborating in the development of the LSDF in workstreams that cut across our organisational boundaries, and where there are clear benefits in working together to determine priorities to achieve our collective vision.

3.9 NHS Lothian is of course completely respectful of and committed to the statutory duty of our IJB partners in the planning and commissioning of large parts of the organisation's activities. The current programme board approach already supports this duty for mental health and unscheduled care, and discussions will take place for the other areas of joint interest to make sure that these are aligned and appropriately facilitated and collaborated upon. Commencing and maintaining an ongoing discourse with IJB Strategic Planning Groups will support alignment of the LSDF with IJB Strategic Plans and Directions.

3.10 It would be our intention to take the presentation of how we intend to develop the framework through our community planning infrastructure to make sure that all of our key partners are aware of how we intend to take this forward. It may be that more detailed discussions with local authorities will be appropriate at a relatively early stage.

3.11 The appended timeline and communication cascade includes dates for engagement with key partners.

Governance Architecture

3.12 Governance of this process remains ultimately with the Board. Regular discussions and updates will be brought to the Planning, Performance, and Development Committee, and there remains the option for non-executives to invite the Director of Strategic Planning and the programme team to brief them individually or in informal group sessions.

3.13 From a formal management perspective, the approach will be owned and overseen by the Corporate Management Team, with monthly updates to this and day-to-day discussion and coordination by the Director of Strategic Planning and his team.

3.14 Alongside this, there is clearly a requirement to ensure appropriate engagement and discussion with formally-established mechanisms, explicitly including both the NHS Lothian Partnership Forum and the Area Clinical Forum.

3.15 The Lothian system has a range of extant governance and planning arrangements that it seems sensible to use to manage the various workstreams of the development. In particular, the Unscheduled Care Programme Board and the Mental Health Programme Board, where the IJB Chief Officers come together with NHSL officers, seem crucial parts of this landscape, as they provide a forum for both performance improvement and strategic development. These two groups are chaired by IJB Chief Officers.

3.16 There are a range of other "subject matter" meetings and groups which seem crucial to this work. Table 1, below, illustrates the breadth of this work.

Table 1 – example programme boards supporting LSDF

Group	**Chair**	**"Programme Director"**	**Frequency**
Unscheduled Care Programme Board	Allister Short (Alison MacDonald)	Jenny Long	Monthly
Mental Health Programme Board	Judith Proctor	(Stewart Robertson/Nickola Jones)	Monthly
Scheduled Care Programme Board	Jacquie Campbell	Catherine Kelly	Monthly
Rehabilitation Collaborative (Programme Board)	Allister Short	TBC	Monthly
Children's Services Programme Board	Alex McMahon	Oliver Campbell	Monthly
Lothian Capital Investment Group	Susan Goldsmith	TBC	Monthly
Workforce Planning Development Board	Janis Butler	Amanda Langsley Nick McAllister (HR Leads)	Monthly

3.17 Each of these major programmes has a series of workstreams – so, for example, the Scheduled Care Programme Board oversees the work of the outpatients programme board, while the Mental Health Programme Board also includes the planning and commissioning of children's mental health services, which is a reserved area for the NHS Board.

3.18 Further to the above Boards there are two additional major areas of work where careful thought will be required; Primary care and public health.

3.19 Primary Care is a function delegated to IJBs, with operational management provided by the four HSCPs. Budgets are passed to IJBs through NHS Lothian and the latter also provides a central primary care contracting organisation for independent contractors. The recommendations of the "Feeley Review" into adult social care suggest that, should the recommendations ***be*** fully implemented, financial flows will directly flow from SGHSCD to IJBs, and it is assumed that the accountability for the delivery of primary care services will also move from NHS Boards to the IJBs as independent organisations directly accountable to Parliament, as NHS Boards are. Depending on the outcome of the Review it may be helpful for IJBs to consider establishing a forum for primary care strategy, which may also benefit from NHSL input.

3.20 It is not yet clear whether the recommendations of the Feeley Review would extend to capital. If this remained with NHS Boards, then there would be an expectation that NHSL would need to manage its capital effectively and seek to invest in appropriately modern facilities which delivered on its principles and assumptions.

3.21 In the public health arena, the pandemic has underlined the importance of the principles of the Christie Report and of working across boundaries with public sector partners, and the LSDF must lay out how the organisation will work to reduce health inequalities. The new Anchor Institution Development Board will set out NHS Lothian's role in reducing inequalities though both its role as a large employer and through its strategic influence across partnerships, as outlined in the the Covid-19 and Inequalities paper presented to the Board in April 2021 by the Interim Director of Public Health.

4 Key Risks

4.1 This proposal is intended to support the management and mitigation of risks faced by NHS Lothian

5 Risk Register

5.1 There are no specific implications for the risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This proposal is intended to support improved health outcomes for those living in Lothian, and to positively impact health inequalities. The anchor institutions approach mentioned above will inform NHS Lothian's approach to tackling inequalities and poverty, and inform the Lothian Strategic Development Framework. Emerging plans will be subject to inequalities impact assessment

7 Duty to Inform, Engage and Consult People who use our Services

7.1 Development of this proposal to date has involved over 100 senior NHSL staff, through strategy development workshops facilitated by the Royal Society of Arts Manufactures and Commerce (RSA).

7.2 As outlined in section 3.3.1 above, the next stage of this work will include engagement with service users, ideally through an external "honest broker" to understand the priorities of those who use our services, and ensure service users are able to influence our plans going forward. There may also be opportunities to share learning with our partners to further enhance the picture of what is important to those who use our services.

7.3 It is also our intention to subject the draft strategic framework to a public consultation that is externally facilitated towards the end of the first quarter of the calendar year 2022.

8 Resource Implications

8.1 Re-allocation of resource within the strategic planning directorate will support the evolution of the strategic development framework during 2021/2.

8.2 Further work is to be concluded on resources and discussions are ongoing with the finance team. There will, however, be non-recurring requests for;

8.2.1 External support to engage in the public square and with local communities;
8.2.2 Development of "Public entrepreneurs"
8.2.3 Additional project management support within Strategic Planning, possibly shared with the Finance Directorate through the Sustainability and Value team;
8.2.4 Commissioning support for external consultation

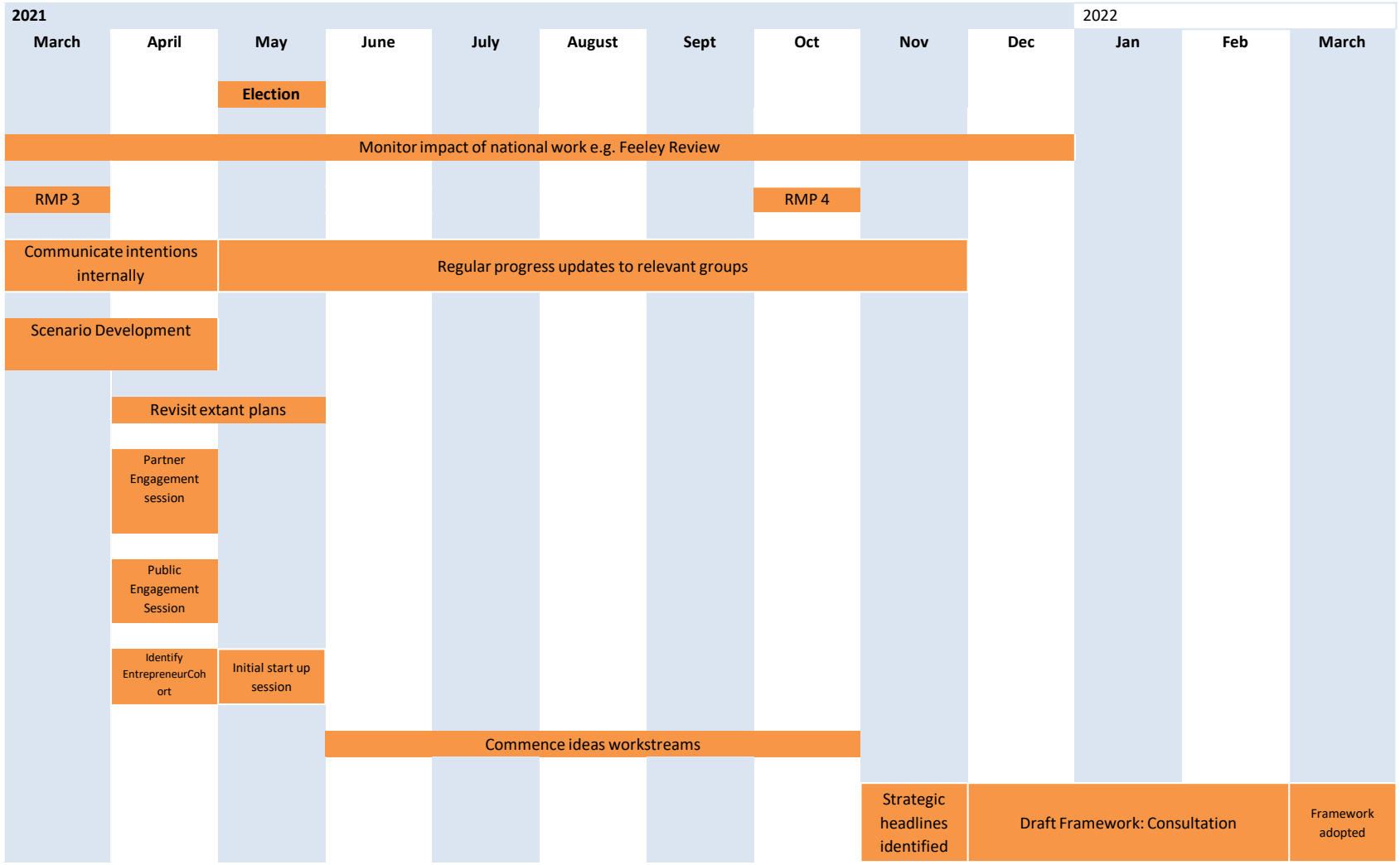
Colin Briggs
Director of Strategic Planning
colin.d.briggs@nhslothian.scot.nhs.uk
25th March 2021

Rebecca Miller
Head of Stategy Development
rebecca.miller@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Lothian Strategic Development Framework Timeline & Communication Cascade

LSDF Timeline



Communication Cascade

Group	Initial Communication	Update Frequency
Planning & Performance Development Committee	3rd March 2021	Every two months
East Lothian Integration Joint Board (Strategic Planning Group)	5th May 2021	TBC
Edinburgh Integration Joint Board (Strategic Planning Group)	12th May 2021	TBC
Midlothian Integration Joint Board	11th March 2021	TBC
West Lothian Integration Joint Board (Strategic Planning Group)	1st April 2021	TBC
Area Clinical Forum	14th April 2021	Every three months
Partnership Forum	27th April 2021	Every three months
Unscheduled Care Programme Board	15th March 2021	Monthly
Scheduled Care Programme Board	21st April 2021	Monthly
Mental Health Programme Board	12th April 2021	Monthly
Workforce Planning & Development Programme Board	TBC	Monthly
Digital	TBC	TBC
Primary Care Transformation	TBC	TBC
Sustainability	TBC	TBC
Corporate Management Team	February 2021	Monthly
NHS Lothian Board	April 2021	October 2021 March 2022

NHS LOTHIAN

Board Meeting
07 April 2021

Director of Communications, Engagement and Public Affairs

NHS LOTHIAN PUBLIC ENGAGEMENT FRAMEWORK

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress in NHS Lothian's approach public engagement and to seek the Board's agreement that the Public Engagement Framework will strengthen the role of engagement in shaping the development of services.

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

2 Recommendations

The Board is asked to:

2.1 Accept the Public Engagement Framework as a source of moderate assurance of a shared commitment to ensure consistent, high quality public engagement in shaping services across the Lothian-wide system.

2.2 Note the Framework will assist in ensuring compliance with the recently published (March 2021) updated Scottish Government guidance: *Community Engagement and Participation Guidance for NHS Boards, IJBs and Local Authorities – 'Planning with People'* which replaces Chief Executive letter (CEL) 4 2010 for NHS Boards. The updated guidance applies not just to NHS Boards, but also, as evidenced in the title, to Integration Joint Boards and Local Authorities.

3 Discussion of Key Issues

3.1 As the provider of health services to a large population spanning four council areas (City of Edinburgh, West Lothian, Midlothian and East Lothian), NHS Lothian must be publicly accountable and engage with the communities it serves, actively involving them in development plans.

3.2 The 'Blueprint for Good Governance' also recognises the importance of patient engagement and this has been identified as a key risk by NHS Lothian Board.

3.3 An investigation carried out by Internal Audit for the Audit and Risk Ctte in 2019 found examples of good practice in engagement and noted improvements following the (then) recent appointment of a Public Involvement Manager to a long vacant post. However it reported that standards were not consistent across the organisation.

3.4 That report identified a need for:

- Clear articulation of what good engagement looks like
- Clear expectations set for staff involved in service design, development or change
- Training and knowledge sharing of best practice
- Sufficient resource dedicated to engagement
- Improved, meaningful assurance to be provided to the Board on patient engagement activities being undertaken within the organisation

3.5 A Public Engagement Framework (Appendix 1) has been developed specifically to address these findings and to ensure compliance with the new national guidance

3.6 The Framework suggests that a future commitment to additional dedicated resource may be required in order to support the spread of expertise and good practice (so that staff carrying out engagement exercises feel well supported) and ensure compliance with national guidance and legislation.

3.7 Work has already begun to implement the action pan at Appendix 2

4 Key Risks

4.1 There is a risk NHS Lothian fails to meets its obligations in relation to public and patient engagement without an approved Framework.

4.2 There is a risk services and reputation are damaged if engagement is not meaningful and effective as we reshape them to continue to meet evolving demand and challenge.

5 Risk Register
Not Applicable

6 Impact on Inequality, Including Health Inequalities
6.1 Not applicable / not completed

7 Duty to Inform, Engage and Consult People who use our Services
7.1 Not applicable.

8 Resource Implications
8.1 The resource implications are not yet defined as these are subject to CMT discussion

List of Appendices
Appendix 1: NHS Lothian Public Engagement Framework
Appendix 2: Action Plan

Judith Mackay
Director of Communications, Engagement and Public Affairs
25/03/2021

Judith.mackay@nhslothian.scot.nhs.uk

NHS Lothian Appendix 1

Public Engagement – A New Framework

Introduction

This framework seeks to provide a starting point for a systemic and coordinated approach to public engagement across the NHS Lothian geographical area. It lays out the principles and strategic steps that will provide a strong foundation for effective engagement in NHS Lothian and beyond. It also ensures the public engagement activity to support the continued development of our health and care system complies with the Scottish Government's updated guidance published in Mach 2021; *Community Engagement and Participation Guidance for NHS Boards, IJBs and Local Authorities – 'Planning with People'*.

Purpose of this document:

- Increase the profile of engagement across the full range of NHS Lothian's local, regional and national services.
- Contribute to increased prioritisation of engagement in service redesign, improvement and general development work.
- Ensure a coordinated approach to engagement across the Board and HSCPs whenever this will be of value.
- Provide the conditions for wider and improved engagement by ensuring those who are responsible for services understand the requirements and expectations for engaging with patients and carers.
- Help to build and embed a culture that embraces engagement as a valuable and integral process supporting service change, development and improvement.

Common Understanding of Public Engagement

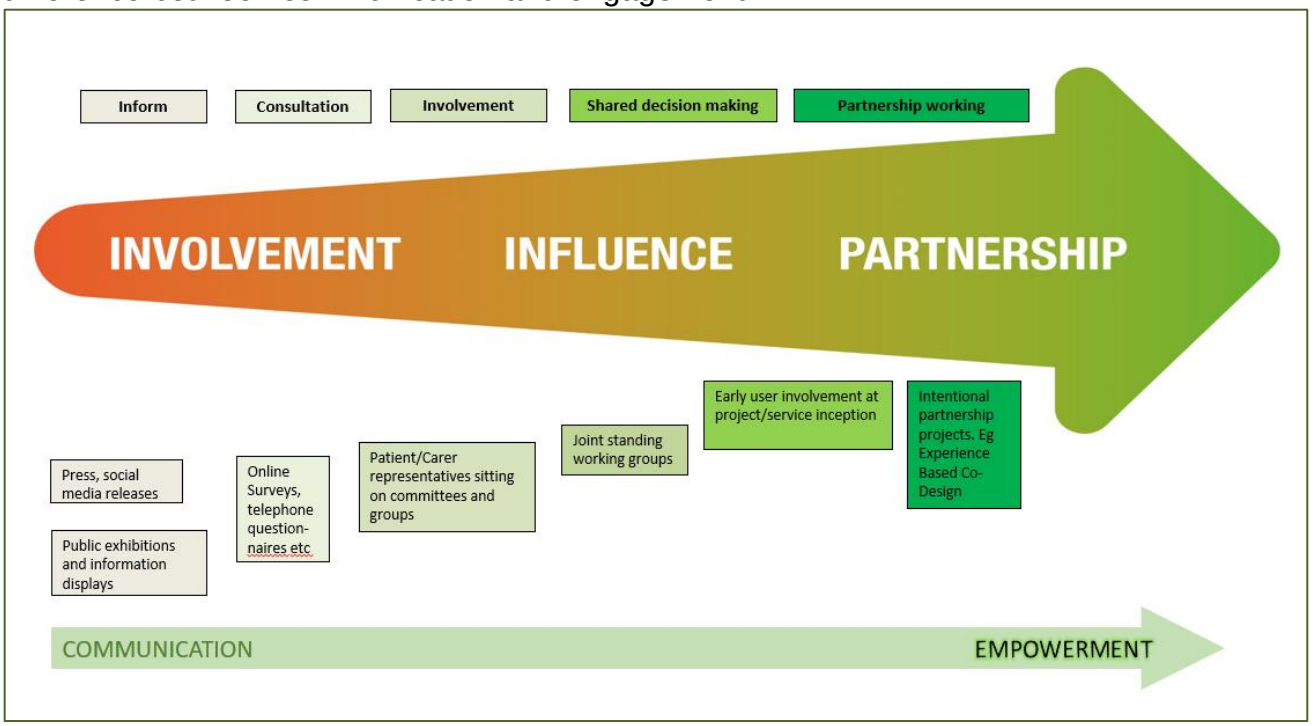
Involving the public takes many forms. It's important to start from the same place when thinking about engagement and the diagram on the following page creates that shared starting point. This is the NHS Lothian Engagement Model.

This is an aspirational model that sees engagement as a spectrum. It is based on existing established engagement models and looks to provide an accessible, easily remembered reference point. "Light" forms of engagement take place at the thin end of the spectrum and the forms of engagement activity become more advanced as the spectrum progresses towards full partnership working on the right side.

People become more empowered to contribute meaningfully to the process as the engagement activities move more in the direction of partnership approaches. At the same time, services benefit from valuable input based on authentic experience, enabling more responsive approaches and improved quality. The intention is that those who undertake engagement work across NHS Lothian maintain a sense of this aspirational model and seek to create meaningful engagement activity that progresses along this spectrum.

A graphical representation of what we want to achieve through engagement is a way of helping staff and users to understand the direction of travel in an accessible and easy to

remember way. Also, within the context of NHS services, it aids understanding of the difference between communication and engagement.



NHS Lothian Engagement Model

The Three Building Blocks

This framework sets out NHS Lothian's strategic approach to public engagement. It provides the foundation for more detailed work at local level and sets out a path towards a coordinated approach to public engagement between NHS Lothian, East, Mid and West Lothian and Edinburgh Health and Social Care Partnerships.

The key elements required to achieve this are:

- **Enabling Conditions**
  - Leadership, values and shared purpose
  - Resources
  - A prepared and supported workforce

- **Capacity Development**
  - Develop "cultural competence"
  - Define roles and responsibilities
  - Build collaborative structures

- **Implementation and Support**
  - Ensure early engagement interventions at strategic planning level
  - Develop toolkit to support staff
  - Build engagement networks across the region

Each of these elements is explored in more detail below.

1 – Enabling Conditions

Leadership, values and shared purpose

A culture of meaningful engagement starts with the commitment of those who lead it. Without this commitment to lead well, engagement will be tokenistic and will risk alienating the public, who quickly see through half-hearted or tick box approaches to engagement and are at liberty to make their observations widely known, thereby also putting at risk organisational reputation.

This commitment is essential to generate the drive and enthusiasm that creates genuine engagement. And it is genuine engagement that drives lasting and successful service transformation.

Putting high quality engagement at the heart of service change and development may require degrees of culture change. While this can appear daunting as a concept, the rewards are great, with sustainable transformation based on authentic, coproduced solutions; services that are fully connected at multiple levels to the communities they serve; more motivated staff; more "open", learning based organisations.

This framework begins the work of enabling this culture change.

Resources

Good community engagement is "*inherently long term and unpredictable and it is important that resource allocation takes account of these factors*" (World Health Organisation – Community Participation in Local Health and Sustainable Development).

Alongside the important human resources of commitment, understanding and competence, adequate financial resources need to be provided if public engagement is going to be effective and coordinated.

A prepared and supported workforce

Enabling staff to carry out effective engagement activities is a key principle of this framework. As a function, across the wide range of activities undertaken by NHS Lothian, with widely varying levels of complexity, engagement needs to be carried out at service level. This allows activity to be tailored to specific needs.

NHS Lothian is committed to providing staff with the expertise and know how to carry out these engagement activities. Without the necessary support, placing an expectation to carry out involvement activities on staff whose primary focus is very different to public engagement does not work well. Supporting staff to do engagement well is an essential element of getting good results.

Key elements of this support are described below.

Training

NHS Management

Staff who are responsible for services need to have awareness of the legislative requirements to engage and an understanding of engagement principles and practice.

Public

Ensuring public representatives understand the responsibilities of their role is also important. Being accountable, ensuring contributions are constructive and learning about

group interaction and how to influence it as an external voice are all areas where effective training will greatly enhance results.

Induction

Staff responsible for services need to understand the legislative context affecting NHS services with regard to public engagement, in order to ensure the organisation complies with its duties. An awareness among relevant staff and managers about the availability of training and other support to carry out engagement activities will lead to a wider distribution of high quality engagement activity throughout the organisation. This might be referenced in within the Equalities module of the induction programme.

Online Resources and specialist support

Staff will have access to support via an "Engagement Learning Zone" on the NHS Lothian website. This will share good practice models, case studies and other advice aimed at creating a supportive environment for staff.

To support this framework, an online, practical tool kit will be developed so that staff have a step by step guide to how and when to carry out engagement activity.

In addition, specialist engagement advice and support is available from the central engagement team at NHS Lothian.

2 – Capacity Development

Developing "Cultural Competence"

Closely linked to leadership and values above, developing cultural competence within organisations to enable good engagement is about creating the conditions for change.

Managers at all levels in the organisation need to understand what public engagement is and the implications of doing it effectively. This will involve openness to change and making the connection between engagement, organisational development and service improvement.

These are wide ranging and far reaching factors, well beyond the scope of this framework. But successful and effective engagement will mean consideration needs to be given to culture change.

Defining Roles and Responsibilities

Clear definitions of roles along with increased and fit for purpose capacity at local and strategic level are all important aspects of developing a strategy to deliver engagement outcomes that are effective in influencing change.

Building Collaborative Structures

An opportunity exists to coordinate engagement work across NHS Lothian and all the HSCPs. Increased collaboration will:

- maximise the effectiveness of resources
- eliminate duplication of efforts to involve people across the region

- increase credibility of engagement work in the perception of the public and workforce, leading to improved engagement.
- Contribute to a more strategic and coherent approach to engagement across the region.
- Allow sharing of skills, experience and good practice to support high quality public engagement.

3 – Implementation and Support

Ensure early engagement interventions at strategic planning level

Reactive and tokenistic engagement efforts can arise from attempts to "bolt on" engagement to planned developments when the opportunity to influence has either passed or is close to passing. Experience shows this tends to happen when staff working on the development realise at a late stage that they will need to undertake engagement activity in order to satisfy funding requirements etc.

This is a failure of engagement strategy linked to existing cultural priorities and would be addressed by the steps outlined in 1 and 2 above.

However, those are medium to long term steps. In the short term, a focus on the mechanisms that lead to the inception of new developments will be helpful. The aim is to ensure engagement is built into the inception process and helps inform the development from an early stage and as it progresses.

If this focus becomes an immediate priority, much more effective engagement will ensue and will provide models for future ways of working.

Develop toolkit to support staff

Progress in this area is covered in the implementation plan appended to this Framework document.

Build engagement networks across the region

Progress in this area is covered in the implementation plan appended to this Framework document.

Summary

This is a framework document which sets out the strategic building blocks and refreshed workflows which NHS Lothian needs to expand and develop in order to achieve effective public engagement across the Lothians. Implementing this Framework will ensure public engagement is:

- Coordinated and rational
- Efficient
- Sensitive to need
- Meaningful for those involved

++++++++++++++

NHS Lothian Strategic Public Engagement Framework Appendix Two

Action Plan

Introduction

Each of the elements in the Framework is given a timeframe below. Several workstreams described in the Framework are contained in the most recent Internal Audit on public engagement (2019). Progress on these and other elements described in the Framework is well underway and this plan provides the current status of these.

Public Engagement Framework Action Plan

	Workstream	**Action**	**Time scale**	**Lead**
1 – ENABLING CONDITIONS	Leadership, shared values and purpose	Corporate Management Team sign up to commitments set out in the Framework	**March 30th 2021**	**ALL**
	Resources	i) The Framework creates a common understanding and commitment to engagement. It will be for each HSCP to decide how the work should be resourced in their organisation. ii) In NHS Lothian, proposals will be brought forward to senior management on adequate resourcing of the engagement function in light of this new commitment.	**May 2021**	**ALL** **Dir Comms**
	A prepared and supported workforce	i) Online resources: A new Engagement Learning Zone is in place on NHS Lothian website, containing case studies, information and signposts to further support for staff. This is public facing to promote transparency and increase engagement profile ii) Training in roles, representation and structures for public reps currently being piloted with the Healthcare Governance Patient Group in partnership with HIS-Community Engagement	**Autumn 2020** (complete) **March 2021** (underway)	**Dir Comms** **Public Involvement Manager**

	Workstream	Action	Time scale	Lead
		iii) Promotion of Framework to staff	**Summer 2021**	**Dir Comms**
		iv) Develop a training programme in engagement awareness, key principles and tools for all staff who are responsible for services (NHS Lothian)	**Delivery Spring 2022**	**Public Involvement Manager**
		(v)NHS Lothians' commitment to Engagement and availability of support incorporated into in Equalities module of induction. To be coordinated with introduction of training	**Spring 2022**	**Public Involvement Manager**
		v) Specialist engagement support: Ongoing via engagement manager and will be expanded pending further resources	**Ongoing**	
2 – CAPACITY DEVELOPMENT	Developing Cultural Competence	This can be characterised as connecting engagement to the wider system. Creating "*openness to change and making the connection between engagement, organisational development and service improvement*" (from the Framework)	**Starts 30th March 2021**	**ALL**
	Defining Roles and Responsibilities	Clear definition of engagement roles and functions in each HSCP and NHS Lothian	**Autumn 2021**	**ALL**
	Building Collaborative Structures	Developing a coordination network consisting of engagement practitioners and managers from all the HSCPs and NHS Lothian is complete. The Engagement Network meets monthly.	**Established Nov 2020**	**ALL**

	Workstream	**Action**	**Time scale**	**Lead**
3 – IMPLEMENTATION AND SUPPORT	Ensure early engagement interventions at strategic planning level	Link with Strategic Planning to build engagement into inception processes.	**Autumn 2021**	**Dir Comms/ Dir Strategic Planning**
	Developing a toolkit to support staff	i) Work is currently underway within NHS Lothian to develop a practical range of resources to support staff in their own services to carry out successful engagement work. These resources will be accompanied by a guide that will help to identify key steps, triggers and pathways for staff to develop plans and implement them. ii) Lothian Engagement Network collaborating on this currently. Some HSCPs in process of introducing engagement toolkit at this time.	**Autumn 2021**	**Dir Comms & HSCP COs**
	Building engagement networks across the region	Complete. As described at 2 above, building strong collaborative ways of doing engagement between NHS Lothian and the HSCPs is key.	**Nov 2020**	**ALL**

NHS LOTHIAN

Board Meeting
7 April 2021

Chief Executive

CMT OBJECTIVES 2021-22

1 Purpose of the Report

1.1 The purpose of this report is to advise the Board that the attached CMT Objectives 2021-22 have been discussed at the Planning, Performance and Development Committee (PPDC). Alterations have been made based on the feedback received.

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

2 Recommendations

2.1 The Board is asked to discuss any final alterations they wish to see and thereafter approve the CMT Objectives 2021-22.

3 Discussion of Key Issues

3.1 The draft CMT Objectives 2021-22 have previously been discussed at the PPDC and are before the Board for approval.

4 Key Risks

4.1 In the absence of clear and measurable objectives there is a risk that the Corporate Management Team's attention would not be focussed on the key Strategic Deliverables and in particular the need to focus on moving NHS Lothian out of escalation with the Scottish Government.

5 Risk Register

5.1 Not applicable.

6 Impact on Inequality, Including Health Inequalities

6.1 The CMT Objectives as drafted aim to minimise and address Heath Inequalities.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 This duty will be relevant in relation to the development and consultation of the new Organisational Strategy when developed. The remainder of the CMT Objectives are a continuation of current policies and guidance.

8 Resource Implications

8.1 The process will be managed within existing resources.

Douglas Weir
Business Manger
25.3.21
douglas.weir@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: CMT Corporate Objectives 2021-22

NHS Lothian Corporate Management Team Objectives 2021-22 FINAL

CMT OBJECTIVES 2021-2022

Overview

This document sets out the key objectives for the Corporate Management Team (CMT) over the next year. The aim is to set out the strategic initiatives and operational goals that we need to progress within Lothian over the next year. Given current uncertainties due to the pandemic situation these focus on immediate priorities as well as a number of strategic initiatives that will support the subsequent recovery agenda. The objectives cover nine broad themes illustrating the breadth and depth of issues facing NHS Lothian with patient and staff safety woven through all of the themes over the coming year:

1. Maintain the immediate **public health response** to the pandemic including the management of outbreaks, contact tracing and delivery of the vaccination programme;
2. Develop **post- COVID-19 recovery strategies** to mitigate against the impact of the pandemic on health inequalities, poverty and place.
3. Support the **recovery of scheduled care** and contribute to a national discussion about the challenge the NHS faces in relation to elective waiting times. This includes the continued prioritisation of clinically urgent treatment and cancer care, as well as planning for a broader recovery process for services with the longest waiting-times;
4. Deliver national and locally driven redesign priorities across **unscheduled care**, including the scheduling of further urgent care through 111 and Call MIA services, whilst building community capacity and pathways to manage patients closer to home;
5. Continue to prioritise **mental health** and staff wellbeing services given the impact of the pandemic. This includes the implementation of waiting time recovery plans in psychological services and CAMHS services;
6. Embed and sustain the rapid growth in **digital** provision seen during the pandemic by strengthening existing digital infrastructure as well as online and virtual capabilities;
7. Develop a longer-term **strategic plan** for NHS Lothian, including future financial and capital plans taking into account the environmental sustainability agenda;
8. Continue to focus on **staff wellbeing and experience** through the development of a system wide staff strategy and Covid-19 workforce recovery plan; and
9. Manage the full opening of the **Royal Hospital for Children and Young People (RHCYP)** and commitments in relation to the associated Public Inquiry.

The NHS Board has a statutory requirement to implement formal Directions issued from all four Lothian Integration Joint Boards. These directions are issued following decisions of the IJBs and are sent by the Chief Officer of the IJB to the Chief Executive. They will be logged with Strategic Planning for operational delivery to the relevant Director as they are received.

The above themes provide an overview of our priorities which will help our staff and members of the public to understand what we are aiming to achieve. A series of more specific objectives have been developed including success measure, lead(s) and target dates. These have been organised into four categories reflecting NHS Lothian's four overarching priorities and are set out below.

- **To improve the health of the population**
- **To improve the quality of healthcare**
- **To improve staff experience**
- **To achieve value and sustainability**

Improving the Health of the Population

1. Increase activity aimed at preventing people from developing health issues or becoming unwell. Reduce health inequalities and the burden of avoidable suffering and premature death.
2. Re-design our arrangements to provide sustainable access to primary care services.
3. Increase support for communities and individuals to take care of their own health and health conditions (where this is appropriate).

IMPROVING THE HEALTH OF THE POPULATION			
OBJECTIVES	**SUCCESS MEASURE**	**LEAD**	**TARGET DATE**
Context for 2021-22 Overarching theme guiding our action focus / priority areas is that we want to get to a place this year where Public Health is framing the agenda for NHS Lothian and tapping into the expertise that exists here. We can have a role as an anchor institution that exerts and influence on national policy direction. We have place-based teams now which puts us in a better position to tackle inequalities with our partners. There is a new Public Health intelligence remit. More focussed use of data on day to day basis that helps guide response and priorities ensuring that we continue to improve the health of the population.			
1. Deliver the **Health Protection response** to the pandemic including the management of outbreaks and the Test and Protect Contact Tracing service	• Contribute to the Regional review of health protection • Review and revise Lothian's health protection operating model in line with best practice and the changing needs of the pandemic • Embed the Test and Protect service within the health protection model	Katie Dee	Regional review – by end of Q1 2021/22 Ongoing and depend on the outcomes of the Regional review Ongoing and depend on the outcomes of the Regional review
2. Develop strategies to **mitigate the wider harms** associated with the COVID-19 Pandemic	• Establish public health locality teams • Establish NHS Lothian public health COVID recovery	Katie Dee	PH locality teams: by end Q1 2021-22 NHS L PH priorities:

	priorities to inform work with local partnerships • Develop Public Health action plans with HSCPs and CPP in each of the four partnership areas.		by Q1 2021-22 PH action plans finalised: by end Q2 2021-22
3. Lead the development of NHS Lothian's role as an **anchor institution** to support the Edinburgh Poverty commission aims and poverty prevention work across all community planning partnerships.	• Develop the NHS Lothian approach that will integrate our response to the Edinburgh Poverty Commission with the ambitions of an anchor institution and the requirements of the Fairer Scotland Duty • Establish and lead work to develop NHS Lothian's anti-poverty plans • Develop NHS Lothian anchor mission	Katie Dee	Establish short-term NHS Lothian group to work on anti-poverty: by end Q1 2021-22 Develop NHS L framework to integrate Fairer Scotland and anti-poverty work: by end Q3 2021-22) Develop NHS Lothian anti-poverty approach: by end Q2 2021-22 Define and develop NHS Lothian anchor mission: by end Q1 2021-22
4. **COVID Vaccination** / Vaccination Transformation Programme	• Complete Covid vaccination programme 1st and 2nd doses. Timescales will depend on vaccine supply. If supply improves could be complete in July 2021 • Develop and implement plan for removal of all vaccination from general practice with new models of delivery. • Review public health governance requirements for immunisation programmes.	David Small Alison MacDonald Katie Dee	July or August 2021 Plan to be agreed by June 2021 and implemented by October 2021

5. Develop and deliver **communication strategy** to support extended delivery of NHSL's Covid-19 vaccination programme, contact tracing and restrictions which together are the route out of pandemic.	• Staff and public are clear on importance of these 3 measures • Metrics for vaccination exceed national targets • Metrics for testing exceed national targets • Reduction in associated complaints / confusion	Judith Mackay Katie Dee	Extended Plan March 2021 Delivery to Oct 2021
6. Screening Programmes	• Oversee the remobilisation of the screening programmes (Breast cancer, Bowel cancer, Cervical cancer, Diabetic eye screening, Abdominal Aortic Aneurysm and pregnancy and newborn screening) focusing on the backlog of appointments that were missed due to the pandemic and then expanding services as capacity permits.	Katie Dee	March 2022
7. Increase the number of people supported to **stop smoking**	• Establish a tobacco control board • Develop Lothian tobacco control prevention and protection plans • Improve performance against SG target for successful 12 week quits within the 40% most deprived data-zones in Lothian	Katie Dee/ Chief Officers	Establish tobacco control board: by end of Q1 2021/22 Develop Lothian tobacco control prevention and protection plans: by end of Q3 2021/22 Deliver SG quits target: by end of Q4 2021/22
8. Feeley Review of **Adult Social Care.**	• Create a delivery plan for Board consideration and approval	Chief Officers / CMT	October 2021
9. Review model of G**eneral Practice**	• Review implications of revised timescale for new contract – produce revised update on each area. Initial focus on removing all vaccinations by October 21. • Clarity on role of general practice, activity and	Colin Briggs/David Small/Tracey Gillies/Chief Officers	June 2021 June 2021

	throughput in relation to investment. Build on "data loch" to develop reporting and analysis. • Revised approach to capital investment in general practice and primary care. Ensure access to general practice. Revised PC investment strategy to LCIG. Update on immediate premises priorities for population growth		October 2021 June 20 21
10. To work towards the attainment of the **nationally set key performance indicators** for *Staphylococcus aureus* Bacteraemia, *Clostridioides difficile* and *Escherichia coli* Bacteraemia. For the period 2020-2021, for NHS Lothian these are calculated as:	• SAB - to achieve an incidence of 12.6 healthcare associated episodes (or less) per 100,000 bed days (<123 episodes approx.) • C Diff –to achieve an incidence of 11.8 healthcare associated episodes (or less) per 100,000 bed days (<115 episodes approx.) • E Coli –to achieve an incidence of 29.6 healthcare associated episodes (or less) per 100,000 bed days (<290 episodes approx.)	Alex McMahon	March 2022
11. Deliver revised strategic and tactical plan for the implementation of **Best Start**	• Draft plan in place for July 2021 • Best Start reframed and streamlined into practice	Alex McMahon / Justine Craig	July 2021
12. Provide professional nursing oversight of **care homes**, with particular focus on infection.	• Respond timeously to infection outbreaks and provide appropriate professional support.	Alex McMahon	March 2022
13. Responsive **Laboratory Testing** Capacity	• Capacity through NHS, Regional and Hub laboratories meet the demand of national objectives and changing pandemic scenarios	Michelle Carr	March 2022
14. Continue to lead the NHS Lothian approach to design and delivery of the Scottish Government's National Framework for the Prevention, Early Detection and Early Intervention of **Type 2 Diabetes** in collaboration with the East of Scotland Type 2 Diabetes Partnership.	• Completion of EQIA and Fairer Scotland assessments for all programmes, with a resulting plan to address any inequalities. • Embed a digital first, but not digital only approach across whole programme, establishing and delivering digital group programmes for Type 2 Diabetes prevention, education and intervention	Chief Officers/ Fiona Huffer	March 2022

	and adult weight management. • Single point of access to the NHS Lothian Weight Management Service for all adults and children seeking treatment, including digitally accessible self-referral. • Review and agree SLAs through locality leisure services for Tier 2 weight management in adults and children • Implement COVID mobilisation plan for over 2,000 patients on the long waiting list > 52weeks. • Create Dietetic Service Lead post to manage diabetes and weight management teams. • 100% of patient contacts recorded on the national dataset attached to this programme and reported annually through PHS for publication, using regional dashboard to report regional progress.		

Improving the quality of healthcare

1. Improve performance on unscheduled care, and the timely discharge of people from our hospitals to home or a homely environment.
2. Increase the level of care and support provided within the community for adult mental health services, psychological services, and learning disabilities services.
3. Reduce waiting times for scheduled care, cancer services, and Child & Adolescent Mental Health Services.

IMPROVING THE QUALITY OF HEALTHCARE			
OBJECTIVES	**SUCCESS MEASURE**	**LEAD**	**TARGET DATE**
Context for 2021/22 The focus for this year will be to maintain and remobilise services across our key mental health, unscheduled care and scheduled care pathways with a particular focus on the management of waiting times that have been impacted by the pandemic. This will focus on those with the highest clinical priority, cancer and mental health services. We need to contribute to national discussion about access in its widest sense. There is a need for an agreed recovery plan and the public need to understand that our ability to recover this year will be limited and it is likely that waiting times may further deteriorate until Autumn before improvement is seen.			
MENTAL HEALTH			
1. **Children & Adolescent Mental Health Service (CAMHS):** Implement the CAMHS 2021 Project	• the establishment of a CAMHS Neurodevelopmental Service by mid-2021 and subsequently progress towards multiagency neurodevelopmental pathways (timescale to be confirmed); • adoption by September 2021 of the Choice and Partnership Approach (CAPA) demand and capacity model and associated ways of working that will meet the needs of the young people who use our specialist services, and deliver the CAMHS Trajectory for reduction in waiting lists by March 2022; • undertake a review and development of Tier 2 Services with the aim of increasing capacity and strengthening collaboration between Tier 2 and Tier	Tracey McKigen	March 2022

	3 by end 2021.		
2. **Psychological Therapies:** Continue the implementation of the Performance Improvement Project comprising of:	• further embedding the performance management model across the psychology teams by mid-2021 within a framework of professional support and development; • further development of the Psychological Therapies Governance, Professional Standards and Training Board and enhancement of its role in approving the therapies delivered across Lothian and monitoring the outcomes for patients; • continuing the trend established in April 2020 of reducing numbers of patients within the Adult Mental Health Outpatients Service waiting longer than 18 weeks to commence treatment based on an updated trajectory which will be established for 2021/22.	Alex McMahon	Mid 2021
3. **REH Phase 2 Re-Development**	Deliver disaggregated and prioritised proposals for the Phase 2 re-development of the REH Campus recognising the likely limitations on capital funding.	Alex McMahon	March 2022
4. **Unscheduled Care**: Collaborate with the Unscheduled Care Recovery Project	Deliver the mental health components of the redesigned Unscheduled Care Framework which are aimed at delivering more immediate and appropriate care for patients and relieving the pressure on acute mental health beds.	Tracey McKigen	March 2022
5. Edinburgh IJB Directions on **Learning Disabilities** delivered	An implementation plan for the delivery of the Direction, where it is to be delivered by the NHS Board will be developed.	Judith Proctor	This takes place in 2 tranches as commissioned accommodation is being purpose built 1 - by end of 21/22 2 by end of 22/23

UNSCHEDULED CARE			
6. **Redesign of Urgent Care**: Phase 1 a) Maximise impact of phase 1, aimed at those self-presenting to MIU/ED, by improving public understanding about when to attend ED, and developing the interface between NHS24, the Lothian Flow Centre, and downstream clinical services including increasing the number of scheduled minor injury assessments.	• Reduction in self-presenters at ED/MIU. • Increased 111 call volumes. • Increase in scheduled minor injury assessments (either NearMe or face-to-face) • Consistent triage and sign-posting/redirection approach in place across all acute sites with increased sign-posting/redirection activity from ED	Jenny Long / Judith Mackay/ Alison MacDonald Jenny Long / Jacquie Campbell	March 2022 September 2021
7. Redesign of Urgent Care: Phase 2 b) Develop and improve professional referral pathways (phase 2) into same day community services and same day secondary care services to achieve right care in the right place at the right time, including: i) Improving ease of access of General Practice referral to secondary care services via the Lothian Flow Centre ii) Increasing provision of planned same day secondary care, including expansion of the SDEC (same day emergency care) model, which is provided outwith the ED	• Sustainable LFC workforce to meet call answering KPIs for GP urgent referrals, NHS24 electronic referrals, and new additional professional referral demand. • Expand WGH SDEC service to 7 days, with SDEC to take 40% of pre-SDEC MAU trolley activity (approximately 8,000 patients per year) • 90% of SDEC attendances to have diagnosis and care initiated without admission to hospital • Agreed proposal for long-term location of SDEC to integrate with WGH masterplan	Joan Donnelly Jacquie Campbell /Alison Macdonald/ Chris Stirling	June 2021 October 2021 March 2022

iii) Improving ease of access of primary care referral to same day community services within each HSCP iv) open professional referral pathway for ambulance service clinicians via the Lothian Flow Centre to both same day secondary care and community services	• Plan agreed for SDEC model at RIE and SJH via the Front Door Redesign programmes • Reduction in professional referrals received in ED • Increase in scheduled professional referrals to same day secondary care services • Increased community alternatives to secondary care attendance/admission. • Reduction in patients conveyed to ED by SAS	Alison MacDonald/ Chief Officers Jenny Long / Joan Donnelly	June 2021 March 2022 June 2021 June 2021
8. Clear and consistent **system wide pathways** in place for urgent care that are easy for residents and professionals to navigate	• Description of how to access urgent care across whole system covering both public and professional access (including national partners NHS24 and SAS), across HSCPs and acute services. • Reduction in inter-hospital transfers • Defined full scope of expanded Lothian Flow Centre and clear interface with each HSCP to access community services	Jenny Long / Chief Officers Joan Donnelly / Jenny Long	June 2021 June 2021
9. **Provision of care as close to home** as possible, embedding home first philosophy, with a stay in hospital when clinical needs can only be met in hospital. **Develop the right size of community provision** to manage population growth that supports care at home and prevention of hospital admission, with an initial focus on Hospital at	• Agreed consistent model for delivery of Hospital at Home across HSCPs, with defined benefits and costs, and plan for expansion as appropriate. • Programme approach for planned development of other community services. • Reduced admissions • Increased occupied bed days saved by community	Alison MacDonald / Peter Lock / Chief Officers	September 2021 March 2022

Home capacity and delivery in 2021	services • Acute hospital occupancy does not exceed 90%		
10. **Reduced delays across whole system** embedding home first philosophy with assessment of health and care needs determined by appropriate professional at appropriate time	• Develop and implement a pan-Lothian Discharge Operating Model with clear roles and responsibilities across acute and community teams • Reduced delayed discharges • Reduced delays for transfer from acute hospital to rehabilitation / intermediate care etc • Reduced occupied bed days due to all delays • Reduced Length of Stay • Acute hospital occupancy does not exceed 90%	Alison MacDonald / Chief Officers	March 2022
11. Review (redesign) **rehabilitation services** (especially post-Covid) including Ortho rehabilitation/complex physical disability rehab	• Review recommendations from SG document - "Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic". • Understand capacity and demand in relation to Rehabilitation Framework • Ensure Therapies 'Ready to Go' (R2G) aligns and keeps up with, or ahead of, EDD/PDD • Responsiveness of community services to support D2A • Reduced OBD – wider AHP input/AAH redesign	Heather Cameron	March 2022
SCHEDULED CARE			
12. Update **Demand and Capacity** modelling to detail recurrent gap	• Local, regional and national activity models to meet recurrent gap due to significant gap in capacity within Acute services, specific capacity solutions will include the procurement of independent sector activity	Jacquie Campbell	April 2021 to complete DCAQ Activity models to March 2022

13. Focus on clinical prioritisation - access to Out-patients, diagnostics and treatment for those who need it most	• Activity for USOC to meet demand • Activity for Urgent to meet demand • Long waits minimised • Clinical categorisation for TTG on Trak • Patient communication aligned to clinical priority	Jacquie Campbell	Reported fortnightly through ELT -March 2022
14. **Cancer services**: 31 and 62 day performance Establish pan-Lothian 'Improving the Cancer Journey'(ICJ) service to support people's non-clinical needs following a cancer diagnosis.	• Sustain 31 day performance at 95% • Improve 62 day performance to 90% • ICJ service established in all HSCPs	Jacquie Campbell Chief Officers/Sandra Bagnall	March 2022 Summer 2021
15. **Services Under Pressure** to be reviewed and scrutiny / support to be provided (e.g. Dermatology / Ophthalmology / EDI)	• Develop recovery plan(s) • Implement in line with trajectory and plan(s).	Calum Campbell, Jim Crombie, Jacquie Campbell, Peter Lock	June 2021 March 2022
16. Model for **Ophthalmology**.	• Revised model of service developed and agreed, based on best practice that doesn't entail a rebuild of the whole of the Eye Pavilion.	Aris Tyrothoulakis	May 2021
17. **Review model of outpatients**. Set new expectations on what outpatient services can be delivered remotely and which need to be bolstered, with revised footprint and infrastructure plans	• Develop an outpatient strategy for NHS Lothian • Implement the identified 5 modes of service change: ACRT, PIFU, PFB, monitoring service, virtual consultations • Extend role of Refhelp and establish processes to ensure guidance up to date. • Expand the delivery of care outside secondary care settings including CTACS/ monitoring services	Jacquie Campbell/Tracey Gillies/Colin Briggs/Martin Egan Peter Lock	March 2022
18. **Review Theatre scheduling process –** including evaluation of scheduling tools such as Infix	• Evaluate and introduce new theatre scheduling process by June 2021 • Align theatre sessions to specialty waiting list to ensure capacity matches demand by July 2021 • Establish Baseline Measures June 2021	Michelle Carr/ Jacquie Campbell Peter Lock	To March 2022

	• Increase number of cases per session by 3-5% based on more accurate booking times by August 2021 • Improve theatre turnaround time between cases by streamlining the process and removing unnecessary steps by August 2021. Reduce turnaround to only current cleaning/ fallow regimes. • Improve overall theatre utilisation to 80% by maximising session uptake and in session utilisation		
COMMUNICATION & ENGAGEMENT			
19. Develop communications strategy linked to **waiting times management**	Aid public understanding of principle of clinical prioritisation and manage expectation via: • Patient letters / KIT letters – generic text reviewed every quarter and updated if required • Proactive media coverage of mitigating measures and innovation to support pts & increase access as much as possible e.g. via tech, • Internal and external campaign to explain principles • Stakeholder comms (GPs and other referrers, third sector / patient support groups / elected representative) •	Judith Mackay	Strategy June 2021 Implementation ongoing to April 2022
20. Complaints - Develop a patient outcome approach that sets new expectations around complaint handling with a trajectory for improvement and evidencing action from the learning	• Increase the proportion of complaints managed at stage 1 to 20% of all complaints in each Directorate • Increase the proportion of complaints managed within the 20-day timescale to 90% of stage 2 complaints in each Directorate • Reduce the proportion of complaints reaching a second delay to <2% of the total number of current open complaints	Alex McMahon / Fiona Ireland	March 2022
RESEARCH, DEVELOPMENT & INNOVATION			
21. Research, Development & Innovation	• Deliver the CSO objectives in Research, Development and Innovation by running an SBRI in Hip fracture, to complete in 2021	Tracey Gillies	Dec 2021

	• Contributing on behalf of East region to national innovation projects		

Improving Staff Experience

1. Improve our workforce sustainability and widen our workforce supply routes. Maintain an up-to-date 3-year NHS Lothian Board Workforce Plan to support workforce and service sustainability across services, professions, sites, and health & social care partnerships.
2. Implement the Staff Experience and Engagement Programme, to have a workplace which is safe, staff are healthy, fit for their jobs, and feel that their work contributes to their wellbeing.
3. Develop the capacity and capability of leadership at every level of the organisation.

IMPROVING STAFF EXPERIENCE			
OBJECTIVES	**SUCCESS MEASURES**	**LEAD**	**TARGET DATES**
1. System Wide **Staff Wellbeing** and Promotion Strategy developed and approved.	• Clarity on the actions (S/M/L Term) and resource investment to support and promote Staff Wellbeing to improve staff experience and maximise staff ability to remain at work: well, engaged and present over the next 3 years.	Janis Butler/Amanda Langsley	Launch Strategy April 2021 Action Plan for year 1 developed by end May 2021. Year 2 action plan developed by January 2022
2. **Talent Management** approach developed and approved to support succession plan	• Options for introducing a talent management approach scoped, priority areas for action agreed (phase 1) and test change ideas in the 2nd half of the year for priority grouping (phase 2)	Amanda Langsley	Scoping by August 2021, test of change by March 2022
3. Plan to improve **staff engagement and experience** across our system, to improve recruitment and attraction	• Launch refreshed Staff Engagement and Experience Framework for 2021-23, suite of corporate enablers in place and local staff engagement and experience priorities agreed by HSCP/Sites/Service Directorates.	Janis Butler	Launch framework April 2021, local action plans by September 2021 Corporate enablers April 2021 – March 2022
4. Launch the **East Regional Recruitment** Service and single employer model	• TUPE transfer effected, new model operational and performance infrastructure in place.	Janis Butler/Jenni Duncan	TUPE transfer by September 2021 and new operating model March 2022
5. Develop a strategic approach to **Homeworking** for	• Short -medium term operational plan in place and	Jim Crombie/Janis	Operational plan for S-M

NHS Lothian	options developed for a longer-term approach.	Butler	term by July 2021 and longer-term approach by March 2022.
6. **Covid Workforce Recovery** Plan developed with clear exit strategies and risk assessment.	• Track additional covid workforce (core and flexible) to determine financial and HR policy impacts, assess and mitigate risk and identify sustainable solutions where required.	Janis Butler/Nick McAlister/ Craig Marriot	Framework in place by June 2021
7. Develop and implement **Comms strategy** to support Staff Experience / Wellbeing	• Staff feel supported, understand and make use of the range of wellbeing initiatives on offer. • Evidenced via take-up metrics and staff survey.	Judith Mackay	Staff Experience / Wellbeing Comms Strategy delivery – May 2021
8. Develop and implement **Comms strategy** to support East Regional Recruitment Strategy	• Single Regional Employer & what the means is publicised effectively	Judith Mackay	Regional Recruitment Comms Strategy delivered - September 2021
9. Corporate Management **Team (CMT) development** programme developed and delivered to build and sustain Strategic Focus, Collective Approach and Team Interaction to ensure CMT is a highly effective team	• A programme of activities is planned for 2021-22 – mixture of virtual, face-to-face, whole-team & 1-1s • Success measures for strategic focus, collective approach and team interaction are agreed and actions to realise these are in place and being delivered • The support from non-execs will be sought as required	Calum Campbell/OD Team	Ongoing to March 2022
10. Implement the **national whistleblowing standards**	• Launch the new standards for directly employed staff and contractors in line with SG requirements. Assess any ongoing risks to implementation and deploy risk mitigation within the Boards scope of responsibility. Establish appropriate support, governance and reporting infrastructure.	Janis Butler/Ruth Kelly	Implement standards April 2021 Infrastructure by June 2021. Other actions ongoing until March 2022
11. Continue to implement extant 3-year **workforce plan** with particular attention to workforce	• A robust programme of youth employment and workforce development activity is delivered 2021 -	Janis Butler/Amanda	Ongoing to March 2022

enablers.	2022 including launch of the SG Kickstart Programme, ongoing Modern Apprenticeship and Graduate Apprenticeship recruitment and development, work experience opportunities and activities that support the widening access agenda. • Once recruited our workforce will be developed and supported by via a range of interventions to meet identified and emerging gaps including digital skills, our youth network and business and administration network. • Implement the specific actions outlined in the plan for professional groups (eg safe staffing) and/or strategic work programmes (eg GMS)the period through to end of March2022 and prepare for the anticipated revised national guidance for workforce planning wef from March 2022.	Langsley	
12. **Equality & Diversity** - Take action to create more inclusive and diverse workforce within NHS Lothian and implement actions to prevent racism and other forms of discrimination in our organisation. • A particular focus for 2020-21 on the senior leaders in the organisation.	• Start Coffee Roulette sessions for senior leaders (including executive staff, and non-executive Board members) with a range of staff network members • Facilitated, structured conversations about race and ethnicity, disability, sexuality and gender, age, personal bias, and institutional discrimination at Board, ELT and CMT, with Staff Network members • Reverse mentoring partnerships established and supported for at least 30% of EMT and CMT members, with Staff Network members • Communications plan developed and implemented – month by month – to celebrate diversity and the wealth of culture within NHS Lothian	Jim Crombie, Depute CE Janis Butler, Director of HR & OD Chris Bruce, Lead on Equalities & Human Rights Rakiya Suleiman, Equality & Diversity Advisor	30 May 2021 30 March 2022 Established by 30 August 2021 test & evaluate by 31 March 2022 31 May 2021

	• Further developments of actions to demonstrate zero tolerance of racism and other forms of discrimination; plan agreed and implemented. • Advancing Equalities Action Plans reviewed, agreed, year one actions implemented		Autumn 2021 31 March 2022

Achieving Value and Sustainability

1. Cut out avoidable travel and avoidable visits to healthcare premises.
2. Support integrated whole-system working across health and social care.
3. Transfer children's hospital services, the department of clinical neurosciences, and Child & Adolescent Mental Health Services to the new hospital at Little France.
4. Progress the sustainable workforce plan to fully re-open the paediatric inpatient ward at St John's Hospital.
5. Always develop and carry out robust implementation plans, and review their impact on Our Priorities. Learn from all attempts to make improvements, and share that learning with others.

ACHIEVING VALUE & SUSTAINABILITY			
OBJECTIVES	**SUCCESS MEASURES**	**LEAD**	**TARGET DATE**
DIGITAL			
1. Existing key **Digital Initiatives** are realised. (e.g. HEPMA/Outpatients).	• Benefits defined with the business cases are realised • Deployment in line with agreed plan • Delivery of platform and approaches for the sharing of clinical images particularly tele-dermatology • Delivery of HSCP digital programmes eg Midlothian TEC Pathfinder and IJB Direction (2020) to NHS Lothian.	Martin Egan Chief Officers/Midlothian IJB	Unified Communications Rollout complete 30/06/21 HEPMA Complete at WGH 31/05/21 HEPMA Complete at RIE 31/12/21 HEPMA Complete at SJH 31/03/22 OP Redesign deployed to plan as at 31/03/22
2. **Online Appointment** Booking.	• Test of change evaluation is positive and roll out plan developed and agreed.	Martin Egan	Proof of concept by 30/06/21 proposal for full deployment by 30/09/21
3. **E-Health** Infrastructure.	• Backlog maintenance and replacement programme developed and approved.	Martin Egan.	30/4/2021

4. **Near Me and telephone consultations** are evaluated and utilised as a business as usual product where clinically appropriate	• Gov Framework developed and approved & signed off • Governance framework will be developed through Acute Outpatient Board and signed off by Scheduled care Board • Each service in acute will undertake an assessment of current and future utilisation of virtual consultations • Principles for the introduction and implementation of virtual consultations will be developed • Support the implementation of virtual consultations across a whole service starting with Cancer services • Patient/public engagement will be undertaken to clarify the suitability of this mode of outpatient delivery to ensure equity of access to care. • Each service will agree a target for implementation. The overall target for Acute services has been set at 30%. • Blended templates will be developed. • Mode of contact will be recorded on SMR0. • Criteria to assess business, patient and clinical benefits will be developed and agreed.	Jacquie Campbell / Martin Egan / Peter Lock	Governance Framework March 2021 BAU- March 2022 By March 2021 By November 2021 By May 2021 May 2021 EHealth to set timeline EHealth to set timeline June 2021 BAU- March 2022
5. Develop proposal for **Staff App** to improve staff engagement especially of 'harder to reach' (traditionally offline) staff groups.	• Benefits paper • Scope Budget • Outline Plan	Judith Mackay	Develop Proposal by June 2021
6. Rebuild new **NHSL website and intranet** on sustainable platform that meets accessibility obligations as Sharepoint becomes unsupported and to meet accessibility legislation	• Options paper • Scope Budget • Proposal Supplier appointed	Judith Mackay	Develop proposal by June 2021 Supplier- September 2021 Completion March 2022

STRATEGIC AND SERVICE PLANNING/ REVIEW			
7. Organisational **Strategic Plan** (Momentum sustained and gained).	• Clarity on short, medium- and longer-term organisational priorities and commitments are clearly articulated. • Airtight Engagement and Consultation Strategy developed and delivered with external provider to support development of Strategic Plan	Colin Briggs / CMT Judith MacKay	
8. Develop and secure agreement for system-wide **Public Engagement Framework** across NHSL and HSCPs	• Shared value placed on meaningful engagement among CMT • Staff recognise its role in service change and development • Shared online resources / training suite for staff across the system	Judith Mackay / Simon Malzer	March 2021 for Framework agreement Resource development ongoing
9. Contribute to the development of a **National Recovery Plan.**	• Waiting times recovery is achieved equitably across Scotland.	Tracey Gillies/ Colin Briggs	March 2020
10. Implement **Sustainability** Development Framework	• The Board's Sustainability Development Framework action plan elements relevant to 2021-22 will be implemented	Jane Hopton	March 2022
CAPITAL PROJECTS			
11. Review longer term **capital plan** and deliver capital programme for 2021/22	• New capital plan aligned with new organisational strategy • Agreed projects and rolling programmes delivered as per plan • Fully developed assurance framework for capital projects finalised in line with internal audit recommendations for the RHCYP/DCN	Colin Briggs/ Susan Goldsmith	March 2021 and regular reporting and oversight by the Finance and Resources Committee.
12. Cancer Centre	• Work with SG and key partners to strengthen the case	Jim Crombie /Judith Mackay/	Engagement Strategy agreement April 2021

Influence SG view on case for Edinburgh Cancer Centre for sustainable research, treatment and care facilities for cancer. Developing outstanding Business Case Develop and implement Engagement Strategy to take us to OBC	• Draft additional chapters complete by Sept 2021 for F&R to allow Governance progress for NHSL Board submission October and December CIG submission Continuing development the site masterplan and infrastructure planning to facilitate future development at WGH • Alignment with refreshed government strategy, the 3 year remobilisation plan, and provide the roadmap for the regional transformation programme. Success factors: • Strength of case accepted by multiple audiences – and SG • IA accepted.	Chris Stirling	September 2021 F&R Dec 2021 CIG submission
13. Full Occupancy of RHCYP	• Agreed programme to finalise the commissioning and transfer of remaining services to the new hospital • Ensure the effective operational management of the PPP is in place • Lead the decommissioning and sale of the Sciennes Road campus • All staff transferring from RHSC fully orientated to new hospital and completion of patient safety simulations by w/c 15 March 2021 • Safe and complete move of all remaining clinical and support services w/c 22 March 2021, with all services operating at pre- move activity levels w/c 29 March 2021 • Comprehensive Site Liaison processes in place	Susan Goldsmith / Jacquie Campbell/ Jim Crombie	March 2021 For commissioning October for decommissioning and sale

	between Children's services, CAMHS and DCN – and with RIE Site – to support safe and effective patient care, particularly in shared/ conjoined areas eg Adult and Paediatric ED, Theatres- and to support Major Trauma services, Mass casualties planning. April 2021 onwards • Plan for identifying and maximising the patient, family and staff benefits of the move to the new hospital developed and agreed by August 2021 • Effective management of PPP contract		
14. Decommissioning of RHSC	• Successful Decommissioning of RHSC after services vacate, by 6 weeks after move date (w/c 3 May 2021) • Any Hazardous materials/ items not appropriate to leave safely removed. • No confidential patient identifiable information, slides or specimens left • Building handed over on time, in the condition specified in the Terms of Sale	Jim Crombie	October 2021
15. Short stay elective centre	• Agreed (physical) options to accommodate Opthamology theatre capacity • Reworking of business case • Business case to SG by sept 2021 on interim capacity to support elective waiting times recovery.	Jim Crombie/Susan Goldsmith	June 2021 June 2021
16. Develop strategic plan for **WGH campus** 21/22	• Formal proposal for demolition of DCN building • Formal proposal for demolition of Laundry building	Jim Crombie	June 2021 June 20-21
COMMUNICATIONS			
17. Develop **communications and engagement strategy** to support NHSL Sustainability Development Framework	Strengthen Comms resource to build on early successes and generate commitment and buy-in from our staff, partners and public on NHSL's key sustainability goals which include:	Judith Mackay/ Jane Hopton	May 21 - - Strategy Delivery and comms resource Implementation ongoing

	• To have zero carbon emissions by 2045 • Ensure sustainable development is embedded in governance and decision making, clinical practice & partnership working • Put sustainability at core of its strategies for promoting health and wellbeing among staff and patients. To support these aims Comms will: • advise and support approaches to developing patient feedback on SDF in service planning and redesign. • Develop and deliver internal and external comms and engagement strategy (public, SG, Parliament)		
18. Public Inquiry Ensure smooth operation of Inquiry project office, Document management etc to ensure NHSL's case is represent fairly and accurately, Develop Strategy for effective reputation management of NHSL in this regard	• Agree a programme of work with the Public Inquiry team and the CLO for 21/22 • Ensure the right resources are in place to support the work programme • Develop Board position statements for key aspects of the line of enquiry	Calum Campbell / Jim Crombie / Susan Goldsmith / Judith Mackay	Regular reporting and oversight by the Finance and Resources Committee
19. Develop and Implement a comms strategy to support he final full migration to **RHCYP** and that rebuild reputation of the building	• Smooth migration. Positive coverage. Public confidence.	Judith Mackay	March / April 2021 onwards
ESTATES AND FACILITIES			
20. Further develop assurance framework for **Estates & Facilities**	• Water • Fire • Ventilation • Electrical	Jim Crombie	
21. Develop **Traffic safety and access** provision across Adult Acute sites (4)	• Implement agreed permit system@ RIE within 3 months of relevant SG 'Lockdown' control • Develop and seek approval for traffic management systems across NHSL 4 Adult Acute sites	Jim Crombie	TBC May 2021

	• Provide proposals re establishing 'permit' access only for staff @ RIE		May 2021
CONTRACTS AND FINANCE			
22. Agreed **Financial Plan** for 21/22 and beyond	• Agreement and delivery of financial plan that identifies the ongoing impact of Covid and recovery • Development and delivery of key opportunities for improved efficiency • Development of a longer-term financial plan aligned with organisational strategy	Susan Goldsmith	April 2021 (for agreement of plan) April 22 for delivery and longer-term plan
23. Commercial arrangements for **buy-out** developed in accordance with Scottish Government policy	• Establish the key commercial terms for the buy-out of RIE Car park • Agree Heads of Terms with Consort Board • Delivery of Supplementary Agreement with Consort	Susan Goldsmith	December 2021 (subject to engagement of Consort)
24. Implement effective management of Consort/Engie **PFI Contract** at Royal Infirmary of Edinburgh	• evidenced by agreement on performance scores and the application of appropriate contract measures • oversight of rectification of critical system defects identified through assurance work	Susan Goldsmith Jim Crombie	Reported at every F&R Committee
REPUTATION MANAGEMENT			
25. Protect and defend **reputation** of NHS Lothian	• Reputation begins with staff - ensure staff are informed and engaged via all internal channels • Support service social media accounts where appropriate • Weekly monitoring & Monthly analysis of media reporting • Promote NHSL successes • Anticipate periods of adverse publicity & ensure proactive positive coverage to counter-balance • Regular sector briefings for media for fairness in coverage • Regular briefings to elected members to equip with context	Judith MacKay	On-going to March 2022


Our Values
Into Action

NHS LOTHIAN

Board Meeting
7th April 2021

Director of Finance

FEBRUARY 2021 FINANCIAL POSITION

1 Purpose of the Report

1.1 This paper provides an update to the Board on the financial position at Period 11 and NHS Lothian's year-end forecast position.

1.2 Any member wishing additional information on the detail of this paper should contact the Director of Finance prior to the meeting.

2 Recommendations

2.1 The Board is recommended to:

- **Accept** this report as a source of **significant assurance** that NHS Lothian will achieve a breakeven outturn this financial year;

3 Discussion of Key Issues

Financial Position as at February 2021 and Year End Forecast

3.1 The F&R Committee received a paper on the Period 10 financial position and the year end outturn overspend projection for 2020/21 at its March meeting. The F&R paper highlighted a year-to-date core overspend of £1.37m. The financial position has now been updated to period 11 which now shows a further improvement with a year to date core overspend of £0.5m shown in appendix 1.

3.2 Based on the information provided at period 10, the F&R Committee agreed that it had **significant assurance** that the Board is able to achieve a breakeven outturn in 2020/21.

3.3 The F&R Committee was informed that the achievement of a balanced outturn for 2020/21 was largely achieved due to one off benefits and did not resolve the issue of recurrent financial sustainability in future years.

3.4 The financial impact of COVID-19 in 20/21 has been fully funded by the Scottish Government. Funding for the £500 Bonus payment and the Agenda for Change interim pay award are also be assumed to be fully funded by the Scottish Government.

4 Risk Register

4.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

4.2 The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

5 Impact on Inequality, Including Health Inequalities

5.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

6 Duty to Inform, Engage and Consult People who use our Services

6.1 The implementation of the financial plan and the delivery of a breakeven outturn will require service changes. As this paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

7 Resource Implications

7.1 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
25th March 2021
susan.goldsmith@nhslothian.scot.nhs.uk

Appendix 1 - NHS Lothian Income & Expenditure Summary to 28th February 2021

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)	Period Variance (£k)
Medical & Dental	303,889	277,889	283,998	(6,109)	(116)
Nursing	492,247	451,121	452,082	(961)	(1,034)
Administrative Services	139,167	121,057	115,574	5,484	736
Allied Health Professionals	83,692	76,117	75,840	277	90
Health Science Services	44,473	40,805	41,092	(287)	(24)
Management	9,321	8,534	7,480	1,054	102
Support Services	76,234	69,533	75,029	(5,495)	(490)
Medical & Dental Support	13,228	12,190	13,005	(815)	(90)
Other Therapeutic	39,617	35,907	38,787	(2,880)	(249)
Personal & Social Care	3,776	3,463	3,258	204	19
Other Pay	(1,761)	(1,787)	(1,960)	174	13
Emergency Services	3	3	3	0	0
Vacancy Factor	(99)	(35)	0	(35)	(3)
Pay	**1,203,787**	**1,094,799**	**1,104,189**	**(9,390)**	**(1,047)**
Drugs	130,199	118,545	120,009	(1,464)	(693)
Medical Supplies	93,638	85,279	80,556	4,723	387
Maintenance Costs	6,259	5,839	10,712	(4,873)	(466)
Property Costs	41,178	36,509	37,881	(1,372)	(114)
Equipment Costs	34,101	28,001	36,204	(8,203)	(1,136)
Transport Costs	8,719	7,987	7,374	613	(17)
Administration Costs	213,947	101,442	95,704	5,738	1,920
Ancillary Costs	12,708	11,684	12,564	(881)	(69)
Other	(2,858)	(21,824)	(21,842)	18	171
Service Agreement Patient Serv	34,249	32,908	34,897	(1,989)	(646)
Savings Target Non-pay	(1,032)	(922)	0	(922)	8
Resource Trf + L/a Payments	157,025	129,585	130,951	(1,366)	(196)
Non-pay	**728,135**	**535,032**	**545,011**	**(9,978)**	**(850)**
Gms2 Expenditure	143,741	128,417	129,430	(1,013)	(253)
Ncl Expenditure	888	814	809	5	(0)
Other Primary Care Expenditure	87	80	46	33	4
Pharmaceuticals	153,848	140,707	139,819	888	149
Primary Care	**298,563**	**270,017**	**270,104**	**(87)**	**(100)**
Other	**(1,457)**	**(1,350)**	**(1,040)**	**(311)**	**(13)**
Income	**(292,964)**	**(273,337)**	**(282,095)**	**8,758**	**1,372**
Revenue Resource Limit	**(6,000)**	**(6,000)**	**(6,000)**	**0**	**0**
Extraordinary Items	**0**	**0**	**(3)**	**3**	**0**
CORE POSITION	**1,930,065**	**1,619,161**	**1,630,167**	**(11,006)**	**(638)**
Additional Reserves Flexibility	10,552	10,552	0	10,552	1,556
TOTAL	**1,940,617**	**1,629,712**	**1,630,167**	**(454)**	**918**

NHS Lothian

Board Meeting
7 April 2021

Director of Finance

NHS LOTHIAN 5-YEAR FINANCIAL OUTLOOK AND OUTLINE PLAN 21/22

1 Purpose of the Report

1.1 The Director of Finance, with the management team, has been developing the NHS Lothian Financial Plan for 2021/22 for approval by the Board. This is consistent with the Board's Standing Orders which state the requirement: "The Board shall approve its Financial Plan for the forthcoming financial year, and the opening revenue and capital budgets."

1.2 The Finance and Resources Committee, in its consideration of the Financial Plan for 21/22 and longer term financial strategy has endorsed the following plan, in order for initial budgets to be set.

1.3 The Board also has a requirement to set budgets for the delegated functions of the IJBs for 2021/22. The outline plan presented at this stage will form the basis of a formal allocation of budgets to the IJBs.

1.4 Any member wishing additional information on the detail of this paper should contact the Director of Finance before the meeting.

2 Recommendations

2.1 The Board is asked to:

- **Approve** the Financial Plan as a basis for opening budgets only and submit to Scottish Government as required.
- **Acknowledge** that, based on the latest information available at the time, the Finance & Resources Committee accepted **limited assurance** that NHS Lothian was able to deliver a balanced Financial Plan for 2021/22.
- **Endorse** the allocation of resources agreed by the Finance & Resources Committee for the purposes of budget setting.

3 Discussion of Key Issues

Financial Outlook 2021/22 to 2025/26

3.1 The Finance & Resources Committee received routine updates on the Financial Plan in recent months. Each update was provided based on the latest information available at that time. The final iteration in March is now presented to the Board for endorsement.

3.2 This Plan sets out current information on the baseline budgets for next year, with further assessment on cost pressures and the deployment of available resources to offset these where feasible.

3.3 Key to the finalisation of this Plan was the communication from the Scottish Government to Boards on the 28th of January on the indicative budget allocation for next year – a one-year budget only. This set out a 1.5% uplift on baseline budget, noting that this allocation would be reviewed following final agreement on the pay settlement from 21/22 onwards.

3.4 Table 1 below provides an updated summary of the 5 year financial outlook from next year. Further detail is provided in Appendix 1 with the Outlook split by Business Unit in Appendix 2. The figures as shown include the potential impact from Covid.

3.5 The overall gap for next year totals £91m and splits into two elements:

- £25m gap relating to the Core financial position;
- £66m relating to projected costs associated with Covid.

Table 1 – Projected 5 Year Financial Outlook Summary

	21/22 Variance	22/23 Variance	23/24 Variance	24/25 Variance	25/26 Variance
	£k	£k	£k	£k	£k
Full Year Recurring Expenditure Budget	**1,760,772**	**1,798,702**	**1,827,191**	**1,855,716**	**1,885,024**
Baseline Carry Forward Pressures	(43,807)	(136,369)	(146,117)	(158,487)	(168,968)
Additional Expenditure, Growth, Uplift & Commitments	(71,602)	(42,741)	(44,382)	(43,212)	(43,791)
Total Projected Costs	**(115,409)**	**(179,110)**	**(190,498)**	**(201,699)**	**(212,758)**
Additional Resources	64,422	32,513	32,864	33,222	33,584
Financial Outlook Gap before FRP's	**(50,987)**	**(146,597)**	**(157,634)**	**(168,478)**	**(179,174)**
Financial Recovery Actions	**25,914**	**3,483**	**1,614**	**1,614**	**1,614**
Financial Outlook Gap after FRP's	**(25,073)**	**(143,114)**	**(156,020)**	**(166,864)**	**(177,561)**
Additional Covid Costs	**(65,969)**	**(4,110)**	**0**	**0**	**0**
Total Financial Outlook Gap	**(91,042)**	**(147,224)**	**(156,020)**	**(166,864)**	**(177,561)**

Core Position (i.e. net of Covid) 21/22

3.6 The issues identified within the core position for next year of £25m are broadly made up of the following:

- A baseline gap of £44m;
- Additional in year cost growth of £72m for new (non-Covid) issues;
- Assumed additional resources of £64m, of which circa £31m is recurring;
- Offsetting efficiency savings identified to date of £26m.

3.7 The baseline gap moving into the new year includes almost £34m of cost pressures which were funded in 20/21 using non-recurrent resources. These costs are assumed a priority for funding in the new financial year and resources contained within the available £64m will be committed here in the first instance, leaving circa £30m available to allocate against the £72m of in year pressures.

3.8 As a reminder, the carry forward recurrent pressures that have previously been funded non recurrently include the following:

- **£15.7m** invested in Hospital Drugs largely funded from the New Medicines Fund (Voluntary scheme for branded medicine Pricing and Access – received non recurringly each year);
- **£7.1m** for Unscheduled Care, agreed in 2019;
- **£2.4m** National Services/ NDC;
- **£2.2m** for Energy/Rates at the new Royal Hospital for Sick Children;
- **£2.0m** eHealth investment;
- **£1.8m** Office 365;
- **£1.4m** Diagnostics/Theatres/Critical Care activity;
- **£1.4m** for other smaller schemes.

3.9 Adjusting for these pressures, and assuming these cost pressures continue to be funded as previously agreed, the baseline carry forward gap reduces to circa £9m overall.

3.10 The £64m of additional resource is based on the latest available information and makes assumptions around the delivery of flexible resource into next year. Resources assumed at this stage are shown in Table 2 below:

Table 2 – Summary of Additional Resources

	21/22	22/23	23/24	24/25	25/26
	£k	£k	£k	£k	£k
Base Uplift - 1.5%	23,107	23,454	23,806	24,163	24,525
NRAC	5,900				
OHB Income	1,666	1,666	1,666	1,666	1,666
VPAS	7,393	7,393	7,393	7,393	7,393
Asset Disposal	9,000				
Flexibility	17,356				
Additional Resources	**64,422**	**32,513**	**32,864**	**33,222**	**33,584**

3.11 In addition to the base uplift allocation, additional elements of uplift as are as follows:

- NRAC – NHS Lothian has received notification of a £5.9m allocation in order to maintain the board at 0.8% short of NRAC parity. Of the 11 mainland territorial boards, 8 are now in the same position as Lothian with this funding gap. For Lothian, 0.8% of a funding gap represents circa £12-14m of a shortfall. Cumulatively since 2015, NHS Lothian has received circa £80m less funding than NRAC parity would provide up to the end of this year, before inclusion of the 21/22 gap;
- VPAS – This represents the New Medicines Fund received non-recurrently each year. In prior years this value has been circa £12m but all boards have been notified by the SG to expect a significant reduction to this value in 21/22;
- Asset Disposal – This relates to the profit on sale of the RHSC building at Sciennes;
- Year end flexibility - Each year NHS Lothian is able to create some flexibility from one year to the next based on revisions to previous assumptions around in-year spend. This will be subject to confirmation following the conclusion of the year end and remains a risk.

3.12 In terms of the utilisation of the remainder of the assumed £64m resource, Appendix 3 sets out the elements of the additional costs in the new financial year, and the potential distribution of the remaining £30m.

3.13 The pay award for next year is the single largest additional cost pressure in 21/22, and is composed of two elements:

- Firstly, the assumed pay award (upon which the current uplift to boards is based) is measured at 1% for AfC and other staff, adjusted for lower and higher earners. This

additional cost is estimated at £16m. At the time of writing it has just been announced that NHS staff in Scotland are to be offered 4%. The funding of this will be followed up with Scottish Government colleagues in advance of the Board meeting.

- Secondly, the three year pay deal running from 18/19 through to 20/21 has an adjustment to pay scales between bands 5 and 7 in 21/22 which increases the costs to all boards for this cohort. The cost to Lothian is estimated at a further £10.2m;

- Scottish Governments pay offer is to be backdated to the 1st December 2020 (in addition to the one-off £500 payment paid to NHS staff), and this will require to be reflected in the 20/21 accounts.

3.14 Most of the remaining £30m resource is allocated to the pay uplift per above, with additional elements allocated against other smaller cost pressures already committed. Significantly, there are potential cost pressures identified of £41m next year with no funding solution at this stage (per Appendix 3). This, added to the £9m of net carry forward pressures brings the overall core gap next year to £51m, before efficiency savings, as reported above.

3.15 This core gap is made up of a number of issues, with £43m of this is comprised of:

- Carry forward baseline gap of **£9m**;
- Acute prescribing cost increases over baseline largely at the WGH of **£10m**;
- Additional acute prescribing cost increases of **£4.5m** (based on 5% growth);
- GP Prescribing growth estimated at **£5.5m**;
- Life Cycle and PFI costs of **£5.3m**;
- Assumed growth of non pay costs at 2% of **£4.7m**;
- Energy cost increases of **£1.5m**;
- Consultant seniority and Discretionary points **£2.4m**.

3.16 Due to the financial challenges presented by the additional costs of pay uplift, this will be the first time for a number of years that additional funding will not be available within the Plan to support anticipated drug growth.

3.17 Note also that the IJBs will receive an additional £0.6m of resource as part of the pass through of uplift (the balance being committed against pay awards as per previous years) and the plan assumes this will be utilised to meet existing cost pressures within health.

3.18 The Efficiency programme for next year has made some progress since the previous iteration of the Plan shared with this Committee in January. The total value of schemes identified at this point equates to almost £26m, which is consistent with the levels identified in prior years. The challenge for 21/22 remains however that service leads will have restricted ability to apply sufficient focus to the delivery of these recovery actions whilst delivering competing priorities, particularly relating to Covid.

3.19 Within the £26m savings programme, circa £19m is expected to be recurrent. A reduced recurring delivery from 20/21 due to the effect of Covid will already impact on the new financial year, with a recurrency from schemes identified in 20/21 lower by around £10m moving into 21/22. This is not recognised as a Covid related cost at this stage. The increased reliance on non-recurring savings to offset recurring pressures in support of breakeven provides further challenge to delivering sustainable services into the future.

3.20 Recognising the scale of the challenge in delivering recurring efficiencies to support the Plan, Finance are working with service teams to explore where to invest resources in developing and embedding productive opportunities. These opportunities will likely require

collaboration between different sites, directorates or organisations, and given the current pressures on services the timing will be carefully considered.

Impact of Covid in 2021/22

3.21 The assessment of the potential financial impact on services of Covid next year based on approvals or anticipated additional costs continues to be routinely updated, and Appendix 4 sets out the summary of investments for 21/22 that has been approved by Gold Command or separately identified as a future cost. Whilst not shown within the Plan at this stage, we would expect that any commitments made by Lothian to meet the costs of Covid will continue to be covered by the Scottish Government next year in the same way that they are being met in the current financial year. This is a risk, and may be dependent on successful outcomes around the management of year end nationally.

3.22 Some of the more significant ongoing Covid investments into 2021/22 within the £66m identified include:

- **£4.5m** to support the opening and staffing of a NHS Lothian run Regional Laboratory Hub to increase testing capacity;
- The Test and Protect service that has been set up requiring 80 contact tracers on per shift alongside additional clinical and admin staff will cost an estimated **£5.2m** for the year;
- East Lothian has utilised 2 wards within the new East Lothian Community Hospital Facility to help with ongoing bed capacity and that is estimated to cost approximately **£3.5m** for the year;
- Midlothian Partnership have also supported additional bed capacity by opening a ward within Midlothian Community Hospital to support activity flows at an estimated cost of **£1.5m**;
- West Lothian Partnership have increased staffing within the REACT team to cope with additional activity estimated to cost **£1m**;
- There are significant ongoing facilities costs to deal with the ongoing Covid requirements in terms of Domestics, Portering and Logistics and these are due to continue into 2021/22 at an ongoing cost of **£5m** in total;
- Ongoing Covid Vaccination costs in terms of staffing, logistics and venues estimated to cost **£9m**.
- Ongoing impact to GP prescribing costs, estimated to be circa **£5m**;
- Extended Flu campaign in line with last year estimated to be a cost of **£2.4m**;
- Ongoing Loss of Income experienced due to being unable to continue normal services and activity that is estimated to be **£5m** impact;
- Based on SBARs presented to Gold Command for approval that have not been specifically listed individually, there is a further **£4m** of costs estimated to relate to ongoing additional services and changes in service provision.

Additional cost of Access

3.23 The financial assessment contained within this paper does not include any additional cost implications arising from closing the gap on waiting times, rather it provides a framework of cost based on a continuation of activity within current resource constraints.

3.24 The level of waiting time increases has been significant over the past year as a result of the constraints to capacity imposed by Covid. Separately, NHS Lothian has completed an updated Remobilisation Plan for next year, which reflects a significant degree of uncertainty around the cost of remobilisation and other constraints which impact on delivery. These

costs have been excluded from the Financial Plan for these reasons, but also due to the need for funding to be agreed with Scottish Government.

3.25 While the proxy cost estimates represent the scale of investment required to eliminate the backlog, further analysis is required to quantify the ongoing cost of gaps in capacity. Activity forecasts to complete the supporting schedules to the Annual Operational Plan (AOP) provide an estimate of the level of activity that can be delivered internally. Services have also indicated where additional investments in capacity will support access performance. Options to procure this capacity will be considered, either through internal investments or the independent sector, with additional funding sought from the Scottish Government.

Integration Joint Board Financial Plans

3.26 The NHS Lothian Financial Outlook has been split by IJB based on the current mapping table of services used to report 2020/21 IJB forecast outturn positions. The output of this work is shown in further detail within Appendix 5. This shows the split of the anticipated cost pressures and the allocation of the expected uplift funding across IJBs. Note these figures include the net position for each IJB before efficiency savings, after savings schemes identified, and after additional Covid costs.

3.27 The values for the IJBs in Appendix 5 have modified slightly since the paper to the Finance and Resources Committee. This reflects an adjustment to the distribution of baseline pressures moving into the current year between delegated and non-delegated functions. This does not affect the overall budgets of the IJBs, nor does this impact on the overall position of the health board.

3.28 NHS Lothian can expect Directions from each of the IJBs in relation to the deployment of resources for next year. This process may produce further risks and issues that are not yet identified.

Next Steps

3.29 Finance colleagues continue to with Business Unit leads to discuss plans to deliver a balanced position at a local level as part of the quarterly finance meetings. In parallel, a number of other actions require to be progressed, including:

- Updates to the Plan following final confirmation of uplift settlements and pay awards;
- Ongoing dialogue with Integration Joint Boards, providing them with an estimate of the level of financial challenge within each IJB and NHS Lothian based on the financial outlook;
- Assessment of the continued requirement for previously agreed investment;
- Recovery actions/efficiency schemes to be continually developed and implementation plans produced in order to close the gap within Business Units;
- Review of the costs associated with Covid, including those not yet identified, and the risks attached to those costs included;
- A review of assumptions embedded within the growth estimates, reflecting any subsequent agreements to reduce and control spend in any specific areas.

3.30 Moving into the new year and with a Financial Plan gap of £25m, the potential volatility of Covid activity and cost, the challenge of recovery and remobilisation, and the reduced

ability to provide focus to financial performance within services, this plan is focussed on the Board's statutory responsibility to deliver of break even.

3.31 This report does not deal with the implications for the Board's delivery of its strategies, plans, and performance targets. As the Board develops its revised organisational strategy over the next year a longer term financial plan will be required to assess the options to address the care deficit within the current financial constraints, and at the same time address the impact of demographic change, as well as rebuilding and redesigning services after Covid.

4 Risks and Assumptions

4.1 Whilst every effort has been made to ensure all likely additional costs and national, regional and local priorities for investment have been incorporated into the financial outlook at this time, there remain a number of inherent uncertainties and associated risks. The financial planning process is an ongoing and iterative cycle, and it is not possible to fully identify all financial risks facing individual service areas, or the wider organisation, at this stage.

4.2 A number of risks should be considered by the Board. A risk register is set out in Appendix 6, with key risks noted below:

- The future impact of Covid, the consequences this has on service delivery and the financial support that will be required to manage this;
- The impact of Brexit on the cost base for next year, particularly across medicines and clinical supplies. The Plan currently makes no assumptions around additional costs of this;
- The ability of NHS Lothian to deliver the level of flexibility identified within the Plan to support identified cost pressures;
- Continued management of the financial exposure arising from the escalation of operational performance on elective, mental health and unscheduled care capacity pressures including delayed discharges;
- Availability of SGHSCD funding for both nationally funded programmes & initiatives and services funded annually on a non recurring basis.

5 Risk Register

5.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

5.2 The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

6 Impact on Inequality, Including Health Inequalities

6.1 As this plan only deals with one financial year and focuses on delivery of break even, it is has not been possible to assess whether there are any new implications for health

inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 As this particular paper relates to a financial outlook and not an agreed financial plan and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

8 Resource Implications

8.1 This report provides the Board with a financial plan which aims to support the Board's statutory responsibility to break even. The broader implications of the financial position will require to be addressed through the development of the Board's revised organisational strategy.

Susan Goldsmith
Director of Finance
24th March 2021
susan.goldsmith@nhslothian.scot.nhs.uk

Appendix 1 – 5 Year Financial Outlook
Appendix 2 – 21/22 Financial Outlook by Business Unit
Appendix 3 – 21/22 Additional cost and commitments
Appendix 4 – 21/22 Projected Covid Costs
Appendix 5 – 21/22 Financial Outlook by Integrated Joint Boards
Appendix 6 – Financial Outlook Risk Register

Appendix 1 – 5 Year Financial Outlook

	21/22 Variance	22/23 Variance	23/24 Variance	24/25 Variance	25/26 Variance
	£k	£k	£k	£k	£k
Full Year Recurring Expenditure Budget	**1,760,772**	**1,798,702**	**1,827,191**	**1,855,716**	**1,885,024**
Baseline Pressures	**(43,807)**	**(136,369)**	**(146,117)**	**(158,487)**	**(168,968)**
Projected Expenditure Uplifts & Commitments	(49,589)	(29,866)	(30,564)	(31,080)	(31,794)
Growth and Other Commitments	(14,773)	(11,325)	(10,762)	(11,218)	(11,693)
Policy Decisions	(433)	0	0	0	0
Strategic Investments	(3,916)	(1,550)	(3,056)	(914)	(303)
Essential Service Development	(1,990)	0	0	0	0
Unscheduled Care	(899)	0	0	0	0
Projected Expenditure Uplifts & Commitments	**(71,602)**	**(42,741)**	**(44,382)**	**(43,212)**	**(43,791)**
Percentage of Recurring Budget	*(4.1%)*	*(2.4%)*	*(2.4%)*	*(2.3%)*	*(2.3%)*
Projected Costs	**(115,409)**	**(179,110)**	**(190,498)**	**(201,699)**	**(212,758)**
Recurring Resources					
Base Uplift	23,107	23,454	23,806	24,163	24,525
NRAC	5,900				
OHB Income	1,666	1,666	1,666	1,666	1,666
Non Recurring Resources					
VPAS	7,393	7,393	7,393	7,393	7,393
Asset Disposal	9,000				
Flexibility	17,356				
Additional Resources	**64,422**	**32,513**	**32,864**	**33,222**	**33,584**
Financial Outlook Gap before FRP's	**(50,987)**	**(146,597)**	**(157,634)**	**(168,478)**	**(179,174)**
Financial Recovery Plans	**25,914**	**3,483**	**1,614**	**1,614**	**1,614**
Financial Outlook Gap after FRP's	**(25,073)**	**(143,114)**	**(156,020)**	**(166,864)**	**(177,561)**
Percentage of Recurring Budget	*(1.4%)*	*(8.0%)*	*(8.5%)*	*(9.0%)*	*(9.4%)*
Additional Covid Costs	**(65,969)**	**(4,110)**	**0**	**0**	**0**
Total Financial Outlook Gap	**(91,042)**	**(147,224)**	**(156,020)**	**(166,864)**	**(177,561)**

Appendix 2 – 21/22 Financial Outlook by Business Unit

	NHS Lothian	Acute Services Division	Reas	Directorate Of Primary Care	East Lothian Partnership	Edinburgh Partnership	Mid Lothian Partnership	West Lothian Partnership	Facilities And Consort	Corporate Services	Strategic Services	Inc + Assoc Hlthcare Purchases	Research + Teaching	Reserves
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Full Year Recurring Expenditure Budget	**1,760,772**	**744,362**	**98,400**	**(3,234)**	**76,601**	**324,172**	**67,560**	**137,657**	**165,578**	**104,533**	**4,990**	**11,430**	**(9,647)**	**38,370**
Baseline Pressures	**(43,807)**	**(33,294)**	**(774)**	**(178)**	**(368)**	**218**	**(216)**	**1,313**	**(7,672)**	**(9,100)**	**1,543**	**4,810**	**(1,109)**	**1,016**
Projected Expenditure Uplifts & Commitments	(49,589)	(28,705)	(2,596)	(295)	(819)	(2,709)	(563)	(1,786)	(6,658)	(2,576)	(27)	(229)	(1,690)	(937)
Growth and Other Commitments	(14,773)	(4,290)	(88)	840	(748)	(3,430)	(661)	(1,835)		(71)	(49)			(4,440)
Policy Decisions	(433)	(403)		(30)										
Strategic Investments	(3,916)	(505)												(3,411)
Essential Service Development	(1,990)	(1,825)								(165)				
Unscheduled Care	(899)	(663)					(2)	0	(101)	(133)				0
Projected Expenditure Uplifts & Commitments	**(71,602)**	**(36,391)**	**(2,684)**	**515**	**(1,567)**	**(6,139)**	**(1,227)**	**(3,621)**	**(6,759)**	**(2,945)**	**(76)**	**(229)**	**(1,690)**	**(8,788)**
Percentage of Recurring Budget	*(4.1%)*	*(4.9%)*	*(2.7%)*	*(15.9%)*	*(2.0%)*	*(1.9%)*	*(1.8%)*	*(2.6%)*	*(4.1%)*	*(2.8%)*	*(1.5%)*	*(2.0%)*	*17.5%*	*(22.9%)*
Projected Costs	**(115,409)**	**(69,684)**	**(3,458)**	**337**	**(1,935)**	**(5,921)**	**(1,442)**	**(2,308)**	**(14,430)**	**(12,045)**	**1,467**	**4,582**	**(2,799)**	**(7,772)**
Recurring Resources														
Base Uplift	23,107	10,945	2,193	242	762	2,273	593	1,357	2,521	2,201	20		0	0
NRAC	5,900	3,638	34			10			6	2,007				206
OHB Income	1,666	800												866
Non Recurring Resources														
VPAS	7,393	7,393												0
Asset Disposal	9,000	1,432							422	99				7,047
Flexibility	17,356	9,592					2		2,059	1,966				3,737
Additional Resources	**64,422**	**33,800**	**2,227**	**242**	**762**	**2,282**	**595**	**1,357**	**5,008**	**6,273**	**20**	**0**	**0**	**11,855**
Financial Outlook Gap before FRP's	**(50,987)**	**(35,885)**	**(1,231)**	**579**	**(1,173)**	**(3,639)**	**(847)**	**(952)**	**(9,423)**	**(5,771)**	**1,488**	**4,582**	**(2,799)**	**4,083**
Financial Recovery Plans	**25,914**	**13,441**	**1,000**		**616**	**4,232**	**564**	**1,215**	**2,370**	**2,092**	**384**			
Financial Outlook Gap after FRP's	**(25,073)**	**(22,443)**	**(231)**	**579**	**(557)**	**593**	**(283)**	**264**	**(7,053)**	**(3,679)**	**1,872**	**4,582**	**(2,799)**	**4,083**
Percentage of Recurring Budget	*(1.4%)*	*(3.0%)*	*(0.2%)*	*(17.9%)*	*(0.7%)*	*0.2%*	*(0.4%)*	*0.2%*	*(4.3%)*	*(3.5%)*	*37.5%*	*40.1%*	*29.0%*	*10.6%*
Additional Covid Costs	**(65,969)**	**(13,791)**	**(1,300)**	**(540)**	**(6,067)**	**(3,716)**	**(3,636)**	**(3,832)**	**(1,555)**	**(30,189)**		**(1,343)**		**0**
Total Financial Outlook Gap	**(91,042)**	**(36,235)**	**(1,531)**	**39**	**(6,624)**	**(3,123)**	**(3,920)**	**(3,568)**	**(8,608)**	**(33,868)**	**1,872**	**3,239**	**(2,799)**	**4,083**

Appendix 3 – Additional cost from Projected Uplifts and Commitments for 2021/22

	Recurring	Non Recurring	Total	Funded Recurring	Funded Non Recurring	Not Funded	Total
	£k	£k	£k	£k	£k	£k	£k
Pay Uplift	16,552		16,552	16,552			16,552
AfC Framework Change	10,250		10,250	10,250			10,250
Non Pay Uplift - 2%	4,702		4,702			4,702	4,702
GP Prescribing	5,506		5,506			5,506	5,506
Hospital Drugs	5,897		5,897			5,897	5,897
National Services/ NDC	390		390			390	390
Energy Price Increase	1,500		1,500			1,500	1,500
Revenue Consequence of Capital Investment	899		899			899	899
Consultant Seniority	1,237		1,237			1,237	1,237
Discretionary Points	1,148		1,148			1,148	1,148
PFI - Indexation Consort Increase	850		850			850	850
Office 365	748		748		748		748
Psychological Therapies		650	650		650		650
PFI Uplift	717		717			717	717
Blood Science MSC Contract	308		308		308		308
Haematology Enabling	150		150		150		150
Oncology Enabling	55		55	55			55
PET SCAN	38		38	38			38
Bed Management	340		340		340		340
USC Investment	899		899			899	899
Drugs Growth - WGH	10,000		10,000			10,000	10,000
Robot	400		400			400	400
Haematology oncology expansion	500		500			500	500
Business cases	552		552			552	552
R&T funding	780		780			780	780
Deputy Medical Director	200		200		200		200
Oral Health Business Case	264		264		264		264
Public Enquiry - (1yr of 3yrs)		200	200		200		200
Other Local adjustments	338	782	1,120			1,120	1,120
Life Cycle costs - Revenue to Capital		3,000	3,000			3,000	3,000
IT Devices		250	250			250	250
RIE PFI Management Contract	1,500		1,500			1,500	1,500
Balance of IJB Uplift		*560*	560	*560*			560
Contribution from IJB Uplift		*(560)*	(560)			*(560)*	(560)
Total	**66,720**	**4,882**	**71,602**	**27,455**	**2,860**	**41,287**	**71,602**

Appendix 4 – Projected Covid Costs, 2021/22

	APPROVED BY GOLD COMMAND	COVID OTHER	TOTAL ESTIMATED 21/22 COVID COSTS
	£000	£000	£000
Additional Drug costs	£0	£1,485	£1,485
Additional Acute Staffing	£2,160	£3,247	£5,407
Additional Mental Health Staffing	£0	£1,100	£1,100
Capacity Creation	£2,722	£0	£2,722
Community Additional Costs	£6,428	£653	£7,081
Community Home Care Costs	£1,749	£1,417	£3,166
Corporate Services Additional Staffing	£4,928	£635	£5,564
Covid Vaccination Costs	£9,000	£0	£9,000
Extended Flu Costs	£0	£2,437	£2,437
Facilities Pressures	£4,205	£1,350	£5,555
IT Costs	£0	£2,000	£2,000
Loss of Income	£0	£3,279	£3,279
Prescribing Pressures	£0	£5,603	£5,603
Primacy Care Costs	£0	£852	£852
Testing	£10,718	£0	£10,718
Total	**£41,911**	**£24,058**	**£65,969**

Appendix 5 - 21/22 Financial Outlook by Integration Joint Boards

	NHS Lothian	East Lothian IJB	Edinburgh IJB	Mid Lothian IJB	West Lothian IJB	Acute Non Delegated	CHP Non Delegated	Corporate Non Delegated
	£k	£k	£k	£k	£k	£k	£k	£k
Full Year Recurring Expenditure Budget	**1,760,772**	**106,020**	**447,393**	**89,586**	**164,273**	**508,060**	**51,180**	**394,260**
Baseline Pressures	**(43,807)**	**(1,108)**	**(4,773)**	**(767)**	**(1,446)**	**(12,308)**	**71**	**(23,476)**
Projected Expenditure Uplifts & Commitments	(49,589)	(1,608)	(6,219)	(1,145)	(2,487)	(23,854)	(1,420)	(12,856)
Growth and Other Commitments	(14,773)	(733)	(3,333)	(657)	(2,063)	(2,491)	(56)	(5,442)
Policy Decisions	(433)	4	18	3	7	(465)	0	0
Strategic Investments	(3,916)	0	0	0	0	(505)	0	(3,411)
Essential Service Development	(1,990)	(77)	(368)	(65)	(136)	(1,180)	0	(165)
Unscheduled Care	(899)	(7)	73	(35)	197	(893)	0	(234)
Projected Expenditure Uplifts & Commitments	**(71,602)**	**(2,421)**	**(9,829)**	**(1,898)**	**(4,482)**	**(29,387)**	**(1,475)**	**(22,109)**
Percentage of Recurring Budget	*(4.1%)*	*(2.3%)*	*(2.2%)*	*(2.1%)*	*(2.7%)*	*(5.8%)*	*(2.9%)*	*(5.6%)*
Projected Costs	**(115,409)**	**(3,529)**	**(14,602)**	**(2,665)**	**(5,929)**	**(41,695)**	**(1,404)**	**(45,585)**
Recurring Resources								
Base Uplift	23,107	1,420	5,375	1,073	1,916	6,682	1,185	5,455
NRAC	5,900	0	0	0	0	3,594	44	2,262
OHB Income	1,666	19	530	113	635	64	0	306
Non Recurring Resources								
VPAS	7,393	0	0	0	0	0	0	7,393
Asset Disposal	9,000	0	0	0	0	1,432	0	7,568
Flexibility	17,356	821	3,331	851	1,231	1,133	0	9,989
Additional Resources	**64,422**	**2,260**	**9,236**	**2,037**	**3,782**	**12,905**	**1,229**	**32,973**
Financial Outlook Gap before FRP's	**(50,987)**	**(1,269)**	**(5,366)**	**(629)**	**(2,147)**	**(28,790)**	**(175)**	**(12,612)**
Financial Recovery Plans	**25,914**	**1,118**	**5,825**	**1,054**	**2,062**	**10,725**	**0**	**5,130**
Financial Outlook Gap after FRP's	**(25,073)**	**(152)**	**459**	**426**	**(85)**	**(18,065)**	**(175)**	**(7,481)**
Percentage of Recurring Budget	*(1.4%)*	*(0.1%)*	*0.1%*	*0.5%*	*(0.1%)*	*(3.6%)*	*(0.3%)*	*(1.9%)*
Additional Covid Costs	**(65,969)**	**(6,042)**	**(6,121)**	**(3,991)**	**(4,896)**	**(10,635)**	**(780)**	**(33,504)**
Total Financial Outlook Gap	**(91,042)**	**(6,194)**	**(5,662)**	**(3,565)**	**(4,981)**	**(28,701)**	**(955)**	**(40,985)**

Appendix 6 – Financial Outlook Risk Register

Key Assumptions / Risks	Risk rating	Impact
SGHD Allocations - Covid	High Risk	The forecast contains an underlying assumption that the Core overspend remains the responsibility of NHS Lothian, while the Covid related costs will be supported by additional allocations from tthe SG. Confirmation of funding arrangements are still awaited.
Covid Activity	High Risk	There is a high degree of uncertainty relating to the future activity levels of Covid. Therefore, the additional costs as identified are based on a set of assumptions around activity levels which may change.
Brexit	High Risk	No additional costs for the impact of Bredxit have been built into the plan. At present they have not been quantified, however they will need to be considered as part of the in year forecast as well as the longer term financial outlook.
NRAC	High Risk	We have assumed that NHS Lothian remains behind NRAC parity by circa £14m and that the SG will work to bring NHS Lothian to within 0.8% in 2021/22. There is a risk that Lothian's NRAC share will not require additional funding to remain within 0.8% of parity.
Escalation Framework	High Risk	Costs associated with improved operational performance may be greater than anticipated
Access/Urgent Care	High Risk	There requires to be continued management of the financial exposure on elective capacity pressures. The risk is that the current investment plans are revised to improve performance, without additional funding.
Delayed Discharge	High Risk	There is a requirement to manage the volume of delayed discharges - the estimate for 21/22 does not consider any further deterioration in this area.
Winter Costs	High Risk	The risk remains whether sufficient additional resources are available to meet the pressures from anticipated winter demand.
Efficiency Savings	High Risk	There is a very real risk that Directorate Management will not have the opportunity to provide sufficient focus to the Efficiency programme next year due to in year challenges around Covid
Agenda for Change	Medium Risk	The Agenda for Change three year pay deal concludes this year. However a risk remains that the arrangements for 21/22 will increasebeyond the levels assumed here.
RHSCYP and DCN	Medium Risk	The full financial implication of the delays to the new hospital may yet change, with some of this cost expected to be funded within SLA arrangements with other health boards.
Integration	Medium Risk	The forecast is based on the assumption that any flexibility from NHS resources at an IJB level will stay within Lothian. The IJBs may wish to consider other options for utilising any flexible resource
IJB Performance	Medium Risk	As IJBs attempt to deliver financial balance across health and social care portfolios, there is a risk that an additional operational and subsequent financial burden is placed on the health board.
Recovery Actions	Medium Risk	Delivery of planned recovery actions to the value required to cover the known pressures and developments within the individual Business Units.
GP Prescribing	Medium Risk	The financial forecast has been reviewed in line with current unit cost and activity, but this could change during the remaining months of the year-end and impact into next year
Acute Medicines	Medium Risk	There is a risk that the level of growth exceeds that estimate in the Forecast. The impact of any additional growth or additional spend on high cost drugs remains an issue.
New Medicines Fund	Medium Risk	There is a risk that the total resources available from the NMF will reduce next year beyond that already planned for, with Boards required to cover any reductions.
Availability of trained staff	Medium Risk	The availability of trained staff, particularly in light of guidance and regulations relating to the pandemic, has resulted in supply issues which has seen an increased use in agency staff and the associated costs. To maintain the current forecast the use of agency needs to be held static or reduce.
Asset Disposal	Medium Risk	Asset Disposal is included within the Financial Plan. There is a risk in the current environment that disposals could be delayed or that sale values will be reduced.
Backdated pay claims	Low Risk	NHSL no longer has a provision for backdated pay claims, therefore any further claims will be an unplanned in year cost.

NHS LOTHIAN

Board
7 April 2021

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to review NHS Lothian's Corporate Risk Register and associated processes to ensure it remains fit for purpose.

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

2 Recommendations

The Board is recommended to:

2.1 Approve the Corporate Management Team recommendations for individual risks on the Corporate Risk Register as set out in Table one.

2.2 Note the scope of the Internal Risk Management Audit 2021.

3 Discussion of Key Issues

3.1 The NHS Lothian Corporate Risk Register (CRR) has been subject to change due to the Covid-19 pandemic, the 3-year Recovery Plan and capital plans. In response to these contextual changes and following discussion at the Audit and Risk committee, it seemed timely to review the risks on the Corporate Risk Register and the associated processes. The Corporate Management Team (CMT) agreed in February 2021 based on the methodology set out below to review a number of risks on the corporate risk register in order to strengthening the risk management system.

3.2 **Methodology** The following have been used to inform the question set out below and guide the review:

- NHS Lothian Risk Management Policy
- NHS Lothian Risk Management Procedure
- Diagram one below (3.4.2)

1. What is the risk that cannot be managed at an operational level and what information/data supports the escalation of this risk?
2. Does the risk description articulate the residual risk not being managed at a service level?

3. Who owns this risk and associated controls and do the controls set out clear lines of accountability?
4. Is there a plan in place to manage this risk which will be appraised at a senior management level and by a governance committee of the Board?
5. Does the risk grading reflect the plans in place to manage the risk and any remaining residual risk?
6. Is there a clear relationship between the risk grading, plans in place and level of assurance accepted by the governance committees of the Board?
7. Is there any overlap/duplication of risk across the CRR?

3.3 Table 1 below sets out the specific risks, proposed board recommendations and rationale based on meetings with executive owners.

Table 1 Risk Register recommendations and Rationale (see Appendix one for risk description grades and assurance levels)

Risk ID	Opened	Risk Title	Recommendation	Rationale
Close				
4813	**23/07/19**	Royal Hospital for Children & Young People/Dept of Clinical Neurosciences	Remove from the CRR	Services will be fully operational by the end of March 2021
4694	**04/04/19**	Waste Management	Remove from the CRR	This risk was accepted onto the CRR due to unforeseen external provider availability which resulted in additional financial risk and H&S issues. The financial risk has been addressed, a new contractor is in place and any residual service risk is being managed at an operational level with clear management oversight
3527	**26/07/13**	Medical Workforce	Remove from the CRR	Aspect of the Medical Workforce within our control are being managed at an operational level and captured on operational risk registers
Review/Amalgamate				
3454	**13/02/13**	Learning from Complaints	Review this risk	This risk requires review with a focus on performance and set within the context of the corporate objectives.
3600	**23/04/14**	Finance	Review this risk	This is a long-standing risk on the CRR and as such warrants review
3726	**11/03/15**	Timely Discharge of Inpatients (Previously Unscheduled Care:	Review the risk description with a focus on community capacity, with clear control owners across the system and measurement framework which would inpatient and community measures	Ensure clarity with respect to the focus and management of this risk and reduce duplication across other risks on the CRR such as 4 hour emergency access standard.
3829	**10/10/15**	GP Sustainability.	Review this risk	This is a longstanding risk and the GP landscape has been subject to significant change and as a result

Risk ID	Opened	Risk Title	Recommendation	Rationale
				this risk merits review.
4693	**04/04/19**	Brexit/EU exit	Review this risk	This risk has been reviewed and will be downgraded to medium from high risk with regular review in place to assess potential risks that cannot be managed at an operational and/or national level.
4820	**29/07/19**	Delivery of level 3 recovery plans	Review this risk	To reduce overlap with other risks on the CRR, associated plans and measures such as Access to Treatment. Timely discharge of inpatients etc to strengthen the management of risks across the CRR
3189	**19/10/15**	Facilities Fit for Purpose	Review this risk	There is a need to clearly articulate the risks that are not being managed at an operational level. This may lead to revised or new risks related to the RIE estate (end of the PFI contract) which has both financial and patient safety implications. The Finance Director has agreed to develop this risk.
3455	**13/02/13**	Violence & Aggression.	Review this risk	This is a long standing risk on the CRR and there is a need to articulate risks that are not being managed at an operational level supported by data as there is currently clear management oversight at a service level through the H&S operational groups and H&S Committee at the Board.
3328	**01/03/13**	Roadways/ Traffic Management	Review this risk	This Risk would benefit from a review to identify residual risk, associated mitigation plans including control owners. An initial review would suggest that the focus should be on the 4 inpatient sites where there is a mismatch between demand and capacity resulting risky behaviour plus verbal and physical aggression to traffic management staff.
1076	**11/06/07**	Healthcare Associated Infection	Review this risk	This risk would benefit from a review in the light of interrelated risks on the CRR which include Facilities fit for purpose, COVID-19 and Water Safety Risk, to clarify the focus of this risk and identify the plans in place to manage the risk including control owners
3203	**26/03/12**	4 Hours Emergency Access Standard (Organisational)	Combine the organisational and patient risk on the Corporate Risk Register.	The management oversight and plans to mitigate these two risks are the same. Having one risk will ensure clarity with respect to

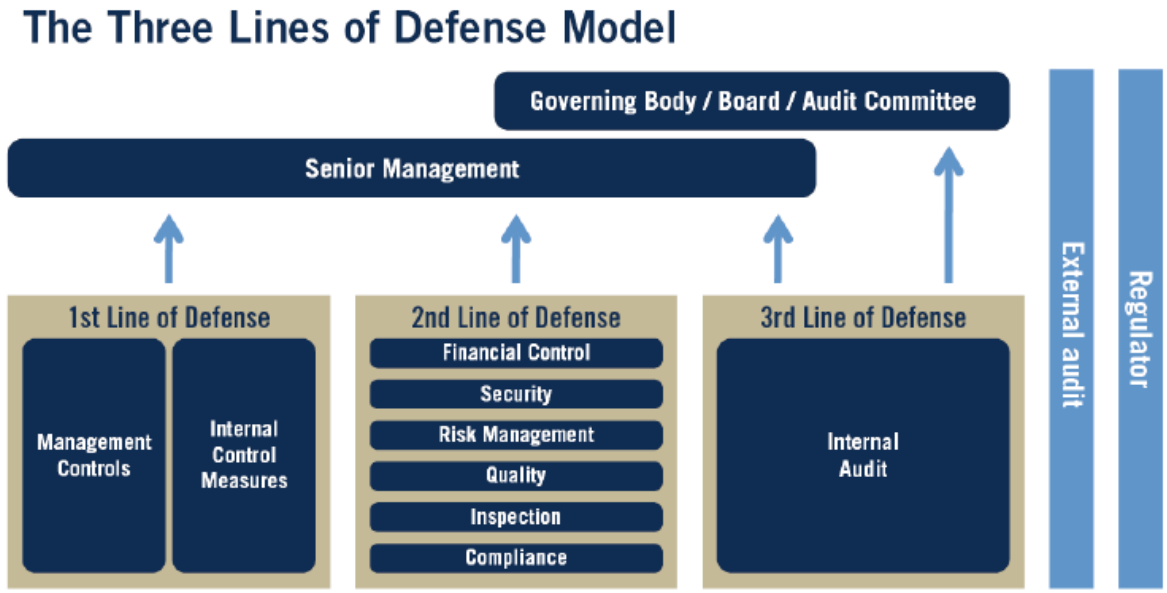
Risk ID	Opened	Risk Title	Recommendation	Rationale
				control owners, management oversight, mitigation plans and governance reporting
4688	**21/03/19**	Patient safety in RIE ED	Combine the organisational and patient risk on the Corporate Risk Register and clearly state plans in place to mitigate the risk, control owners etc.	See above
3211	**02/04/12**	Access to Treatment (Organisation Risk)	Combine the organisational and patient risk on the Corporate Risk Register and state the key plans in place to manage this risk including control owners as there is considerable overlap between the two risks with respect to plans, measures, and oversight	The management oversight and plans to mitigate these two risks are the same. Having one risk will ensure clarity with respect to control owners, management oversight, mitigation plans and governance reporting
4191	**16/05/17**	Access to Treatment (Patient Risk)	Combine the organisational and patient risk on the Corporate Risk Register and state the key plan in place to manage this risk including accountability. .	See above
Remain				
4984	**19/03/20**	Covid-19	Remain on the CRR and include vaccine availability. Gold command to review the grading	This risk cannot be managed at an operational level, with a number of controls out with Lothian
4921	**28/10/19**	Bed Capacity in Acute Mental Health	No change to this risk on the CRR	This risk is clearly articulated and there are dedicated plans in place to mitigate the risk.
5034	**29/06/20**	Care Homes	No change to this risk on the CRR	This risk cannot be managed at an operational level. Significant infrastructure and systems for management oversight have been put in place within a tight timeframe, however, risks currently remain around providing assurance on the 4 aspects of care the Nurse Director is accountable for.
5020	**10/06/20**	Water Safety (Legionella)	No change to this risk on the CRR	This risk has been magnified as service have been reduced due to COVID. Water safety plans are being developed to support remobilisation and embed systems of control.
3828	**19/10/15**	Nursing Workforce	No change to this risk on the CRR.	Well written, clearly articulated risk, with clear plans in place to mitigate the risk

3.4 Role of the Corporate Management Team

3.4.1 It was agreed at the February 2021 CMT that the CRR would be managed through the CMT and subject to review every two months, with the risk manager in attendance to ensure proactive management, including timely feedback from assurance committees and alignment of assurance levels and risk grading.

3.4.2 The CMT would make recommendations to the Board with respect to new and/or amended risks, with a clear articulation of the risk that cannot be managed at an operational level, explicit plans to mitigate the risk along with associated measures to assess the impact of these plans. This collective oversight strengthens the NHSL risk management system including our assurance system and mirrors the diagram set out below.

Diagram 1



Graphic taken from The IIA Position Paper The Three Lines of Defense in Effective Risk Management and Control *published in 2013, adapted from ECIIA/FERMA Guidance on the 8th EU Company Law Directive, article 41*

3.5 Internal Audit Risk Management

3.5.1 Every year Internal Audit conducts a review of an aspect of the NHSL risk system. The audit, which is about to commence, will focus on the controls in place (design and operation) to ensure risks are managed at an operational level at the division level on the hierarchy. This will look at how this is managed within Acute services and at an HSCP level. Will consider how at this level, risks are captured ensuring risks are not duplicated and how this links to the corporate risk register, including appropriate escalation and de-escalation of risks, focusing on how risks are escalated to a corporate risk level.

4 Key Risks

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

5 Risk Register

5.1 Will positively impact on the CRR and associated risk system.

6 Impact on Inequality, Including Health Inequalities

6.1 Not applicable.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 This paper does not consider developing, planning and/or designing services, policies and strategies.

8 Resource Implications

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

Jo Bennett
Associate Director for Quality Improvement & Safety
26 March 2021
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Risk Assurance Table

Appendix 1

Risk Assurance Table

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
4984	**Covid-19** There is a significant risk to the health of the population from the current Covid-19 outbreak and that NHS Lothian will not have sufficient capacity to respond because of the number of people requiring care, including critical care, reduced numbers of staff available to deliver care due to illness or isolation, timely availability of supplies leading to reduced quality and safety of patient care as well as physical and psychological pressure on staff. There will also be a significant impact on routine activity including waiting lists as resources are diverted to managing the impact of Covid-19. New risk added June 2020	Healthcare Governance & Risk Committee (HCG) July 2020 - HCG accepted limited assurance on this risk overall. A standing item on the HCG Agenda, last discussed November 2020. Update paper requested for May meeting.	Very High 20		Very High 20	Very High 20	Very High 20
4813	**Royal Hospital for Children & Young People/Dept of Clinical Neurosciences** There is a risk to patient safety, experience and outcome of care plus financial impact, due to the delay in providing clinical care for RHCYP and DCN patients on the Royal Infirmary of Edinburgh campus.	Finance & Resources Committee (F&R) & Healthcare Governance Committee (HCG) May 2020 - Board accepted: • Significant assurance that the facilities and the service are ready for DCN migration to Little France to commence on 11 May. • Moderate assurance of progress towards the signing of Supplemental Agreement 2 to deliver the required ventilation works in the RHCYP, noting that the timescale for Autumn completion is subject to further	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
		discussion. • Moderate assurance that the proposals for contract management of IHSL and their FM partners will be sufficient for the commencement of operations in the new facility. July 2020- F&R agreed risk remains very high. The Scot Gov oversight Board continues to meet monthly and will remain in place until fully open. It is intended that the grading and the residual risk will be revisited, given significant progress to date and the 'amber' rating agreed by the oversight Board.					
3600	**Finance** There is a risk that the Board is unable to respond to the service requirements arising from the population growth in all age groups across NHS Lothian. This is as a result of a combination of the level of resource available and uncertainty around future resource leading to inability to plan for, and deliver the additional capacity required.	<u>Finance & Resources Committee</u> November 2020 – F&R continued to accept limited assurance on the management of this risk.	High 12	Very High 20	Very High 20	Very High 20	Very High 20
3203	**4 Hours Emergency Access Standard (Organisational)** There is a risk that NHS Lothian will fail to meet the 4 hour performance target for unscheduled care which could mean that patients fail to receive appropriate care, due to volume and complexity of patients, staffing, lack and availability of beds, lack of flow leading to a delay to first assessment, a delay in diagnosis and therefore in treatment for	<u>Healthcare Governance Committee</u> November 2020 - HCG accepted moderate assurance on the Winter plan which includes 4 hour emergency access performance.	High 10	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
	patients and a reputational risk for the organisation.						
4688	**Patient safety in RIE ED** There is a risk to patient safety and outcome of care in RIE ED due to unreliable timely triage, assessment, treatment and discharge due to overcrowding leading to increased likelihood of patient harm and poor experience of care.	Healthcare Governance Committee November 2020 - HCG accepted moderate assurance on the Winter plan which includes 4 hour performance in RIE ED.	High 15	Very High 20	Very High 20	Very High 20	Very High 20
3726	**Timely Discharge of Inpatients** There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	Healthcare Governance Committee September 2020 – delayed discharge was discussed as part of HSCP annual reports, with moderate assurance accepted. November 2020 - HCG accepted moderate assurance on the Winter plan, which includes timely discharge.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3829	**GP Sustainability** There is a risk that the Board will be unable to meets its duty to provide access to primary medical services in and out of hours for its population due to increasing population with multiple needs combined with difficulties in recruiting and retaining general practitioners, other staff and premises issues (e.g. leases or constraints on space), which will impact on patient care and experience and have a negative impact on other parts of the health and social care system.	Healthcare Governance Committee July 2020 – HCG continued to accept limited assurance. Acknowledged that risk needs to be re-evaluated. Deferred from January 2021 agenda.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3211	**Access to Treatment (Organisation Risk)** There is a significant risk that NHS Lothian will fail to achieve waiting time standards & that waits increase for in-/	Healthcare Governance Committee October 2020 - Board accepted limited assurance that Remobilisation plans will mitigate growing volumes of long wait patients for scheduled care/ cancer	High 12	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
	day case, out-, diagnostic & 31 & 62 day patients, due to impact of COVID 19 on capacity and high volume cancellations during wave 1. USoC demand has risen to higher than pre-Covid level	services, against rising Covid infections & Winter. November 2020 – HCG accepted moderate assurance on the Winter plan and Clinical prioritisation plan. December 2020 – the Board accepted limited assurance that Remobilisation will mitigate growing volumes of long wait patients for scheduled care/ cancer services, against rising Covid infections & Winter.					
4191	**Access to Treatment (Patient Risk)** As a result of Covid-19 cancellations there is significant risk that patients will wait longer than national standards. Prioritisation of USoC/ urgent & emergency work & patient ability/ willingness to attend for consultation/ treatment has impacted on routine patient wait times. National Screening programmes were cancelled but are now re-established. Capacity is restricted due to distancing, PPE/ infection control measures & staff unavailability. Longer term impact on quality/ patient safety/ experience to be addressed.	<u>Healthcare Governance Committee</u> October 2020 - Board accepted limited assurance that Remobilisation plans will mitigate growing volumes of long wait patients for scheduled care/ cancer services, against rising Covid infections & Winter. November 2020 – HCG accepted moderate assurance on the Clinical prioritisation plan. January 2021 – HCG discussed recommendation of moderate assurance in relation to CAMHs, however deferred decision on assurance level with request to bring back further detail in 6 months. March 2021 – HCG accepted moderate assurance that lung cancer patients are being managed appropriately, despite challenges of Covid-19	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
4693	**Brexit/EU exit** There is a risk that patient experience and outcome care may be compromised due to uncertainty relating to EU Exit	<u>Healthcare Governance Committee</u> Agreement to keep under review pending discussions on trade agreements. October 2020 – Board agreed to reinstatement of this risk.	Very High 20	Very High 20	Closed 9/4/2020	Very High 20	Very High 20

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
		January 2021 - HCG accepted limited assurance.					
3828	**Nursing Workforce** There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and/or inability to recruit to specific posts. The subsequent high use of supplementary staffing to counteract shortfalls potentially leading to compromise of safe patient care impacting on length of stay and patient experience.	<u>Staff Governance Committee</u> July 2020 - increase in grading from 6 to 12 Significant assurance that there is a robust mobilisation plan and mechanism to co-ordinate the responses across the nursing and midwifery workforce. Limited assurance that there is sufficient capacity in the event the pandemic requires that the Board delivers a full surge plan in acute and community, including supporting the NHS Louisa Jordan October 2020 – verbal update provided no new level of assurance agreed. December 2020 – increase in grading to very high agreed. Significant assurances accepted that robust corporate oversight to co-ordinate and prioritise responses across workforce. Limited assurance regarding capacity to respond to increased demand due to Covid activity and increase in staff absence due to Covid/isolation.	High 12	Med 6	High 12	High 12	Very High 20
4820	**Delivery of level 3 recovery plans** There is a risk that the Board does not deliver NHS Lothian's Level 3 Recovery Plans to agreed timescale impacting on patient experience and outcome of care. Risk update provided January 2021	<u>Board</u> January 2020 - Board accepted moderate assurance on the management of the risk and agreed to reduction in the risk grading. Although this process is currently paused	Very High 20	High 12	High 12	High 12	High 12

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
		with Scot Gov, with acknowledgement of the need for substantial review of plans/metrics in view of Covid-19, all elements of the risk continue to be managed and reported as part of relevant risks i.e. Access to Treatment, 4 Hours Emergency Access Standard, Bed Capacity in Acute Mental Health and Timely Discharge of Inpatients.					
4921	**Bed Capacity in Acute Mental Health** There is a risk that acute admissions exceeds the inpatient bed capacity due to increasing demand, beds being reduced in the move to The Royal Edinburgh Building, and barriers to patient flow through the adult mental pathway leading to patients having to be boarded overnight in other specialities, being placed out of area or sleeping in areas within wards not designed for this purpose. Risk update provided January 2021	Healthcare Governance Committee January 2021- moderate assurance accepted. 15 additional beds remain open, but demand is being managed within that capacity.	High 15	High 15	High 15	High 15	High 15
4694	**Waste Management** There is a risk that NHS Lothian will not be compliant with statutory Health and Safety and environmental regulations for disposal of special waste because of the abrupt ending of the national contract leading to potential harm to people and the environment and financial penalties.	Staff Governance Committee August 2019 - Health & Safety Committee accepted moderate assurance. July 2020 - moderate assurance continues to be accepted by the Staff Governance Committee. Although the new contract is now embedded and operating effectively, some risk remains as restrictions due to the pandemic are currently preventing necessary audits from being carried out. Risk therefore needs to be re-evaluated.	High 15	High 15	High 15	High 15	High 15

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
5034	**Care Homes** There is an ongoing risk to the health and well-being of care home residents and staff from Covid-19 outbreaks. This is as a result of the potential for community transmission to a vulnerable population and the enhanced requirements for infection prevention and control within non-clinical environments. Health Boards have been given additional responsibilities for multi professional oversight in organisations that they have no formal jurisdiction over. This presents potential reputational, political and legal risk to NHS Lothian. New risk –approved by Board, 12 August 2020 Risk update provided October 2020	Healthcare Governance Committee September 2020 – moderate assurance accepted on oversight of quality in care homes by HSCPs as part of HSCP annual reports. January 2021 – moderate assurance accepted that governance infrastructure in place to deliver the enhanced professional oversight. Limited assurance in respect of the 4 aspects of care for which Exec nurse director given accountable.	High 12			High 12	High 12
5020	**Water safety (Legionella)** There is a risk that Legionella may be present in water supplies to healthcare premises due to reduced or no usage of water in some areas during Covid pandemic, seasonal increase in water temperature and incomplete implementation of existing plans to improve systems of control around water safety and provide assurance through documented evidence. This may lead to harm to patients, staff and the general public, potential prosecution under H&S law. In addition, the ability to remobilise services following Covid-19 will be affected where we are not able to demonstrate safety of water	Staff Governance Committee October 2020 – limited assurance accepted.	High 12			High 12	High 12

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
	systems. New risk –approved by Board 12 August 2020						
3454	**Learning from Complaints** There is a risk that learning from complaints and feedback is not effective due to the lack of reliable implementation of complaints and feedback processes leading to the quality of patient experience being compromised and adverse effect on public confidence and expectation of our services.	Healthcare Governance Committee November 2020 – Moderate assurance accepted. March 2021 – limited assurance accepted on the effectiveness of processes to collect feedback on complaints handling and performance in respect of stage 1 and 2 complaints.	High 12	High 12	High 16	High 16	High 16
3527	**Medical Workforce** There is a risk that the availability of medical staffing will not be adequate to provide a safe and sustainable service to all patients, because of the inability to recruit and retain doctors. Specific issues include availability of doctors through specialty training schemes and retention of capacity in service through senior medical staff due to changes in pension tax rules. This affects the ability to provide a safe and sustainable service and to meet government commitment	Staff Governance Committee July 2020 - moderate level of assurance accepted that the controls in place mitigate any risks to immediate patient safety and quality of care. October 2020 – verbal update provided no new level of assurance agreed. December 2020 – moderate assurance accepted. Grading 16 – currently considering recommendation to increase to 20 (Impact 5, likelihood 4)	High 16	High 16	High 16	High 16	High 16
3189	**Facilities Fit for Purpose** There is a risk that NHS Lothian is unable to deliver an efficient healthcare service because of unsuitable accommodation and clinical environments leading to potential delays in patient care and threatening patient and staff safety.	Finance & Resources Committee June 2020 - Moderate assurance agreed, reduction in grading from High 16 to high 12 (impact changed from high to moderate) On agenda for further review Jan 2021.	High 15	High 16	High 12	High 12	High 12

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
3455	**Violence & Aggression**. (Reported at H&S Committee) There is a risk of violent and/or aggressive behaviour of individuals, in mental health, learning disability services, and emergency departments; resulting in harm to person and poor patient and staff experience plus potential prosecution by HSE.	Staff Governance Committee October 2020 - moderate assurance accepted on processes in place, limited assurance on implementation of required actions. December 2020 - moderate assurance accepted on processes in place, limited assurance on implementation of required actions, specifically on the use and provision of personal alarms.	Med 9	High 15	High 15	High 15	High 15
3328	**Roadways/ Traffic Management** There is a risk of injury to staff, patients and the public from ineffective traffic management as a result of inappropriate segregation across NHS Lothian sites leading to loss of life or significant injury	Staff Governance Committee October 2020- limited assurance accepted regarding safe traffic management at the acute sites. December 2020- limited assurance accepted regarding safe traffic management at acute, East and Midlothian sites. Moderate assurance accepted for REH and community sites.	High 12	High 12	High 12	High 12	High 12
1076	**Healthcare Associated Infection** There is a risk of patients developing an infection: 1) as a consequence of healthcare interventions because of inadequate implementation and monitoring of HAI prevention and control measures. 2) linked to the built environment as a consequence of non-compliant design, maintenance or monitoring. This includes infections associated	Healthcare Governance Committee January 2021 - Moderate assurance accepted. Standing item on HCG agenda. March 2021 – moderate assurance accepted overall, limited on ventilation systems in RIE theatres.	High 12	High 16	High 16	High 16	High 16

Datix ID	Risk Title & Description	Committee Assurance Review Date	Initial Risk Level	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020
	commonly occurring environmental organisms e.g. *Pseudomonas aeruginosa*. 3) associated a failure to decontaminate reusable invasive and semi invasive medical equipment effectively. Potential increase in individual patient morbidity & mortality risk, extended length of stay and duration of treatment associated with healthcare associated infections.						