# NHS Lothian Board

**13 May 2020, 09:30 to 13:00**
**TEAMS**

# Agenda

## Declaration of Interests

### 1. Declaration of Interests

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

### 2. Items proposed for Approval or Noting without further discussion

Decision

Esther Roberton

### 2.1. Minutes of Previous Board Meeting held 8 April 2020

For Approval

Esther Roberton

Board Minutes Public - 08-04-2020 final draft.pdf (18 pages)

### 2.2. Appointment of Members to Committees

For Approval

Esther Roberton

13 May 2020 Board - Committee Appointments (final 290420).pdf (2 pages)

### 2.3. Initial Agreement - South East Outer GP Provision

For Approval

Susan Goldsmith

NHSL Report South East Edinburgh 20200513 v1.0 final.pdf (4 pages)

South East Edinburgh Initial Agreement v4.8 final.pdf (44 pages)

### 2.4. Initial Agreement - Re-Provision of the Hospital Sterilisation and Decontamination Unit

For Approval

Jim Crombie

NHS Lothian Board Paper HSDU Reprovision IA May 2020_v4.pdf (5 pages)

Updated HSDU reprovision Initial Agreement for NHS Lothian Board_May2020.pdf (41 pages)

**2.5. Finance and Resources Committee Minutes - 25 March 2020**

For Noting

Martin Hill

FR 25-03-20 Minutes signed.pdf (6 pages)

**2.6. East Lothian IJB Minutes - 27 February 2020**

For Noting

Fiona O'Donnell

East Lothian IJB Minutes - 27-02-2020.pdf (9 pages)

## Items for Discussion

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

Esther Roberton

**4. Public Health Briefing on COVID-19**

Alison McCallum

COVID-19 PUBLIC HEALTH UPDATE.pdf (10 pages)

**5. COVID-19 - Operational Update**

Jim Crombie

Board paper COVID operational briefing MAY.pdf (7 pages)

**6. Scheduled and Unscheduled Care Performance**

Jacquie Campbell

Board Paper_Scheduled Unscheduled Care_May 2020_Final_Submitted v3.pdf (20 pages)

**7. Post COVID-19: Recovery, Renew and Tilt to Digital**

Pete Lock

Board Paper_Post Covid Recovery May 2020 v0.2.pdf (7 pages)

**8. Healthcare Associated Infection (HAI) Update**

Alex McMahon

20200424 HAI Board Paper 13 May 2020 v1.0.pdf (6 pages)

HAI Appendix 1 Temporary changes to IPC Activities v 1.0.pdf (5 pages)

**9. Review of Integration Schemes**

Alex McMahon

13 May 2020 Board - Review of the Integration Schemes (final).pdf (3 pages)

**10. RHCYP, DCN & CAMHS Project Update**

Susan Goldsmith

RHCYP & DCN PUBLIC Board Paper 13 May 2020.pdf (4 pages)

**11. Financial report on COVID 19**

Susan Goldsmith

NHS Lothian COVID-19 Finance Update May 2020.pdf (4 pages)

## 12. Any Other Business

Verbal

Esther Roberton

## 13. Future Board Meetings

Information

- 24 June 2020
- 12 August 2020
- 02 September 2020
- 14 October 2020
- 04 November 2020
- 09 December 2020

## 14. 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 9.30 am on Wednesday, 8 April 2020 using Microsoft Teams.

**Present:**

**Non-Executive Board Members:**

Mrs E Roberton (Chair); Mr M Hill (Vice Chair); Mr M Ash; Mr M Connor; Dr P Donald; Cllr G Gordon; Ms C Hirst; Ms F Ireland; Mr A Joyce; Mrs K Kasper; Mr A McCann; Cllr J McGinty; Mr W McQueen; Mrs A Mitchell; Mr P Murray; Cllr F O'Donnell; Professor M Whyte and Dr R Williams.

**Executive Board Members:** Mr T Davison (Chief Executive); Ms T Gillies (Executive Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Executive Director, Nursing, Midwifery & AHPs – Executive Lead REAS & Prison Healthcare).

**In Attendance:** Mrs J Butler (Director of HR & OD); Mrs J Campbell (Chief Officer, Acute Services); Mr J Crombie (Deputy Chief Executive); Mr P Lock (Director of Improvement); Mrs J Mackay (Director of Communications and Public Engagement); Mr C Briggs (Director of Strategic Planning); Mr A Payne (Head of Corporate Governance) and Mr D Weir (Business Manager, Interim Chair, Chief Executive and Deputy Chief Executive's Office).

Apologies for absence were received from Cllr D Milligan.

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

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. There were no declarations of interest.

## 1. Chair's Introductory Comments

1.1. The Chair acknowledged that it was strange to be holding the Board Meeting in such unusual circumstances and thanked the Executive Team for moving so quickly to respond to the current Covid-19 position. She advised that the previous day she had met with the Minister for Public Health who would be contacting Chairs individually and would arrange regular Regional Group discussions around the Covid-19 response. The following day a discussion would be held involving NHS Lothian, Borders, Fife and Forth Valley. The Minister for Public Health had asked her to pass on the thanks of the Cabinet Secretary and other colleagues at St Andrew's House for the work that had so quickly been undertaken to get us to the current position. The Chair also asked for her personal thanks to be minuted.

1.2. The Chair advised that although this would be a public Board Meeting that there would be no members of the public present as previously agreed.

**2. Standing Order 5.3**

2.1. It had earlier been agreed through correspondence to invoke Standing Order 5.3 to hold a Board Meeting in Private because of some items being commercial and confidential.

**3. Items for Approval**

3.1. 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 they had had the opportunity to advise in advance if they wished matters to be moved out of this section. No such requests had been made. The following items were agreed without further discussion:

3.2. Minutes of the Board Meeting held on 4 March 2020 – Approved. The Chair thanked Mr Hill for Chairing the March 2020 meeting in her absence.

3.3. Finance and Resources Committee Minutes - 26 February 2020 – Approved.

3.4. Audit and Risk Committee Minutes – 13 January 2020 – Approved.

3.5. Health Care Governance Committee Minutes – 14 January 2020 – Approved.

3.6. West Lothian IJB Minutes – 26 November 2019 and 21 January 2020 – Approved.

**Items for Discussion**

**4. Opportunity for committee chairs or IJB leads to highlight material issues for awareness.**

4.1. Mr Hill advised that at the Finance and Resources Committee ON 25 March 2020 that most of the discussion had been around the RHCYP/DCN/CAMHS and the financial position both of which were on the Board agenda for discussion. He advised however that the Committee had agreed the provision of General Medical Services in Edinburgh South essentially bringing three practices together into new accommodation. He commented that it would be interesting when NHS Lothian considered its own Covid-19 exit strategy to consider how models in primary care might change in the future.

**5. Revised Approach to Governance Meetings**

5.1. Mr Payne referred to the circulated paper and commented that he hoped it represented a common sense approach to rationalise business during the current Covid-19 position. Committees would continue to meet although there

would be reflection on the frequency of meetings. It was noted that the Executive lead for the various committees had been consulted and were content with the proposals. The proposals had been developed because of the need to free up the capacity of Executive Directors as supporting meetings involved workload around the preparation of papers etc.

5.2. The Chair advised that there had been discussion around the need for the Staff Governance Committee to continue to meet given that issues like iMatter were in abeyance. Issues had however been raised about the health and wellbeing of staff which was a major issue. Mrs Mitchell reported that Miss Gillies had been of the view that Health and Safety was an element for consideration by the Staff Governance Committee and it would be important that issues were addressed in the interim. It was felt that there was a possible overlap with the Health Care Governance Committee in terms of Medical and Nursing staff pressures. There was also a need to ensure that Whistleblowing remained on the agenda particularly through the Covid-19 period. The Board agreed that a focused meeting of the Staff Governance Committee should be held in May around Covid-19 and Whistleblowing.

5.3. Professor Whyte advised that she and Miss Gillies had yet to discuss the agenda for the next Health Care Governance Committee although it would be important to minimise routine work .It would be important that the Committee had an oversight of clinical and patient care to both Covid-19 and non Covid patients. Miss Gillies supported this position and advised that the most important Health and Safety issue was around the provision of PPE (Personal Protective Equipment) for staff. The Chair concurred advising that clinicians had written to the Cabinet Secretary raising concerns around PPE. An update was provided on work currently underway to address the position. It was noted this was being addressed by Professor McMahon and was logged as an issue at the Strategic Management Group where an audit trail of issues was kept.

5.4. Mr. Murray in respect of PPE advised that there was a need to work closely with IJB colleagues and Care Homes as the provision of PPE was being reported as an issue. The Chair commented this had been one of the issues she had raised the previous day with the Minister for Public Health and that before engaging in the forthcoming Regional telephone call she would be keen to understand the NHS Lothian position. Professor McMahon reported that the PPE guidance had been refreshed the previous week and this opened up PPE to almost every health and social care professional to have an assessment of their individual needs. This has had an impact on both volume and the nature of demand which will need to be carefully managed.

5.5. The new guidance had caused anxiety amongst some members of staff. Professor McMahon reported in respect of care home staff that work was underway with IJB Chief Officers and Chief Nurses to create a single point of distribution in each of the four Partnership areas in order that the provisions they got from health and separate lines of provision for social care would come into the one area for decisions on distribution. Professor McMahon advised that at this point, it would be difficult to meet all need and a process was being developed around this. He commented that training, education and support

would be provided given that many staff would not be familiar with PPE and there was a need to ensure there was no cross-contamination.

5.6. The Chief Executive commented that NHS Lothian was one of the more connected systems and had fully involved the HSCPs. A Strategic Management Group had been established and met twice weekly on a whole system basis which included the Corporate Management Team and the four HSCP Directors. He advised that the system had been clear about the need to coordinate the four HSCP Mobilisation Plans that had been submitted to the Scottish Government the previous week. There had been a common statement of introduction to each of the Mobilisation Plans. The guidance around PPE particularly in social care settings and for unpaid carers was adding a significant level of demand into the system and this remains a significant issue.

5.7. Professor McMahon advised that National Services Scotland had ordered 7 million blue facemasks which was a new product and would require every staff member who had previously been face fit tested with a different mask to be further tested. He felt this was an important piece of context. The Chair commented on the need to get the face fitting process correct from both a staff and patient perspective.

5.8. Mrs Butler in response to a question confirmed that the business of the Remuneration Committee had been suspended in terms of iMatter and objective setting. It was noted that any critical issues could be addressed at the Staff Governance Committee of which the Remuneration Committee was a subcommittee.

5.9. Dr Williams commented in respect of the Staff Governance Committee whether there was a need to know about risks and assurances around previously retired colleagues who had agreed to come out of retirement to work. The Chair advised that both Dr Donald and Dr Williams were in this cohort and thanked them for being willing to step in. Mrs. Butler reported that these issues would be addressed in a paper to the Staff Governance Committee in May 2020. Dr Williams advised that the process had not been as seamless as it could have been. He felt it would be helpful as a Board member to know more about the process. Miss Gillies undertook to brief Dr Williams and any other interested parties out with the meeting. Mrs. Butler would pick up arrangements for returning GPs as the current focus had been around the acute sector where clear training and induction arrangements were in place.

5.10. The Chair confirmed that she would convene a weekly Non-Executive teleconference. The Chief Executive or a member of the Executive Team would participate if available.

5.11. The Board agreed to approve the recommendations contained in the circulated paper and to review the position at the June 2020 Meeting.

**6. Covid-19**

6.1. The Chair advised that there had been an omission on the agenda for a report from the Director of Public Health. She therefore asked Professor McCallum for an oral update from a Public Health perspective and then invite Mr Crombie to lead discussions on the operational response to the current crisis.

6.2. Professor McCallum provided the Board with a detailed update on the work being undertaken from a Public Health perspective in responding to Covid – 19. The background to the outbreak was explained leading up to the decision on 23 March 2020 to put the country into lockdown in order to minimise contact between people and thus stem the flow of infection.

6.3. The Board were advised that since December 2019 up until the previous day there had been in the UK 61,608 people who had tested positive with 42,990 of these being in England. Approximately 25,000 tests had been undertaken in Scotland with a 12.5% positivity rate. As of 7 April 2020, there had been 4229 confirmed cases in Scotland in total. Of those 268 had occurred between 6 April and 7 April 2028. There had been 296 deaths recorded as being from Covid – 19 although this was an underestimate and would rise with the reasons for this being explained. In Lothian based on laboratory data on 7 April 2020 there had been 647 positive cases (48% female and 52% male) with 66 deaths. All age groups were affected but 86% of those tested positive were over 40 years of age. About 10% of people who have tested positive had been admitted to Intensive Care. The socioeconomic and ethnic distribution was not yet known in Scotland although it was anticipated that this would follow a similar gradient to other conditions because people with fewer resources were more vulnerable because they were less able to self-isolate, work from home and were more likely to be in a key worker role.

6.4. Professor McCallum advised that the current estimates of infectivity was that each case of infection resulted in 2 – 3 additional cases. There was some suggestion that this was coming down but the official position remained as above. The estimated doubling time of cases without shielding was 4 – 5 cases and 3 – 4 days for deaths. A peak was expected in the next few weeks. A detailed update was provided on isolation periods and the point at which people could come out of isolation. Professor McCallum provided an update on the sampling process in Scotland advising that from 1 April 2020 the system for sampling for influenza would be adopted for Covid-19.

6.5. Dr Williams asked whether a distinction was being made between people who had died because of Covid–19 and those who had died with Covid–19. The point was made that the official death statistics related to people who had died as a result of Covid-19 disease.

6.6. The Chair advised that she had been notified of a number of questions from Board Members. These were whether assessment centres could be used for testing, whether figures were available for the different specific areas in Lothian and whether data would be available by IJB area. Professor McCallum reported that dashboard work was mapping testing and cases in order that more detail could be provided.

6.7. The Board were provided with an update on the “Drive Through” service that had been established and tested 1000 people, mostly NHS and some social care staff, over a two-week period. The testing process and outputs were explained. Plans for expanding the service were explained with it being noted that proposals were at an early stage. The Scottish Government were also discussing opportunities for staff testing as part of a UK scheme that would be adapted to meet Scottish requirements.

6.8. Councillor McGinty asked whether plans were in place for establishing localised testing. Ms Kasper questioned how confident the system could be about the accuracy of testing. It was reported that in Lothian testing was done to accredited standards and was verified. No non-accredited testing was undertaken in Lothian. In terms of localised testing services, the rate-limiting factor was the sustained availability of the reagent used for verified validated testing. Miss Gillies advised that in Lothian no commercial testing was being undertaken as it was not validated to the necessary standards and could therefore not be supported. It was noted that at the Board Chief Executives meeting the previous day discussion had been held around the UK Governments mass testing proposals. Local plans for an increase in the sites for staff testing would need to be cognisant of the need to link in with UK arrangements. Miss Gillies reported that capacity was available for testing prioritised staff from health, social care and from the care sectors and this had been circulated to the Chief Officers.

6.9. Professor McCallum advised in response to a question that the “Drive Through” service was available for social care staff and their families as prioritised by their managers in terms of the risk to the team and the nature of respective roles. It was noted that the team were looking at other models on how to expand the offering although it was important that this happened in a quality assured and sustainable way. The point was made in terms of community testing that the local approach was to think about testing for clinical reasons. Plans were being developed to increase the capacity to test people presenting as symptomatic to the Primary Care Covid – 19 Hubs and again this would be from a clinical perspective. This would ensure that people had adequate advice and support.

6.10. Professor McCallum advised that the next stage was to minimise the adverse impact on populations at additional risk including those in closed settings like prisons, hospitals and care homes where more than two cases would be considered as an outbreak. There was also an issue about the number of people who were homeless or insecurely housed who had now been provided with accommodation that allowed them to self-isolate. A similar process had been undertaken for women and children at risk who were in temporary accommodation.

6.11. The Board were advised that they was a specific outbreak of Covid – 19 on a cruise ship moored on the Forth and the details of the outbreak and the method of managing this was explained in detail and was in accordance with WHO guidance for ships. An appropriate process was in place for other cruise ships in the Forth.

6.12. Professor McCallum advised that care homes were another closed setting and that as of 7 April 2020 there were 28 confirmed and 64 possible cases and 13 deaths across the 14 care homes that were currently under active surveillance. It was noted that a strategic approach was being developed to prevention and early intervention and outbreak management rather than dealing with issues on a case-by-case basis.

6.13. Mr McCann sought an update on work around testing projection numbers over the coming weeks and the confidence in those. The point was reiterated that the rate-limiting factor was the availability of reagents on verified validated tests. In terms of numbers the system would be guided by the laboratory service and clinical leaders. It would be important not to ramp up services in this area that might result in an inability to undertake rapidly tests in people who were unwell or of tests in key staff. It was therefore not possible to state how quickly the service could be expanded and the possible numbers involved.

6.14. Professor McCallum advised in respect of caring for people that in Scotland the pandemic was being managed as a multiagency emergency. This meant that each Local Authority and Resilience Partnership had a “Care for People Group” with the details of how this operated being explained to the Board in terms of people with particular clinical conditions requiring them to stay at home for 12 weeks and self isolate. National arrangements in terms of providing basic support to these patients was outlined. Local teams were working to provide a more practical and tailored offer in order to ensure that clinical needs were met in a safe and effective way. It was noted that each area also had a “Data Group” and a “Clinical Issues Group” with the functions of these also being explained. All of these arrangements were to ensure that concerned people were not left without support.

6.15. The Board noted that the recommended way forward remained to support all of the work that was underway and this had happened rapidly to help the system to evaluate and capture lessons learned and share good practice including acknowledging approaches that had not worked. People should continue to stay at home and stay connected by telephone or online and to ask for help if they were unwell or having difficulty managing on a day-to-day basis. A critical key issue was to continue with handwashing. Professor McCallum advised that consideration also needed to be given to ensuring that the system was ready to develop programmes of recovery for the population’s health as well as the ongoing delivery of healthcare.

6.16. The Chair requested that a report from the Director of Public Health should be a standing item and asked Professor McCallum to prepare a short briefing paper for future Board meetings.

6.17. Professor McCallum advised that she would liaise off-line with Councillor Gordon in respect of a specific case raised by him in terms of the anticipated receipt of a screening letter that had not yet been received by a colleague for a member of his family. The Board noted that this was a nationally driven process

that was being reviewed from a Scottish perspective to ensure that the Chief Medical Officer issued such letters.

6.18. The Board were advised in terms of volunteering that in so far as possible coordination was been undertaken nationally through Volunteer Scotland. The Third Sector interface bodies in each of the Community Planning Partnerships were also heavily engaged in trying to ensure that national organisations were joined up locally. Steps were also in place to ensure that volunteers met the appropriate standards and were not putting people at risk.

6.19. The Chair advised that there was an issue that vulnerable people's details were being passed to supermarkets to allow them to receive provisions. She felt that would be a significant data protection issue at the other end of the process.

6.20. The Chair thanked Professor McCallum for her comprehensive update and invited Mr Crombie to update the Board on the operational response.

6.21. Mr Crombie commented that he did not think it was overstating the case to say that this was the most impactful paper that he had ever brought to a Board meeting. He felt that there would be significant downstream consequences for months and perhaps years. He felt that it was correct to recognise the impact of the disease on communities as this could not be understated.

6.22. Mr. Crombie advised that on 17 March 2020 the acute system had had its first positive case. As of 8 April 2020, there were 158 positive cases in the wards and 39 positive cases in Critical Care. He reported on some of the demand processes that acknowledged doubling of cases every four days. Recently there had been a doubling around ward beds of around 8 days and in Critical Care every 10 days. There was some evidence that the steps being taken were flattening the demand curve.

6.23. Mr Crombie advised that at the 4 March 2020 Board meeting the initial approach and command structure to be deployed had been discussed. It was noted that this had quickly moved to an oversight command structure. A Strategic Management Group had been established on a whole system basis and met three times per week. An Executive Team had also been created and met twice a week. This approach had been deployed in order to take command of what was going on and to enable agile decision-making.

6.24. Mr Crombie reported that the circulated paper referred to the development of mobilisation plans and that these were whole system in nature. They also quantified the magnitude of financial commitment in this area. It was noted that one element of the impact of the pandemic had been a significant reduction in the number of Delayed Discharges the details of which were explained. The system had benefited from the deployment of two British Army Liaison Officers who were providing support in a number of areas including logistics and process overview. This position was not unique to NHS Lothian with 35 British Army Liaison Officers having been deployed across NHS Scotland.

6.25. The Board were advised that one of the most seismic decisions that had to be taken by the Executive Team had been the discontinuation of the elective programme. The quantum impact of that decision had been reflected upon. The Chair asked for confirmation there was an audit trail of decisions or central log as this information would be needed for the future.

6.26. Mr Crombie advised that actions taken to date were detailed in the paper and included as previously reported the cancellation of elective procedures as well as the expansion of Critical Care Level 3 facilities that were the highest level of support for patients requiring one to one care and often requiring ventilation. Previously NHS Lothian had 29 level 3 beds with plans in place to expand this to 113 beds in the next few weeks. The implications of moving staff resources to support this level of intensity was recognised

6.27. The Board was advised that Professor McMahon was central to the PPE process around identifying significant issues for patients and staff. It was pointed out that the impact of the disease have resulted in a seismic change in service provision with an example provided of GP practices now being more agile in their interaction with patients including the use of technology like “Near Me” which had been deployed to all 121 GP practices. In the previous week, 570 Consultations had taken place using this technology that was being expanded to the Out Patient environment with Dermatology being the first specialty to adopt this approach.

6.28. The Board were advised that at the early stages, testing had commenced at the Western General Hospital (WGH) and the Regional Infectious Diseases Unit (RIDU) teams had come up with the idea of drive through testing which was now being deployed across Scotland. Communications had been central to the process and the system had developed the concept of a “Speed Read” issued on a daily basis with positive feedback having been received. It was noted that NHS Lothian was liaising with colleagues from the Louisa Jordan Hospital in Glasgow in terms of finding out information about clinical pathways that could be interacted with. Mr. Crombie made specific reference to the support provided by colleagues from RIDU and the Infection Prevention and Control team in allowing the system to move forward and provide safe care and safe staff. The input of other teams was also recognised.

6.29. Mr Crombie advised off the critical importance of supporting staff and to recognise the personal impact the current position was having on them. A helpline had been established for staff. In addition, a more focused psychological support framework had been introduced and was now in place. The Chair advised that she had discussed with the Chief Executive the need for the Executive Team to safeguard their own health during these difficult times. Mr Crombie commented on the importance of not losing the benefit of some of these initiatives as the system moved into the recovery period particularly in respect of digital working. It was noted that working from home had been established and was operating effectively.

6.30. In terms of the psychological support service it was pointed out by Mrs Mitchell that this was internet based and it would be important to ensure its availability

to staff who did not have such access. She also made the point in respect of delayed discharges whether patients were being discharged to infected care homes and if so what provisions were being made for them. Mrs Butler updated on the significant push that had been put in place in respect of staff welfare with examples provided including local initiatives over and above corporate approaches. She pointed out that most of the help could be accessed by telephone and that the services that were online could be accessed via the NES TURAS platform. In particular she reported that a “before you go home” huddle template had been developed to support staff well-being. A Well-being Champion had been appointed to help share good local practice.

6.31. Professor McCallum reported that the Infection Protection and Control Team in the hospital along with the Public Health team worked closely with the HSCPs and care homes to ensure that people were discharged safely. A patient would not be knowingly discharged to an environment that was less safe than the hospital.

6.32. Mrs Hirst along with other Board members commented on the examples of excellent leadership throughout the organisation. She commented that there were issues around risk and selectivity decisions that clinicians in particular would need to make in respect of clinical practice. She felt that there was likely to be some legal implications not least in terms of Equality and Diversity and Human Rights. She questioned whether the guidance needed to be obtained on the NHS Lothian approach as well as considering how to support staff when they needed to make these very difficult decisions.

6.33. Miss Gillies advised that the Scottish Government had produced some Ethical Support guidance intended to support staff when ethical issues came into play and that these replicated the guidance currently in use in the hospital environment. She commented however that it was important to recognise that difficult decisions were made every day in the acute sector in terms of reconciling who might benefit from treatment regimes. The point was made that the physical absence of relatives from these conversations was a difficulty and made it harder to have good nonverbal communication. It was pointed out that there would be a need to support staff to have conversations in a different way and this would be discussed at a meeting later in the day. Miss Gillies commented that it would be important not to devolve such decision-making to a committee.

6.34. Mr Crombie in response to a question advised that prior to Covid – 19 that NHS Lothian had been in a good position in respect of ventilator capability and had recently replaced some machines with the old ones having been retained and would be available to support the initial phases of the expansion of level 3 Critical Care capacity. Work was also underway to convert anaesthetic machines to provide ventilator support and these steps would allow NHS Lothian to support the move to 113 beds. The Scottish Government was also procuring additional ventilators from recognised manufacturers and NHS Lothian would receive a share of these. In addition, NHS Lothian would also be procuring additional ventilators for delivery in May or June 2020. Miss Gillies

reported that NHS Lothian would not use nonstandard ventilators. Issues around CPAP would be discussed at the Health Care Governance Committee.

6.35. Mr Crombie in response to a question from Dr Williams who was a past Chair of the NHS Lothian Organ Donation Committee and advised that this was an area that had been recognised as being important by the Strategic Management Team and had also been reflected in the Lothian Strategic Transformation Plan. Miss Gillies provided an update on the UK wide stance in terms of transplantation advising that NHS Lothian was fully in line with the UK guidance that had been issued.

6.36. Councillor Gordon expressed his concern about the impact on equalities and possible discrimination as the system moved to a digital focus. He commented that not all members of the public nor staff had Internet access and there would be a need to address this. The Chair advised that she was aware that the Scottish Government were leading work across a number of organisations including the third sector to begin to address the digital exclusion. Professor McCallum reported that the Head of Equality and Human Rights was also playing an active role in ensuring that equality issues were addressed with examples provided. She felt that the fact that a Board level strategy and Board level equality outcomes were in place provided a framework against which to address each decision.

6.37. The Chair commented that the drop in A&E attendances might have different explanations. She also commented that the paper would benefit from referencing how the public would be communicated with during this process. The Chair suggested in terms of training that opportunities should be taken to play into Universities and utilise assistance from this area. Professor Whyte advised that the University of Edinburgh was happy to participate. She commented that the final year Medical Students had graduated and that NHS Lothian had been one of the most proactive Boards in employing the graduates.

6.38. The Board received the update report and commended the work being undertaken by the Executive Team.

**7. Lothian System Transformation Plan (LSTP) and Lothian Recovery Programme Plan Re – Prioritisation**

7.1. The Board agreed to consider both the LSTP and the Lothian Recovery Programme as a single item.

7.2. Mr Briggs reported that there was a requirement for the Board to approve the LSTP before it could be progressed further. He reminded the Board that they had considered a previous iteration of the plan at the January 2020 Board meeting where it had been well received in terms of the approach being adopted. Since then further work had a occurred with Board members, other Health Boards and the Scottish Government and others to ensure that the plans were joined. A key issue was the desire for the plans to move forward not only on an annual basis but to include a 3 – 5 year forward look. IJBs had also bought into the pathway to provide a system wide transformation plan.

7.3. The Board noted that finances and modelling had been put on pause because of Covid–19. Work continued on steps to be taken as part of the Covid-19 recovery process. Mr Briggs commented that a letter had been received from the Scottish Government stating that the process had been paused and that they had noted what had been done in respect of the LSTP with individual points having been neither agreed nor disagreed at this juncture.

7.4. The Board were advised that the Finance and Resources Committee at its meeting on 25 March 2020 had approved the financial plan. An update was provided on the IJB input into approving the LSTP and the Scottish Government approach to this with it being noted that the intention was to obtain strong support from IJBs and HSCP Chief Officers.

7.5. Mr Murray commented that the LSTP as it currently stood would need a significant rewrite to reflect the Covid–19 position. He felt that Board Committees and in particular the Strategic Planning Committee would want to have a view on how to move this work forward. Mr Briggs felt that points of detail would need to be refreshed although he felt the agreed platform was still valid.

7.6. Mr. Murray commented in terms of the implications of the changes borne out of the current crisis that there were many strategic perspectives that would need to be considered including the approach to the recovery plan. The Chair commented on the complexity and range of detail in the paper advising that she felt a lot of this would stand but would need to be reviewed and the post Covid–19 world.

7.7. The Chair commented that there had been a clear message from the Minister for Public Health about the need to protect drug and alcohol services as this involved a vulnerable group of people. She commented that the LSTP for obvious reasons was very service delivery focused. She hoped that in the future plans would start from the perspective of Public Health.

7.8. The Chair invited Mr Lock to speak to the circulated paper in respect of setting out a re- prioritisation of the recovery programme that reflected the national priority of focusing on Covid-19 for the near future. Reference was made to a letter dated 1 April 2020 from the Director General of the NHS in Scotland effectively stating that the expectation was that performance would be maintained in all areas as far as possible. It also clearly and correctly noted that priorities had shifted and that moving forward the Scottish Government approach would change. NHS Lothian as an organisation remained at level 3 but that effectively the recovery programme would not continue in its current form.

7.9. Mr Lock commented that part of the purpose of the paper was to log with the Board the position in terms of the programme and what the position should look like going forward given the current situation. He commented that the Military liaison officers had commented that currently NHS Lothian had been planning in a linear fashion and that an exponential approach now needed to be taken

as this was how the epidemic was changing. Mr Lock commented that like the LSTP a longer-term view needed to be adopted and embedded.

7.10. The Board noted that there had been a significant reduction in attendances and whilst some of this might be welcome, it was important to recognise the position in respect of vulnerable groups. There was a need to learn from current experience and identify what needed to be challenged in the post Covid world. Mr Lock advised that the paper logged February performance although it was not proposed to discuss this in detail at the meeting. He commented that there was a need to monitor what was going on and what the challenge would be around issues like Waiting Times over the next period of time whilst not majorly focusing on this.

7.11. Mr Lock commented that the final part of the paper set out some of the changes that had already happened and what the implications of these were or may not be in terms of issues like Primary Care moving to more use of technology for triage and shielding purposes in terms of Unscheduled Care. It was not anticipated that moving back to a traditional approach to the recovery planning would be the correct thing to do. There was a need to look at what the future might look like and to take a proportionate approach to this given the current crisis and not to over burden existing teams.

7.12. The Board were advised in respect of Mental Health recruitment that all new posts had joined NHS Lothian as planned and where possible the team had been keen to maintain progress recognising the fact that there would be a likely increase in anxiety and depression given the current circumstances leading to an influx into the service.

7.13. The Vice Chair commented whilst he understood the need for the response to be proportionate he did not think the Board should underestimate the opportunities around reimagining and what this might look like given the experience of recent times. He advised that he was unsure about what was meant about redefining the investment case in the paper and whether this related to the development of a Business Case where there were clearly defined benefits and clear issues of affordability.

7.14. Mrs Campbell confirmed that the possibility of using the Paediatric ward as part of the expansion plan for St. John's was being explored. There would be a need to make a strong case back to the Scottish Government given the expectation in the letter from the Director General. The Chief Executive has advised that the issue had been raised informally with the Scottish Government. Should actions be required an SBAR would be formally submitted. It would be made clear that Paediatrics would be towards the very end of the line of wards that NHS Lothian would seek to open.

7.15. Mr McCann advised that he applauded the changes made to move to a more digital approach although he felt what was being achieved was only the tip of what the organisation could and should be doing whilst recognising the financial constraints. He felt there was a need to increase the leadership focus on digital data as well as capturing information on what had been successful or otherwise.

Mr McCann felt that there was a key question about how the Board maintained this emphasis on digital post Covid. The Chair commented that the Head of eDigital recognised the real opportunities in this field.

7.16. Mr Murray commented in respect of the letter from the Director General whether there was a need at some point to respond to this in respect of whether it would ever be proper to go back to the previous recovery programme approach. He commented in respect of TTG and on the short-term future of this from a Government perspective over the next 12 – 24 months based on the ability to get back to where the system had previously been never mind starting to erode some of the earlier gaps.

7.17. Mr Murray suggested that it appeared that the delayed discharges were not a systemic issue because the position had been resolved in the space of 3 weeks. He felt NHS Lothian needed to position itself in a way that guaranteed finance moving forward so that the NHS had a chance to operate effectively.

7.18. The Chair invited Mrs Campbell to comment on the impact and quantum of cancellations. Mrs Campbell suggested that this discussion should be paused, as these were large strategic discussions that the Board needed to consider sooner rather than later. She commented in terms of A&E attendances that she did not know how to assess the risk of people who had not attended but should have as they were probably vulnerable. The Chair commented that the Board would need to take a view around the recovery position as would the rest of Scotland.

7.19. The Chair advised there would need to be more about public engagement in terms of service changes although the narrative focused on staff and patients and not the public. She advised that there would be a clear need for public engagement around some of the future decisions that would need to be made.

7.20. Mr Briggs spoke to the current position in respect of modelling assumptions advising that the key issue was that the Board needed to have a clear understanding of when demand presented by the Covid–19 Pandemic placed the system under very significant pressures or not. It would be important to keep close track of some of the Public Health indicators to determine the number of ward beds, critical care beds and the level of PPE required. It was noted work was underway in this regard. It was noted that a best case and worst-case scenario had been produced although the details could not be shared at this point because of the exponential nature of the data. The position in respect of modelling across Scotland was described. It was encouraging that despite the different approaches that the assumptions and answers were broadly the same.

7.21. The Board were advised that the latest confirmed position was that there was a belief that critical care capacity would come under significant pressure in the next few days. The caveat to this was that the epidemiological curve had moved from cases doubling in 2 ½ days to a position closer to 5 or 7 days. The key issue was that the Public Health intervention measures introduced on 23 March 2020 had made a difference and was demonstrating a shallowing of the position moving forward.

7.22. Mr Briggs reported that future conversations needed to focus not on the recovery process but how the system backed out of the current position with a need to consider people who had received shielding letters. The challenge around people staying at home for a sustained period was an issue. There was a particular concern about the forthcoming Easter weekend period given that good weather was forecast.

7.23. The Chair commented that she was encouraged by the evidence that the Public Health message was working and was concerned about how long this could be sustained. Mrs Hirst commented on the finances being used to support people at home with there being a need to consider how to sustain this in the longer term as this would be an important point moving forward.

7.24. The Board approved the following recommendations:

2.1 Acknowledge that in the short term the Recovery Programme places a hold on the majority of the work plan, as well as reprioritising its future focus onto learning from the current Covid-19 pandemic situation, and how this can be embedded into clinical practice to support longer term recovery actions.

2.2 Agree that the current situation should provide a broader catalyst for a "tilt to digital" and greater virtual health and care delivery across Lothian.

**8. Royal Hospital for Children and Young People / Department of Clinical Neurosciences / Child and Adolescent Mental Health Services (RHCYP/DCN and CAMHS)**

8.1. The Chair commented that it had been intended to have Mrs Morgan, Senior Programme Director available to attend the meeting but other diary commitments had prevented this happening.

8.2. The Board received an update on progress since the previous meeting with it being noted a fuller report would be provided in the Private Board session later in the day.

8.3. The Board noted the update report.

**9. Financial Position**

9.1. Mrs Goldsmith advised she had difficulty revisiting this paper given the uncertainties around what the financial position would like as the year progressed. There was a need for the Board to approve the financial plan in order that opening revenue and capital budgets could be set. The Finance and Resources Committee had accepted the plan recognising the need for a detailed review in respect of Covid-19.

9.2. Mrs Goldsmith commented that for the first time in a number of years a forward plan had been produced that was close to breakeven at the opening of the year. She provided an update on a number of key issues in the paper including

NRAC, a critical review of cost pressures, acute and GP drug costs and the funding of the pay award. The full 3% uplift would be provided to IJBs to support financial stability wherever possible. The financial plan had also made inroads into the care deficit in respect of Unscheduled care access and Psychological Therapies where funding had been made recurrent. Strategic investment in eHealth continued although this was an area where further work was required.

9.3. Mrs Goldsmith in response to a question advised in terms of the care deficit down to ward level advised that there was still work to be done and this needed to be aligned to the recovery plan and the LSTP. Currently it was difficult to quantify the impact of investments. In addition, there had been a fundamental change at the front door that needed to be quantified. A number of issues would need to be revisited post Covid-19. Up until recently, it had been clear there was a need for infrastructure and the Elective Centre would deliver that albeit at additional cost. In terms of debts being written off in England it was noted that a similar process had happened in Scotland. The impact on the Barnett consequentials in Scotland was unknown although Mr Ash suggested there would be none as the funds would have come out of Health Department budgets.

9.4. Dr Williams reported that a possible reason for the reduction in delayed discharges might be because people were working from home or not working and were therefore able to look after family members. There was a need to consider the impact as the system moved out of Covid-19 and to provide carers or consider making available care home places. He questioned whether this position had been quantified. Mrs Goldsmith updated on steps being taken in this and other areas. It was noted that there would be a need to look at data before decisions could be taken. It was noted that there would be similar impacts across the country. Dr Williams commented on the need to ensure Partnerships were properly funded.

9.5. The Board agreed the recommendations in the circulated paper.

**10. Corporate Risk Register**

10.1. Ms Gillies advised that the Covid-19 position had been rehearsed in detail elsewhere in the meeting. She reported that Covid-19 would have a significant impact on other corporate risks on the register the details of which were now dated given the current climate. Ms Gillies advised that it would take time to re-engage with risk holders to refresh the position and this would not happen at this point given the need to maintain focus on managing Covid-19.

10.2. The proposal was that Brexit should be removed from the register albeit it would remain subject to review at two checkpoints in the future. This would be used to look at any emerging issues like travel and workforce movement. It was recognised that many aspects of Brexit remained work in progress at national level.

10.3. Mr Ash commented that it would be useful to establish a process for reviewing the risk register when the system emerged from Covid-19 as at that point all

risks would need to be re-evaluated. He reminded the Board that the UK had left the European Union (EU) and there was a need to look at risks around issues like recruiting staff. He felt although Brexit might not be on the corporate risk register there would be merit in it remaining an issue for consideration in the governance committees.

10.4. Professor Whyte advised that it would be for the Health Care Governance Committee to look at Covid-19 as well as non Covid-19 issues in respect of patient care. She did not feel that Brexit remained a live risk given that the UK had now left the EU. Professor Whyte commented that without knowing the terms of future engagement post Covid-19 it would be difficult at this point to meaningfully update the remainder of the risk register.

10.5. The Board agreed the recommendations contained in the circulated paper and in particular the inclusion of Covid-19 as a high risk.

**11. Any Other Competent Business**

11.1. Communications from the NHS Board – Councillor Gordon raised the issue about communications from the Board as this currently looked relatively invisible to the general public. He questioned whether something was being put together that would allow the Board to be more vocal and supportive of staff and communities.

11.2. The Chair commented that a statement had been sent to staff but not to the general public. She advised she would issue a message on social media later in the day although she recognised this would only reach a limited audience. The Chief Executive and Ms Mackay would pick up the wider issue. It was recognised that it might be difficult to get much coverage in the current climate.

11.3. The Chief Executive commented that there had been a media strategy in place that had received positive feedback from TV and the national news print outlets. The Chief Executive advised he would ask Ms Mackay to issue details of recent issues.

11.4. The Chair confirmed that Councillor Gordon was referring to communication from the NHS Board in terms of a public face and getting information out to the public in terms of decision-making. The issuing of a press release would be discussed.

**12. Future Board Meetings**

12.1. Post Board it was agreed that for a variety of reasons the Board meeting would be postponed from 6 May 2020, and would be held on Wednesday 13 th May 2020 using Teams. The June meeting would also be held using Microsoft Teams. The position in respect of the format of the August Board Meeting would be discussed nearer the time.

Chair's Signature ……

Date ……

**Mrs Esther Roberton**
**Interim Chair – Lothian NHS Board**

**NHS LOTHIAN**

Board
13 May 2020

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 Extend Mike Ash's appointment as a member of the Audit & Risk Committee to 31 August 2020.

2.2 Extend Mike Ash's appointment as the Chair of the Audit & Risk Committee to 31 July 2020, and defer Martin Connor's appointment as Chair to 1 August 2020.

2.3 Appoint Angus McCann as the deputy for the Vice-Chair of Midlothian Integration Joint Board during its emergency recess period.

### 3 Discussion of Key Issues

Audit & Risk Committee

3.1 On 4 March 2020 the Board received a report which advised that the Chair of the Audit & Risk Committee, Mike Ash, would leave the Board on 31 July when his term of office ends. Additionally the report advised that Mike was not available to chair the meeting on 22 June, and that he would stand down as a member and chair of the committee on 31 May. The Board agreed to appoint Martin Connor (who is already a member of the Committee) as the committee chair with effect from 1 June 2020.

3.2 The Scottish Government will be extending Mike's term of appointment, and he is now available for the June meeting It is proposed that Mike remains a member of the Committee until 31 August and chairs the June meeting. Martin will become the chair of the Committee from 1 August. This will mean that Mike will chair the meeting which attends to the annual accounts, and is available to the Committee for its meeting on 24 August.

Midlothian Integration Joint Board

3.3 On 16 April 2020, the Midlothian Integration Joint Board agreed a 12-week period of

emergency recess, which it will formally review by the end of that period. The integration joint board agreed to ask the NHS Board and the local authority to nominate deputies for the Chair and Vice-Chair to approve business during the recess period, in the event that either is unavailable. Carolyn Hirst is the lead NHS Lothian member of the integration joint board and the Vice-Chair. Angus McCann is also a member of the integration joint board and is willing to be the deputy. The Board is recommended to appoint Angus McCann as the deputy for the Vice-Chair of Midlothian Integration Joint Board during its emergency recess period.

## 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
27 April 2020
alan.payne@nhslothian.scot.nhs.uk

**NHS Lothian**

Board Meeting
13 May 2020

Director of Finance, NHS Lothian

# SOUTH EAST OUTER GP PROVISION INITIAL AGREEMENT

## 1. Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the Initial Agreement for Edinburgh South East (Outer Area) GP capacity provision

1.2 NHS Lothian invited Edinburgh Health and Social Care Partnership (EHSCP) to submit an Initial Agreement for this proposal following the conclusion of the 2018/2019 NHS Lothian Capital Prioritisation Process.

1.3 Approval was given by Edinburgh Integration Joint Board on 22nd October 2019, by NHS Lothian Capital Investment Group on 15th April 2020 and by NHS Lothian Finance and Resources Committee on 22nd April 2020.

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

## 2 Recommendations

2.1 The Board is recommended to approve this Initial Agreement for submission to the Scottish Government Capital Investment Group (CIG) as required under the Scheme of Delegation, with the format and timing of the CIG submission to be delegated to the Director of Finance to agree. In parallel, EHSCP will continue to develop the business case.

## 3 Discussion of Key Issues

3.1 The South East Locality serves a population of c126k in two GP clusters. The Initial Agreement (IA) relates to the outer area of the South Cluster and the implications of the extensive housing developments in the area which directly impact on Ferniehill, Southern, Gracemount and Liberton Medical Practices. There is further effect on another three medical practices whose catchment areas overlap the above practices.

3.2 Ferniehill and Southern Medical Practices are located in practice owned premises which are functionally unsuitable for the sustainable delivery of primary care. Although it may be possible to improve and marginally expand the premises, the benefits are likely to be modest and cost prohibitive. Liberton Medical Group is also in practice owned premises and has recently benefitted from an extension with three consulting rooms.

3.3 Gracemount Medical Practice is located in NHS Leased purpose built premises and has agreed to expansion within its current footprint. It may be possible to further increase the internal clinical space.

3.4 As an interim measure to address the growth impact from the development sites, both Ferniehill and Southern practices have agreed to increase their list sizes by 500 each through 'LEGUP' investment and, at Ferniehill, a small capital scheme to create an additional consulting room. Braefoot Medical Practice, which is directly managed, has altered its practice boundary to include some of the Gilmerton development sites.

3.5 Whilst these measures are welcomed and provide some relief in the short term, the rate of population growth requires the major scheme proposed in the Initial Agreement to address longer term needs and offer sustainable delivery of primary care.

3.6 The project scope is limited to the provision of sufficient high quality clinical accommodation with adequate ancillary space to provide General Medical Services (GMS) to a population of 21,000 in order to meet the growth in the South East Outer area. The two GP practices have a combined list of 15,000 and housing developments are expected to generate a minimum of an additional 6,000 people in the Gilmerton area.

3.7 The schedule of accommodation, which equates to 1743sqm, also includes provision of space for Community Treatment and Care Services (CTAC) or a Mental Health Hub and some clinical space for Locality community services.

3.8 The original IA recommended that a shortlist of two options should be taken forward for further investigation when potential sites had been identified

Option 4 New build for both a new practice and re-provision of existing practices

Option 7 Refurbish available property for a new practice and re-provision

3.9 Since that time six potential sites have been identified within the boundaries of the practice catchment areas and considered for their suitability for the re-provision of GP services. An initial feasibility report was completed by South East Scotland Hub providing details of potential capacity, timescales and site considerations enabling the selection of a preferred option.

3.10 Although three sites were identified for refurbishment, none were in a geographically appropriate location and therefore Option 7 has been discounted.

3.11 A further three sites were identified as relevant to achieve Option 4

Option 4A Liberton High School, suitable for the replacement of Ferniehill and Southern Medical Practices. This would be part of a wider community hub project to replace the school and potentially other public sector services.

Option 4B Commercial site, Gilmerton Station Road – suitable for one practice

Option 4C Moredunvale, suitable for the replacement of Ferniehill and Southern Medical Practices

3.12 The preferred option to be taken forward to business case is a new build for two practices on one site (either Liberton High School or Moredunvale) with additional capacity for the new population.

3.13 There is the potential that the practices may prefer to retain their current list size and elect to remain in their existing premises. Consequently, the final version of the preferred option, 4B, will be the fit out of leased premises at a commercial site on Gilmerton Station Road for a new practice with sufficient capacity to accommodate all the new population.

3.14 This would leave both existing practices in poor accommodation, however it should be noted that consideration to re-provide the existing practices without any significant increased capacity on one site combined with a new practice on another site would not represent an economic option.

3.15 As the upper end of the estimated cost of the preferred option are in excess of the Board's £10m capital delegated limit, the IA should be considered by the Scottish Government Capital Investment Group (CIG). This also aligns with the approved approach to focus the Board's Formula capital funding on the existing estate, with investments in 'growth' to be submitted to the Scottish Government for funding. The format and timing of this submission may become part of a programme approach to Primary Care provision, and should be delegated to the Director of Finance to agree with CIG.

3.16 In parallel with this approval process, and recognising timescales around service provision, EHSCP will continue to develop the business case.

## 4. Key Risks

4.1 The earlier completion date and increase in housing units on nearby sites adds significant pressure to existing practices which are already unable to manage the increasing population within their current premises.

4.2 Failure to reach agreement with GPs on relocation or increase in practice list size.

4.3 Additional local population unable to register with a GP resulting in increased assignments and greater presentations through emergency provision.

4.4 Site loss due to delay in reaching agreements either with City of Edinburgh Council or the commercial landlord.

## 5 Risk Register

5.1 The constraints of inadequate GP premises are an identified list in EHSCP's section of NHS Lothian's Risk Register.

## 6. Impact on Inequality, Including Health Inequalities

6.1 The project will allow local people to be registered and cared for in accommodation which is functionally suitable and accessible for people with impaired mobility and other disabilities.

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

7.1 Whilst there has been initial engagement through the Neighbourhood Partnership, meaningful engagement with the general public, patients and service users is envisaged at the stage when there are a range of potential options offering realistic solutions. The location and accessibility of any design solution will be key to addressing local need and developing this engagement. The EHSCP Patient Involvement Worker will support engagement with patients.

## 8. Resource Implications

8.1 The resource implications are a capital investment of c£10million (including VAT) at 2019 prices from NHS Lothian for either Option 4A or 4C. As NHS Lothian's delegated limit is £10million, the proposal will require submission to the Scottish Government Capital Investment Group. Should agreement on options 4A or 4C not be reached, then option 4B would be recommended.

8.2 Provisions have been made in the capital costs to provide accommodation for EHSCP staff in line with the new GP contract; however no revenue associated costs have been identified and included at this time. Additional EHSCP staffing will be funded by the Primary Care Investment fund.

8.3 Funding has been identified for the additional revenue costs from the existing NHSL depreciated budget. There remains a funding gap in relation to facilities costs of £113k per annum. Further work is required as part of the Standard Business Case to identify a funding source.

8.4 Practice related revenue costs have not been included in revenue costs as these will be funded via GMS income. However it is acknowledged that there will be an increase in these revenue costs due to the creation of a new practice. Further work will be done at SBC stage to assess these costs.

Fiona Cowan
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27 April 2020
Fiona.cowan@nhslothian.scot.nhs.uk

**List of Appendices**

Appendix 1: South East Outer GP Provision Initial Agreement

# South East Outer GP Provision

## NHS Lothian

## Initial Agreement

Project Owner: Fiona Cowan

Project Sponsor: David White

Date: 27/04/2020

Version: 4.8

## Version History

| Version | Date | Author(s) | Comments |
|---|---|---|---|
| 1 | 09/05/2019 | Maggie Gray | First Draft |
| 1.1 | 21/05/2019 | Laura Smith | Update template |
| 1.2 | 20/06/2019 | Maggie Gray<br>Fiona Cowan | Update template |
| 1.3 | 04/07/2019 | Maggie Gray<br>Fiona Cowan | Update template |
| 1.4 | 26/07/2019 | Fiona Cowan | Strategic and Economic Case update |
| 1.5 | 06/08/2019 | Laura Smith | IA update for review, addition of Appendices |
| 1.6 | 16/08/2019 | Fiona Cowan | IA update for review |
| 2 | 29/08/2019 | Fiona Cowan | IA update for review by Project Group |
| 2.1 | 03/09/2019 | Fiona Cowan | IA update for review |
| 2.2 | 06/09/2019 | Fiona Cowan | IA update for review |
| 2.3 | 13/09/2019 | Laura Smith | Updated Economic and Financial Case |
| 3 | 19/09/2019 | Maggie Gray | Final review |
| 3.1 | 26/09/2019 | Laura Smith | Updated for EIJB submission |
| 3.2 | 30/09/2019 | Fiona Cowan | Final review for EIJB submission |
| 3.3 | 03/10/2019 | Maggie Gray | Updated appendices for EIJB submission |
| 4.0 | 10/02/2020 | Fiona Cowan | IA update for review |
| 4.1 | 20/02/2020 | Fiona Cowan | IA update for review |
| 4.2 | 04/03/2020 | Fiona Cowan | IA update for review |
| 4.3 | 09/03/2020 | Fiona Cowan | IA update for review |
| 4.4 | 11/03/2020 | Fiona Cowan | IA update for review |
| 4.5 | 11/03/2020 | Fiona Cowan | IA Update for review |
| 4.6 | 12/03/2020 | Fiona Cowan | IA update for review |
| 4.7 | 16/04/2020 | Fiona Cowan | Updated for F&R submission |
| 4.8 | 27/04/2020 | Fiona Cowan | Updated for NHSL Board submission |

## Contents

# 1 Executive Summary

## 1.1 Purpose

1.1.1 The purpose of the Initial Agreement is to seek approval for the proposal to address GP capacity planning in the South East Outer area of the South East Locality. The extensive housing developments under construction in the area will generate at least an additional 6,000 people who will require provision of General Medical Services (GMS) which existing practices will be unable to provide from their current premises.

1.1.2 The proposal is to develop sufficient accommodation to deliver the additional capacity required together with re-provision of premises for the two existing practices most impacted by these new developments.

## 1.2 Background and Strategic Context

1.2.1 The South East Locality serves a population of c126k and has two GP clusters. The Initial Agreement (IA) relates to the outer area of the South Cluster within the locality and the implications of the extensive housing developments in the area which directly impact on Ferniehill, Southern, Gracemount and Liberton Medical Practices. There is further effect on another three medical practices whose catchment areas overlap those of the above practices.

1.2.2 Ferniehill and Southern Medical Practices are located in practice owned premises which are functionally unsuitable for sustainable delivery of primary care and although it may be possible to extend the premises, the benefits are likely to be modest and cost prohibitive. Liberton Medical Group is also in practice owned premises and has recently benefitted from an extension of three clinical rooms.

1.2.3 Gracemount Medical Practice is located in NHS Leased purpose built premises and has agreed to expansion within its current footprint. It may also be possible to further increase the internal physical space if required.

1.2.4 Between 33% and 54% of the patient population of the above practices are within the most deprived quintile.

1.2.5 The extent of the planned new housing is such that the existing arrangements are insufficient to address the capacity required to ensure that all the new population will be able to access General Medical Services (GMS).

1.2.6 Additionally, the introduction of the new GMS Contract (Scotland) 2018 required the provision of alternative delivery of certain services to enable implementation of the contract. The changes such as Mental Health Hubs and Community Treatment and Care Services (CTACs) will impact on the accommodation requirements to support the current and future population of the area.

## 1.3 Need for Change

1.3.1 The population of Edinburgh has increased by some 65,000 people over the last 10 years and will continue to grow at a rate of c5,000 per annum till at least 2026.This trend is expected to continue further in the next Local Development Plan. Much of the additional population has been absorbed by existing primary care provision.

1.3.2 The South East Outer Area comprises a significant area of green belt release where extensive housing is programmed and already underway with a considerable number of houses already occupied.

1.3.3 The Integration Joint Board previously approved the Edinburgh Health and Social Care Partnership (EHSCP) Population Growth and Primary Care Premises Assessment 2016 – 2026 and the subsequent high prioritisation of this area need through the NHS Lothian Capital Prioritisation Programme. The Strategic Assessment (SA) identified the need for change since existing practices are unable to provide GMS to the current population let alone the significant additional population to be generated by the new housing.

1.3.4 Two practices are accommodated in functionally unsuitable premises which are practice owned and therefore a risk for long term provision given their restrained functionality and potential uncertainty over tenure.

1.3.5 The need to address the population growth and the re-provision of existing practices offers an opportunity for co-location in a joint development which will also account for the accommodation required to support delivery of the new contract, such as Community Care and Treatment Services or a Mental Health Hub.

1.3.6 South East Locality has limited resilience where premises are required in the event of an emergency due to existing pressure on accommodation. Space within a CTAC would provide an option should such a situation arise.

## 1.4 Investment Objectives

1.4.1 The investment objectives the project seeks to achieve are:

- To improve service capacity
- To improve service access and provide sufficient accommodation
- To improve service performance and configuration
- To enable delivery of the Primary Care Improvement Plan
- To improve functional suitability for the healthcare estate

## 1.5 The Preferred Option(s)

1.5.2 The preferred option to be taken forward to business case is for a new build for two practices on one site together with a fit out of leased premises for a new practice on a commercial site identified at Gilmerton Station Road.

## 1.6 Readiness to proceed

1.6.1 The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that HubCo will be the likeliest option.

1.6.2 The total indicative costs for the preferred option at this stage range from £2.8m to £10.2m including VAT. It is anticipated that the procurement of the project will be led by NHS Lothian supported by Edinburgh Health and Social Care Partnership where required.

1.6.3 A benefits register has been included in Appendix 3 with a high level risk register to be completed and included when submitted to the Lothian Capital Investment Group (LCIG).

1.6.4 Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

1.6.5 NHS Lothian and Edinburgh Health and Social Care Partnership are ready to proceed with this proposal. Section 6.3 details the project management arrangements. Section 6.2 outlines the governance support and reporting structure for the proposal.

1.6.6 Engagement with stakeholders is outlined in the Economic Case. Members of the Project Management Group have been involved in its developments to date and will continue to support it.

## 1.7 Conclusion

1.7.1 The need for development in the South East area was first raised in the Edinburgh Health and Social Care Partnership Population and Premises report 2014. This reported on the Housing and Land Audit 2014 which showed significant planned housing development in the South East area, and has long been an area of concern.

1.7.2 The strategic assessment for this proposal (included in Appendix 1) scored 17.25 out of a possible maximum score of 25. However this was re-scored by NHS LCIG Moderation Group to 18.55 matching that to similar proposals throughout NHS Lothian.

1.7.2 The proposal has been prioritised by the relevant governance groups and the Prioritisation Projects Update from LCIG in May 2019 identified it as one of the number one priorities for NHS Lothian and Edinburgh Health and Social Care Partnership.

# 2 The Strategic Case

## 2.1 Existing Arrangements

2.1.1 The South East Locality serves a population of circa 126,000 and has two GP Clusters. The Initial Agreement (IA) relates to the outer area of the South Cluster within the locality and the implications of the extensive housing developments in the area, much of it on green belt land which directly impacts on the following practices:

-Ferniehill
-Southern
-Gracemount
-Liberton

The practice catchment areas are attached as **Appendix 2a**

2.1.2 Additionally there is an impact on three other practices whose catchment areas partially overlap or about those of the above practices:

Inchpark
Braefoot
Dr Ferguson & Partners } Based in Conan Doyle Medical Centre

The practice catchment areas are attached as **Appendix 2b**

2.1.3 **Ferniehill Surgery** (list size 6,500)
Independent contractor located in practice owned premises which are functionally unsuitable for sustainable delivery of primary care. The premises comprise a converted and extended c1930s building in a residential area with limited opportunity for further conversion and increased capacity; although a further extension may be possible, the investment required would outweigh the potential benefits and would not address the other constraints of the present accommodation. A small scheme has been delivered in 2019, together with a Legup grant, to create additional consulting space and enable some modest growth of 500 patients to mitigate the early impacts from the housing developments.
The practice is in closest proximity to the areas of intensive housing developments at Gilmerton described in detail later in the IA, most of which fall within its catchment area. The practice list is managing registrations at c25 per week and 46% of the practice population is in the most deprived quintile.

2.1.4 **Southern Medical Group** (list size 7,306)
Independent contractor located in practice owned premises which are functionally unsuitable for sustainable delivery of primary care. The premises comprise a detached house which has had a couple of extensions. Whilst it may be possible to further extend the building into the back garden, the costs associated with this option

make it prohibitive and it would not address patient flow within the building. The practice has agreed to increase its list size by 500 supported by a Legup grant. The practice is within a mile and a half of the most extensive development sites at Gilmerton, located on the main road. 37% of the practice population is in the most deprived quintile.

2.1.5 **Gracemount Medical Practice** (list size 7,700)
Independent contractor located in NHS leased purpose built premises, Gracemount Medical Centre, which also accommodates community services teams. The practice has agreed to further expansion of c1,000 which would be possible within its current footprint. There is also the opportunity to review services located in the centre and further increase internal physical space if required. 54% of the practice population is in the most deprived quintile. The practice is located within half a mile of the development sites at Broomhills and Burdiehouse, and is restricting its list.

2.1.6 **Liberton Medical Group (list size 7,128)**
Independent contractor located in practice owned purpose built accommodation. The practice benefitted in 2016 from an extension of three clinical rooms, funded by a capital grant from NHS Lothian, to address population growth pressures from a new housing development of 300 houses directly across the road from the practice. The practice is within a mile of the Broomhills and Burdiehouse developments, as well as adjacent to the development referenced above. The practice has recently received a Legup grant to support the increased growth. A third of the patients are in the most deprived quintile, with the majority of patients in the age range 25-64

2.1.7 Whilst the other three practices referenced in 2.1.2 are not in immediate proximity to the housing developments, their practice list sizes are pressurised by the knock-on effect of the population from the new housing and, in some cases, overlap of catchment areas. Inchpark is currently restricted to registering 10 patients per week.

2.1.8 Braefoot Surgery (formerly Southside) was moved from practice owned premises in 2017 to NHS Lothian leased premises in Conan Doyle Medical Centre, co-locating with the Dr Ferguson and Partners practice in this purpose built building. Braefoot Surgery has capacity to grow, and the practice boundary is being extended further south to include the housing development sites which will support the practices most under pressure from the new housing.

2.1.9 The extent of the planned new housing is such that the existing arrangements are insufficient to address the capacity required to ensure that all the new population will be able to access General Medical Services (GMS).

2.1.10 Additionally, the introduction of the new GMS Contract (Scotland) April 2018 requires boards to provide alternative delivery of certain services to enable implementation of the contract. These changes, such as Mental Health Hubs and Community Treatment and Care Services (CTACs), will impact on the accommodation requirements to support the current and future population of the area.

## 2.2 Drivers for Change

2.2.1 The population of Edinburgh has increased by some 65,000 people over the last ten years and will continue to grow at a rate of c 5,000 per annum till at least 2026. This trend is expected to continue with the subsequent implementation of City Plan 2030 which will ultimately supersede the current development plan. Most of the growth has been absorbed into existing primary care provision.

2.2.2 City of Edinburgh (CEC) Local Development Plan 2016-2026 details the planned housing developments across the city. The South East Outer Area comprises a significant area of green belt release within the plan where extensive housing is programmed and already underway, with a considerable number of houses already occupied.

2.2.3 Although the house building programming extends over several years, the Housing Land Audit (HLA) 2019 details the expected completions rate of circa 200 houses per annum in the Gilmerton area. If developers are confident of house sales, that rate can be increased.

The known planned developments are illustrated in **Table 1** below:

**Table 1: Planned Developments**

The table below, covering the period 2019 – 2026 and the longer term, is a snapshot of the City of Edinburgh Council Housing Land Audit (HLA) 2019 (provisional), showing housing sites that are under construction, sites with planning consent, sites in the Local Development Plan and constrained sites which have not yet been programmed.

| Area | Number of housing units | Population* |
|---|---|---|
| Anticipated increase in population which cannot be accommodated within existing GMS facilities and which therefore requires additional provision | | |
| Gilmerton | 1047 | 2199 |
| Lasswade Road | 636 | 1336 |
| Moredunvale | 200 | 420 |
| Edmonstone | 806 | 1693 |
| | **2689** | **5648** |
| | | |
| Increase in population anticipated to be absorbed between Gracemount Medical Practice and Liberton Medical Group | | |
| Broomhills | 549 | 1153 |
| Burdiehouse | 210 | 441 |
| Liberton | 298 | 626 |
| | **1057** | **2220** |

* Population projections have been calculated by multiplying the planned number of units to be built by the average household size for Edinburgh, source National Records Scotland (NRS). The average household size of 2.1 has been used in these calculations, although it is expected to decrease over time. Given the predominance

of family housing to be built within all developments, it is likely that the population figure could be significantly higher and the numbers illustrated are the **minimum**.

The planned development sites, HLA 2019, with indicative **minimum** population numbers and housing completion dates are illustrated on the map at **Appendix 7**

2.2.4 In addition to the above, there are a number of other sites which will be developed for housing in due course, including the Liberton Hospital site (quantity of houses unknown) and Ellen's Glen site (240 dwelling places), when their current use comes to an end.

2.2.5 City Plan 2030 may release more sites within the South East boundaries enabling further expansion of housing developments however details of the content of the plan will not be available until Autumn 2022.

2.2.5 The Integration Joint Board previously approved the EHSCP Population Growth and Primary Care Premises Assessment 2016-2026, and the subsequent high prioritisation of this area need through the NHS Lothian Capital Prioritisation Programme which invited the submission of the Initial Agreement.

2.2.6 The Strategic Assessment (SA) identified the need for change that existing practices, due to a mixture of limitations of workforce and physical capacity, are unable to provide GMS to the current population let alone the significant additional population generated by the new housing.

2.2.7 The Ferniehill and Southern practices are in accommodation which is functionally unsuitable for sustainable delivery of primary care. These premises are practice owned and are a risk for long term provision given their constrained functionality and potential uncertainty over tenure.

2.2.8 Primary care workforce provision nationally has been challenging of late, and the ability of practices to recruit is often impacted by their premises ownership and condition. Whilst much of this is addressed through the terms of the new GMS Contract 2018, difficulties remain for practices with premises implications.

2.2.9 The need to address the population growth and the re-provision of existing practices offers an opportunity for co-location in a joint development which will also account for the accommodation required to support delivery of the new contract, such as Community Treatment and Care Services (CTACs) or a Mental Health Hub.

2.2.10 CTACs, which form part of the Primary Care Improvement Plan, are being developed within Edinburgh according to the needs of the locality. Whilst these are primarily comprised of clinical space, it is likely that administrative accommodation will be required as investment progresses and there is a significant increase in staffing within localities.

2.2.10 Developments and accommodation requirements within the South East Locality are such that all conceivable administrative and clinical space has been utilised, leaving no resilience should there be an urgent need for temporary or permanent accommodation. The provision of CTAC space will allow resilience capacity to be developed providing stability for services within this area

Table 2 below summarises the need for change, the impact it is having on present service delivery and why this needs action is required now:

**Table 2: Summary of the Need for Change**

| Cause of the need for change | Effect is it having, or likely to have, on the organisation | Why action now |
|---|---|---|
| Current service demand exceeds available capacity | Existing practices are unable to provide GMS to current population and future population | Service is under strain as evidenced by restricted lists and inability of practices to increase capacity to address this |
| Some practices are operating from premises which prevent them responding to changing service needs | Existing premises restrict the ability of practices to increase capacity and meet the needs for service provision | Practices are unable to respond to demand and increase capacity due to the limitations of their premises |
| Known future service demand will increase significantly with planned house building on green belt and windfall sites | Existing service arrangements unable to cope with future projected levels of population growth and address current high levels of deprivation | City of Edinburgh Council Local Development Plan details the housing developments programmed for the area with 4,000 additional population expected over the next 5 years and a further c3,000 thereafter |
| Implementation of the new GMS Contract Scotland | Transformation of primary care services to meet the requirements of the new GMS contract with the development of Community Treatment and Care Services (CTACs) and Mental Health Hubs for existing and new population | New GMS contract came into effect on 1st April 2018, with time limited implementation for delivery of the Primary Care Improvement Plan to deliver the contract requirements |
| Accommodation with high levels of unsatisfactory physical condition | Practices are operating from premises which are neither functionally suitable nor sustainable | Building condition, performance and associated risks will continue to deteriorate if action isn't taken now |
| Long term tenure of GP owned premises | GPs could sell premises creating instability for provision of GMS | Opportunity to create long term sustainable premises for service delivery |

## 2.3 Investment Objectives

2.3.1 The assessments of the existing situation and the drivers for change have been used to identify what has to be achieved to deliver the changes required. These are defined as the investment objectives and are summarised in the table below:

**Table 3: Investment Objectives**

| | Effect of the need for change on the organisation | What has to be achieved to deliver the necessary change? (Investment Objectives) |
|---|---|---|
| 1 | Existing practices are unable to provide GMS to current population and future population | Improve service capacity to enable everyone to access GMS |
| 2 | Existing GP premises restrict the ability of the practices to increase capacity and meet the demands of service provision | Improve service access and provide sufficient clinical accommodation to meet service needs |
| 3 | Existing service arrangements unable to cope with future projected levels of population growth and address current high levels of need in an area of significant deprivation | Improve service performance and configuration to respond to increased demands of known significant population growth and existing deprivation needs, and ensure easy accessibility |
| 4 | Transformation of primary care services to meet the requirements of the new GMS contract | Enable delivery of the Primary Care Improvement Plan as required for implementation of the new GMS contract |
| 5 | Practices are operating from premises which are neither functionally suitable nor sustainable | Improve functional suitability of the healthcare estate and address long term future needs and tenure |

## 2.4 Benefits

2.4.1 A Strategic Assessment (SA) was completed identifying the need for change, benefits of addressing these needs and their link to the Scottish Government (SG) five Strategic Investment Priorities below:

- Safe
- Person-Centred
- Effective Quality of Care
- Health of Population
- Value and Sustainability

2.4.2 The above investment objectives and the Strategic Assessment, Appendix 1 have informed the development of a draft Benefits Register, Appendix 3. As per the draft Scottish Capital Investment Manual guidance on `Benefits Realisation`, this initial register is intended to record all the main benefits of the proposal. A full Benefits Realisation Plan will be developed at OBC stage.

2.4.3 A summary of the key benefits to be gained from the proposal are described below:

- Ensure everyone is able to register with a GP by increasing capacity
- Increase in the services and clinical accommodation provided within the community
- Ensure that people who use health and social care services have positive experiences and their dignity respected
- Reduce the rate of attendance at A&E
- Provide safe and easy access to GP services; premises are DDA compliant
- Improve the functional suitability of the healthcare estate
- Improve sustainability and efficient use of resources

## 2.5 Strategic Risks

2.5.1 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:

**Table 4: Strategic Risks**

| Theme | Risk | Safeguard |
|---|---|---|
| Business | Failure to acquire suitable site or premises for development | Site search in progress<br>Work with partners to identify opportunities |
| | Premises costs are unacceptable to the practices | Provide high level indicative costs to practices prior to business case submission |
| | Proposed development not well received by patients and public | Clear communication and engagement plan |

| | | |
|---|---|---|
| Scope | Scope of the project exceeds deliverability | Clarity on scope and reduction of scope |
| Funding | Capital or revenue funding to deliver the project is unaffordable | Optimise resource usage<br>Value engineering<br>Cost certainty for business case |
| Workforce | Insufficient workforce to meet the required capacity provision | Joint working by EHSCP and practices to facilitate required recruitment |
| External | Earlier impact and timing than projected of population growth | Monitor growth and work with practices to address interim measures |

A register of strategic risks will be included in the submission to the Lothian Capital Investment Group. A full risk register will be developed for the project at the business case stage.

## 2.6 Constraints and Dependencies

2.6.1 The key constraints to be considered are:

- Availability of either capital or revenue funding may limit the ability to deliver the preferred solution

2.6.2 The key dependencies to be considered are:

- Availability of suitable sites or alternative premises to deliver a timely solution
- Agreement with practices to terms of re-provision;
- Agreement with practices to capacity increase to address growth.

# 3 Economic Case

## 3.1 Do nothing/baseline

3.1.1 It is not feasible to continue with the existing arrangements ('Do Nothing') as it does not address any of the strategic drivers for change and has the potential to cause existing practice instability. A 'Do Minimum' option is therefore included as the baseline (as required by Scottish Capital Investment Manual guidelines) against which other options are assessed, however this will only address the strategic drivers in part and will result in capacity constraints which fail to provide for the population growth. The table below defines the 'Do Minimum' option including the requirements to implement this option.

**Table 5: Do Minimum**

| Strategic Scope of Option 2 - Do Minimum | |
|---|---|
| Service provision | Continue with existing |
| Service arrangements | Existing GP practices with support for some capacity increase if possible |
| Service provider and workforce arrangements | Existing GMS provision – will require additional workforce to address any increase |
| Supporting assets | Limited physical alteration to premises to increase capacity if feasible |
| Public & service user expectations | Public and service users will expect full access to GMS, and require the ability to register with a GP in the local area |

## 3.2 Engagement with Stakeholders

3.2.1 The table below summarises the stakeholders impacted by this proposal and the details of the engagement that has taken place with them to date and notes their support for this proposal.

**Table 6: Engagement with Stakeholders**

| Stakeholder Group | Engagement that has taken place | Confirmed support for the proposal |
|---|---|---|
| General public | Initial engagement has been through the Liberton Gilmerton Neighbourhood Partnership | Presentation to Neighbourhood Partnership. Further engagement will be developed as project progresses |
| Key stakeholders and partners :<br>Fernhiell Surgery<br>Southern Medical Group<br>Gracemount Medical Practice<br>Liberton Medical Group | Discussions have taken place with each of the practices to ascertain their intentions. | Support confirmed |

3.2.1 Whilst there has been initial engagement through the Neighbourhood Partnership, meaningful engagement with the general public, patients and service users can only occur once there are a range of potential options offering realistic solutions. The location and accessibility of any design solution will be key to addressing local need and developing this engagement. The EHSCP Patient Involvement Worker will support engagement with patients.

3.2.3 Staff who are affected are primarily those of the practices identified above and those practices will engage with their own staff as the project progresses.

## 3.3 Long-listed Options

3.3.1 The strategic scope of each option – that is the service provision, arrangements, provider and workforce – is the same for each option, namely GMS provision delivered by the independent contractor model.

3.3.2 It should be noted that the key outcome that this project seeks to achieve is to ensure that sufficient capacity is provided to accommodate the planned growth. Consideration has been given to the development of a new GP practice, meaning a new partnership or managed service to deliver the additional GMS required. This will be dependent on whether additional capacity to address the local growth can be accommodated by existing practices if they are in new premises, or not.

3.3.3 The need to provide additional capacity must also recognise the business models of existing practices who may not wish to increase their practice population by the quantity generated by the housing developments. In short whilst it may be relatively straightforward to address the physical capacity to meet demand, how the GMS is delivered by existing practices will dictate whether new practice provision is also required within the same physical footprint.

3.3.4 The eight options identified are detailed in **Appendix 5**, and are outlined below:

**Option 2: Do Minimum**
Minor refurbishment in existing practices to increase capacity to accommodate some of the increased population due to the housing expansion

**Option 3: New build for a new practice**
Identify a new site within the catchment area of Ferniehill and Southern Medical Practice to create a new practice with the capacity to accommodate only the increased population from the housing expansion

**Option 4: New build for a new practice and re-provision**
As option 3 but with the opportunity to provide accommodation for a new practice and Ferniehill and Southern Medical practices which will also accommodate increased GMS demand from the housing expansion.

**Option 5: New build re-provision only**
Identify a new site within the catchment area to re-provide premises for the existing practices but without providing any additional capacity for demand from the housing expansion.

**Option 6 Refurbish available property for a new practice**
Source and upgrade available premises to accommodate a new practice to provide capacity for the increased population

**Option 7: Refurbish available property for a new practice and re-provision**
Source and upgrade available premises to accommodate the current practices in combination with space for a further practice to provide capacity for the additional demand.

**Option 8: Refurbish available property re-provision only**
Source and upgrade available property to provide more functionally suitable premises for the delivery of primary care services.

3.3.5 The following options were not taken forward for assessment as detailed below:

Option 1: Do nothing

Do Nothing was discounted as it does not address the Investment Objectives; do minimum is retained as required by SCIM for comparison, however it is recognised that even doing minimum does not address the scale of the problem. The minor works in 'do minimum' to increase capacity by a modest amount have already been completed

## 3.4 Initial Assessment of Options

3.4.1 Each of the long- listed options have been assessed for their advantages and disadvantages, and the extent to which they meet the investment objectives (as outlined in the Strategic Case) to identify the preferred solution(s).

**Table 7: Assessment of options against investment objectives**

| | Option 2: Do Minimum | Option 3: New build for a new practice only | Option 4: New build for a new practice and re-provide existing practices | Option 5 : New build for re-provision only |
|---|---|---|---|---|
| **Advantages (Strengths & Opportunities)** | Invest in existing practices and premises to increase capacity | Potentially addresses capacity and access needs<br><br>Complements existing practice provision<br><br>Functionally suitable premises | Addresses capacity and access needs<br><br>Functionally suitable premises<br><br>Long term provision /sustainability of existing practices | Functionally suitable premises<br><br>Sustainable, long term needs of existing practices |
| **Disadvantages (Weaknesses & Threats)** | Will not address all strategic drivers; part solution only with limited impact<br><br>Capacity constrained | Challenges /time implications of setting up new practice/management support onerous<br><br>Significant revenue implications until practice stable<br><br>High risk of failure<br><br>Does not address re-provision of existing practices<br><br>Site availability | Challenges /time implications of setting up new practice/management support onerous<br><br>Significant revenue implications until practice stable<br><br>High risk of failure<br><br>Site availability | Practices willingness to re-locate<br><br>Insufficient capacity to address population growth<br><br>Site availability |
| **Does it meet the Investment Objectives (Fully, Partially, No, n/a):** | | | | |
| Investment Objective 1 | No | Fully | Fully | No |
| Investment Objective 2 | No | Partially | Fully | No |
| Investment Objective 3 | No | Fully | Fully | No |
| Investment Objective 4 | Partly | Partially | Fully | No |
| Investment Objective 5 | Partly | No | Fully | Fully |

| | Option 2: Do Minimum | Option 3: New build for a new practice only | Option 4: New build for a new practice and re-provide existing practices | Option 5 : New build for re-provision only |
|---|---|---|---|---|
| **Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)** | | | | |
| Affordability | Yes | Unknown | Unknown | Unknown |
| **Preferred/Possible/ Rejected** | Rejected | Rejected | Possible | Rejected |

| | Option 6 Refurbish available property for a new practice | Option 7 Refurbish available property for a new practice and re-provision of existing practices | Option 8 Refurbish available property, re-provision of existing practices only |
|---|---|---|---|
| **Advantages (Strengths & Opportunities)** | Potentially addresses capacity and access needs<br><br>Complements existing practice provision<br><br>Functionally suitable premises | Addresses capacity and access needs<br><br>Functionally suitable premises<br><br>Long term provision /sustainability of existing practices | Functionally suitable premises<br><br>Sustainable, long term needs of existing practices |
| **Disadvantages (Weaknesses & Threats)** | Practices willingness to re-locate<br><br>Does not address re-provision of existing practices<br><br>Property availability and tenure | Practices willingness to re-locate<br><br>Property availability and tenure | Practices willingness to re-locate<br><br>Insufficient capacity to address population growth<br><br>Property availability and tenure |
| **Does it meet the Investment Objectives (Fully, Partially, No, n/a):** | | | |
| Investment Objective 1 | No | Fully | No |
| Investment Objective 2 | No | Fully | No |
| Investment Objective 3 | No | Fully | No |
| Investment Objective 4 | No | Fully | No |
| Investment Objective 5 | Fully | Fully | Fully |
| **Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)** | | | |
| Affordability | Unknown | Unknown | Unknown |
| **Preferred/Possible/ Rejected** | Rejected | Possible | Rejected |

Those options that have been rejected above have been done so on their inability to deliver the identified benefits and investment criteria.

## 3.5 Short-listed Options and Preferred Way Forward

3.5.1 The table below identifies the short-listed options for this **project**

**Table 8: Short Listed Options**

| Option | Description |
|---|---|
| Option 2 | Do Minimum |
| Option 4 | New build for new practice and re-provision of existing practices |
| Option 7 | Refurbish available property for new practice/re-provision of existing practices |

3.5.2 Six potential sites have been identified within the boundaries of the practice catchment areas and considered for their suitability for the re-provision of GP services. An initial feasibility report was completed by South East Scotland Hub providing details of potential capacity, timescales and site considerations enabling the selection of a preferred option.

3.5.3 The table below summarises the potential sites which have been identified within the practice catchment areas.

| Site option | Short description |
|---|---|
| Liberton Hospital | Liberton Hospital is due for closure in 2020. A section of the hospital would be suitable for refurbishment for any or all practices |
| Liberton High School | Liberton High School is due to be replaced although timescales are not clear at present. Early discussions with CEC have indicated a willingness to make land available for up to 2 GP practices, as part of a wider community hub project to replace the school and potentially other public sector services |
| Commercial site, Gilmerton Station Road | A commercial site lying within the main housing developments with planning approval for medical provision, currently identified for one practice, though developer likely to support additional space if required |
| Moredunvale<br>CEC owned land | Land around Moredunvale is due to be developed for housing with the potential for up to three practices incorporated into the site |
| Gilmerton Community Centre | Gilmerton Community Centre is part of CEC service design considerations for 2020/21. Refurbishment of this building would provide space for one practice |
| Gilmerton Dykes Street | As part of CEC service design, there is a proposal to |

| | |
|---|---|
| *CEC owned* | develop land at this site for housing with provision for a single GP practice on the ground floor |

3.5.3 Each option was scored to reflect the impact on each of the practices individually, avoiding the need to average scores resulting in non-representative outcomes and providing an opportunity to determine the preferred options for each practice. A summary of the results of this are shown in the table below while the full outcome is included in Appendix 8.

**Table 8a: Site Assessment**

| Option | Practice 1 | Ranking | Practice 2 | Ranking |
|---|---|---|---|---|
| **Do minimum** | 490 | 6th | 490 | 6th |
| **Liberton Hospital** | 520 | 5th | 490 | 6th |
| **Liberton High School** | 840 | 1st | 660 | 3rd |
| **Commercial Site, Gilmerton Stn Road** | 660 | 3rd | 780 | 2nd |
| **Moredunvale** | 790 | 2nd | 820 | 1st |
| **Gilmerton Community Centre** | 460 | 7th | 610 | 5th |
| **Gilmerton Dykes Street** | 540 | 4th | 630 | 4th |

3.5.4 The following options are not being taken forward for consideration:

- Liberton Hospital – location is considered unsuitable for the density of either practice population. In the meantime until the future planning of the site is confirmed, a space for Primary Care provision will be maintained.
- Gilmerton Community Centre – this option was considered to offer less opportunities in terms of accessibility, quality of environment and long term viability
- Gilmerton Dykes Street – although this option ranked higher for both practices than Liberton hospital or Gilmerton Community Centre, there is capacity for only one practice and no opportunity for future expansion. This would result in a three location option to meet both the existing and new population requirements and is therefore not considered a feasible option.

3.5.5 Three sites were identified as suitable to achieve Option 4 and were shortlisted for further consideration

**Option 4A** Liberton High School, suitable for the replacement of Ferniehill and Southern Medical Practices as part of a wider community hub project

**Option 4B** Commercial site, Gilmerton Station Road – suitable for one practice

**Option 4C** Moredunvale, suitable for the replacement of Ferniehill and Southern Medical Practices

3.5.6 Due to the exclusion of sites as detailed above, there are not sites available which would present the option to refurbish an existing property. Therefore, option 7 has not been explored further.

## 3.6 Non financial benefits assessment

3.6.1 Each of the identified benefits was weighted and the shortlisted options were scored against its ability to deliver the required benefits. The results of the benefits assessment are summarised below:

**Table 9: Results of Non-Financial Benefits Assessment**

| | Weighting % | Option 1 Do minimum | Option 4A 2 practices at Liberton High School | | Option 4B Commercial Site | | Option 4C 2 practices at Moredunvale | |
|---|---|---|---|---|---|---|---|---|
| | | Score | Score | | Score | | Score | |
| | | Both Practices | S | F | S | F | S | F |
| Clinical effectiveness and service improvement | 20 | 4 | 9 | 9 | 9 | 9 | 9 | 9 |
| Accessibility | 30 | 7 | 8 | 2 | 1 | 5 | 6 | 7 |
| Quality of physical environment | 20 | 5 | 9 | 9 | 9 | 9 | 9 | 9 |
| Sustainability | 20 | 1 | 9 | 9 | 10 | 10 | 9 | 9 |
| Deliverability | 10 | 8 | 6 | 6 | 7 | 7 | 7 | 7 |
| Total weighted benefit points | | 490 | 840 | 660 | 660 | 780 | 790 | 820 |

## 3.7 Indicative Costs

3.7.1 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 Section 5 – Financial Case.

3.7.2 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.
- A useful life of 50 years has been determined for the projects.
- Phasing of the costs reflects the useful life and the programme of works as identified in Section 4.2 – Timetable.

**Table 10: Indicative Costs of Shortlisted Options**

| Cost (£m) | Option 1 Do Minimum | Option 4A 2 practices at Liberton High School | Option 4B Commercial Site | Option 4C 2 practices at Moredunvale |
|---|---|---|---|---|
| NPV Whole life capital costs | 0 | 8,460 | 2,304 | 8,460 |
| NPV Whole life operating costs | 0 | 2,777 | 1,067 | 2,777 |
| **Estimated Net Present Value (NPV) of Costs** | **0** | **11,237** | **3,371** | **11,237** |

## 3.8 Overall assessment and preferred way forward

3.8.1 Option 2 has been rejected due to its inability to meet the demands of growth in capacity, therefore to 'Do minimum' is not a viable option.

3.8.2 The preferred option to be taken forward to business case, Option 4A or C, which is for a new build for two practices on one site with additional capacity. This can be delivered either at Liberton High School or Moredunvale.3.8.3 Negotiations will progress with the two GP practices to encourage the expansion of practice lists in a new site, however there is the potential risk that the practices may prefer to retain their current list size and remain in their existing premises. Consequently, the final preferred option would be the fit out of leased premises at the Gilmerton Station Road site for a new practice (Option 4B), to accommodate the housing developments in the immediate vicinity.

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## 3.9 Design Quality Objectives

3.9.1 The project will use the Achieving Excellent Design Evaluation Toolkit (AEDET) to assess design quality throughout the procurement and design process and as part of the Post Project Evaluation.

3.9.2 An initial AEDET (Achieving Excellence Design Evaluation Toolkit) workshop will be undertaken as part of the OBC/SBC process.

# 4 The Commercial Case

## 4.1 Procurement Strategy

4.1.1 The total indicative capital costs for the preferred option are £10.2m. NHSL delegated limit is £10m, therefore as the costs of the business case exceed that, it will require Scottish Government approval. The costs include both the reprovision of Ferniehill and Southern Medical practices on the same site with the inclusion of capacity to provide GMS for the increased population.

It is anticipated that the procurement of the project will be led by NHS Lothian supported by the Edinburgh HSCP.

4.1. 2. The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that HubCo will be the likeliest option.

## 4.2 Timetable

4.2.1 A detailed Project Plan will be produced for the business case. In view of the decision to keep three options open for further investigation in the Business Case it is not possible to provide a project timetable at this stage. The time scales relating to the availability of suitable alternative premises are unclear at the present time and only when there is certainty that sites will become available can a credible programme be developed.

**Table 12: Project Timetable**

| Key Milestone | Date |
|---|---|
| Initial Agreement approved | March 2019 |
| Pre OBC Option Appraisal | April 2020 |
| Outline Business Case approved | May 2021 |
| Purchase of land completed (if required) | May 2022 |
| Full Business Case approved | May 2022 |
| Construction starts | July 2022 |
| Construction complete and handover begins | December 2023 |
| Service commences | January 2024 |

# 5 The Financial Case

## 5.1 Capital Affordability

5.1.1 The estimated capital cost associated with each of the short listed options is detailed in the table below. Construction costs were provided by independent quantity surveyors. The cost to build two practices, regardless of site choice, is assumed to be the same.

| **Capital Cost (£m)** | Option 2 Do Minimum | Option 4A 2 practices at Liberton High School | Option 4B Commercial Site | Option4 C 2 practices at Moredunvale |
|---|---|---|---|---|
| Construction | 0 | 6,802 | 1,796 | 6,802 |
| Professional Fees | 0 | 20 | 30 | 20 |
| Equipment | 0 | 157 | 60 | 157 |
| IT & Telephony | 0 | 131 | 50 | 131 |
| Inflation | 0 | 0 | 0 | 0 |
| Optimism Bias | 0 | 1,351 | 368 | 1,351 |
| **Total Cost (excl VAT)** | **0** | **8,460** | **2,304** | **8,460** |
| VAT | 0 | 1,692 | 461 | 1,692 |
| Project Team Costs | 0 | 0 | 0 | 0 |
| **Total Capital Cost** | **0** | **10,152** | **2,765** | **10,152** |

**Table 13: Capital Costs**

The assumptions made in the calculation of the capital costs are:

- New build and refurbishment construction costs are estimated on the basis of recent primary care projects however included as HubCo costs.
- A sqm rate of £3,900 has been used for a new build with a sqm rate of £2,680 used for refurbishment.
- Total sqm is based on the Schedule of Accommodation **Appendix 6**
- Professional fees have been estimated on the basis of prior primary care project submissions.
- Equipment costs are estimated at £90 per sqm on the basis of previous primary care projects.
- IT & Telephony are estimated at £75 per sqm on the basis of previous primary care projects.

- Optimism bias has been included at 19% of total costs including commissioning costs
- There has not been an allowance for inflation as yet, due to the uncertainty of the project timeline, draft project timeline has been detailed in **Section 6.2**
- No cost in relation to site purchase has been included at this time.
- VAT has been included at 20% on all costs. No VAT recovery has been assumed. VAT recovery will be further assessed in the OBC

## 5.2 Revenue Affordability

| **Incremental Revenue Cost/year (£k)** | Option 2 Do Minimum | Option 4A 2 practices at Liberton High School | Option 4B Commercial site | Option 4C 2 practices at Moredunvale |
|---|---|---|---|---|
| HSCP Staffing | - | - | - | - |
| Facilities | - | 113 | 44 | 113 |
| Depreciation | - | 203 | | 203 |
| **Total Annual Incremental Revenue Cost** | **-** | **316** | **44** | **316** |

5.2.1 The estimated recurring incremental revenue costs associated with each of the short listed options are detailed in the table below. These represent the additional revenue costs when compared to the 'Do Nothing' option.

**Table 14: Incremental Revenue Costs**

The assumptions made in the calculation of the revenue costs are:

- Depreciation is based on a useful life of 50 years and assumed to be funded from the existing NHS Lothian Depreciation funding allocation. With the exception of Option 4B as this will be a leased premises and will not be subject to deprecation.
- It is expected that there will be additional HSCP staff due to the Schedule of Accommodation providing an allowance for this staff group. At this stage this staffing complement has not yet been specified. Any increase in this staffing group will be funded from the Primary Care Improvement Fund.
- No one off revenue costs (e.g. the cost of decant) have been identified for the project at this stage.
- Practice related costs have not been included in revenue costs as these will be funded via GMS income. It is noted that there will be an increase in these revenue costs which will have to be agreed with the practices involved.
- It is also noted that there will be a lease cost in relation to Option 4B, however it is assumed that this will also be funded via GMS income.

5.2.2 Revenue funding will be available from various sources: The PCIF will be utilised for any additional HSCP staff identified relating to the new GP contract. Depreciation costs will be defined and sources will be agreed as part of the business case. Indicative revenue funding for the preferred options are shown in the table below.

| Incremental Revenue Cost/ Funding | Option 2 Do Minimum | Option 4A 2 practices at Liberton High School | Option 4B Commercial Site | Option 4C 2 practices at Moredunvale |
|---|---|---|---|---|
| **Total Annual Incremental Cost** | **-** | **316** | **44** | **316** |
| Funding – Existing NHSL depreciation budget | - | 203 | - | 203 |
| **Total Annual Incremental Revenue Cost** | **-** | **113** | **44** | **113** |

**Table 15: Summary of Revenue Funding**

5.2.3 The funding gap above represents the increased facilities costs, further work will be required in order to identify a funding source.

5.2.4 Given that there are two sites identified at this stage, and no certainty about the future organisation of General Medical Services, e.g. the provision of a new practice or expanding the lists of existing practices, further work will be taken forward to fully capture all revenue costs in OBC stage.

## 5.3 Overall Affordability

5.3.1 The capital costs estimated above are predicted to be funded through traditional capital funding. This project has been prioritised by NHS Lothian and the costs noted above are included in the NHS Lothian Property and Asset Five Year Investment Plan.

5.3.2 Funding has been identified for the additional revenue costs relating to depreciation from the existing NHSL depreciation budget. Any additional HSCP staff costs are anticipated to be cost neutral as this will be funded by the Primary Care Improvement fund. There remains a funding gap in relation to the facilities costs ranging from £44k to £113 per annum.

5.3.3 At this time it is assumed that both site options for the reprovision of Ferniehill and Southern Medical Practices will incur the same level of capital and revenue costs. This is subject to change; however these will be detailed through the OBC process.

# 6 The Management Case

## 6.1 Readiness to proceed

6.1.1 A benefits register is included in **Appendix 3.** A high level risk register will be included in **Appendix 4** for LCIG.

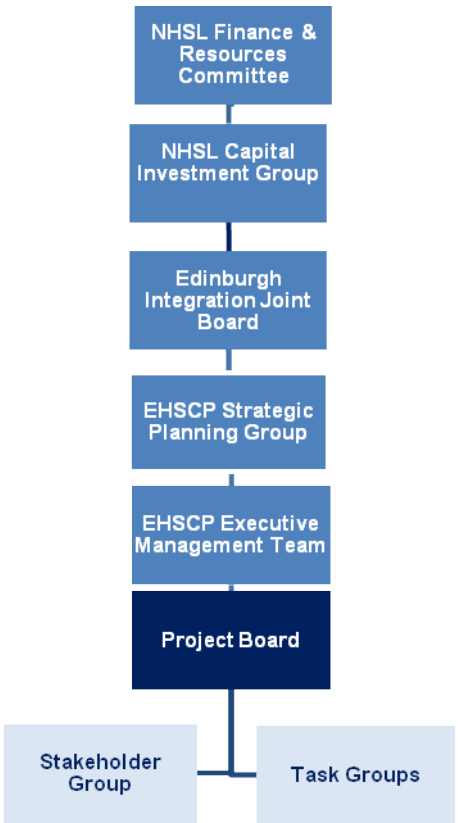
6.1.2 Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

6.1.3 NHS Lothian and Edinburgh Health and Social Care Partnership are ready to proceed with this proposal Section 6.3 details the project management arrangements. Section 6.2 outlines the governance support and reporting structure for the proposal.

## 6.2 Governance support for the proposal

6.2.1 Engagement with stakeholders is outlined in the Economic Case Members of the Project Management Group have been involved in its developments to date and are willing to continue to support it.

The diagram below shows the organisational governance and reporting structure that will be in place to take forward the proposed solution.



## 6.3 Project Management

6.3.1 The table below notes the project board that will be responsible for taking the project forward including details of the capabilities and previous experience.

6.3.2 Legal advice for the project (if required) will be obtained from the Central Legal Office.

**Table 16: Project Management Structure**

| Role | Individual | Capability and Experience |
|---|---|---|
| Project Sponsor | David White, Strategy Planning & Quality Manager, Primary Care and Public Health | Previous experience as Project Sponsor in primary care capital projects |
| Project Owner | Fiona Cowan | Previous experience of NHS capital projects |
| Project Manager | Campbell Kerr | Senior Project Manager in NHSL Capital Planning with extensive experience and responsibility for primary care projects |
| Capital Finance Support | Laura Smith | Experience supporting capital investment projects including similar primary care provisions. |
| EHSCP Chief Finance Officer | Moira Pringle | Previous experience at Senior Manager level in similar projects, formerly Head of Capital Finance NHSL |
| SE Locality Lead | Judith Mann | Locality Development Manager with experience of primary and community care provision |
| Practice Rep – Ferniehill | To be confirmed | Dependent on appointee |
| Practice Rep – Southern | To be confirmed | Dependent on appointee |
| Clinical Lead | Carl Bickler | Experience as GP and Clinical Lead for South East Locality |
| Communications Rep | To be appointed | Dependent on appointee |

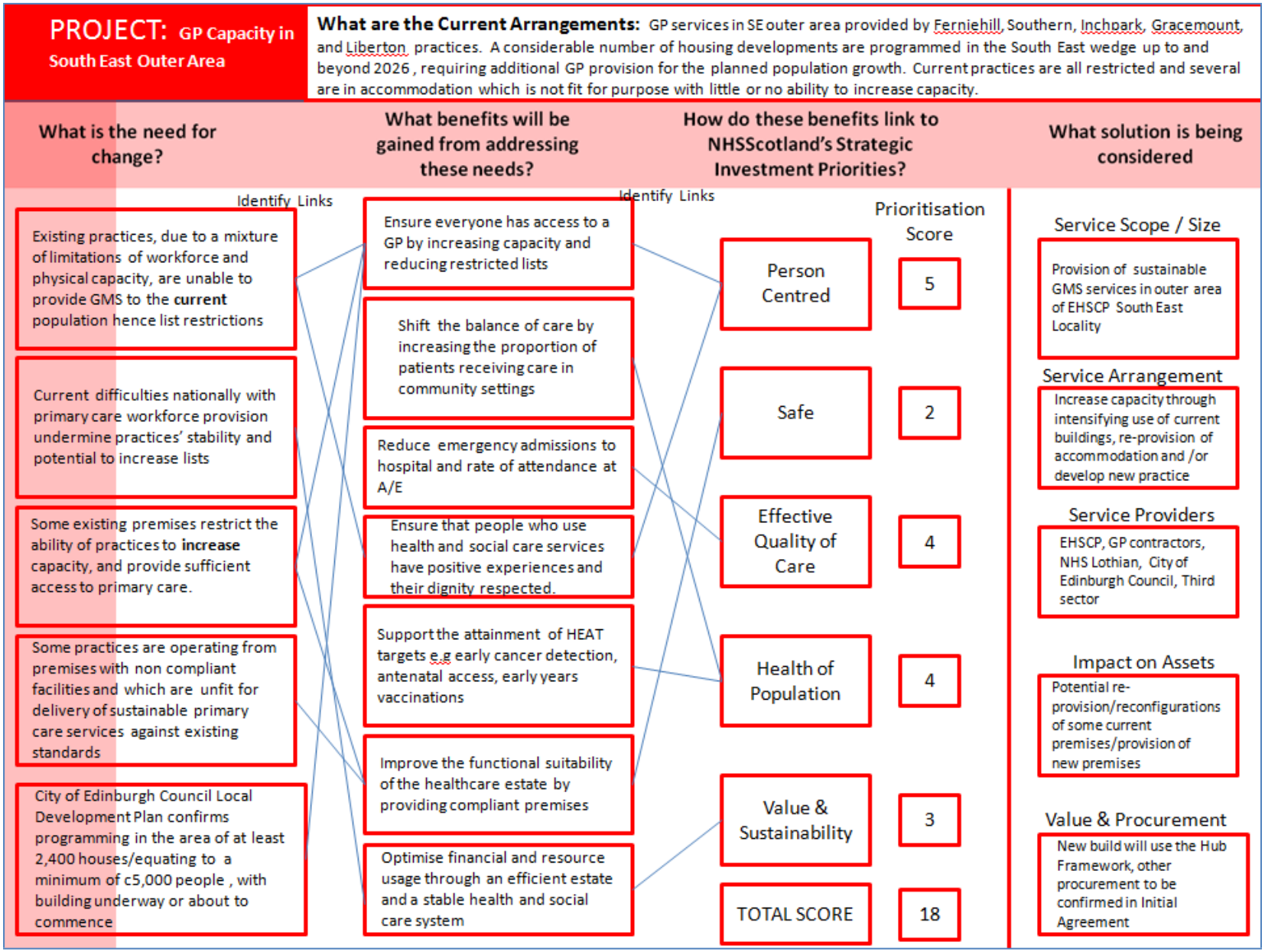
# 7 Conclusion

7.1.1 The need for development in the South East area was first raised in the Edinburgh Health and Social Care Partnership Population and Premises report 2014. This reported on the Housing and Land Audit 2014 which showed significant planned housing development in the South East area, and has long been an area of concern.

7.1.2 The strategic assessment for this proposal (included in Appendix 1) scored 17.25 out of a possible maximum score of 28. However this was re-scored by NHS LCIG Moderation Group to 18.55 matching that to similar proposals throughout NHS Lothian.

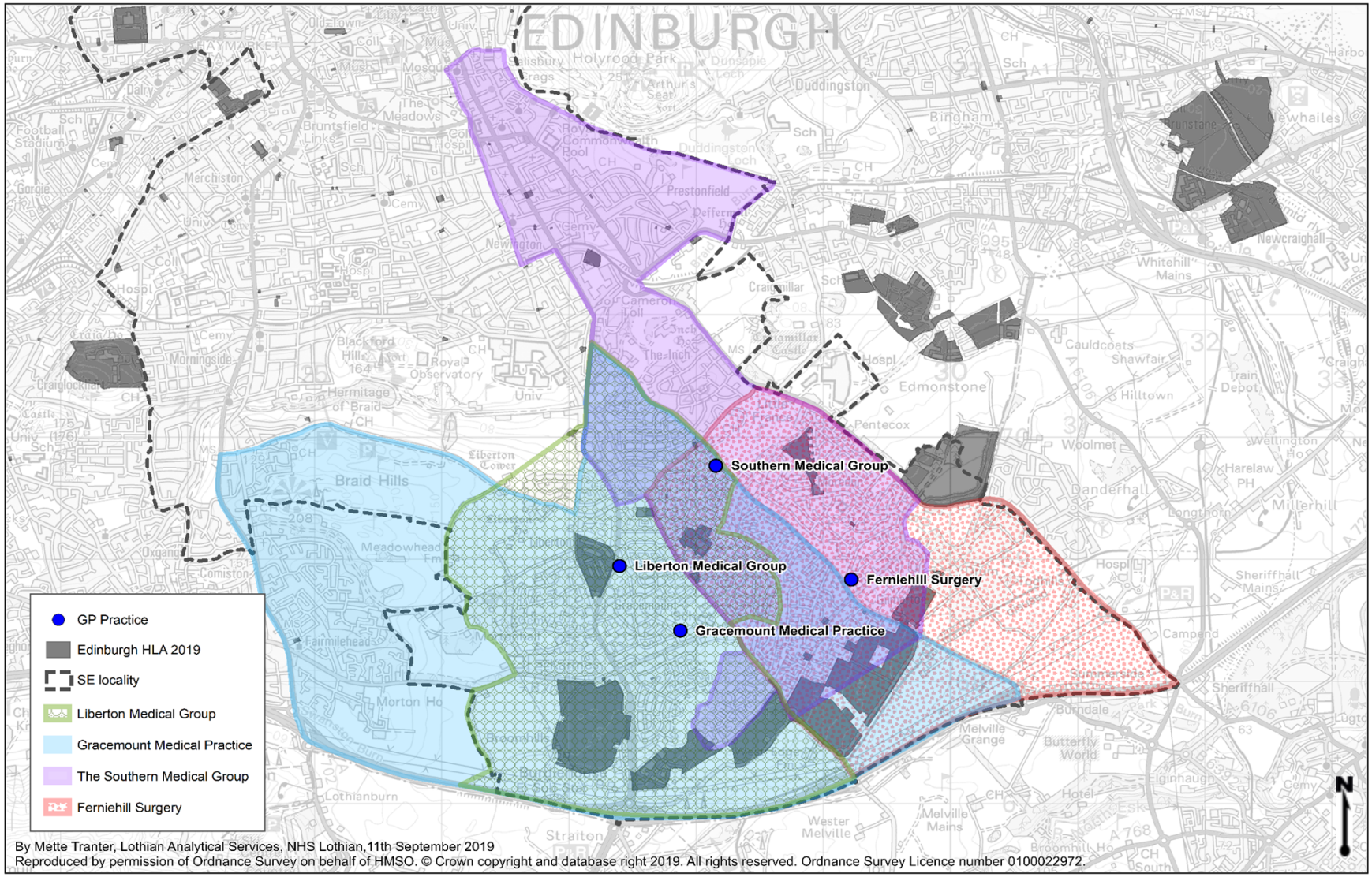
7.1.3 The proposal has been prioritised by the relevant governance groups and the Prioritisation Projects Update from LCIG in May 2019 identified it as one of the number one priorities for NHS Lothian and Edinburgh Health and Social Care Partnership.

## Appendix 1: Strategic Assessment



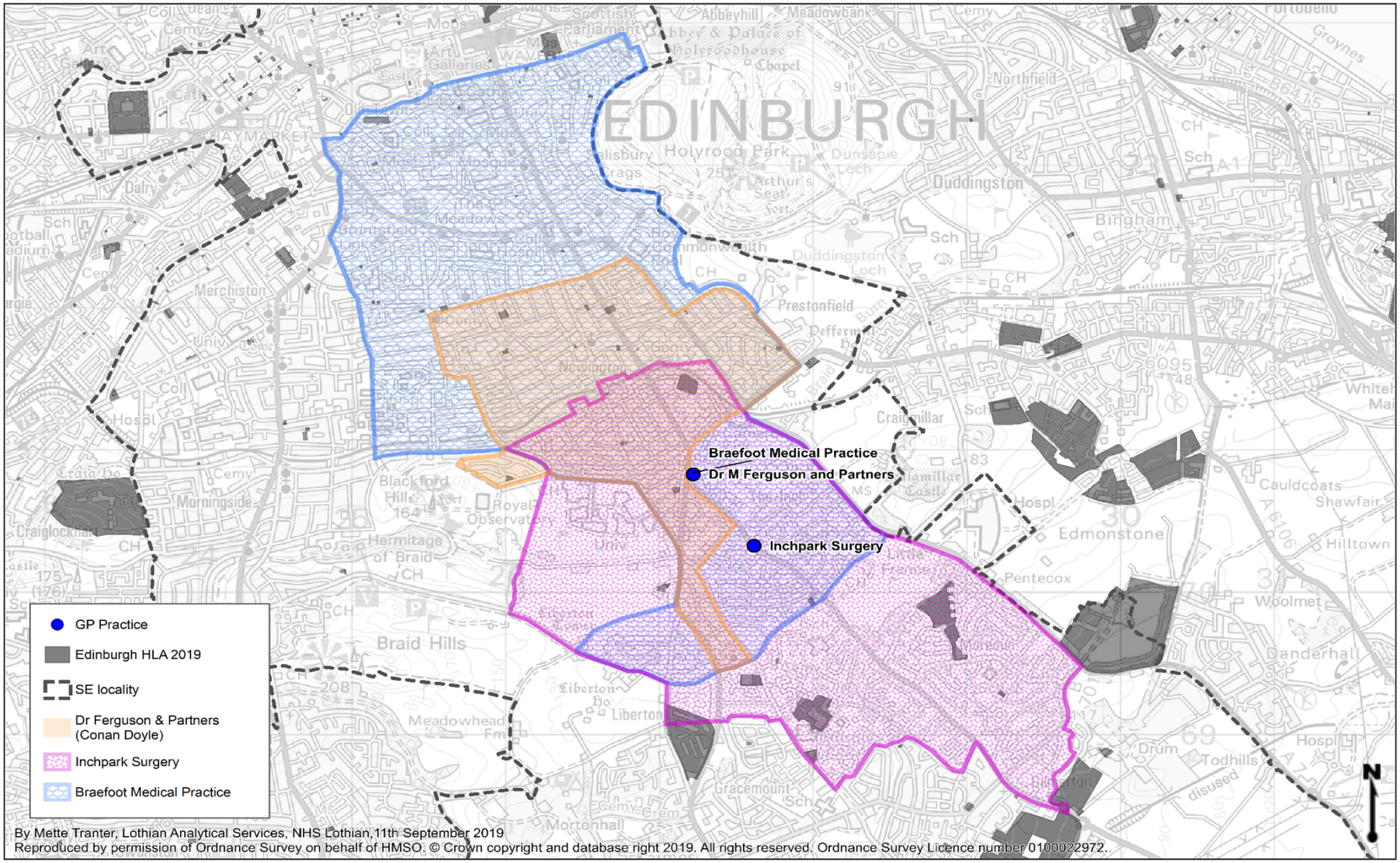
## Appendix 2a

# Map showing Liberton, Gracemount, Southern & Ferniehill GP Practice boundaries



## Appendix 2b

# Map showing Dr Ferguson & Ptnrs, Braefoot, & Inchpark GP Practice boundaries



## Appendix 3: Benefits Register

| *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 | Everyone can register with a GP | Quantitatively | Capacity increase, restricted lists, patient assignments | No of patients resident assigned | No restricted lists, patients assigned | 5 - Vital | Patients, GP Practices | GP/EHSCP/NHSL | Improve Service Capacity to enable everyone to access GMS. Enable delivery of the Primary Care Improvement Plan as required for implementation of the new GMS contract | | | 12 months post project |
| 2 | Increase in services and clinical accommodation provided in the community | Quantitatively | Proportion of services offered in the community | Current service provision | Increase in community services and clinical accommodation | 3 - Moderately important | Population, EHSCP, NHSL | EHSCP | Improve service access and provide sufficient clinical accommodation to meet service needs. Improve service performance and configuration to respond to increased demands of known significant population growth and existing deprivation needs, and ensure easy accessibility | | | 24 months post project |
| 3 | Ensure that people who use health and social care services have positive experiences and their dignity respected | Qualitatively | Patient experience of GP practice, patient experience of Health and Social Care services | Results of HACE Patient Survey 2019/20 | Improvement on previous results in post completion survey | 4 - Important | Patients | EHSCP/ Practices | Improve service performance and configuration to respond to increased demands of known significant population growth and existing deprivation needs, and ensure easy accessibility | | | 12 months post project |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | Reduce the rate of attendance at A&E | Quantitatively | RIE A&E activity reports | Current measurements by practice | Reduction in attendance rates | 4 - Important | Patients | EHSCP/ Secondary Care/ Practices | Improve service performance and configuration to respond to increased demands of known significant population growth and existing deprivation needs, and ensure easy accessibility | Provision of corresponding services in secondary care/3rd sector | | 36 months post project |
| 5 | Provides safe and easy access to GP services. Premises are DDA compliant | Qualitatively | Patient experience of travel options questionnaire | Results of questionnaire to patients pre-move | Results of post completion questionnaire and full DDA compliance achieved | 4 - Important | Patients | ESCP | Improve service access and provide sufficient clinical accommodation to meet service needs. Improve functional suitability of the healthcare estate and address long term future needs and tenure. | | | 24 months post project |
| 6 | Improve the functional suitability of the healthcare estate | Quantitatively | Proportion of the estate categorised as either A or B for the functional suitability facet | B/C | A | 5 - Vital | Patients/EHSCP/NHSL | EHSCP | Improve functional suitability of the healthcare estate and address long term future needs and tenure. | | | 12 months post project (NB supporting figures may not be available until later date) |
| 7 | Improve sustainability and efficient use of resources | Quantitatively | Annual Statutory Appriasal | B/C | A | 3 - Moderately important | Population/ EHSCP/NHSL | EHSCP | Improve functional suitability of the healthcare estate and address long term future needs and tenure. | | | 24 months post project |

## Appendix 4: Risk Register

For development for LCIG

## Appendix 5: Long Listed Options

| Strategic Scope of Option | Service Provision | Service Arrangements | Service Provider and Workforce Arrangements | Supporting Assets | Public and service user expectations |
|---|---|---|---|---|---|
| **Option 1:**<br>**Do Nothing** | As current arrangements | As current arrangements | As current arrangements | As current arrangements | As current arrangements |
| **Option 2: Do Minimum** | Continue with existing | Existing practices with support for some capacity increase if possible | Existing GMS provision – will require additional workforce to address any increase | Minor refurbishment in existing practices to accommodate the increase of some of the population due to housing expansion | Will expect full access to GMS and require the ability to register with a GP in the area |
| **Option 3: New build for a new practice only** | Increases GMS service provision | New practice with high risk of failure and significant revenue implications until practice stable.<br>Existing practices continue with current arrangements | Will address recruitment difficulties impacted by premises conditions.<br>Will require additional workforce to address the increase | Identify a new site within the catchment area of South East to create a new practice with capacity to accommodate only the increased population<br>New premises will be designed to be functionally appropriate and fully compliant | Will be designed with sufficient space to partially accommodate increased population requirements |
| **Option 4: New build for a new practice and re-provide existing practices** | Existing arrangements with additional capacity in all practices | Addresses capacity and access needs.<br>New practice with high risk of failure and significant revenue implications until practice stable.<br>Time implications of setting up new practice / management may be challenging and onerous | Existing GMS provision – will require additional workforce to address any increase.<br>Will address recruitment difficulties impacted by premise conditions | Identify a new site within the catchment area of South East to create a new practice with capacity to accommodate increased population and GMS demand as well as the re-provision of the existing Ferniehill and Southern Medical practices<br>Purpose build premises designed with sufficient and appropriate space to accommodate increasing population and provide opportunities to respond to changing needs | Will provide full access to GMS and opportunity to register with GMS in the local area |

| Strategic Scope of Option | Service Provision | Service Arrangements | Service Provider and Workforce Arrangements | Supporting Assets | Public and service user expectations |
|---|---|---|---|---|---|
| **Option 5: New build to re-provide existing serviced only** | Existing arrangements | Existing practice with support for some capacity increase if possible | Existing GMS provision. Will address recruitment difficulties impacted by premise conditions | Identify a new site within the catchment area of South East to re-provide premises for the existing premises only.<br>Purpose built premises designed with sufficient and appropriate space to accommodate only existing population. | Insufficient capacity for population growth |
| **Option 6: Refurbish available property for a new practice only** | Provision of reconfiguring accommodation to expand current provision | Opportunity to re-evaluate existing practice to expand services | Will require additional workforce to address the increase<br>Will address recruitment difficulties impacted by premise conditions in refurbished premises but no effect on others | Source and upgrade an available premises to accommodate a new practice to have capacity for the increased population only<br>Compliancy and suitability with be improved | Will provide limited access to GMS and opportunities to register with GMS locally |
| **Option 7: Refurbish available property for a new practice and re-provision of existing practices** | Existing arrangements with additional capacity in all practices.<br>Long term provision and sustainability of existing practices | Addresses capacity and access needs<br>New practice with high risk of failure and significant revenue implications until practice stable<br>Time implications of setting up new practice / management support may be challenging and onerous | Existing GMS provision – will require additional workforce to address any increase<br>Will address recruitment difficulties impacted by premises conditions | Source and upgrade existing premises to accommodate the current practices in combination with space for a further practice to provide capacity for the additional demand.<br>Compliancy and suitability will be improved | Will provide full access to GMS and opportunity to register with a GP in the local area |

| Strategic Scope of Option | Service Provision | Service Arrangements | Service Provider and Workforce Arrangements | Supporting Assets | Public and service user expectations |
|---|---|---|---|---|---|
| **Option 8: Refurbish available property, re-provision of existing practices only** | Existing arrangements | Existing practice with support for some capacity increase if possible | Existing GMS provision<br><br>Will address recruitment difficulties impacted by premises conditions. | Source and upgrade available property to provide more functionally suitable premises for the delivery of primary care services for existing practices only<br><br>Compliancy and suitability will be improved | Will expect full access to GMS and require the ability to register with a GP in the area. |

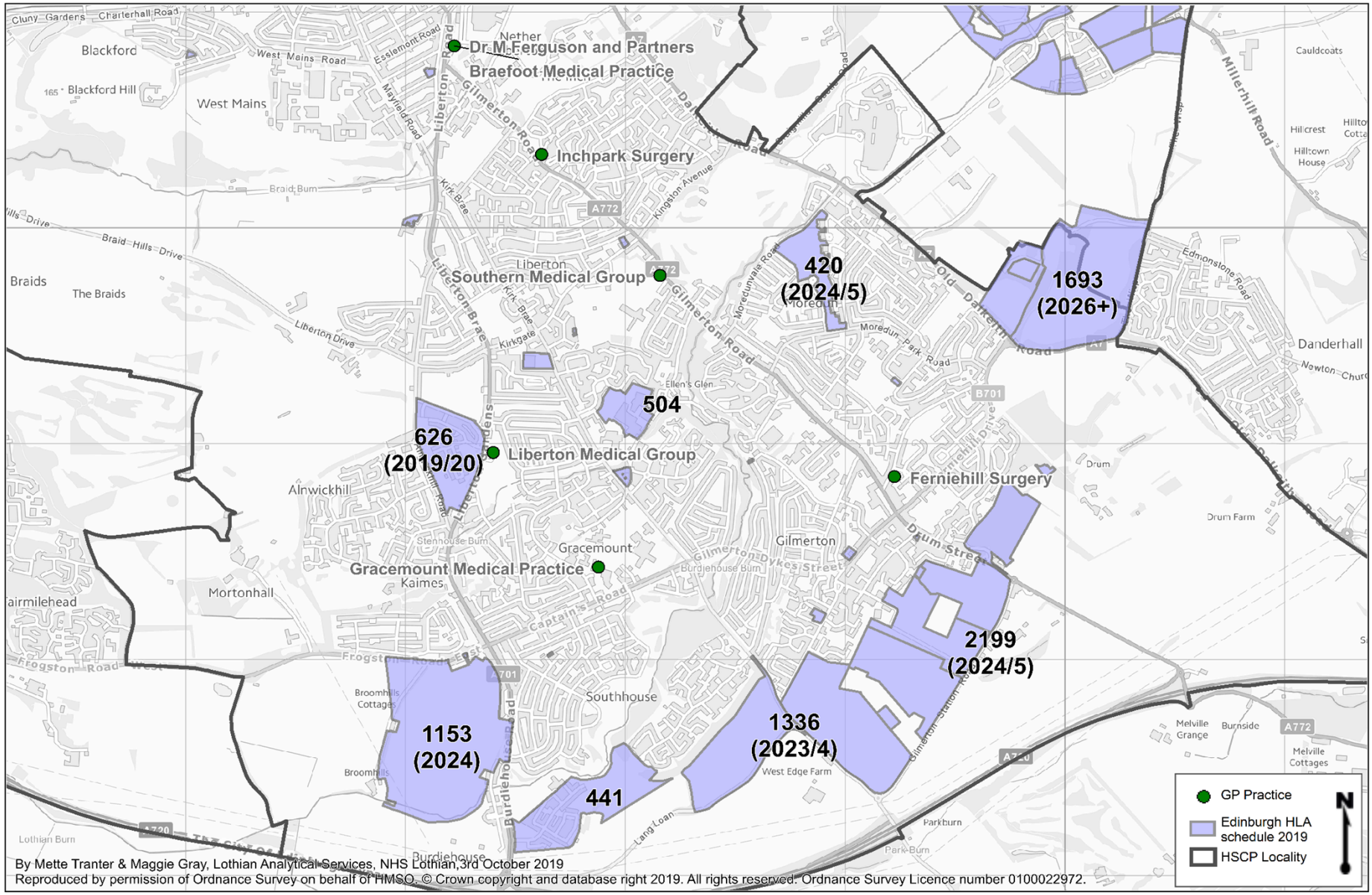
## Appendix 6: Schedule of Accommodation

**Edinburgh SE Outer**
**Schedule of Accommodation**
**30-Aug-19**

| Room | New Practice (6,000) Qty | Area m² | Total Area m² | Ferniehill (7,000) Qty | Area m² | Total Area m² | Southern (8,000) Qty | Area m² | Total Area m² | Joint (21,000) Qty | Area m² | Total Area m² |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GP Clinical Area** | | | | | | | | | | | | |
| Consulting Room | 5 | 15 | 75 | 6 | 15 | 90 | 7 | 15 | 105 | 19 | 15 | 285 |
| Consulting Room (GP training) | 1 | 18 | 18 | 1 | 18 | 18 | 1 | 18 | 18 | 3 | 18 | 54 |
| Practice Nurse Consulting Room | 2 | 15 | 30 | 2 | 15 | 30 | 3 | 15 | 45 | 6 | 15 | 90 |
| Nurse Prep / Utility Room | 1 | 10 | 10 | 1 | 10 | 10 | 1 | 10 | 10 | 1 | 15 | 15 |
| **HSCP Clinical Area** | | | | | | | | | | | | |
| Multi Purpose Room | 1 | 30 | 30 | 1 | 40 | 40 | 1 | 40 | 40 | 1 | 45 | 45 |
| Community Consulting Room | | 15 | 0 | | 15 | 0 | | 15 | 0 | | 15 | 0 |
| Community Treatment Room | | 18 | 0 | | 18 | 0 | | 18 | 0 | | 18 | 0 |
| Interview Room | | 12 | 0 | | 12 | 0 | | 12 | 0 | | 12 | 0 |
| **Reception / Waiting Area** | | | | | | | | | | | | |
| Reception | 1 | 14 | 14 | 1 | 14 | 14 | 1 | 14 | 14 | 1 | 18 | 18 |
| Reception Office | 1 | 11 | 11 | 1 | 17 | 17 | 1 | 22 | 22 | 1 | 55 | 55 |
| Waiting Area | 1 | 55 | 55 | 1 | 60 | 60 | 1 | 80 | 80 | 1 | 120 | 120 |
| **Administration Area** | | | | | | | | | | | | |
| Admin/Secretaries/Data Input | 2 | 28 | 55 | 1 | 28 | 28 | 1 | 33 | 33 | 1 | 94 | 94 |
| Practice Manager Office | 2 | 12 | 24 | 1 | 12 | 12 | 1 | 12 | 12 | 3 | 12 | 36 |
| HSCP Office | 1 | | 0 | | | 0 | 1 | | 0 | | | 0 |
| Meeting Room | 1 | 25 | 25 | 1 | 30 | 30 | 1 | 30 | 30 | 2 | 30 | 60 |
| General Storage | 1 | 15 | 15 | 1 | 20 | 20 | 1 | 20 | 20 | 1 | 35 | 35 |
| **HSCP Area** | | | | | | | | | | | | |
| Consulting Room | | | 0 | | | 0 | | | 0 | 4 | 15 | 60 |
| Other | | | 0 | | | 0 | | | 0 | 1 | 100 | 100 |
| **Other** | | | | | | | | | | | | |
| Patient WCs | 1 | 11 | 11 | 1 | 11 | 11 | 1 | 16 | 16 | 2 | 11 | 22 |
| Staff WCs | 1 | 11 | 11 | 1 | 11 | 11 | 1 | 16 | 16 | 2 | 11 | 22 |
| Staff Room | 1 | 30 | 30 | 1 | 35 | 35 | 1 | 40 | 40 | 1 | 50 | 50 |
| Staff Changing | 2 | 10 | 20 | 2 | 10 | 20 | 2 | 10 | 20 | 2 | 20 | 40 |
| Disposal (General & Clinical Waste) | 0 | 10 | 0 | 0 | 10 | 0 | 0 | 10 | 0 | 0 | 10 | 0 |
| DSR | 2 | 10 | 20 | 2 | 10 | 20 | 2 | 10 | 20 | 3 | 10 | 30 |
| Communications Room | 1 | 15 | 15 | 1 | 15 | 15 | 1 | 15 | 15 | 1 | 15 | 15 |
| Plant Room | 1 | 25 | 25 | 1 | 30 | 30 | 1 | 30 | 30 | 1 | 45 | 45 |
| Multi Service Store | 1 | 10 | 10 | 1 | 15 | 15 | 1 | 15 | 15 | 1 | 20 | 20 |
| | | | 504 | | | 525 | | | 601 | | | 1,311 |
| **Circulation @ 33%** | | | 166 | | | 173 | | | 198 | | | 432 |
| | | | 670 | | | 698 | | | 799 | | | 1,743 |

## Appendix 7

# Development sites - population projections/housing completion dates



**NHS LOTHIAN**

Board Meeting
13 May 2020

Deputy Chief Executive

# Hospital Sterilisation and Decontamination Unit reprovision – revised Initial Agreement

## 1 Purpose of the Report

1.1 To recommend that the NHS Board approve the revised Initial Agreement for the re-provision of the Hospital Sterilisation and Decontamination Unit (HSDU).

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

## 2 Recommendations

NHS Lothian Board are asked to:

2.1 Accept this report as significant assurance that the Finance and Resources Committee has reviewed the Initial Agreement and agreed to recommend it to the Board.

2.2 Approve the Initial Agreement.

## 3 Discussion of Key Issues

3.1 The purpose of the re-provision project is to:

- Avoid a loss of decontamination services to NHS Lothian as a result of the failure of the current HSDU.
- Ensure continuity of compliant and high quality decontamination services and hence surgical services in Lothian by ensuring there is HSDU capacity available.
- Provide HSDU capacity to meet growth in demand and to provide a defined level of contingency capacity (for NHS Lothian or other NHS Boards).

3.2 The following key assumptions and parameters have been used to model the options and costs in the IA:

- Projected capacity requirement 2 x current processing capacity, activity will double over the lifecycle of the developments
- The preferred staffing model is for no overnight staffing and a standard 2 shifts (6 am to 2 pm and 2 pm to 10 pm) was used as a basis for the model. The rationale for this is that it would mean a) that there was built in contingency, implementation of longer working hours would increase capacity if required b) known health and workforce development issues in relation to night shift working c) higher costs of an overnight workforce.
- Models based on 3 shifts including a night shift of 10 pm to 6 am) (i.e. 24/7) were developed for comparative purposes.
- The models were based on projected need for NHS Lothian capacity only.
- However there is explicit recognition in the strategic options for a future arrangement that provided cost efficient contingency within NHS Lothian or for other NHS Boards.

3.3 A version of this Initial Agreement was approved by NHS Lothian Finance and Resources Committee in March 2019. Subsequent to this approval further work has been carried out:

a) on options to undertake refurbishment work in the existing HSDU whilst maintaining operations to provide an interim increase in capacity within a shorter timescale and
b) to refine the capital costs.

3.4 In relation to the further exploration of options for refurbishment of the existing HSDU whilst maintaining operations to provide an interim increase in capacity. These refurbishment options (presented to LCIG in January 2020) raised significant concerns as follows.

3.5 Firstly, in relation to the feasibility of current services in the unit, particularly drainage, to support any additional equipment. This exploratory work also indicates that a full refurbishment of the HSDU as in Option 2 below may not be cost effective.

3.6 Secondly, it was considered too high risk to seek to undertake any of the refurbishment options whilst maintaining operations.

3.7 In consideration of these concerns, options for refurbishment of the existing HSDU whilst maintaining operations and have now been rejected as not feasible (HSDU Re-provision Project Board held on 2nd March 2020).

3.8 The current IA retains the original strategic options (1, 2 and 4 below) but adds option 3 two new units on different sites.

Option 1: a new single HSDU at scale to meet current and projected demand operating with a two shift system.

Option 2: a new HSDU and full refurbishment of the existing HSDU (with new HSDU built to scale to provide existing HSDU capacity and additional capacity during refurbishment of existing HSDU)

Option 3: two new units on different sites (included to recognise that a full cost efficient refurbishment of the existing HSDU may not be achievable but that a model of two HSDUs provides additional resilience and contingency capacity and an additional opportunity for adjacency with surgical provision in NHS Lothian.

Option 4: decentralised model of three or 4 CDUs

3.9 Critical factors in the evaluation of the strategic options in respect of location will need to consider a) adjacency to the sites of major surgical activity (in order of level activity as per Figure 1 of the IA : Little France, St John's Hospital and the Western General Hospital and b) provision of contingency.

3.10 In relation to the review of cost , cost variations observed between IA and OBC in other projects prompted a fuller costing exercise which was undertaken by Thomson Gray Ltd (17 September 2019) for the options involving a new build, that is preferred options 1 and 2. The costing exercise was based on the modelled footprints provided and as contained in the previous IA. The revised costs are given in Table 1 Section 7 Resource Implications below and there is a significant increase on the cost estimates previously presented.

3.11 Approval of the IA at Finance and Resources Committee April 2020 was subject to the following points being addressed in the next stages of the process and in the business case.

There needs to be more detail on the consideration given to national and regional plans, particularly in relation to contingency.

In relation to this, the report into the NSS Health Facilities Scotland report (September 2019) into the Cowlairs CDU incident in November 2018 recommended that contingency for CDUs in Scotland should be reviewed again looking at high volume and long opening hours and the age and condition of buildings and that Scottish Government direct Board design teams and contractors to comply with revised SHPN 13 Part 1. The models in the IA provide an additional 33% contingency and assume compliance with SHPN13:1 as well as supporting operational aspects of mobilising contingency for other NHS Boards. The modelling underpinning the IA can be adjusted to provide additional capacity and contingency if required.

NHS Lothian is engaged with national work planning additional CDU capacity for elective centres and exploring the option of temporary pop up facilities to provide interim support for additional surgical activity but whilst this may provide temporary assistance it does not change the strategy in the NHS Lothian IA.

The Facilities risk register rating in relation to NHS Lothian HSDU should be reviewed.

Clinical and ehealth engagement in the process should be strengthened and the Project Board membership reviewed and extended to achieve this engagement.

In considering potential sites and locations, proximity to the major centres of surgical activity at Little France and St John's Hospital (West Lothian) should be evaluated taking account of the full economic and social opportunities of developments to the local areas.

## 4 Key Risks

4.1 The key risks for the project are:

Failure to deliver additional HSDU capacity in line with growth of demand in surgical activity.

On-going remedial costs (finance and service disruption) of sustaining the existing HSDU without achieving an improvement in quality of process, environment and compliance.

Failure to design and resource a project management team and organisational approach and engagement which can analyse complex options quickly to deliver an agreed business case within an timescale appropriate to increasing demand and on-going risk.

Over reliance on the HSDU Reprovision Project to deliver efficiency and effectiveness of processes across the decontamination and failure to maintain continuous quality improvement.

## 5 Risk Register

5.1 The loss of HSDU department due to failure of services is currently a yellow risk on the Facilities Risk Register, with failure of services considered as possible or likely.

## 6 Impact on Inequality, Including Health Inequalities

6.1 There are no expected impacts on inequality or health inequalities.

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

7.1 Consultation with service users and stakeholders will be strengthened in the next stages of the business case development.

## 8 Resource Implications

8.1 The indicative resource implications for the options are set out below.

Option 1: New build HSDU to Scale

| **Full scale new build HSDU, Standard 2 x shift pattern, closing existing HSDU** | | |
|---|---|---|
| | DIN P/W Output | Unit area m2 |
| Build area necessary to fulfil production target | 7990 | 3318 |
| | | |
| Estimated new build cost | | **£28,442,032** |

Option 2: a new HSDU and full refurbishment of the existing HSDU

| **Existing HSDU, standard 2 x shift pattern + smaller scale new build HSDU** | | |
|---|---|---|
| | | |
| Target capacity = 2 x 3995, less refurbished HSDU capacity | DIN P/W Output | Unit area m2 |
| Peak output possible in refurbished HSDU (refurbished area 1733 / required area 1991) under 2 x shifts / 7 days | 3516 | 1733 |
| Remaining output requirement after refurbishment (=New build HSDU) | 4474 | 1585 |
| Overall total capacity of refurbished HSDU and new build HSDU = 7990 | 7990 | |
| Estimated minimum refurbishment cost[1] | | £4,988,134 |
| Estimated new build cost | | £13,586,684 |
| | | |
| Estimated total cost | | **£18,574,818** |

Option 3: Two new build units on different sites.

| **2 x new build HSDU, standard 2 x shift pattern, closing existing HSDU** | | |
|---|---|---|
| Smaller scale new build, standard shift pattern, keeping refurbished HSDU | | |
| Target capacity = 2 x 3995, less refurbished HSDU capacity | DIN P/W Output (each) | Unit area m2 (each) |
| Peak output possible in each new HSDU under 2 x shifts / 7 days | 3995 | 1659 |
| Overall total capacity of both new build HSDU | 7990 | |
| | | |
| Estimated new build cost per HSDU | | £14,221,016 |
| Estimated new build cost | | **£28,442,032** |

[1] Will not comply with the current planning SHPN13 Part 1: Central Decontamination Units

Option 4 Maximally decentralised provision of 3 (or 4) CDUs.

| 3 x new build HSDU, standard 2 x shift pattern, closing existing HSDU | |
|---|---|
| Smaller scale new build, standard shift pattern, keeping refurbished HSDU | |

8.2 In relation to the above it should be noted that:

- Changing from 3 x shifts per day to 2 shifts per day increases build costs as 33% more capacity per unit time is necessary to support this however it also facilitates around 33% contingency through having a vacant night shift period.
- Options exclude land purchase costs but assume a complete new build on brown/green site.
- Where multiple HSDU are discussed, the figures assume identical build configurations and costs are extrapolated from estimated cost for 1 x new build HSDU, so 50% costs per unit if 2 HSDU, 33% costs if 3 x HSDU.
- Market research regarding similar units recently completed in NHS England indicates that the build costs may be significantly lower where an existing facility is refurbished rather than establishing a complete new build from the ground up.

Jane Hopton, Programme Director Facilities
David Hill, Senior Project Manager
Nick Bradbury, Head of Property and Asset Management Finance
6th May 2020

**List of Appendices**

Appendix A: Revised IA for HSDU Re-provision – Full set of Appendices available on Request.

| | |
|---|---|
| Appendix 1 | AEDAT Generic Design Statement Review |
| Appendix 2 | Overview of Scottish Health Planning Note 13 Part 1, (SHPN13:1) |
| Appendix 3 | Known growth in surgical activity |
| Appendix 4 | HFS audit: Compliance of existing HSDU with SHPN 13 Part 1 |
| Appendix 5 | Explanation re existing HSDU infrastructure |
| Appendix 6 | *No longer applicable* |
| Appendix 7 | Overview of need for change |
| Appendix 8 | Strategic Assessment |
| Appendix 9 | Thomson Gray - HSDU Redevelopment - RIE - Feasibility Cost - New Build (rev B) 17 September 2019 |
| Appendix 10 | *No longer applicable* |
| Appendix 11 | Paper describing the process of set benchmarking, currently underway. |
| Appendix 12 | Review of HSDU capacity and work area. |

Appendix A

# NHS Lothian

# Updated Initial Agreement

# Re-provision and development of Hospital Sterilisation and Decontamination Unit

# Table of Contents

# 1 Overview

NHS Lothian currently has a single Central Decontamination Unit (CDU) (Hospital Decontamination and Sterilisation Unit HSDU) which is part of the Royal Infirmary of Edinburgh. This unit processes all re-useable surgical instruments from all theatres and clinical services requiring this service in NHS Lothian.

This building:

- Does not meet the current guidance (SHPN13 Pt 1) for a compliant CDU in terms of layout and design
- Has infrastructure which is beyond its usual lifecycle and requires to be replaced within the next 5 years
- Is close to meeting its maximum processing capacity for the following reasons:

  the space cannot accommodate any additional washers or sterilisers,

  there is very little scope to increase the space in order to increase staffing numbers on shift to maximise the use of the existing washers and sterilisers

  as the unit currently operates 24/7 with maximum staffing Monday to Friday and 24/7 but with reduced staffing at weekends the only way to increase capacity is to enhance weekend staffing and the additional capacity that this can provide is limited
- Does not have capacity to meet predicted growth in surgical activity in NHS Lothian
- Does not have space to respond to developments and innovations which may require installation of additional decontamination equipment, for example to process robotic surgical instruments
- Is not able to provide or to access additional processing capacity should any Boards in Scotland require this contingency

This initial agreement sets out options in order to:

- Avoid a loss of decontamination services to NHS Lothian as a result of

failure of the current HSDU

- Ensure continuity of compliant and high quality decontamination services and hence surgical services in Lothian by ensuring there is HSDU capacity available

- Provide HSDU capacity to meet growth in demand and to provide a defined level of contingency capacity (for NHS Lothian or other NHS Boards)

## 2 What is the proposal about?

The proposal sets out the need for NHS Lothian to re-provide its existing HSDU in order to ensure NHS Lothian can continue to provide surgical and other clinical services for which decontamination of surgical instruments is essential.

NHS Lothian needs to avoid loss of service arising through failure of the existing HSDU and ensure there is CDU capacity which can meet the predicted growth in surgical and other clinical activity requiring CDU services.

NHS Lothian also requires to maintain current level of CDU service throughout any reprovision.

This proposal sets out options for re-provision.

In setting out these options it also sets out the following

1. Unit Design Requirements (NDAP and AEDET)
    - Modelling the interrelationships between.
    - Space
    - Demand and Capacity
    - Workforce
    - Costs
    -
2. Potential site or sites for re-provision (related to both of the above) .

## 2.1 Unit Design requirements –

Appendix 1 reviews the AEDET generic statements.

There are defined standards for the development and re-provision of an HSDU. Scottish Health Planning Note 13 Part 1, (SHPN 13:1 2011), provides guidance to help plan and design a new or an upgrade to a Central Decontamination Unit (CDU) in a controlled manner as required by the quality management system standard BS EN ISO 13485: 2006.

Within this Planning Note there are Sections covering general considerations (including CDU operational policies), general functional and design requirements and engineering services. An overview of SHPN13 Part 1 is available in Appendix 2.

The review of generic design statements in Appendix 1 identifies which of these will be addressed by meeting the requirements of SHPN 13 Part 1 2011. It assigns a priority, from 1 to 5, where 1 is highest priority and 5 is least priority for all the statements. Appendix 1 also assigns categories to key aspects of the design.

The following points should be noted:

- The proposed unit is a specialist process environment for staff, with no requirements for patient provision and controlled access for contractors and clinical staff (visitors).
- Design issues pertaining to minimising or obviating disruption to clinical services are dealt with as a core issue in relation to the options for re-provision.

### 2.1.1 Design Statement

- The re-provision of the unit will be fit for purpose, as a minimum, meeting the design requirements of SHPN 13 Part 1.
- The design will provide for innovation, flexibility and future development.
- The design will provide a safe and modern working environment for staff which promotes quality, efficiency and well-being.
- The design will give high priority to environmental sustainability.

- The design will ensure resiliency in relation to main systems interruptions or failures.

- The design will take account of the logistics of service delivery to multiple sites, with good access to transport routes.

- The design will take account of workforce access in terms of location, transport routes and facilities provided.

## 2.2 Modelling space/capacity/demand/workforce requirements and costs for HSDU reprovision.

The options in this IA have been generated using a model which defines relationships between demand, capacity (space and workforce requirements) and costs thereby allowing the variation of any one of these variables such as demand to adjust the others.

### 2.2.1 Capacity/ Demand for surgical instruments

A key parameter for assessing options is the capacity which re-provision is seeking to provide, so this proposal is also about how we have estimated growth in clinical activity (demand), particularly but not exclusively in relation to surgical activity.

There are two aspects of demand we need to consider:

- projected short term growth and how this can be provided for by the existing HSDU

- projected long term growth in activity and how this can be provided for using a combination of a re-provisioned existing HSDU and/or a new build HSDU

- innovations in clinical activity such as robotics which may require additional specialist decontamination equipment and hence space/staffing

We have based our projected growth in surgical activity in Lothian surgical activity over the next 2/3 and 15 year periods in order to evaluate the cost of additional capacity available from a re-provided HSDU (to meet capacity requirements increase of 31% by 2021) and for a new HSDU with a production capability of 200% current capacity running on 2 x daily shifts x 7 days instead of the current 3 x daily

shifts x 7 days.

Appendix 3 shows the information provided in existing plans SJH ward 20 and elective centre, RHSC/DCN, and PAEP[1] (increase of 31% by 2026 and 42% by 2036)

For illustrative purposes in this paper we have assumed a growth in capacity required of 131% as per current best projection for elective centre, or 200% by 2036.

The following methodological issues should be noted.

1) These estimates were based on analysis by ISD for growth in selected surgical procedures and day cases. Extrapolating this growth based on selected procedures to all procedures may not be valid.

2) Implicit in this approach is that overall growth in procedures is in linear relation to growth in surgical set utilisation and hence demand on HSDU. Growth in some surgical procedures which use large numbers of sets could generate a higher demand.

3) These estimates (and costs) make no changes to the existing overall model of decontamination facilities which include Local Decontamination Units (see Figure 1) which currently process dental instruments and some podiatry instruments. These are not required to meet the same standards as an HSDU (CDU), however instruments could be processed in a CDU were there capacity to do so available and should this prove cost effective to do so.

In the absence of more robust analysis of projected growth in surgical activity the assumptions underlying the IA are reasonable.

The primary focus of the business case is demand for Lothian services and the options in this proposal are based on our projections of demand in Lothian.

The model and the options could be adjusted to cover growth generated by the requirements of other NHS Boards/NHS Scotland.

At present the demand assumptions are as follows;

*Table 1 Current and Projected Demand expressed as Din baskets / week*

| | Current | Projected 2036 | % increase |
|---|---|---|---|

| | | | |
|---|---|---|---|
| NHS Lothian | 3995 | 7990 | 100% |
| NHS Board A | 0 | 0 | |
| NHS Board B | 0 | 0 | |
| NHS Scotland | 0 | 0 | |
| **Total** | **3995** | **7990** | **100%** |

Capacity in HSDU is measured in DIN units of volume where a single DIN basket is used to contain surgical instruments during reprocessing and transportation. A DIN basket volume = 480x250x60mm. Surgical procedures require varying amounts of surgical instruments and these are provided (and reprocessed) in DIN baskets. HSDU reprocesses 242,476 of these DIN baskets per year containing some 324,850 surgical instruments.

### 2.2.2 Process design

For the IA , using baseline data from HSDU means that we have assumed that a) there is one ultrasound for Da Vinci b) all sets and instruments are processed in the same way and share the same space (no separate prep areas or washers for different streams of instruments) assumes ratio of Sterrad (low temp) to autoclave. Further specification of process design needed at OBC and BC.

### 2.2.3 Staffing model

The capacity of a unit is determined by the processing equipment (how many instruments can the Washer Disinfector process and how long does each processing cycle take) and the staff and hence space required to operate this equipment.

If the processing equipment is in operation 24/7 and staff deployed 24/7 then the equipment and space for staff requirements will be reduced, though overall staffing costs will increase for any given 24 hour WTE because of enhancements payable overnight.

The model used to generate options can vary staff shift patterns to any configuration.

This IA assumes and recommends a standard working pattern of two shifts (6 am to 2 pm and 2pm to 10 pm) - early and back shift over 7 days with no overnight shift.

The rationale for excluding night shift in the modelling of space/capacity requirements is that

a) this would mean that there was built in contingency – implementation of weekend or night shift working would increase capacity if required

b) known health and workforce development issues in relation to night shift working

c) higher costs of overnight workforce.

### 2.2.4 Washroom space: Total space & washer disinfector utilisation

Wash room space and number of washer disinfectors (WD) is key critical determinant of capacity and throughput. Other space and staffing requirements are driven by this entry point to the process, so by determining the staffing to be compatible with washer disinfector capacities, the proportional space requirement for washers and staffing to meet the increasing capacity needs can be extrapolated.

An analysis into the relative size of the current HSDU was evaluated using the most recent HSDU build in Scotland as a baseline, NHS Ayrshire and Arran CDU. This analysis concluded that NHS Lothian HSDU wash room is smaller in area than the wash room at the baseline CDU and NHS Lothian compensates for this by operating more shifts using more staff. However, it's only possible to get a certain amount of staff into a space before a productivity ceiling is reached and the information that has been reviewed indicates that it has been reached.

Current machine utilisation is 82%.

The reprovisioning model is developed using estimated based on ratio of wash room space to other essential spaces in the existing HSDU.

### 2.2.5 Plant Infrastructure

Based on current HSDU and SHPN13.

### 2.2.6 Estimated major cost drivers

- Staffing
- Equipment costs
- Costs per $m^3$ new build
- Costs per $m^3$ refurbishment (the same figures will be used for HSDU

refurbishment and for developing into an existing building should this be an option).

- Established WD, Steriliser and associated plant and equipment costs.

## 3 What are the Current Arrangements?

There is currently a single central sterilisation and decontamination unit in NHS Lothian (HSDU) based at the Royal Infirmary of Edinburgh. It was commissioned in 2001 and is sited in the corner of the RIE goods yard and is part of the PFI.

Although the unit was compliant with standards at that time, the design of the unit was compromised by the site itself and this remains the case. A full audit of HSDU by Health Facilities Scotland in 2015 identified 51 non-conformances in the design and layout of the building compared to current standards. The findings can be seen in Appendix 4.

HSDU processes 324,850 surgical instruments per year. (Equivalent to 242,476 Din baskets)

It operates 24/7 under 3 main shifts 6 am to 2 pm, 2 pm to 10 pm and 10pm to 6am. Weekend shifts are staffed to provide minimal cover. These shifts are currently staffed close to the maximum safe space available in decontamination and clean room/packing areas. This means that in theory there is some scope to increase the capacity of the unit through revenue investment in additional staffing for the weekend shifts, but this is limited. The Facilities Directorate has prepared proposals to increase the weekend staffing in order to increase capacity of HSDU to meet demand.

All the essential infrastructure within the existing HSDU will require to be replaced within the next 3 – 5 years. See Figure 2 for more explanation of the HDSU infrastructure and its status.

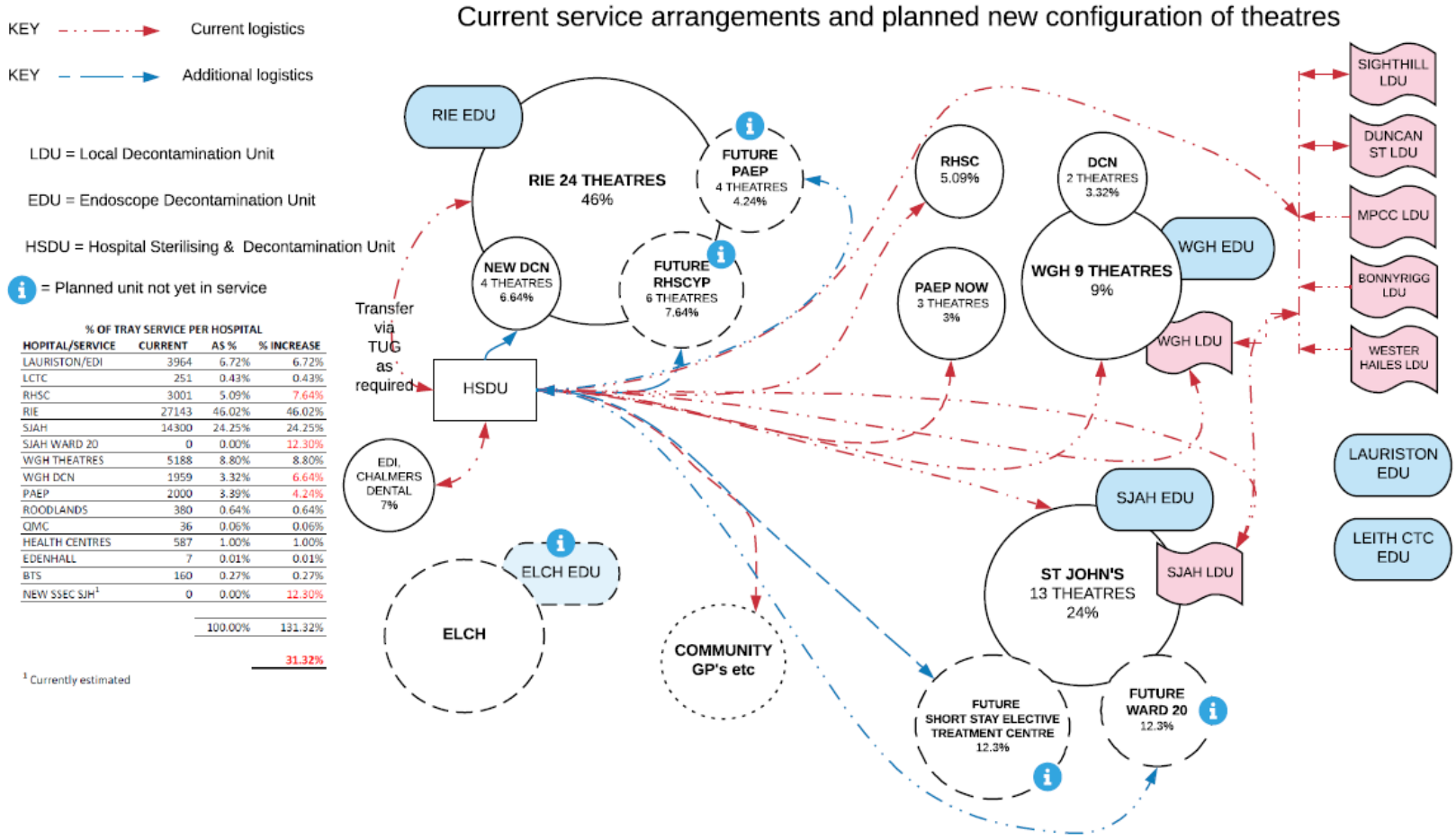
Although there is some contingency for failure of some aspects of infrastructure provided by the design of current HSDU infrastructure, there is currently no viable

contingency plan should the unit as a whole be out of operation. No other units in Scotland could provide contingency for an emergency service for theatres in Lothian without major re prioritization of demand and transfer of surgical equipment to other units presents significant risks in terms of tracking and traceability, certification of the decontamination processes and quality/consistency of tray preparation.

The loss of HSDU department due to failure of services is currently a yellow risk on the Facilities Risk Register as the failure of services is considered possible or likely.

Further information about current services is contained in Figure 1.

*Figure 1 Current service arrangements and planned new configuration of theatres*



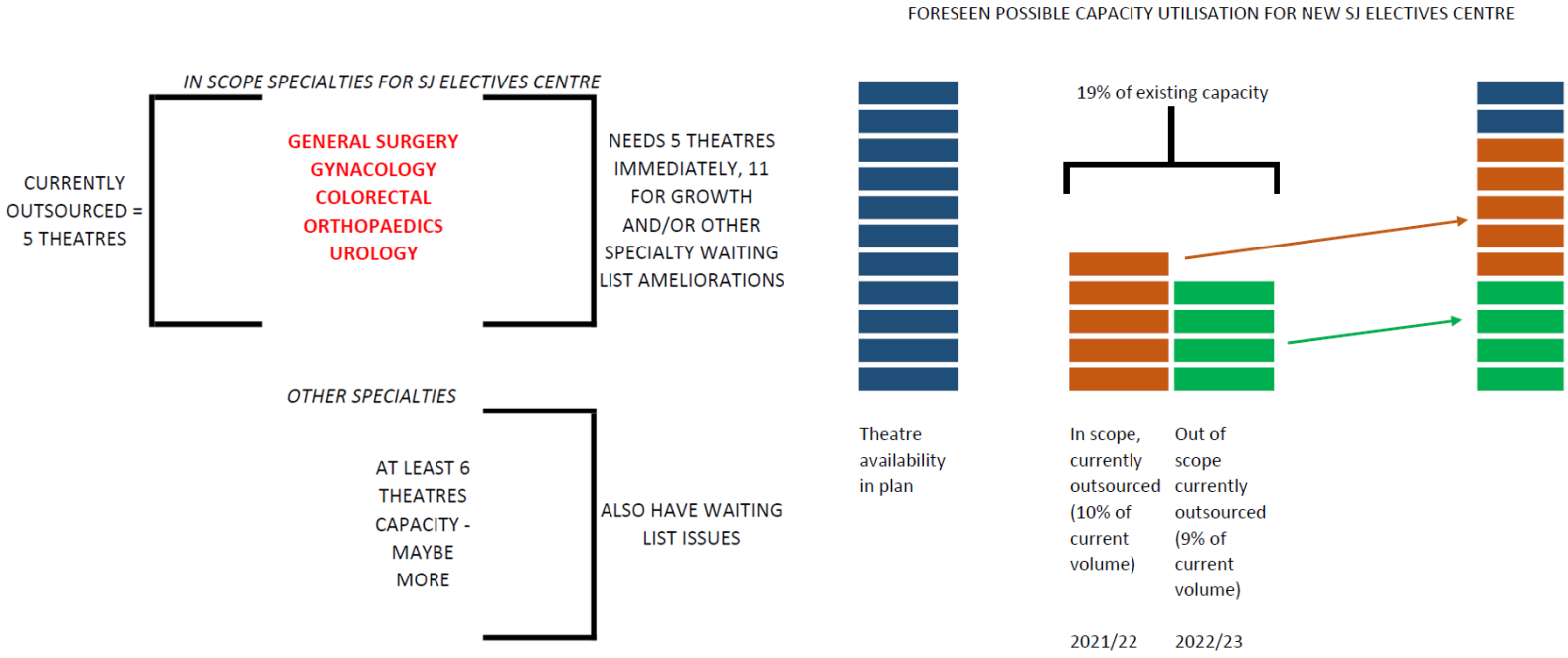

% OF TRAY SERVICE PER HOSPITAL

| HOPITAL/SERVICE | CURRENT | AS % | % INCREASE |
|---|---|---|---|
| LAURISTON/EDI | 3964 | 6.72% | 6.72% |
| LCTC | 251 | 0.43% | 0.43% |
| RHSC | 3001 | 5.09% | 7.64% |
| RIE | 27143 | 46.02% | 46.02% |
| SJAH | 14300 | 24.25% | 24.25% |
| SJAH WARD 20 | 0 | 0.00% | 12.30% |
| WGH THEATRES | 5188 | 8.80% | 8.80% |
| WGH DCN | 1959 | 3.32% | 6.64% |
| PAEP | 2000 | 3.39% | 4.24% |
| ROODLANDS | 380 | 0.64% | 0.64% |
| QMC | 36 | 0.06% | 0.06% |
| HEALTH CENTRES | 587 | 1.00% | 1.00% |
| EDENHALL | 7 | 0.01% | 0.01% |
| BTS | 160 | 0.27% | 0.27% |
| NEW SSEC SJH[1] | 0 | 0.00% | 12.30% |
| | | 100.00% | 131.32% |
| | | | 31.32% |

[1] Currently estimated

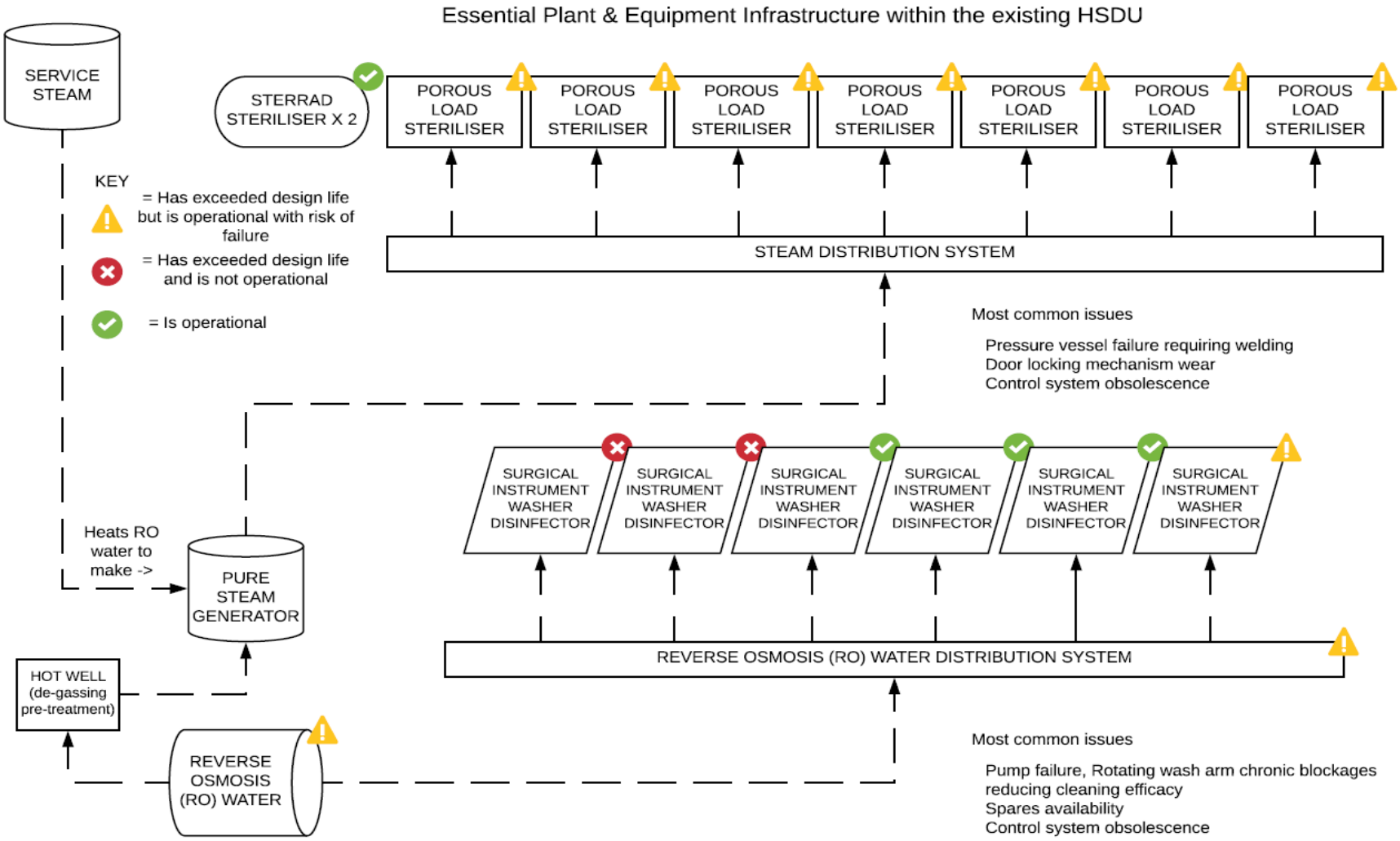
A closer analysis of how the electives services will impact HSDU was carried out. A new surgical building has been proposed to

accommodate these services, to be sited at St John's Campus that has a proposed 11 operating theatres. There are five in-scope specialties that will be directly supported by this plan; General surgery, Gynaecology, Colorectal, Orthopaedics, (not complex – complex will remain at RIE), Urology. These specialties currently outsource around 5 theatres capacity that will transfer to the new electives unit. There are other not-in-scope specialties that also have waiting list objectives to meet and these will either take up freed up outsourced resources or, will more likely take up to four of the new theatres at the new unit. Therefore, very quickly after the new electives centre opens, an additional 20% of capacity at HSDU will be required.



So, this represents 20% increase within two years. Consideration about growth of services up to 2035 would indicate that a year on year growth of 2% would not be an unreasonable estimate which would indicate that a furher 30% capacity will be required during the period. The business case however calculates for 200% current capacity however the figures can be scaled back to 150% if firmer estimates for growth can be assumed. Any new build would be designed for incremental release of capacity over a defined timeline by addition of additional decontamination process equipment although note that the footprint would be constructed from the outset and certain services would be incorporated for reasons of expediance while others can be added incrementally into the building design.

*Figure 2: Essential Plant and Equipment Infrastructure within existing HSDU*



# 4 Why is this proposal a good thing to do?

## 4.1 The Need for Change

Change is essential because the current HSDU:

- Does not meet the current guidance (SHPN 13 Pt 1) for a compliant CDU in terms of layout and design
- Has infrastructure which is beyond its usual lifecycle and requires to be replaced within the next 5 years
- Is meeting its maximum processing capacity for the following reasons:

  the space cannot accommodate any additional washers or sterilisers,

  without carrying out some building remodelling, there is very little scope to increase the space in order to increase staffing numbers on shift to maximise the use of the existing washers and sterilisers.

  as the unit currently operates 24/7 with maximum staffing Monday to Friday and 24/7 but with reduced staffing at weekends the only way to increase capacity is to enhance weekend staffing and the additional capacity that this can provide is limited

- Does not currently have capacity to meet the predicted growth in surgical activity in NHS Lothian by 2021. Reprocessing requirements in HSDU are expected to increase by 31% by 2021 that will largely be contributed by the new Electives Centre in Livingston, increased theatres capacity for RHCYP and DCN and a proposed future PAEP
- Does not have space to respond to developments and innovations which may require installation of additional decontamination equipment, for example to process robotic surgical instrument
- Is not able to provide or to access additional processing capacity should any Boards in Scotland require this contingency

Appendix 7 gives further information on the need for change.

## 4.2 Investment Objectives

The following Investment Objectives address the need for change.

*Table 2 Investment Objectives*

| | **Investment Objectives** | Notes |
|---|---|---|
| O1. | Provide an essential decontamination service to support clinical services of the highest quality and fit for the future | Not projected to be able to fulfil this by 2021 |
| O2. | Minimises the risks in relation to existing HSDU of service disruption or service failure | Quantify the effect of equipment failure |
| O3. | Ensure NHS Lothian Central Decontamination Units/Services meet or exceed required standards | Replacing equipment but remaining not compliant.<br><br>Staff welfare |
| O4 | Maximise the cost effectiveness of the decontamination cycle | Improves operational headroom<br>More appropriate facilities for staff<br>Location of the unit to restrict inventory growth owing to increased logistics |
| O5 | Ensure essential service can meet growth and developments in clinical activity | Illustrated in relation to expected growth in surgical services |
| O6 | Provides defined contingency capacity | Locally<br>Regionally<br>By operating day and back shifts only. |

### 4.3 Critical Success Factors

*Table 3 Critical Success Factors*

| | | |
|---|---|---|
| C1. | Value for money - maximises the return on the required investment | |
| C2. | Supply/ capacity and capability will meet increases in demand and innovation and provide contingency | |
| C3. | Potential achievability | Provides continuity of CDU service for NHS Lothian throughout re-provision<br>Delivered prior to a failure of existing HSDU – i.e. 5 years (figure to be |

| | | |
|---|---|---|
| | | discussed)<br>Delivered in timescale to avoid sunk costs in existing HSDU |
| C4. | Ensuring continuity of supply | E.g. multiple external providers difficult to manage |

### 4.4 Benefits Criteria

*Table 4 Benefits Criteria*

| | **Benefits Criteria** | |
|---|---|---|
| B1 | HSDU meets or exceed required standards | |
| B2 | HSDU supports attainment of quality standards | |
| B3 | HSDU supports attainment of workforce standards | |
| B4 | Provides contingency for NHS Lothian in relation to a CDU unit failing | |
| B5 | Minimises the costs of time from surgery to cleaning | |
| B6 | Maximises the asset value of the surgical instrument inventory | |
| B7 | Maximises the cost effectiveness of surgical services across Lothian | |
| B8 | Innovation, flexibility and future focus | |

## 5 What is the preferred strategic / service solution?:

### 5.1 Opportunities for re-provision of existing HSDU – design report and survey

In June 2018 NHS Lothian prepared a design brief for consideration of the potential to re-provide HSDU in the existing location to maximize potential and to further consider what the maximum potential would be if services were to be maintained on the current site during the works.

NHS Lothian appointed Thomson Gray to undertake this work and data informing their report indicates the following

- New build costs per cubic metre @ £2.2k
- Refurbishment costs per cubic meter (Same figures will be used for HSDU refurb and developing into existing building) @ £1.3k
- WD and Steriliser and associated plant cost data taken from NSS PCF NP174 Framework
- Created a "partial upgrade" scenario that would not meet SHPN13:3 but will improve resilience (e.g. replace plant) of existing unit
- Created a "full upgrade" design that would provide maximum space for wash area, washers and sterilisers that "might" meet SHPN13:1

In August 2019, in light of cost increases that were coming to light for other capital projects, and taking revised capacity calculations into account, a further internal review of projected costs looking only at a full size new build HSDU was carried out that projected costs up to £25m. Thomson Gray was subsequently commissioned to carry out an independent review that estimated costs as £27.2m.

In terms of the opportunities to develop the existing HSDU we had previously put forward the following options:

**Option 1** Minimal refurbishment to meet 2021 capacity requirement. This would be a minimal refurbishment of existing HSDU to increase washroom area and replace existing washer disinfectors in a phased pattern to increase machine capacity and wash room staffing area (assessment of additional capacity based on existing shift pattern 24/7). May have enough staff to maximise washers if enough - no change to staffing

**Option 2** Partial refurbishment of existing HSDU to increase wash area and corresponding areas to current output, no additional capacity.

The HSDU Minimal refurbishment, (really a proposed holding position that could form the first phase of a complete refurbishment), was intended to remove the partition wall in the wash area where the two single chamber washers currently exist to maximise working space for the wash room that creates space for new WD’s that will have a significantly smaller footprint, creating additional floor space in the wash room. Extensive work has been undertaken to establish the feasibility of these works whilst

keeping the unit operational and at a meeting on 2nd March 2020 it was agreed that the risk to operations was too great and consequently it was agreed to scale down the proposal to:

- Replace the existing unserviceable washer disinfectors
- Fully review the workspaces and clear out any features of fixtures, fittings or equipment that were felt to be surplus to requirements.
- Install one further disassembly station within the partitioned area to align with tracking and traceability system implementation.

To avoid confusion, the options have been re-numbered 1-4.

### 5.2 New HSDU at scale - new build or construction within an available building to meet all current and projected demand with standard two shift system

**Option 1 (previously option 4)** a new single HSDU at scale (new build or construction within an available building) to meet all current and projected demand with standard two shift system.

The model outlined above along with SHPN13 forms the basis for analysing required capacity of a new build and estimated costs, as well as estimating the potential processing capacity of a space within an existing building should that become available.

**Option 2 (previously option 5)** a new HSDU and full refurbishment of the existing HSDU

In addition to the above options, and recognition that the refurbishment of the existing HSDU is unlikely to be feasible without a break in production and access to an alternative unit, consideration needs to be given to the option of having two HSDUs via the development of a new HSDU which would enable refurbishment of the existing HSDU. Each HSDU would have potentially have 33% additional capacity available as contingency through adding an extra shift from 2 to 3.

<u>Decentralised local HSDU Model</u>

NHS Lothian has local endoscopy decontamination facilities and local dental decontamination units as shown in Figure 1. NHS Lothian will have four sites with significant surgical instrument reprocessing requirements, RIE and SJH accounting for the overall majority of demand, with the WGH, PAEP and Lauriston Building (EDI and Chalmers Dental Centre) accounting for most of the remaining Lothian demand.

**Option 3: (New option)** Two new build units on different sites, including one new unit at Little France .

Decentralised local HSDU Model

NHS Lothian has local endoscopy decontamination facilities and local dental decontamination units as shown in Figure 1. NHS Lothian will have four sites with significant surgical instrument reprocessing requirements, RIE and SJH accounting for the overall majority of demand, with the WGH, PAEP and Lauriston Building (EDI and Chalmers Dental Centre) accounting for most of the remaining Lothian demand.

**Option 4: (Previously option 6)** Maximally decentralised provision of 3 or 4 CDUs.

Advantages of this approach are: integration with theatres, reduced turnaround time and reduction in travel costs.

### 5.3 Summary table of options:

*Table 5 Summary Table of Options*

| | |
|---|---|
| Option 1 | A new single HSDU at Little France at scale (new build or construction within an available building) to meet all current and projected demand with standard two shift system. |
| Option 2 | A new HSDU and full refurbishment of the existing HSDU |
| Option 3 | Two new build units on different sites, including one new unit at Little France . |
| Option 4 | Local integration model: three or more HSDU. 100% additional capacity. |

All options would require a further site option appraisal.

### 5.4 Criteria for option appraisal of potential sites

There are two potential types of options for a new build facility, purchasing a plot of land and building a unit or purchasing an existing site and building and modifying this.

The purchase and adaptation of an existing facility would offer significant benefits to the board in terms of timescales and costs when compared with the construction of a new facility.

It should be noted that there is an approved IA for the development of a regional catering unit requiring an estimated 6000 $m^2$. This IA notes the potential for any larger sites or buildings to accommodate other non-clinical services including and new Central Decontamination Unit.

Criteria for appraisal of potential sites

- Turnaround time (relates to benefit criteria BC maximising surgical instrument inventory)
- Workforce access

- Stockholding model
- Transport costs
- Land and build costs

### 5.5 Long list to short list criteria

Each of these options was measured against the critical success factors and investment objectives.

*Table 6 Option appraisal in relation to critical success factors*

| | | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|---|
| C1. | Value for money - maximises the return on the required investment | Yes | Uncertain | Yes | Uncertain |
| C2. | Supply side capacity required demand and innovation. | Yes | Yes | Yes | Yea |
| C3. | Potential achievability | No | Yes | Yes | Yes |
| C4. | Ensuring continuity of supply | Better than current | Yes | Yes | Likely |

At this stage, the value for money of each option is uncertain and requires further consideration at OBC.

However only options 4, 5 and 6 can meet the critical success factors.

The results of evaluation of options are presented below:

*Table 7 Option Appraisal in relation to Investment Objectives*

| | **Investment Objectives** | **Option1** | **Option2** | **Option3** | **Option4** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| O1. | Provide an essential decontamination service to support clinical services of the highest quality and fit for the future | YES | YES | YES | Potential |
| O2. | Minimises the risks in relation to existing HSDU of service disruption or service failure | YES | YES | YES | YES |
| O3. | Ensure NHS Lothian Central Decontamination Units/Services meet or exceed required standards | YES | YES | YES | YES |
| O4 | Maximise the cost effectiveness of the decontamination cycle | LIKELY | LIKELY | LIKELY | UNLIKELY |
| O5 | Ensure essential service can meet growth and developments in clinical activity | LESS LIKELY | YES | YES | UNLIKELY |
| O6 | Provides defined contingency capacity | YES (capacity, not facilities) | YES | YES | LESS LIKELY |

**5.6**

| | | |
|---|---|---|
| | Meets Critical Success | Delivers the investment |

| | Factors | objectives |
|---|---|---|
| Option 1 New single HSDU at Little France | NO | NR |
| Option 2 A new HSDU and full refurbishment of the existing HSDU | YES | YES |
| Option 3 Two new build units on different sites, including one new unit at Little France . | YES | YES |
| Option 4 Local integration model: three or more HSDU. 100% additional capacity. | YES | Possible |

*Table 8 Summary of Options to be taken forward to OBC*

| | | |
|---|---|---|
| Option 1 A new single HSDU at Little France at scale (new build or construction within an available building) to meet all current and projected demand with standard two shift system. | Consider | Take forward to OBC |
| Option 2 A new HSDU and full refurbishment of the existing HSDU | Consider | Take forward to OBC |
| Option 3 Two new build units on different sites, including one new unit at Little France . | Consider | Take forward to Take forward to OBC |
| Option 4 Local integration model: three or more HSDU. 100% additional capacity. | Consider | Take forward to OBC |

### 5.7 Revised assessment of capacity

Since the IA was submitted in February, close discussions have been held to evaluate the impact of the SSEC and other service developments. These discussions indicated

that services might be expected to increase to somewhere between 1.5x and 2x current by 2035. Therefore, calculations have been revised to evaluate the area required for facilities capable of providing up to 2x capacity.

Irrespective of the above, figures indicate that an increase in capacity up to 19% will be required by 2021/22 to support planned service developments at SSEC, SJ Ward 20, RHCYP, DCN & PAEP. Option 1 is designed to enable HSDU to support these increases.

### 5.8 Assessment of HSDU re-provision costs Option 1

*Table 9 Option 4 HSDU Re-provision costs: Thomson Gray estimate*

Thomson Gray were commissioned to evaluate the potential cost of building a new HSDU.

The volume of output for a HSDU is described in DIN units per time period. The cost models below assumes a fully new build facility, sized to 2 x current capacity, (7990 DIN/Week) running 2 shifts/day over 7 days.

| Element | Quantity | Unit | Rate | Total (£) |
|---|---|---|---|---|
| **Base build** | | | | |
| HSDU Redevelopment | 3,334 | m2 | 3,500 | 11,669,000 |
| Gantry / walkway | 45 | m2 | 500 | 22,500 |
| First floor - Plant area | 2,138 | m2 | 1,500 | 3,207,000 |
| External works allowance | 5,472 | m2 | 370 | 2,024,640 |
| **Group 2 equipment** | | | | |
| Sterilise (built in steam gen) unit cost inc commissioning | 6 | Nr | 52,000 | 312,000 |
| WD unit cost inc commissioning | 8 | Nr | 60,000 | 480,000 |
| Sterrad (estimated cost) | 4 | Nr | 60,000 | 240,000 |
| RO units (duplex inc ring) | 1 | Nr | 200,000 | 200,000 |
| HVAC | 1 | Nr | 300,000 | 300,000 |
| Furniture, PC's, screens, desks, lockers etc | 1 | Nr | 500,000 | 500,000 |
| **Prime Cost Sub-Total** | | | | 18,955,140 |
| Preliminaries | 14.00% | | | 2,653,720 |
| **Construction Sub-Total** | | | | **21,608,860** |
| **Add On Costs** | | | | |
| Fees | 10% | item | | 2,160,886 |
| Contractor OHP | 5.0% | item | | 1,080,443 |
| Risk | 10.0% | item | | 2,160,886 |
| Statutory Fees | | item | | 100,000 |
| Surveys | | item | | 100,000 |
| **TOTAL (Excl Inflation)** | | | | **27,211,075** |

The modelled scenario indicates that a new build HSDU to provide 100% additional capacity with 2 shifts over 7 days would require a floor area of 3318 m2 and cost £27.2 million[2]. The costs above exclude land and revenue costs. That is the costs pertain to build, plant infrastructure and equipping. At present although staffing numbers and shift patterns have been modelled, the staffing costs have not yet been entered into the model.

[2] Slight variation between TG estimates and this paper are owing to small variation on target capacity figures arising from more recent review. Current figure is £28.5 million.

A revised estimate (March 2020), for option 1 largely concurs with the Thomson Gray estimate as shown:

| **Full scale new build HSDU, Standard 2 x shift pattern, closing existing HSDU** | | |
|---|---|---|
| | DIN P/W Output | Unit area m2 |
| Build area necessary to fulfil production target | 7990 | 3318 |
| | | |
| Estimated new build cost | | **£28,442,032** |

## 5.9 Cost assessment to refurbish existing HSDU

The proposal indicates that once the new HSDU has been completed, service from the existing HSDU would be transferred to the new unit to enable the existing HSDU to be refurbished. Compliance with the planning note would not be achieved and increasing capacity would be, at most +30%. Refurbishing the existing HSDU to provide 44% of target capacity would operate within a floor area of 1733m$^2$ and has been estimated to cost £5 million, e.g.:

| | |
|---|---|
| Estimated minimum refurbishment cost[3] | £4,988,134 |

## 5.10 Assessment of costs for Option 2: a new HSDU and full refurbishment of the existing HSDU

The modelled scenarios assume a change from 3 shifts/day to 2 shifts/day which means that existing HSDU capacity will reduce by one third, (i.e. reducing shift time = lower output). Consequently, in terms of the target capacity of 7990 DIN/Week, the new build capacity would therefore needs to soak up that 1/3 capacity loss and be increased by 1/3.

[3] Will not comply with the current planning SHPN13 Part 1: Central Decontamination Units

Consequently, the modelled scenarios indicates that a new build HSDU to provide 56% of target capacity with 2 shifts over 7 days would require a floor area of 1585 $m^2$ and has been estimated to cost £13.6 million to be added to the refurbishment cost of the existing HSDU of £5 million, e.g. £18.6 million in total. These estimates exclude land and revenue costs. That is the costs pertain to build, plant infrastructure and equipping.

Once the existing HSDU refurbishment has been completed, 44% of capacity would operate from the refurbished HSDU and 56% be delivered from the new unit. There would also be an overall 33% additional contingency capacity available from each unit available by starting up a night shift in the event that this was needed by NHS Lothian or any other Health Board.

| **Existing HSDU, standard 2 x shift pattern + smaller scale new build HSDU** | | |
|---|---|---|
| | | |
| Target capacity = 2 x 3995, less refurbished HSDU capacity | DIN P/W Output | Unit area m2 |
| Peak output possible in refurbished HSDU (refurbished area 1733 / required area 1991) under 2 x shifts / 7 days | 3516 | 1733 |
| Remaining output requirement after refurbishment (=New build HSDU) | 4474 | 1585 |
| Overall total capacity of refurbished HSDU and new build HSDU = 7990 | 7990 | |
| Estimated minimum refurbishment cost[4] | | £4,988,134 |
| Estimated new build cost | | £13,586,684 |
| | | |
| Estimated total cost | | **£18,574,818** |

## 5.11 Assessment of costs for Option 3 - Two new build units closing existing HSDU.

| **2 x new build HSDU, standard 2 x shift pattern, closing existing HSDU** | | |
|---|---|---|
| Target capacity = 2 x 3995, less refurbished HSDU capacity | DIN P/W | Unit area m2 |

[4] Will not comply with the current planning SHPN13 Part 1: Central Decontamination Units

| | Output (each) | (each) |
|---|---|---|
| Peak output possible in each new HSDU under 2 x shifts / 7 days | 3995 | 1659 |
| Overall total capacity of both new build HSDU | 7990 | |
| | | |
| Estimated new build cost per HSDU | | £14,221,016 |
| Estimated new build cost | | **£28,442,032** |

## 5.12 Assessment of costs for Option 4 - Maximally decentralised provision of 3 (or 4) CDUs.

| **3 x new build HSDU, standard 2 x shift pattern, closing existing HSDU** | |
|---|---|
| Smaller scale new build, standard shift pattern, keeping refurbished HSDU | |

## 5.13 Other factors

Other factors to consider when estimating the capacity that a new unit is required to fulfil.

Capacity isn't simply the sum of ***FLOOR AREA x STAFF x REPROCESSING EQUIPMENT***. The efficiency of the overall operation has to be accounted for. While the proposed works will increase the potential capacity of the unit, there are other factors at play that also make a direct contribution to efficiency and capacity. These factors are described below.

## 5.14 New Tracking & Traceability system

A new tracking and traceability system is in the process of being implemented in NHS Lothian. The new system joins up the procedure planning processes for theatres with materials fulfilment from HSDU; when a procedure is planned, the HSDU production management system is automatically notified about what has been planned, where it is being scheduled and which materials are required for the procedure. This means that since there is a direct connection between the demand and fulfilment processes, HSDU will be able to anticipate, well in advance in some cases, theatre requirements and respond to them automatically. Currently, HSDU reprocesses materials without having priority visibility. This works to some extent however on a daily basis all theatres, (54 of them), contact HSDU daily to request prioritisation in accordance with scheduled list requirements.

## 5.15 Enabling the Tracking and Traceability system

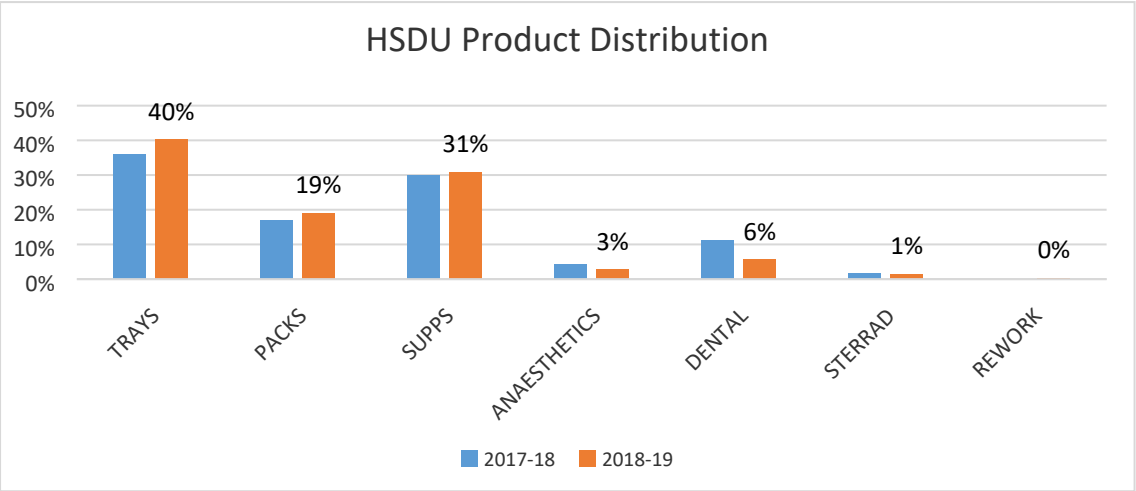
Historically, owing to a range of factors that were described in the FBC for Tracking & Traceability, (T&T), the surgical set inventory has not been fully maintained leading to some instrument and set shortages that is manifested by sets being routinely in circulation with instruments missing. This leads to theatre staff opening additional sets to obtain the needed instruments and of course causes additional reprocessing to be required as well as falling foul of guidance that requires instruments to be maintained within their parent sets.

In addition to shortages, the ratio of supplementary instruments, ("supps"), to sets is currently very high. It is thought that the demand for supps has may have increased as the set inventory degraded. A new regime of "set integrity" will be applied in HSDU under the new T&T system which means that:

- Sets will be complete and fit for purpose on dispatch from HSDU
- Theatres are not permitted to source instruments from other trays if and when a fault has been identified. They must return the defective tray and open a duplicate. (Obviously can be waived under exceptional circumstances if doing so would risk a patient)
- Frequently used supps will be added to trays
- Infrequently used instruments will be converted to supps

## 5.16 Improving the surgical instrument inventory and maintaining it.

In order to support the new T&T system and its control processes, a substantial enabling process is underway that is methodically reviewing the entire surgical set inventory to meet the objective of the Right set, in the Right place, of the Right quality, at the right time. This is described in Appendix 11. The review is ensuring that instruments that are needed in sets are part of the set design and instruments that are rarely needed are converted to supplementary packs. This will reduce the overall reprocessing transaction time significantly, creating more headroom in the unit for training, quality control and additional reprocessing. The table below shows that production of trays is running at 40% and Supps at 31%. The relationship should be closer to 60% trays and 10% Supps since supps are by their nature, less frequently used.




The most significant impact that the new T&T system will have is that a great deal of processes that are currently carried out manually will be automated. Prioritisation will be automated according to planned procedure requirements. At the moment, each of NHS Lothian's 54 theatres contact HSDU on a daily basis via a combination of email and telephone calls to request fast tracking of their requirement materials. The labour transactions involved with this are considerable and are continuous. There will rarely be a need for staff to do this under the new system since planning will have already directed prioritisation and set benchmarking combined with set integrity will have ensured that enough materials are available in the system.

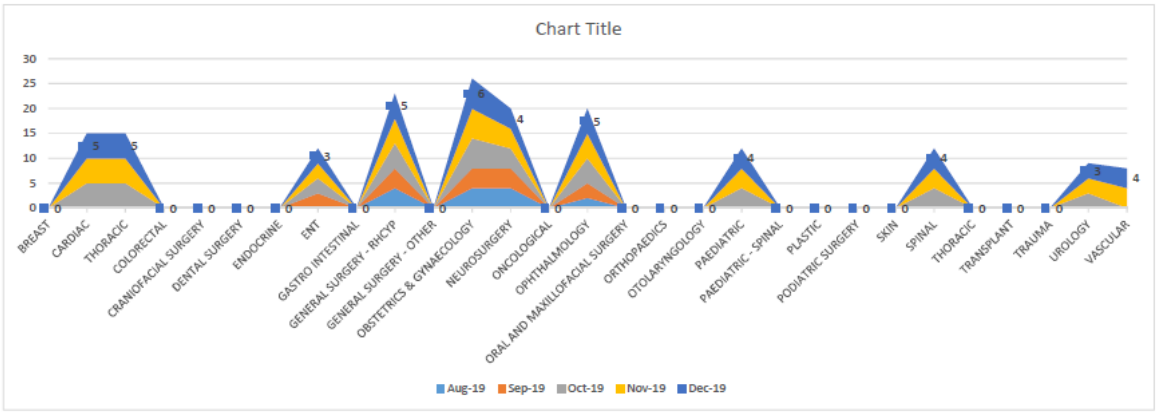
The progress of the T&T project is monitored via the Surgical Instrument Cycle Programme Board via monthly updates similar to the following:

Tracking and Traceability - Benchmarking Report

| SPECIALTY | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 |
|---|---|---|---|---|---|
| BREAST | 0 | 0 | 0 | 0 | 0 |
| CARDIAC | 0 | 0 | 5 | 5 | 5 |
| THORACIC | 0 | 0 | 5 | 5 | 5 |
| COLORECTAL | 0 | 0 | 0 | 0 | 0 |
| CRANIOFACIAL SURGERY | 0 | 0 | 0 | 0 | 0 |
| DENTAL SURGERY | 0 | 0 | 0 | 0 | 0 |
| ENDOCRINE | 0 | 0 | 0 | 0 | 0 |
| ENT | 0 | 3 | 3 | 3 | 3 |
| GASTRO INTESTINAL | 0 | 0 | 0 | 0 | 0 |
| GENERAL SURGERY - RHCYP | 4 | 4 | 5 | 5 | 5 |
| GENERAL SURGERY - OTHER | 0 | 0 | 0 | 0 | 0 |
| OBSTETRICS & GYNAECOLOGY | 4 | 4 | 6 | 6 | 6 |
| NEUROSURGERY | 4 | 4 | 4 | 4 | 4 |
| ONCOLOGICAL | 0 | 0 | 0 | 0 | 0 |
| OPHTHALMOLOGY | 2 | 3 | 5 | 5 | 5 |
| ORAL AND MAXILLOFACIAL SURGERY | 0 | 0 | 0 | 0 | 0 |
| ORTHOPAEDICS | 0 | 0 | 0 | 0 | 0 |
| OTOLARYNGOLOGY | 0 | 0 | 0 | 0 | 0 |
| PAEDIATRIC | 0 | 0 | 4 | 4 | 4 |
| PAEDIATRIC - SPINAL | 0 | 0 | 0 | 0 | 0 |
| PLASTIC | 0 | 0 | 0 | 0 | 0 |
| PODIATRIC SURGERY | 0 | 0 | 0 | 0 | 0 |
| SKIN | 0 | 0 | 0 | 0 | 0 |
| SPINAL | 0 | 0 | 4 | 4 | 4 |
| THORACIC | 0 | 0 | 0 | 0 | 0 |
| TRANSPLANT | 0 | 0 | 0 | 0 | 0 |
| TRAUMA | 0 | 0 | 0 | 0 | 0 |
| UROLOGY | 0 | 0 | 3 | 3 | 3 |
| VASCULAR | 0 | 0 | 0 | 4 | 4 |

Key

0-Not Started
1-Specialty Procedure List
2-Corresponding Set Requirements
3-Record Set Type Info into Excel
4-Record Instances of Set Types into Excel
5-Make Set Design Proposals
6-Evaluate Set QTY Requirements
7-Review & Revise ORSOS Trak Codes
8-Define min and max local set store stock levels
9-Evaluate Design & Remediation CAPEX
10-CAPEX Request to Finance
11-Implement as Approved by Finance
12-Implement UID process for IPG 196 Post 96 Sets
13-Specialty fully transferred onto new system




# 6 Is the organisation ready to proceed with the proposal?

## 6.1 Commercial case

The appropriate procurement route will depend on the specification of the options explored further through OBC. Consideration will be taken of appropriate frameworks, including FS2 and Hub, to ensure value for money and speed of procurement.

### 6.2 Financial Case

The model contains capital and equipping costs. Revenue costs of options 4, 5 & 6 (Pay, ground rent, services etc.), will be modelled in more detail in the OBC in context with existing figures, however high level capital and revenue estimates are summarised in the table below.

Capital and revenue affordability will be assessed through a more detailed understanding of costs at OBC stage.

Capital expenditure is assumed to be funded through a specific SGHSCD capital allocation, potentially linked to business cases that a driving increases, however the Board will consider alternative funding models as part of the OBC.

Additional revenue requirements will be linked to business cases in Governance that drive the additional demand, as well as assumed future NRAC funding.

### 6.3 Management Case

#### 6.3.1 Governance to date and going forward

Timescales for the re-provision of HSDU are driven by:

- The current status of the infrastructure which is beyond its lifecycle and requires replacement. If the infrastructure cannot be validated for use this will either necessitate replacement or reduce the capacity of HSDU. It could lead to critical failure of service for which there is no contingency.
- The current growth in demand and specifically the planned growth in surgical capacity at the Short Stay Elective Centre at SJH.

The Strategic Assessment for re-provision was approved by LCIG in July 2016.

A paper updating on the development of an Initial Agreement for Re-provision of HSDU was supported by LCIG October 2018 and CMT in November 2018.

The chart below shows the organisational governance and reporting structure that will be put in place to take forward the development.

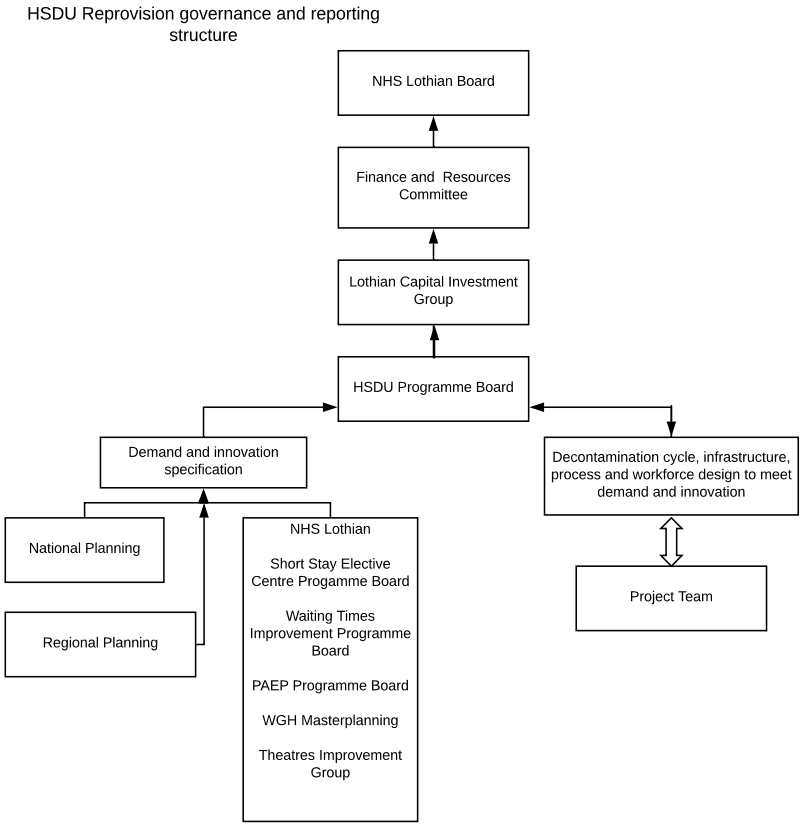



*Figure 3 HSDU Re-provision governance and reporting structure*

HSDU re-provision Project Board

*Table 10 HSDU Re-provision Project Board*

| | |
|---|---|
| Jane Hopton | Programme Director Facilities |
| Robert Aitken | Associate Director Facilities and Operational Lead for HSDU |
| Brian Douglas | Head of Hard FM NHS Lothian and NHS Borders |
| David Hill | Project Manager |
| Nick Bradbury | Head of Capital Finance |
| Laura-Jane Smith | Capital Finance |
| Angus MacIsaac | NHS Lothian Partnership |
| *To be confirmed* | Lead for Demand and Innovation Specification |

Reference Group: Demand and Innovation

The Project Board will need the specification for demand and innovations (any innovations in procedures that may impact on future design). There are already several planning groups within NHS Lothian working on future demand, as indicated above. There needs to be an agreed planning process and lead for providing the demand and innovation scenarios so that the Project Board can use these to model design, scale and process.

There is potential to ensure re-provision provides capacity or specified contingency for additional NHS Boards.

In the absence of specific direction from NHS Scotland or other NHS Boards, the project board proposes that the two shift model which meets NHS Lothian projected demand will provide specified contingency through the availability to put in place a night shift.

# 7 Next Steps

Confirm lead for Demand and Innovation as above.

Appoint senior project manager.

The assembly of a competent design team with a clear understanding of their individual and collective responsibility in producing designs and final cost estimates for a HSDU fit for purpose is key to the overall project delivery. The project will require a development team to complete the specification brief that describes capacity, engineering, services, decontamination & procurement covering areas such as pure steam, sterilisation and decontamination processes, reverse osmosis water, IT and networking, automation, logistics, carbon footprint & BREEAM.

NHS Lothian has most of these skills in house however there will be a need to adequately resource and supplement the project manager to enable them to assemble a dedicated team working on the FBC and its subsequent implementation. The dedicated project staff will require to be complemented with appropriate subject matter experts who can inform the design and planning process.

An objective development process:

As discussed in 2.1, the design planning process will follow the guidance provided by SHPN13 Part 1.

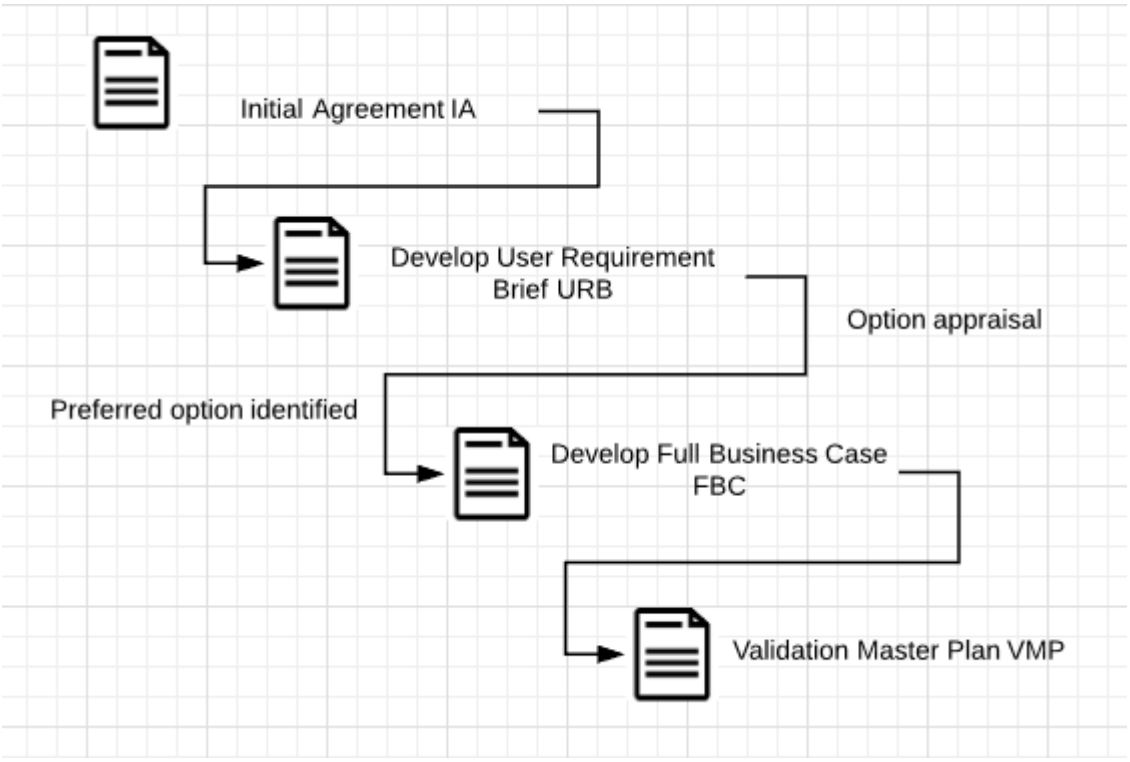
*User Requirements Brief*

The design objective requires input by way of a clear User Requirement Brief (URB) that will be prepared by the HSDU re-provision Project Board that will define the objectives that the preferred option must meet. The URB will be used to finalise the preferred option design and to develop the final capital and revenue models.

The development of the FBC will include a preparatory phase where the options taken forward from this IA are examined in context with the URB under a feasibility process that develops corresponding capital and revenue models leading to a preferred option being realised.

*Validation Master Plan*

All new build and upgrading of CDUs will require to be validated in accordance with the requirements of the quality management system BS EN ISO 13485. The URB development process and final specification naturally forms a means to validate that what is being proposed meets the objectives. Therefore, there should be a Validation Master Plan (VMP) for the project which will define the qualification exercises required for the design, installation, operation and performance of the facility. The VMP reflects the criteria established in the URB so that the objectives set in the URB can be objectively measured. Ensuring compliance with the VMP, which is generated and approved by the design team, is critical to the delivery of a CDU that is fit for its intended purpose. The requirements for a URB and a subsequent VMP arises directly from the Scottish Health Planning Note



A specific feature of the development of the URB will consider designing sufficient contingency for NHS Lothian and some contingency for other Health Boards built in to the proposal.

## 8 Figures, Tables and Appendices



| | |
|---|---|
| Appendix 1 | AEDAT Generic Design Statement Review |
| Appendix 2 | Overview of Scottish Health Planning Note 13 Part 1, (SHPN13:1) |
| Appendix 3 | Known growth in surgical activity |
| Appendix 4 | HFS audit: Compliance of existing HSDU with SHPN 13 Part 1 |
| Appendix 5 | Explanation re existing HSDU infrastructure |

| | |
|---|---|
| Appendix 6 | *No longer applicable* |
| Appendix 7 | Overview of need for change |
| Appendix 8 | Strategic Assessment |
| Appendix 9 | Thomson Gray - HSDU Redevelopment - RIE - Feasibility Cost - New Build (rev B) |
| Appendix 10 | *No longer applicable* |
| Appendix 11 | Paper describing the process of set benchmarking, currently underway. |
| Appendix 12 | Review of HSDU capacity and work area. |

**FINANCE AND RESOURCES COMMITTEE**

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 25 March 2020 by videoconference.

**Present:** Mr M. Hill, Non Executive Board Member (chair); Mr T. Davison, Executive Director; Ms T. Gillies, Medical Director; Ms S. Goldsmith, Finance Director; Mr A. McCann, Non Executive Board Member; Councillor J. McGinty, Non Executive Board Member; Mr B. McQueen, Non Executive Board Member; Mr P. Murray, Non Executive Board Member; Ms E. Roberton, Interim Board Chair.

**In Attendance:** Mr J. Crombie, Deputy Chief Executive; Mr I. Graham, Director of Capital Planning and Projects; Mr A. McCreadie, Head of Management Accounts; Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes); Mr D. White, Strategy, Planning and Quality Manager, Edinburgh HSCP (item 39.3).

**Apologies:** Mr C. Marriott, Deputy Director of Finance; Professor M. White, Non Executive Board Member.

**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.*

**38. Committee Business**

38.1 Minutes and Actions from Previous Meeting (26 February 2020)

38.1.1 The minutes from the meeting held on 26 February 2020 were approved as a correct record.

38.1.2 The updated cumulative action note had been previously circulated.

38.2 Committee's oversight of risk

38.2.1 Mr Payne presented the previously circulated paper. It was noted that although risks were readily added to the risk register when needed, they were less readily removed when the risk was reduced. This did not reflect the good work done on mitigating risks. A more objective and evidence based approach would be beneficial.

38.2.2 Members agreed that the approach laid out in the paper was helpful and accepted the recommendations. This work would be brought forward when there was capacity to do so.

38.2.3 Mr Crombie advised that the risks of the COVID-19 situation were being clarified and a full paper and discussion would be taken to the Board on 8 April 2020 covering all services. A brief paper updating the risk register could also be submitted.

38.2.4 Mr Davison advised that the priority in the coming weeks was the COVID-19 response and maintaining urgent care, and this should be reflected in the considerations of all the governance Committees during this period.

**39. Capital**

39.1 Property and Asset Management Investment Programme

39.1.1 Mr Graham presented the previously circulated paper, advising that it was written before the COVID-19 response had become the main priority. It was noted that there had been a pause in the oncology enabling works due to negotiation on the contract, but the works were expected to continue and would not be restricted by the COVID-19 response.

39.1.2 However, COVID-19 was having a significant impact on work on the estate with the majority of projects no longer active. Work that was still ongoing included imaging works, oncology enabling works, and the RHCYP/DCN.

39.1.3 It was noted that the parking element of the St John's Hospital elective care centre project had been separated from the project but would continue simultaneously. This would be reported to the same project team, and a separate line would be added to the next PAMIP report to include updates on the car parking. **IG**

39.1.4 Mr Crombie advised that NHS Lothian was working closely with the Scottish Government on the requirements of the COVID response and work was being done to maximise the capacity of existing facilities on all three acute sites with escalation plans in place. Car parking expansions had also been agreed on all three sites. Hotels had been made available to NHS Lothian and would be used if required in the first instance for staff accommodation. Other work included expanding the use of clinics, and use of private facilities. It was noted that the limiting factor for capacity was staff, rather than facilities.

39.1.5 Members accepted the recommendations laid out in the paper.

39.2 Royal Hospital for Children and Young People and Department for Clinical Neurosciences

39.2.1 Ms Goldsmith presented the previously circulated paper on the supplemental agreement 2, and gave an update on progress with the project. The agreement was still under negotiation with the contractor. The supplemental agreement would be an addendum to the original business case for the project and gave the detail for approval of capital spend. This would be approved by the Oversight Group as the funding was being provided directly from the Scottish Government and not from NHS Lothian's capital plan. The target cost was £6 million. Due to the size of the amount, this would be submitted to the Board to approve on 8 April 2020.

39.2.2 The initial target of agreement with IHSL by 18 March 2020 had been missed, but agreement had been made on the specification of the air handling unit which would be ordered as soon as the project specification was complete. It was not thought that this would affect the overall timescales of the project. The air handling unit to be purchased was being produced in the UK and so should not be delayed by COVID-19 restrictions.

39.2.3 The ventilation design would continue to develop as needed after the supplemental agreement had been made. The detailed design had been received and all relevant parties would be asked to sign this off.

39.2.4 The supplemental agreement would cover the scope of IHSL responsibilities; NHS Lothian's responsibilities; and the target completion date and target costs. IOM would carry out tests and they and NHS Lothian would have a say in confirming completion of the works. The agreement included the ability for the Board to terminate or change the ventilation works as they continued without this affecting the project overall. The Board was taking on risk but the contractor had already carried out work on the project design and there was a high degree of confidence on the timescale laid out as long as there were not delays to the supply chain due to COVID-19. The Scottish Government had announced that morning that construction work on hospitals would continue.

39.2.5 The fire safety work to DCN continued as planned and would be completed by 17 April 2020. The plan was to go ahead with the move according to the planned timescales as this would help with capacity at the Western General Hospital for the COVID-19 response as it would move neurological cases requiring intensive care to the Royal Infirmary, allowing more space at the WGH for COVID cases. The WGH would be the main centre for COVID patients making use of single rooms in the wards at the Royal Victoria Building.

39.2.6 Further to this, it had had been agreed that as part of the lead in time for moving to DCN was due to notification time for outpatients appointments that had now been cancelled because of the COVID-19 response, it could be possible to move in to the new DCN two weeks earlier by shortening the commissioning period. It had been agreed that all the work planned could be completed in this time. This would be discussed at the Oversight Group on 26 March. The date to make the final decision on the move to DCN would remain 9 April 2020 as planned. Ms Roberton advised change to an early move in date should not be announced before it could be announced in parliament. As re-registered staff became available resources could be directed at helping with the move, with staff on both sites.

39.2.7 The RHCYP/DCN work would continue as planned and the building would not be used as part of the COVID-19 response. This was because the equipment in the hospital was paediatric equipment and not suitable for adults.

39.2.8 Members agreed to recommend that the Board accepts the recommendations laid out in the paper.

39.3 <u>Initial Agreement – Provision of General Medical Services Edinburgh South</u>

39.3.1 The chair welcomed Mr White to the meeting and he presented the previously circulated paper. It was noted that the arrangements laid out were commercially confidential as they referred to contract agreements. The proposal was for reprovision of two south Edinburgh GP practices with the possibility of the inclusion of a further small practice.

39.3.2 Although the proposed new premises was at the corner of the catchment area it was on a main road and patient location had been reviewed showing that most were nearby and those in Marchmont were within 0.5 miles.

39.3.3 One of the GP practices was currently leasing premises shared by a private dental practice. Both practices had a disagreement with the landlord regarding rent and building maintenance and the dental practice was also planning to relocate.

39.3.4 As this proposal had been put together quickly to take advantage of attractive premises becoming available, the usual consultation process had not been carried out, however Mr White advised that the move would address previous discontent of members of the public when another south Edinburgh practice had been moved from the area.

39.3.5 Mr White advised that no further reassessment had been done in terms of COVID-19 restrictions but that this was an excellent opportunity to reprovide these practices and so it should be progressed as soon as possible.

39.3.6 Members accepted the recommendations laid out in the paper.

39.4 NHS Lothian Capital Prioritisation Process and Output for 2020/21

39.4.1 Mr Graham presented the previously circulated paper. It was noted that the mention in the paper of the focus on the existing estate referred to the money received from the Scottish Government specifically for continuous projects that did not require a business case, such as IT services, backlog maintenance and equipment. This was generally on the existing estate but could include some small works on GP practices.

39.4.2 It was suggested that the financial plan may be revisited following the new ways of working which the COVID-19 response had caused to be implemented, including home working and virtual outpatients appointments which could continue to be of benefit in the long term.

39.4.3 Members accepted the recommendations laid out in the paper and approved in principle although there was not a full discussion because of other priorities at this time.

**40. Revenue**

40.1 2019/20 Financial Position

40.1.1 Mr McCreadie presented the previously circulated paper and noted that the paper did not include any financial impact of the COVID-19 response. Since the writing of the paper GP prescribing spend through community pharmacies had had an increase in

demand of 100%. This was likely to be due to people drawing prescriptions early; more information was being sought.

40.1.2 Members accepted the recommendations laid out in the paper.

40.2 2020/21 Financial Outlook

40.2.1 Mr McCreadie presented the previously circulated paper; again, this did not include any financial impact of the COVID-19 response. The current discussions with the Scottish Government were that any additional spend on the COVID-19 response would be covered by the Scottish Government by additional allocation; details had not yet been confirmed.

40.2.2 Ms Goldsmith advised that the financial plan was still required to continue working, but that there may need to be a further review later as some spend has been temporarily reduced due to the reduction of services as part of the COVID-19 response.

40.2.3 It was noted that the office365 business case and purchase had been arranged nationally without any method of approval of spend by individual Boards. This had been raised and more work was being done retrospectively to ensure the business case was robust.

40.2.4 Referring to the second point in recommendation 2.1 in the paper, Ms Goldsmith advised that this was related to the alignment of the Board strategy with the financial strategy to ensure that financial plans took into account the care deficit. Work was ongoing with Pete Lock, Director of Improvement, on measuring the impact of financial planning.

40.2.5 A number of significant changes had been made as part of the COVID-19 response and Pete Lock would look at measuring the impact of this to see whether changes were sustainable for the future. This would be part of the 'recovery' planning post COVID-19 which would be discussed at the Board including which of the key elements there should continue to be a focus on during COVID and recognising the change in working practices in the areas where work had temporarily stopped and the impact of this.

40.2.6 Members accepted the recommendations laid out in the paper.

**41. Committee Business**

41.1 Reflection on the meeting

41.1.1 This was the first meeting held by videoconference and members were satisfied that this had been successful. Microsoft Teams would be available for future meetings and included further features. Mr McCann suggested that videoconference etiquette guidelines should be established.

41.1.2 It was noted that a paper on processes that were necessary for the Board during the focus on COVID-19 would be discussed at the Board and that the results would be shared. This may affect the meeting schedule.

41.1.3 Mr Davison advised that a daily situation report on COVID based on the daily report being sent to the Scottish Government would be developed for all Board members to receive; this included the number of cases and suspected cases in the hospitals and capacity. Weekly briefings with non executive members could also be held with one or two executive directors present at each.

**42. Date of Next Meeting**

42.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 22 April 2020**, by videoconference.

**43. Meeting Dates in 2020**

43.1 Further meetings would take place on the following dates in 2020:
- 20 May 2020;
- 17 June 2020;
- 22 July 2020;
- 26 August 2020;
- 23 September 2020;
- 28 October 2020;
- 25 November 2020.

Signed by the Chair
Date: 23 April 2020

Original kept to file

East Lothian
Integration Joint Board

# MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

## THURSDAY 27 FEBRUARY 2020
## COUNCIL, CHAMBER, TOWN HOUSE, HADDINGTON

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**Voting Members Present:**
Councillor F O'Donnell (Chair)
Councillor S Akhtar
Dr P Donald
Councillor N Gilbert
Ms F Ireland
Mr A Joyce
Councillor S Kempson
Mr P Murray

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

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

**Visitors Present:**
Mr D Williams, Scottish Government

**Clerk:**
Ms F Currie

**Apologies:**
Dr G Choudhury
Ms L Cowan
Dr J Turvill
Ms L White

**Declarations of Interest:**
None

The Chair advised members that she may have to leave the meeting early. In that event the Vice Chair, Peter Murray, would chair the remainder of the meeting.

## 1. CHANGES TO THE MEMBERSHIP OF THE IJB

The Chief Officer had submitted a report informing and seeking approval from the IJB for changes to its voting and non-voting membership.

The Chair presented the report and invited Patricia Donald and Marilyn McNeill to provide a brief summary of their experience and what they would bring to the IJB.

Mr Murray welcomed Dr Donald's appointment as a new voting member and Ms McNeill's re-appointment for a further term as a non-voting member. He added that he was particularly pleased to support the appointment of a new public health representative as this was an important area of focus for the IJB.

The Chair added her own welcome to the new and returning members.

**Decision**

The IJB agreed to:

i. note the appointment of Dr Patricia Donald as a NHS Lothian voting member of the IJB, for the maximum term of office;
ii. approve the re-appointment of Marilyn McNeill as a service user representative and non-voting member, for the maximum term of office; and
iii. approve the creation of a new public health non-voting member of the IJB and the appointment of Dr Philip Conalglen in this role.

## 2. MINUTES OF THE EAST LOTHIAN IJB MEETING ON 5 DECEMBER 2019 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board (IJB) meeting on 5 December 2019 were approved.

## 3. MATTERS ARISING FROM THE MINUTES OF 5 DECEMBER

The following matters arising were discussed:

**Item 10** – Councillor Gilbert asked for an update and whether the new Community Hospital had been integrated into the Winter Plan.

Alison MacDonald reported that dormant wards in the new hospital had been successfully utilised to provide an additional 12-14 beds and that this had been fully funded through additional winter monies from the Scottish Government. However this funding would run out at the end of March and Ms MacDonald was currently seeking to extend the funding as the beds were likely to be required for an additional period.

**Item 7** – the Chair asked for an update on the review of the Change Board structure.

Paul Currie advised that the change board structure, specifically the groups dealing with primary care and mental health issues, had recently been the focus of a review by Internal Audit with a report likely to be completed in the next couple of weeks. The

Partnership's own review of the change board structure would take account of the audit findings as well as consulting with members of the boards and reference groups. A report would be brought to a future meeting of the IJB to present the findings of this review.

The Chair referred to a comment in the minutes about providing updates to members on the work of each of the Change Boards. She asked if these updates could be circulated via the Clerk. Mr Currie agreed to take this forward.

## 4. CHAIR'S REPORT

The Chair reported on East Lothian Council's budget proposals for 2020/21 which were to be considered at a meeting of full Council on 3rd March. She outlined some of the key issues around the social care budget and the likely impact for the Health & Social Care Partnership.

She also reported on a recent meeting of the Strategic Planning Group which had included papers on carers' funding, presented by David Binnie, and primary care presented by Dr Jon Turvill.

Councillor Shamin Akhtar thanked the Chair for her update and suggested it might be helpful for IJB members to see any additional briefing material that might be available to help them understand the implications of Council budget decisions.

The Chair agreed that further information would be useful when the IJB came to determining whether the budget offers from their partners were 'fair and adequate'.

Claire Flanagan acknowledged that Health Boards were facing similar challenges to those of local authorities. She added that NHS Lothian was currently sitting below its fair share of the NRAC formula which meant that it was likely to get additional funding from the Scottish Government to give it parity with other health boards.

Peter Murray also reported on meetings and development sessions he had recently attended which had included very useful discussions on subjects including dental and pharmacy services and the expansion of GP services. He drew members' attention to a paper on performance and accountability issued by CoSLA's Health & Social Care Board and he emphasised the need to ensure that the IJB's focus was aligned with that of CoSLA and the Ministerial Steering Group.

Mr Murray also highlighted the IJB Chairs and Vice Chairs' event taking place on 24th April where the theme would be 'Are IJBs using their authority effectively?' and presentations would be given by health boards and CoSLA.

## 5. NHS LOTHIAN ANNUAL OPERATIONAL PLAN/ SYSTEM TRANSFORMATION PLAN

The Chief Officer had submitted a report informing the IJB of work underway by NHS Lothian to produce a two year Annual Operational Plan (AOP) as part of the System Transformation Plan (STP); which are documents required by the Scottish Government as part of the governance of the Health Board.

Mr Currie presented the report outlining the background to the current draft AOP and drawing members' attention to some of the actions contained within it which would contribute to the delivery of the priorities within the NHS Strategic Plan.

Mr Currie and Ms MacDonald responded to questions from members regarding public engagement and consultation, the need for integrated impact assessments and how to put in place effective monitoring arrangements particularly for hosted services.

Mr Murray welcomed the AOP which he noted had taken almost two years to develop. He said he had been lobbying for IJBs to have a greater impact and he was pleased to see that this was now happening.

**Decision**

The IJB agreed to:

i. note that colleagues in the Strategic Planning Department of NHS Lothian are leading the preparation of the Annual Operational Plan/ System Transformation Plan, working to guidance from Scottish Government on the plan's structure and content. The AOP/STP is still in development with a final draft scheduled for consideration by NHS Lothian's Strategic Planning Committee in mid-March and final sign off by Lothian NHS Board on the 8th April.

ii. note that the plan includes a section describing in summary the strategic priorities of the Lothian IJBs. The Strategic Planning Leads of the HSCPs contributed these sections and are supporting the preparation of the AOP/STP.

iii. consider the final version of the AOP/STP at the IJB meeting on 26th March, with a view to supporting the commitments within.

## 6. INTEGRATION SCHEME REVIEW

The Chief Officer had submitted a report informing the IJB of the statutory requirement for East Lothian Council and Lothian Health Board to carry out a full review of the Integration Scheme for the East Lothian Integration Joint Board.

Mr Currie presented the report outlining the background to the Integration Scheme and the legal requirement to review it within 5 years of its approval by Scottish Ministers. He reminded members that the Scheme had been reviewed in 2019 to take account of the introduction of the Carers Act. Initially it had been thought that this review would' re-set the clock' on the 5 year review process but the Scottish Government had since advised that the IJB was still required to carry out a statutory review by June 2020. Mr Currie then summarised the process for this review, as set out in the report.

Ms MacDonald added that there were some services which the Health & Social Care Partnership managed for NHS Lothian and East Lothian Council but which were not delegated to the IJB. She indicated that there were unlikely to be fundamental changes to the Scheme which related to the IJB or which involved primary care services but that more detailed discussions would be required on areas such as mental health.

Judith Tait drew members' attention to the text of paragraph 3.2 in the report and indicated that the wording of the first sentence was incorrect. It should refer to 'community justice' rather than 'criminal justice' and make clear that this was always a delegated function of the IJB.

Mr Murray said it was important that members understood the review process and impact of nay potential changes to the Scheme. He suggested that a development session would be helpful.

Ms Ireland supported his suggestion and adding that as well as the opportunity to discuss more complex issues it would allow the IJB to consider whether it wanted to make more radical changes to its Scheme.

The Chair suggested that a background paper would help to focus the discussion and Ms McDonald agreed to draft a report for circulation to members along with a proposed timeline, as the review was due to be concluded by the end of June 2020.

Mr Murray said that this would be a useful way forward with the key issue being the practical impact on the people of East Lothian and how the IJB could clearly state its intent in the timeframe available.

**Decision**

The IJB agreed:

2.1 to note the statutory requirement of the Public Bodies (Joint Working) (Scotland) Act 2014 to fully review the Integration Joint Board Integration Scheme every five years;

2.2 to note that although Scottish Government advice was that the introduction of Carers Legislation, which required a revision to the East Lothian IJB's Integration Scheme in 2019, would 'reset' the timeframe for a comprehensive review to 2024, this is no longer the case;

2.3 to note that, as a result of the removal of the 'reset' date, the East Lothian Integration Scheme needs to be fully reviewed at the 5th anniversary of the original scheme's approval, requiring this to be completed by 27th June 2020;

2.4 to note that the Strategic Planning Group supported this proposal at its meeting on 19th February 2020; and

2.5 the indicative review process.

## 7. FINANCIAL POSITION FOR 2019/20, QUARTER THREE FINANCIAL REVIEWS AND FINANCIAL OUTLOOK FOR 2020/21

The Chief Finance Officer had submitted a report informing the IJB of quarter three financial reviews carried out by both its partners. East Lothian Council presented their review at the Council meeting on 25th February and NHS Lothian reported their review to their Finance and Resources Committee on 22nd January.

The financial reviews were used to provide forecast outturn positions. The quarter three forecasts projected that the 'health' arm of the IJB will be underspent and the 'social care' arm of the IJB will be overspent.

Ms Flanagan presented the report highlighting the key points of the Q3 financial reviews and advising members of the resulting forecast underspend of £444,000. However, she remained members that significant financial pressures remained and continued volatility in budgets such as prescribing meant that this position could change before the end of the financial year.

She also updated members on the budget planning for 2020/21, advising that as a result of delays with the setting of UK and Scottish Government budgets and local authority budgets, no indicative offers had been received to date. She outlined some

additional funding which had recently been announced and would be focused on particular costs and services. She confirmed that discussions were ongoing with both partners and that budget offers were expected to come forward in the next few weeks.

The Chair noted that the situation was fluid but that the IJB's baseline position was that the offers must amount to the previous year's budget plus some additional monies. However she acknowledged that in practice this may be difficult to achieve. She also asked Ms Flanagan if East Lothian's share of the additional national funding would be sufficient to cover all of the expected costs.

Ms Flanagan said she had asked colleagues in East Lothian Council to make projections for the next 3 years but her initial impression was that the money would not be sufficient to cover even the carer costs.

Mr Murray commended Ms Flanagan and Ms MacDonald for their work and for the news that the IJB was likely to end the current financial year underspent. He added that the Cabinet Secretary had recently acknowledged that not all IJB s had been able to achieve a positive financial position at year end.

The Chair echoed his comments saying that it reflected well on the whole team and that integration was now making a real difference to people living in East Lothian. She accepted that some may question why the IJB maintained a reserve when there was an increasing demographic in the county but she believed that it was the responsible thing to do.

**Decision**

The IJB agreed to:

i. note the current financial position;
ii. note the quarter three financial reviews of 2019/20; and
iii. note the financial forecast for 2020/21.

## 8. UPDATE ON IJB RESERVES POSITION

The Chief Finance Officer had submitted a report providing an update to the IJB on reserves held and a reminder of the Reserves Policy. It also sought support from the IJB to reinvest delegated funding recently disaggregated from a Medicine of the Elderly ward closure on the Western General Hospital site into local services to support unscheduled care.

Ms Flanagan presented the report outlining some of the key points including the overall reserves position, the use of earmarked reserves within 2019/20 and details of how additional funds received in-year would be used to support operational budgets within the Health & Social Care Partnership. She also confirmed that some of the IJB's reserves remained with the Scottish Government and would be available for draw down in future years.

Ms Flanagan responded to questions from members clarifying the reasons for the use of certain reserves during the financial year.

Ms MacDonald heighted the fact that, for the first time, money had moved from set aside to community services.

The Chair, Mr Murray and Dr Donald all welcomed this news as indicative of a positive direction of travel for the IJB.

In response to further questions, Ms MacDonald advised that a report would be provided on how this ad other money was being spent and that the money moved from set aside would be used to enhance services already identified within the Strategic Plan and approved by the IJB.

**Decision**

The IJB agreed to:

i. note the contents of the report; and
ii. approve the release of East Lothian's share of the NHS Lothian Ward 71 budget; to be reinvested locally supporting unscheduled care.

*Sederunt: Councillor O'Donnell left the meeting and Mr Murray chaired the reminder of the session.*

## 9. IJB AND AUDIT & RISK COMMITTEE MEETING DATES 2020/21

The Chief Officer had submitted a report setting the dates of IJB business meetings and development sessions and meeting dates for the Audit & Risk Committee during 2020/21.

The Clerk drew members' attention to the options for the IJB meeting date in December 2020, as outlined in Appendix 1. The members indicated a preference for Thursday 10th December and all other dates were accepted without amendment.

**Decision**

The IJB agreed:

i. the dates for IJB business meetings during session 2020/21;
ii. the dates of IJB development sessions during session 2020/21; and
iii. the dates for the Audit & Risk Committee meetings during session 202/21.

## 10. ISSUES OF RELEVANCE TO THE IJB (FOR NOTING)

### a. HOSPITAL DELAYED DISCHARGES

The Chief Officer had submitted a report updating the IJB on performance for delayed discharges in East Lothian and seeking agreement to further actions to maintain progress.

Ms MacDonald presented the report explaining what was meant by a delayed discharges and how the census was taken; confirming that the IJB's Direction 11c – to reduce the number of Occupied Bed Days (OBDs) for East Lothian residents by 10% - had been achieved; and highlighting that the monthly delayed discharge figures had remained consistently low for the last 12 months. She outlined some of the factors that had contributed to the improvement in the figures and the continuing challenges facing East Lothian in keeping both OBDs and delayed discharges to a minimum.

Iain Gorman advised that, while not officially published, East Lothian had the lowest rate of delayed discharges in the county and the lowest rate of hospital attendances. He added that work was ongoing to review the factors affecting performance with a view to demonstrating clear cause and effect.

The members welcomed the progress and sustained performance on both OBDs and delayed discharges and acknowledging the work of staff across the relevant services.

Paul White said that this news highlighted the benefits of joined up working and that the achievements should be celebrated.

Dr Donald said it was important to understand why this work had been so successful and what East Lothian was doing differently to achieve these results.

Richard Fairclough said if they were able to improve access to services the people would get the care they needed from the appropriate person at the appropriate time. He added that, as a GP, he could see that areas such as home visits were improving and that visiting frail and elderly patients at an earlier stage could reduce or prevent admissions and keep them in their own homes for longer.

Mr Murray said it would be useful to get some emerging evidence to show why these initiatives were successful.

Mr Gorman said that they were trying to get to the stage of demonstrating cause and effect and that they hoped to be in a position to publish this information in the near future.

**Decision**

The IJB agreed to:

i. note the improving trend on performance and recent actions; and
ii. discuss the issues involved in performance on hospital delayed discharge.

## b. CLINICAL AND CARE GOVERNANCE

Ms MacDonald advised that a review of the clinical and care governance structures was ongoing and the results would be brought to the IJB in due course.

Ms Ireland said she felt that there was an element of duplication in the work of the NHS Lothian Clinical and Care Governance Committee and the IJB's own Committee.

Alex Joyce echoed this remark.

Ms MacDonald pointed out that practitioners who were involved in the local Committee recognised the benefits of presenting cases, reviewing issues and identifying learning from across services. She felt that without this opportunity staff would not get the full benefits from collaborative working.

Ms Ireland agreed that they would not want to lose the local Committee but she questioned the relevance of the work at Health Board level.

Dr Donald said that as a member of the NHS Lothian Committee she recognised the need to seek assurance that there were appropriate governance structures in place.

She hoped that once established there would be greater confidence in these structures and less need for reassurance.

## 12. MINUTES OF OTHER GROUPS OF RELEVANCE TO THE IJB (FOR NOTING)

The minutes of the Audit & Risk Committee meeting on 10 September 2019 were presented for noting.

**Decision**

The IJB agreed to note the minutes of the Audit & Risk Committee.

The Chair asked members to note the following additional items:

Ms MacDonald advised that confirmation had been received from the Cabinet Secretary that the brief regarding the extension to the boundary for Blindwells was correct.

Ms McNeill raised two issues: the cancellation of budgets for health and wellbeing work undertaken by local Area Partnerships; and the delay in community engagement meetings regarding the ongoing reprovision project.

Councillor Akhtar reiterated her earlier point about the importance of IJB members understanding the serious position faced by local authorities regarding budgets for 2020/21.

Mr Murray suggested that Ms McNeill discuss the Area Partnership budgets with the Chair but that she send the information to him in the meantime.

Ms MacDonald advised that there had been a meeting with community groups in January to discuss the reprovision project and they had been advised that there would be delays. She confirmed that the project manager would be in touch with community groups very shortly.

Signed .....

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

**NHS LOTHIAN**

Board Meeting
May 13, 2020

Director of Public Health and Health Policy

# COVID-19 PUBLIC HEALTH UPDATE

## 1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board receive this update on COVID-19 which provides an update on the impact of the pandemic in Lothian.

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

## 2 Recommendations

2.1 To receive this report and to provision of future reports on the wider impact of COVID-19 on the health of the Scottish and Lothian population.

2.2 To continue to support the provision of tried, tested and evidence based approaches to the public health response to the pandemic. This requires an emphasis on investment in locally appropriate programmes, focused multi-agency working in partnership with national and international colleagues that build on existing expertise. The public health response should reflect the provisions of the NHS (Scotland) Act 1978, Public Health Act (Scotland) 2008, Civil Contingencies Act 2004 and Coronavirus (Scotland) Act 2020, which are designed to protect the public's health.

2.3 To ensure that health services remain in place and accessible for all those who may need them. This will require a programme of redesign, an ongoing focus on equity, primary care and person-centredness to take account of the additional demands on services and requirement for physical distancing, as well as staff shortages due to illness, self-isolation and additional caring duties.

2.4 To continue and intensify efforts to reduce the unintended consequences of the social distancing measures (e.g. income protection, improved access to food, wrap around services etc.)

2.5 To support ongoing research, discussion and clarification of the positive and negative impacts of the current and future approaches to social distancing and other pandemic responses. To build on the existing partnership with the Dataloch which is designed to support the local and national response to COVID-19 for the benefit of the public.

2.6 To ensure that national policymakers have access to advice from the range of expertise available from Board staff and partners on how to balance these at all points through the pandemic.

2.7 Support to medical practitioners to ensure certification practices best reflect the likelihood of COVID-19 as a cause of death should be maximised as appropriate.

## 3 Discussion of Key Issues

3.1 Since 31st December 2019, there have been 3,951,031 cases and 277,098 deaths associated with COVID-19 reported globally as of May 11, 2020. As of May 11, 219,183 people have tested positive in the UK (this said to include all UK sources). In Scotland 13,486 people have tested positive of 72,683 tested (this does not include all sources – only those where information can be used to inform risk and decision making about individuals and their contacts). Approximately 19% of tests are positive in Scotland and of those with confirmed disease; the death rate is approximately 13.7%.

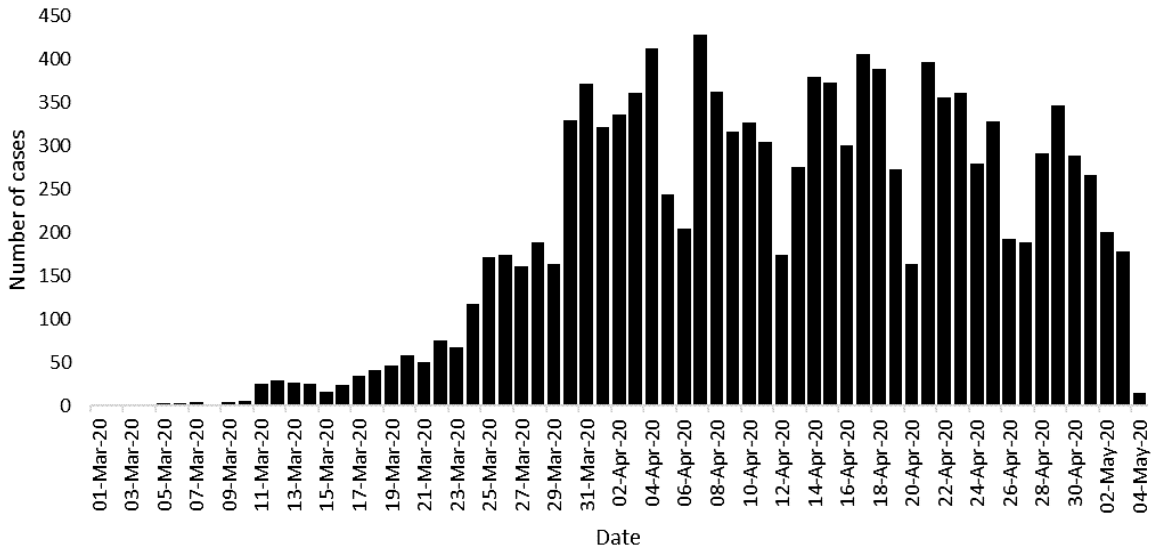
3.2 In an ideal world, we would know the data of transmission and thus which exposures led to infection. However, the incubation period (time from infection to clinical signs) is 1 to 14 days with a median of 5-6 days. There is also evidence of people being infectious before recognisable symptoms develop. There will be a lag between the onset of clinical signs and testing in many cases. It seems likely it is 3 to 5 days on average. That would indicate an average "lag" in the curve of new cases of 7 to 11 days. Serious illness emerges in a proportion of patients a further 5-8 days later; hence ICU admissions and deaths may occur several weeks after initial exposure to the infection.

## 4 The pandemic in Scotland

4.1 The most recent, detailed Scottish data cover the period up to May 4 for epidemiology and activity and this report draws heavily on the Public Health Scotland COVID-19 Statistical Report [https://beta.isdscotland.org/media/4382/20-05-06-covid19-publication_report.pdf] and to May 3 for deaths [https://www.nrscotland.gov.uk/news/2020/deaths-involving-covid-19-week-18-27th-april-to-3rd-may]. These national data indicate that, across Scotland as a whole, 225 people per 100,000 population have tested positive for COVID-19.

### 4.2 Number of confirmed cases over time

The daily number of confirmed cases illustrates the course of the outbreak to date (the epidemic curve). It also identifies the number of cases per day that require follow up, tracing of contacts, advice and support to self-isolate, including formal restriction under the Public Health Act (Scotland) 2008 where this is required.




Public Health Scotland [https://beta.isdscotland.org/media/4382/20-05-06-covid19-publication_report.pdf]

## 4.4 Age and sex distribution of positive cases

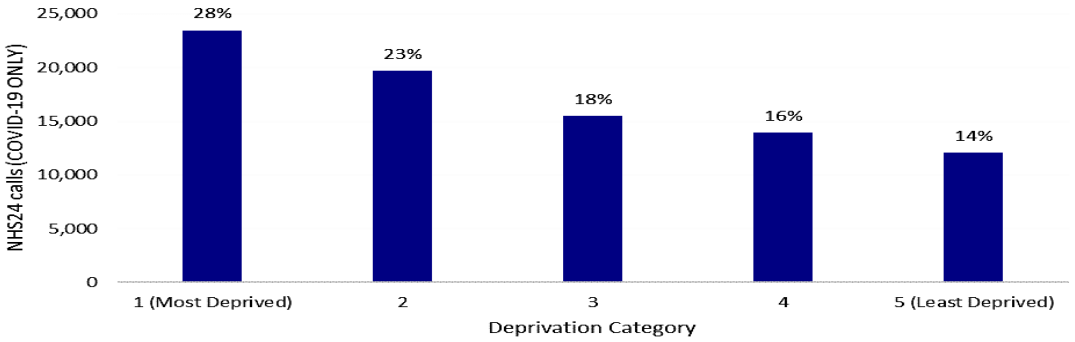
There is significant variation by age: from 13 per 100,000 for those aged 0-4 to 1478 per 100,000 in people aged 85 and over. This table illustrates the total number of confirmed cases by age group and sex as of May 4, 2020

| Age group (years) | Male | Female | Total | *Rate per 100,000 population* |
|---|---|---|---|---|
| 0 - 4 | 15 | 20 | 36 | *13* |
| 5 - 14 | 27 | 30 | 57 | *10* |
| 15 - 44 | 905 | 2074 | 2,990 | *146* |
| 45 - 64 | 1,612 | 2,483 | 4,108 | *274* |
| 65 - 74 | 731 | 534 | 1,267 | *219* |
| 75 - 84 | 967 | 957 | 1,924 | *568* |
| 85+ | 651 | 1,226 | 1,878 | *1,478* |
| **All Age groups** | **4,914** | **7,324** | **12,266** | ***225*** |

Note: Row and Columns do not add up due to 34 cases of unknown sex or age.

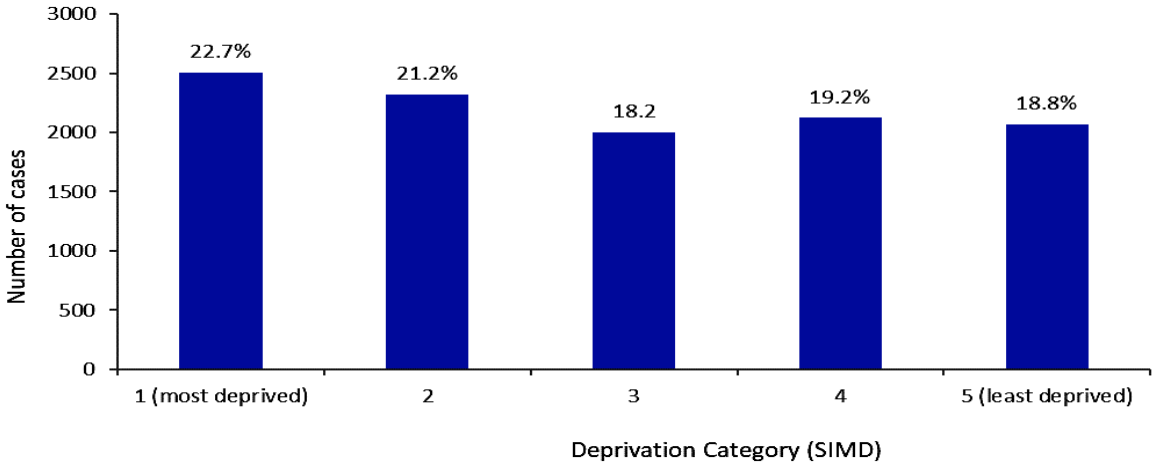
## 4.5 Variation by socio-economic group

At national and international level, the risk of COVID-19 varies by socio-economic group. In Scotland, there is a clear gradient in calls to NHS 24 about COVID-19 as shown in this table. Many of these callers will not have been tested. Without widespread implementation of test, trace, isolate and support, therefore, while this reflects the expected pattern of symptoms in the community it is not clear whether this will be the pattern of true positives that persists throughout the pandemic.




In Scotland, just under 23% of confirmed cases live the 20% areas with the highest levels of multiple deprivation but the preliminary analysis of confirmed cases undertaken to date shows no overall trend by deprivation group. This relationship is currently being explored in more detail following the publication of data from the Office for National Statistics that suggests that key workers in roles that involve significant face to face interaction with the public have a higher likelihood of testing positive.

This figure illustrates the number of confirmed cases across deprivation categories

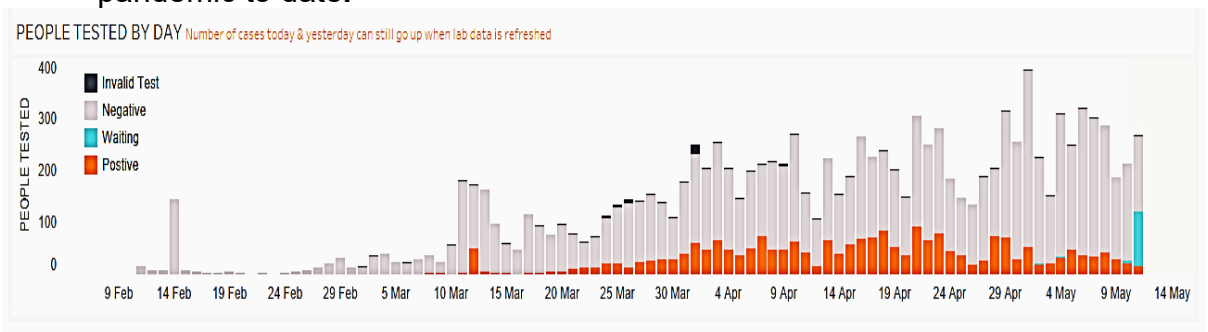



## 5 An overview of the epidemiology of the pandemic in Lothian

5.1 The pandemic began in Lothian with cases imported by overseas travellers and visitors. They were the source of the first obvious outbreaks which appeared to be controlled. Community transmission occurred in early March until the lockdown. Reported illness peaked in early April.

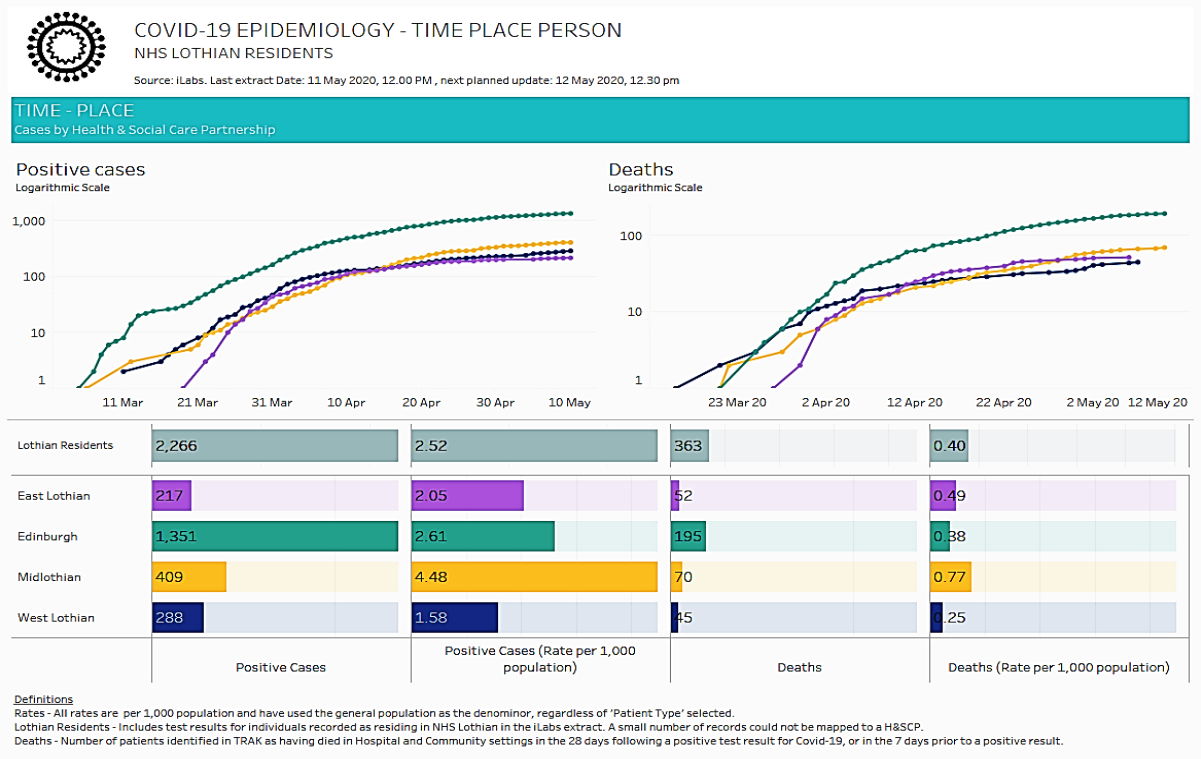
5.2 Since the highest levels of calls to NHS 24 and admissions at the beginning of April, as of May 8, the seven day rolling average number of calls to NHS 24 has reduced to 376 per day, 107 requiring nurse advice, 26 calls to COVID community hubs, 26 people triaged to assessment centres and 9 people admitted through this route.

5.3 To May 11, 19, 180 tests have been ordered. There have been 2281 positive, 9732 negative tests and we are currently waiting for results on 113 tests. We have gathered local data on deprivation, ethnicity and small area but that has not yet been analysed. This figure shows testing undertaken by NHS Lothian across the course of the pandemic to date.



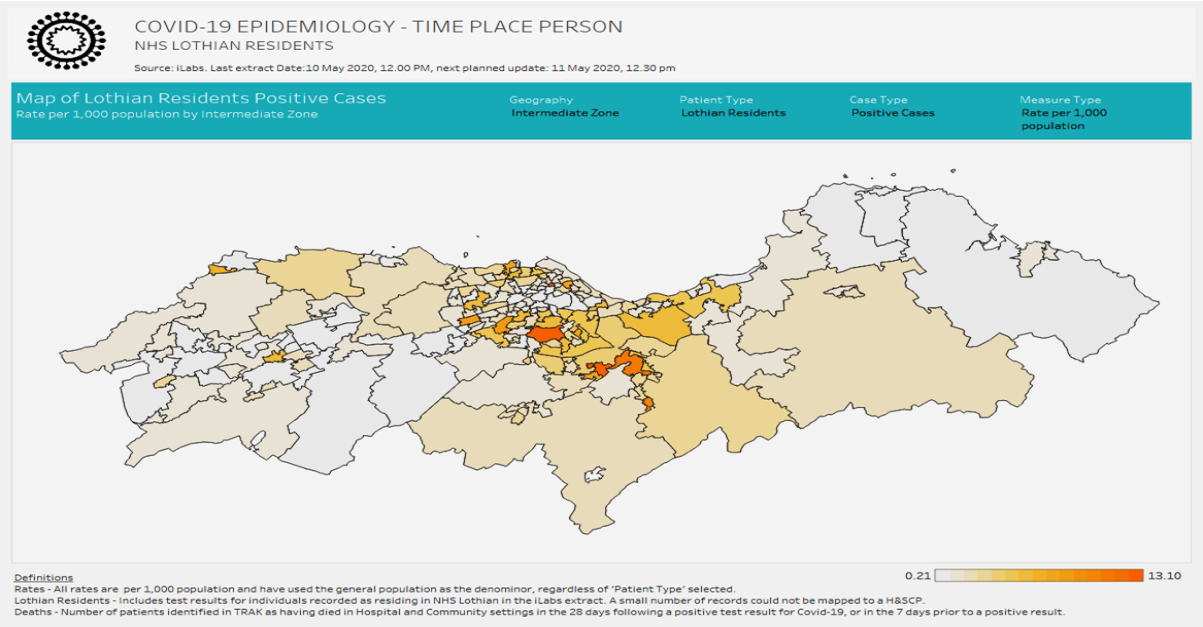

The experience of establishing multidisciplinary home and community testing facilities in February has enabled the development of testing facilities in closed settings and, separately, to the development and governance of staff testing.

5.4 **The figure below shows the cumulative number of positive cases and deaths across Lothian.**




5.5 **Distribution of confirmed positive cases across Lothian**

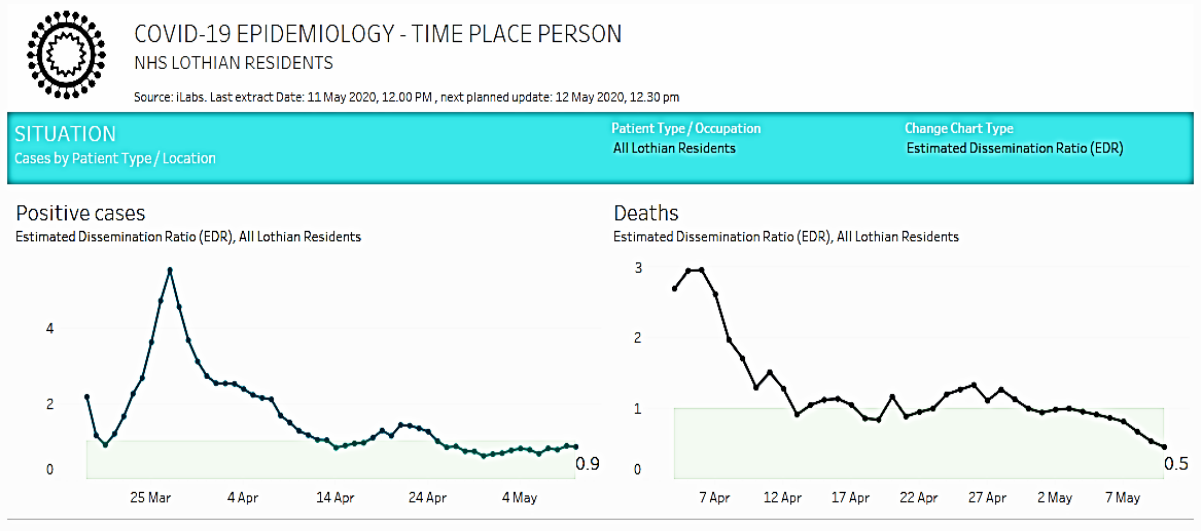
The map below shows the distribution of confirmed positive cases across Lothian with the darker areas being those with a greater number of cases. These cases will be a mixture of people tested because they have presented to services, particularly those who have been admitted to hospital, care home residents, health and care workers, people in other closed settings and members of their households who have been prioritised for testing. We have no information about those who have tested positive but who were tested through UK testing facilities. The overall pattern, however, indicates an opportunity to investigate community clusters as part of the stepwise introduction of test, trace, isolate and support.



## 6 Development of the pandemic in Lothian

6.1 The following graphs examine the changing dynamic of the pandemic in Lothian. We are measuring this using the Estimated Dissemination Ratio. The Estimated Dissemination Ratio can be described simply as the total of new cases this week divided by the total of new cases last week. It is a well-established and useful assumption-free method of estimating the "slope of the curve". An EDR of 1 indicates that the pandemic is neither accelerating nor slowing. An EDR of <1 indicates that the epidemic is slowing. An EDR of >1 indicates that the epidemic is accelerating (growing more quickly). It is a conservative measure and minimises (but does not fully remove) short term variations.

6.2 The EDR for Lothian is still close to 1 for positive cases. In the general population, case numbers have been falling but there is evidence that they are increasing recently, shown in a slowly rising EDR. This suggests that the positive impact of the "lockdown" on the rate of increase of new cases may be waning. This gives cause for concern and highlights the importance of developing a locally led approach to test, trace, isolate and support for people who are still exposed to the virus.




## 7 Care Homes and Closed Settings

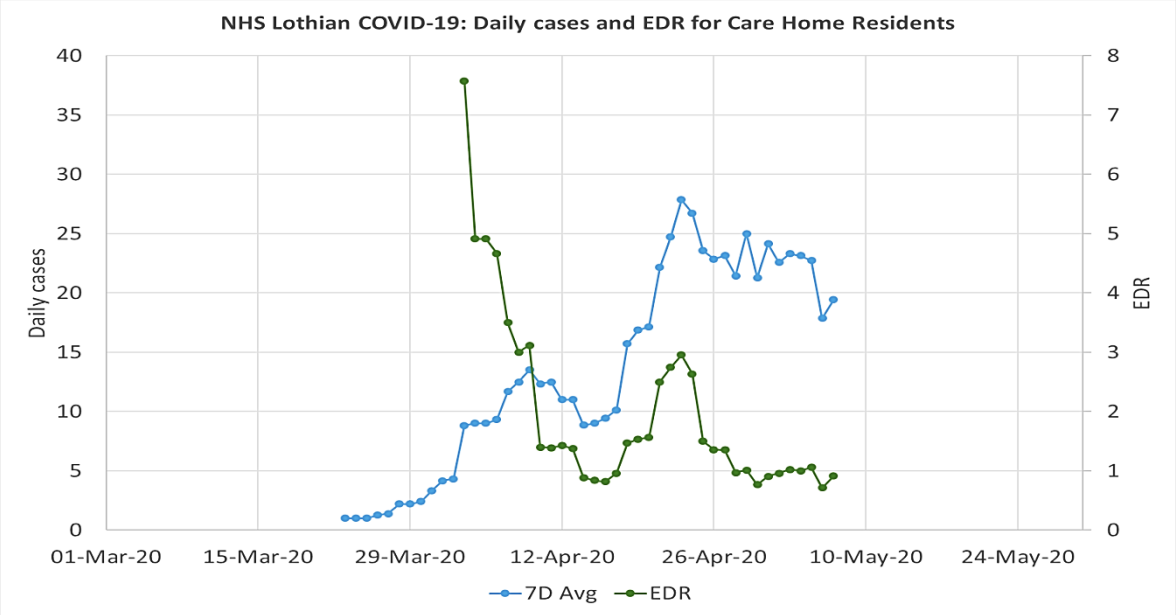
7.1 At the peak of community transmission, and before lockdown, people in closed settings were exposed and as has occurred globally, there are outbreaks in care homes and closed settings which are being managed actively. It is vital that key workers, who are not under lockdown, do not become a source of ongoing transmission in closed settings or communities.

7.2 Before the pandemic, however, there were few, recent and authoritative routine sources of data on the health of people that live in care homes and the places in which they live. For example, there are uncertainties around the number of beds of different types, there is no register of people living in care homes and official data sources hold virtually no information about people who pay for their own care. There is local intelligence, however, based on the work undertaken to support care homes. NHS Lothian and the Health and Social Care Partnerships have enhanced the routine advice, support, training and development work they undertake and, where necessary, are providing intensive support, including supplementing care home staffing with nurses, healthcare support workers and allied health professionals.

7.3 In the week ending May 10 alone, there were 12 Incident Management Teams formed to address incidents in closed settings. As of May 7, samples had been taken from 126

of 143 homes (88%), with positive results reported from 64 (51%) of care homes whose residents have been tested. To date, 1523 care home residents have been tested, of whom 659 were positive (43%). The samples are taken from a reported possible population of 4958 meaning that results are available from 31% of care home residents and that the overall detected incidence rate as of May 7 is around 13% in care home residents though note that the total population size has not been verified.

7.4 The chart below shows the daily cases using a 7 day rolling average because of a clear variation in testing across days and weeks and illustrates the Estimated Dissemination Ratio. The incidence of infection detected to date is over 20% in 30 care homes. Numbers of new cases in care homes and the EDR in that sector seem to be declining slowly but the EDR is still close to 1 so ongoing care is needed. Care home residents are highly vulnerable to the infection and infection may be hard to contain once introduced because of the requirement for intensive, hands on personal care even when residents are isolated in their rooms where possible, visiting is limited and personal protective equipment worn. Care homes are experienced in managing disease outbreaks but this is a highly infectious virus, presents with few or atypical symptoms in older people and can spread easily even if people are asymptomatic and during the presymptomatic period.




7.9 There is clearly a degree of control of the epidemic in care homes as the EDR has fallen from over 7 to around or below 1 but daily case numbers have only fallen slightly from a maximum of 28 to around 20. The EDR is still concerning as it is not consistently falling or below 1. The source of continuing infections in care homes cannot be identified in this type of analysis but there is clearly still significant spread. There is also an indication of shedding into new establishments as the number affected is still increasing, albeit slowly. However, most infection is probably within already affected establishments.

7.10 **Enhanced Outbreak Response: early findings**

Enhanced Outbreak Response is a set of procedures undertaken to support the Care Home response to the pandemic and reduce the impact of COVID-19 on care home residents and staff. It is undertaken under the direction of an Incident Management

Team with rapid and regular feedback to inform the overall public health and care home responses. Initial staff testing within an outbreak setting found that, overall, 10% of staff were positive and 5.5% of staff were positive but asymptomatic. This is within the expected range compared to a study of healthcare workers in a London hospital during the week of March 23, when reported infections peaked there [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31100-4/fulltext].

The enhanced outbreak response work in Lothian also confirmed that each person who tested positive took one hour to follow up without active contact tracing, confirming the European Centre for Disease Control guidance on resource estimation for contact tracing [https://www.ecdc.europa.eu/en/covid-19-contact-tracing-public-health-management]. It also confirmed that, to enable low paid care staff to self-isolate and avoid falling into poverty, they would require the practical and financial support that is available to those excluded from work or otherwise restricted under the Public Health (Scotland) Act 2008.

## 8 Deaths

8.1 National Records for Scotland has registered 469 COVID-related deaths in total in Lothian from week 1-18 (up to May 3) of 2020, an overall death rate of 5.2 per 10,000. During the same period, there were 3530 deaths registered in total with Lothian as Health Board of residence, of which 1103 occurred in care homes, 921 at home/ non institutional settings and 1506 in hospital. Of the 469 registered deaths where COVID was mentioned, 252 occurred in care homes; 29 Home/non-institution and 188 in hospital. Just under half COVID-related deaths occur in people over 85 years. Deaths in hospital peaked on April 12 (7 day rolling average) while deaths for all residents peaked on April 22 (3 day rolling average). Since April 13, the number of deaths in men and women in the 75-84 and men in the 85+ age groups has fallen for two consecutive weeks. Since April 20, the number of deaths in women over 85 years has fallen slightly.

8.2 The first clusters of infection were identified and care home deaths registered in the week commencing March 23. Because it takes a number of days for deaths to be recorded and included in the National Records of Scotland weekly total, we know that there have been at least 272 deaths in total across Lothian (hospitals, community and care homes). Several homes have experienced more than 10 deaths. There have been 151 deaths registered to care homes residents in Edinburgh, 59 in Midlothian, 47 in East Lothian and 15 in West Lothian. The proportion of deaths in care homes versus hospitals varies between the different parts of Scotland for reasons that are not yet clear but may reflect the relative proportion of people in care homes versus long stay hospitals, the extent to which care homes are able to look after residents while supported by specialist teams, for example, hospital at home or palliative care, or for other reasons not yet identified.

8.3 These data are really important to help us understand who is dying from COVID -19 but the overall impact of the pandemic can only be assessed by looking at the effect on all causes of death. Over the coming weeks and months, therefore, we will be working with colleagues in National Records of Scotland and Public Health Scotland to examine excess deaths. This expands the work that had already begun to look at the excess deaths in Scotland over the past decade and will consider the additional impact of the COVID-19 pandemic in detail. This will include assessment of the extent to which the pandemic impacted on deaths from other causes that could have been prevented or delayed. Public health action is intended to reduce the risk of preventable death from

COVID-19 and ensure access to appropriate support and palliative care for those for whom recovery is not possible. The information required is available from various different sources; some data come from routine NHS data while other questions can only be answered follow special studies.

## 9 Key Risks

9.1 That COVID-19 and non COVID-19 disease is not identified and addressed rapidly, leading to potentially avoidable levels of illness and death. That public health action is not effective and inequalities continue to increase. That outbreaks of COVID-related disease persist and the gap between health need and the ability of health, social care and services providing practical support to respond widens over the longer term.

## 10 Risk Register

10.1 The COVID-19 pandemic has been included on the risk register and the impact on all aspects of the work of the Board and its efforts to improve the physical and mental health of the population noted formally.

## 11 Impact on Inequality, Including Health Inequalities

11.1 At national and international level there is a socioeconomic and occupational gradient in the risk of contracting COVID-19 and variation between ethnic groups. The emergence of inequalities in the rate of severe disease and excess death is currently being investigated. NHS Lothian is represented on the national groups formed to undertake Integrated Impact Assessment, Health Literacy and Ethical issues and to examine the wider impacts of COVID-19 on population health.

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

12.1 The response to COVID-19 has delayed planned work to engage with the public representatives on the development of the 2020-2022 Joint Health Protection Plan. Specific interventions undertaken with partners, such as housing people who were rough sleeping, providing practical support, and rapid redesign of services have been undertaken with service users and those affected.

## 13 Resource Implications

13.1 The resource implications of the pandemic are significant but failure to invest in providing effective support for population health and wellbeing, specific preventive interventions, early intervention, universal primary care and social support, complemented by clinically effective, realistic and sustainable health care incurs a larger cost in terms of the healthcare consequences of COVID-19 and non-COVID disease and on society's ability to recover.

Professor Alison McCallum
Director of Public Health and Health Policy
May 12, 2020
Alison.mccallum@nhslothian.scot.nhs.uk

This paper draws on the work of Dr Naomi Honhold, Dr Philip Conaglen, Dr Frederike Garbe Dr Janet Stevenson, Dr Lorna Willocks, Chris Bruce, Lothian Analytical Services, the wider public health and health policy directorate and colleagues in Public Health Scotland.

**List of Appendices**

Appendix 1: Measuring the transmissibility of disease using the Estimated Dissemination Ratio versus R

The Estimated Dissemination Ratio (EDR) is a direct and assumption free measure of how the dynamic of the epidemic is changing and is probably a more useful measure at local level than R. R, the reproduction rate, is a measure of the average number of secondary infections that occurs following the introduction of an infected person into a susceptible population. R is a precise measure of rate of spread but difficult to estimate for a new condition with asymptomatic and presymptomatic spread, unknown levels of susceptibility in the community and limited information about social contact as its estimation requires large populations, several data sources and significant assumptions to be made to do so in most situations. Similarly to R, an EDR of 1 indicates that 1 infected person infects one other person on average.

**NHS LOTHIAN**

Board
13th May 2020

Deputy Chief Executive

# COVID-19 – OPERATIONAL UPDATE

## 1 Purpose of the Report

This report provides the Board with an update on NHSL's response to the COVID-19 Pandemic.

## 2 Recommendations

The Board is recommended to:

2.1 Note the actions undertaken to date.

## 3 Discussion of Key Issues

3.1 Board members are aware of the background to the COVID-19 pandemic. Population-level policy measures have centred on the "lockdown" which commenced 23rd March. Board members will also be aware that the legislation underpinning this "lockdown" mandates that this position is formally reviewed at least every three weeks, with the next formal review being no later than 28th May.

3.2 Board members will also be aware of the developments over the weekend of 9th and 10th May, with an announcement by the Prime Minister on the evening of 10th May. As of the writing of this update, it is not clear what this announcement means in terms of detail and practical action.

3.3 The First Minister has reiterated that Scotland's position remains "stay home, protect the NHS, save lives", as the estimated reproduction ratio for Scotland remains close to 1 – that is, at a steady state of spread.

3.4 The key approaches towards managing the pandemic outlined in the paper for the April session remain in place –

- close working with partners such as Public Health Scotland, NHS24, and the Scottish Ambulance Service;
- a dedicated community hub triaging self-identified patients;
- Significant changes in GP models, switching to use of telephone appointments and "Near-Me" technology;
- Upping baseline capacity in critical care, and of protecting ward areas for COVID patients;
- Deferring routine diagnostic appointments, inpatient and daycase treatments, and moving to telephone and "Near-Me" technology wherever possible;
- Support for staff both in testing capacity and wellbeing support.

3.5 As of Friday 8th May, there had been;

- 2274 confirmed cases of COVID-19 in Lothian;
- Approximately 700 admissions of patients with confirmed diagnoses to acute ward beds;
- On 8th May, 85 patients with a confirmed diagnosis in general beds and 13 in critical care beds, with a further 91 patients with a possible diagnosis in acute ward beds;

3.6 Activity through the COVID community hub pathway remains steady, with an average of approximately 105 calls per day and 30 face-to-face appointments. This now seems to be the primary source of admissions to the system.

*3.6* Estimates of the total number of infections in the community vary, but confirmed infections are probably somewhere between around 5% of the total spread. This would suggest that within Lothian there are roughly 45,000 people who have been infected.

3.7 It does appear that the healthcare part of the system has reached a plateau of activity, but the challenges for the broader system remain and are acute. Approximately a quarter of all cases are originating in Care and Nursing Homes and Board members have been briefed on these issues informally. 55 Care Homes in Lothian have reported cases and there have been 272 deaths in these homes.

3.8 HSCPs have this as their highest priority, and NHSL is supporting and helping manage the work in these care homes, including targeting testing towards residents and staff.

3.9 Given the rapid evolution of this response, some elements of this paper are indicative and fuller briefing will be available in discussion at the Board meeting itself.

***Demand***

3.10 The April paper to the Board noted that the number of cases was doubling every 2-3 days, and the very positive news is that this is now every two weeks or more.

3.11 Board members have been briefed informally on the operational detail as it has evolved, and the paper on scheduled and unscheduled care performance being discussed at the May Board meeting includes detail on this.

3.12 What is now apparent, however, is that some areas of the system are beginning to readjust following a period of lower than normal activity, specifically in the unscheduled care stream, where attendances had dropped by approximately 50%, but which are now back up to roughly two-thirds of previous pre-covid levels.

***Structure of response***

3.13 Board members received a copy of the Lothian Mobilization Plan on 26th March and this has formed the basis of the Lothian-system response. The system has now embarked on the process of developing a successor to the original Mobilization Plan to outline the next 6-12 months of activity, developing a modified response for the winter period.

***Actions taken so far***

3.14 Board members are aware of the following key actions undertaken;

- Postponement of all routine activity, shifting to non-face-to-face work wherever possible;
- Establishment of "red" areas for COVID pathways, peaking at 604 general ward beds and 105 critical care beds being made available in late April;
- Purchasing of additional care home and community places to support a significant reduction in delayed discharges on acute sites;
- Developing a single SITREP for the entire system;
- Establishment of community hub sites in East, Mid, and West Lothian, as well as opening (and closing) an additional Edinburgh site;
- Rapid recruitment of
- Shielding (see appendix 1)
- Developing the NHSL approach to the national test, trace, isolate, and support strategy with a tactical group chaired by the Director of Strategy;
- Enhanced response to the position in care homes, with expert advice provided directly;
- Engaged with independent sector hospitals, with 60 cancer operations being undertaken since mid-April, across breast, colorectal, and urology clinical areas;
- Shifting some urgent cardiac activity across from the Royal Infirmary of Edinburgh to the Golden Jubilee National Hospital in Clydebank.

3.15 NHSL has also established a number of tactical groups to bring focus to key areas and report to the Strategic Management Group for final sign-off and problem-solving. These tactical groups are shown in the table below;

| **Tactical Group** | **Chair** |
|---|---|
| Acute | Chief Officer Acute |
| HSCPs | Chief Officer Midlothian |
| Primary Care | Director of Primary Care Transformation |
| Public Health | Deputy Director Public Health and Policy |
| Care Homes | Chief Officer East Lothian |
| Test, trace, isolate, support | Director of Strategic Planning |
| Personal Protective Equipment | Executive Nurse Director |
| Mental Health | Services Director REAS |
| Facilities | Director of Estates |

***Workforce***

3.16 The Board received an update on the broader issues around support for staff at the last Board meeting, and this continues to be summarized well at the Lothian intranet site, with detail there on the COVID-19 Hub. This includes direct support such as the staff helpline, self-care guidance, links to mindfulness resources, and support for those leading through the pandemic. In addition the Lothian Leader network supported by Amanda Langsley, Associate Director of HR and OD, and Simon Edgar, Director of Medical Education continues to progress and has an understandable focus on COVID-

19 leadership and self-care.

3.17 NHSL has also been very successful in bringing in additional staffing resources. Through the NHS Education Scotland (NES) portal, we have recruited 141 returners, equivalent to 27 whole-time workers, as well as carrying out 1484 interviews for staff contracts. Of these, 740 have received offers of employment.

3.18 NHSL has also taken on 422 3rd year nursing students into employment, and 297 2nd year students. These are all on contracts for between 22.5 and 37.5 hours per week.

3.19 673 individuals have volunteered to help during this period, and these have taken on 3 distinct roles;

- Ward helpers;
- Meet & Greet helpers, to direct people in hospital but also to ask these visitors to stop and apply handgel;
- Distribution, helping with basic supplies, patient laundry and clothing, toiletries from donations, and running shopping errands for patients

3.20 Board members will have seen coverage of the donations made to hospital staff in particular, but it is worth noting that some front-line teams, notably at the Western General, have donated substantial proportions of these donations to local food banks, where it has been possible to do so.

***Next steps***

3.21 Board members are aware of the following major workstreams emerging during early May;

- Test, trace, isolate, and support (TTIS);
- Shielding;
- Remobilization;
- Renewal

***TTIS***

3.22 TTIS is the Scottish Government Strategy to underpin the longer-term response to COVID-19 and more effective management of community spread. Testing capacity in the country is currently estimated at c. 5000 tests per day, with plans to ramp up to give considerably flexibility to go beyond that if required, but this is likely to settle in the region of 15,000 tests per day. Key to ensuring that this capacity is used effectively is to ensure that there is a contact tracing infrastructure in place to allow health boards to support people with positive tests to isolate safely and break the chains of transmission.

3.23 Across Scotland, calculations based on international best practice and experience suggest that we will need roughly 2000 contact tracers, with an additional 150 specialist public health staff, for a period of two years. The latter would be based in local Health Boards, with the contact tracing function in a “call-centre” model and supported by case management technology infrastructure based around a mobile phone app. The target date for this to be up and running is from the end of May onwards. Public Health Scotland is the accountable body for this work, supported by

territorial Boards.

3.24 Within Lothian, the tactical group has identified three stages to ramping up local tracing capacity;

- Phase 1a sees a focus on closed settings such as care homes, hospitals, prisons, and tracing the contacts of confirmed cases. This will be delivered by redirecting health protection and other public health staff, as well as using volunteers from cohorts of staff such as sexual health services and local authority environment health officers;
- Phase 1b will see NHSL move rapidly to work towards having its nominal share of the 2000 contact tracers and 150 specialist public health staff virtually in place, by using NHSL staff who may well be shielding or unable to work in their substantive roles. This would see NHSL aim to have between 150 and 325 staff carry out this work for the Lothian population, and would see us expand our tracing regimen into staff testing as a first step;
- Phase 2 would see the establishment of the nationally-coordinated model building on availability of staff and the new app and case management infrastructure.
- It is anticipated that this process would be in place for 2 years.

***Shielding***

3.25 As of 4 May, approximately 26,300 people have been included on the NHS Lothian master list for shielding. This list changes on a daily basis with additions and subtractions. The largest group is severe respiratory disease. Group 6 numbers are not shown in this table because they are very small.

| Group | | 04-May |
|---|---|---|
| 1 | Organ transplants | 1,203 |
| 2 | Specific cancers | 3,715 |
| 3 | Severe respiratory | 10,848 |
| 4 | Rare diseases | 1,747 |
| 5 | Immunosuppression | 4,538 |
| 6 | Pregnant with heart disease | x |
| 7 | Clinical judgement | 4,240 |
| Total | | 26,300 |

3.26 It is anticipated that people may be advised to continue to shield for several months. As NHS services are re-designed to mitigate risk of COVID-19, it is important that the health care needs of the shielding population continue to be met whilst minimising risk of infection. For this reason, a Shielding Clinical Advisory Function has been proposed, to support clinicians and managers by providing principles and advice specific to shielding to inform redesign of services in primary and secondary care.

3.27 A monitoring framework has been developed to use routine data sources to provide surveillance information on patients advised to shield. The scope of this framework does not include the impact of shielding on this population which would be part of a wider evaluation; data collected for monitoring purposes would contribute to an evaluation.

3.28 The framework will:

- monitor number of COVID-19 cases, healthcare use and outcomes for patients who are shielding
- identify cases of COVID-19 in the shielding population arising from probable/possible healthcare associated infections (HAI) and patterns of such cases which may require further investigation

***Remobilization and renewal***

3.29 Now that the first wave of COVID-19 is receding, the organization is turning its thinking to two key horizons – "pre-vaccine" and "post-vaccine"

3.30 The "pre-vaccine" phase focusses on how services can maximize clinical activity and treatment until such times as we have a vaccine. This incorporates how this activity can be picked up with changes to very basic considerations such as how waiting rooms can be utilized in a world of physical distancing, up to and including how intra-hospital spread of the virus can be minimized.

3.31 This work – led by the Chief Officers from Acute and the 4 HSCPs, supported by the Director of Strategic Planning, will form the basis of the Remobilization Plan mentioned above, but it is important to emphasise that this plan will lay out new principles and assumptions about how NHSL will operate over what may well be an extended period and that these may be very different to those previously in place.

3.32 The "renewal" workstream formed the basis of a recent Board development session and focuses on the post-vaccine period. This will be the subject of a special Strategic Planning Committee session on 27th May, and is being supported by the Director of Improvement.

## 4 Key Risks

4.1 COVID-19 affects all areas of the system, and therefore increases the risks level for all of the very high risks on the corporate risk register. The one exception to this is around unscheduled care and the 4-hour emergency access standard, where a significant drop in attendances is feeding a much higher level of performance.

4.2 The Board is aware of the significant risk COVID-19 poses to the population, and in particular to older age groups and those with underlying conditions.

## 5 Risk Register

5.1 A new risk relating to COVID-19 has been added to the corporate 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 Work on the future, both in the remobilization and renewal agendas, will need to have an eye on informing, engaging, and consulting.

## 8 Resource Implications

8.1 These are being worked through.

Colin Briggs
Director of Strategic Planning
11th May 2020

**NHS LOTHIAN**

Board Meeting
13th May 2020

Chief Officer, Acute Services

## SCHEDULED & UNSCHEDULED CARE PERFORMANCE

### 1 Purpose of the Report

1.1 To update the Board in relation to:-

1.2 Performance against agreed 2019/20 trajectories for Scheduled Care standards: New Outpatients; Treatment Time Guarantee (TTG); Diagnostic key tests; 31 and 62 Day Pathway Cancer patients; Unscheduled Care standards & Delayed Discharge performance;

1.3 Impact of Covid-19 on Outpatient and Inpatient lengths of wait and waiting list additions, Cancer, Diagnostics, 4 Emergency Access standard (4EAS) performance and Delayed Discharges;

1.4 Prioritisation of patients and expedited roll-out of technology for outpatient assessment;

1.5 Overview of the immediate Covid response and plans, including adoption of lessons learned.

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

### 2 Recommendations

Board Members are recommended to;

2.1 **Note** performance against 2019/20 AOP trajectories as outlined in Appendix 1.

2.2 **Acknowledge** that 62.4% of patients were waiting 12 weeks or less for a new outpatient appointment in March 2020. The highest monthly performance for 2019/20 was achieved for inpatients, whereby 80.2% of patients were seen within the 12 Week Treatment Time Guarantee in March 20.

2.3 **Acknowledge** that provisional Cancer 31 day performance for March 2020 has remained above trajectory at 96.2%, and for two consecutive months. March 2020 62 day performance rose five percentage points to 83% although remains below trajectory. Improvement has continued since July (by over 7% points).

2.4 **Acknowledge** that by mid-March 2020 it was forecast that both the outpatient and TTG targets would meet AOP trajectories, but that significant cancellation of routine elective and outpatient activity as a result of Covid has resulted in both breaching.

2.5 **Acknowledge** that NHS Lothian reported performance of 86.9% against the 4EAS standard for March 2020.

2.6 **Recognise** that the pandemic approach from Health and Social Care Partnerships has been to significantly increase community bed capacity, along with a key focus on Home First, resulting in a significant reduction in the number of delayed discharges.

## 3 Discussion of Key Issues

### 3.1 Scheduled Care Performance

3.2 Please see Appendix 1 for performance summaries for March 2020.

3.3 Validated Outpatient MMI performance for March was 20,855 against an AOP trajectory of 18,100, but there was a reduction of almost 5,000 patients waiting longer than 12 weeks from August 19 to March 20. Prior to significant cancellations from 16th March, at the Scottish Government's request, and as part of the response to Covid, outpatient performance had been on target to meet trajectory.

3.4 Validated TTG MMI performance figures for March 2020 of 3,404 indicate that performance exceeded AOP trajectory. As above, pre-Covid mid-March predictions for inpatients also indicated that inpatient performance would have met the agreed AOP trajectory.

3.5 MRI, CT and Ultrasound diagnostics >6 weeks performance were all above trajectory for March. Diagnostics performance declined due to the cancellation of all non-urgent Outpatient appointments from March 16th.

3.6 Validated Gastroenterology Diagnostics performance for March 2020 was 2,491, an increase of 370 on February. Endoscopy, the largest element of Gastroenterology Diagnostics, saw 1,276 breaches in March, an increase of 229 on February. Urology Diagnostic (Cystoscopy) performance was 599, an increase of 139 on February. Both services were impacted by the cancellation of non-urgent activity.

3.7 March 2020 62 day Cancer Waiting Times performance rose five percentage points to 83% although remains below trajectory.

3.8 31 day Cancer Waiting Times performance remained above trajectory at 96.2% for two consecutive months.

### 3.9 Impact of Covid on Scheduled Care Performance

3.10 As a result of Covid, and in line with Scottish Government requirements, NHS Lothian ceased all non-urgent elective activity from Monday 16th March 2020 inclusive.

### 3.11 Impact on Outpatients

3.12 22,900 outpatient appointments (New, Return and Radiology) were cancelled in March 2020, and 31,800 in April 2020. The impact of these changes is being monitored with a new Covid-19 cancellation code created within Trak. Please see Appendix 1 for breakdown of cancellation figures.

3.13 This rapid and significant level of cancellations has impacted outpatient lengths of wait as demonstrated in the charts below. These show that more patients are now waiting longer for treatment. The impact on >12 week waits will not be clear for some time, but efficient embedding of telephone and video consultations will be needed to help mitigate negative consequences.

**Chart 1: OP Length of Wait/ Waiting List Shape – Urgent & Urgent Suspicion of Cancer (USoC) and Routine Patients i.e. All 12 Week Standard Patients**

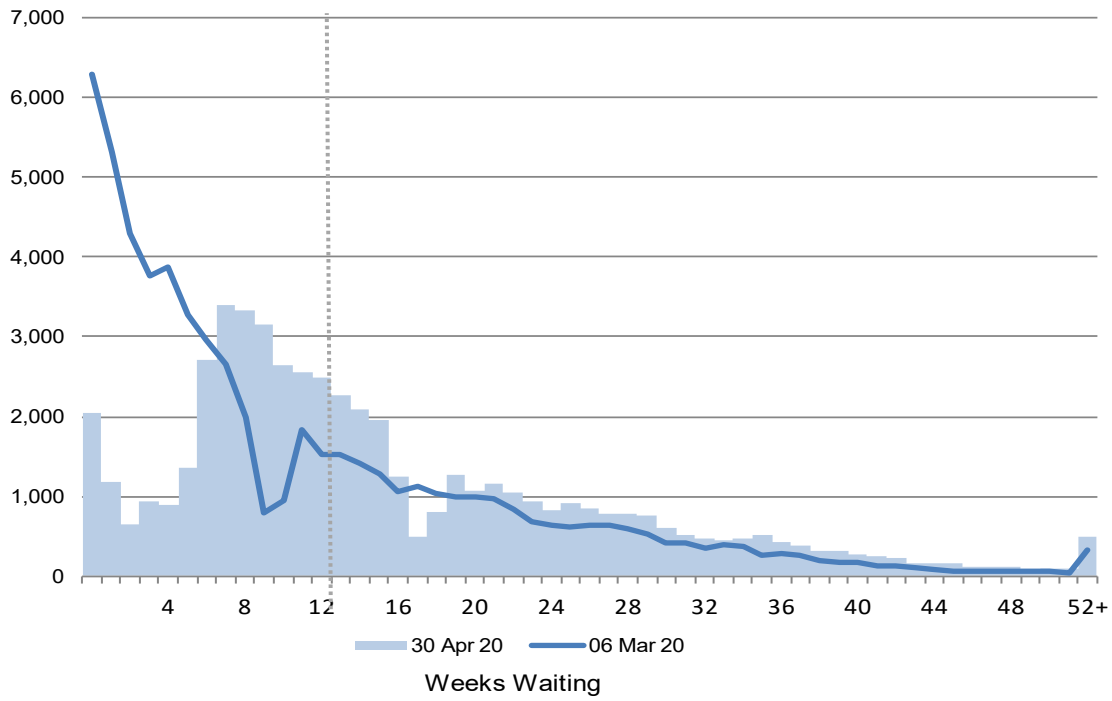



**Chart 2: OP Length of Wait/ Waiting List Shape – All Urgent & USoC 12 Week Std Patients**

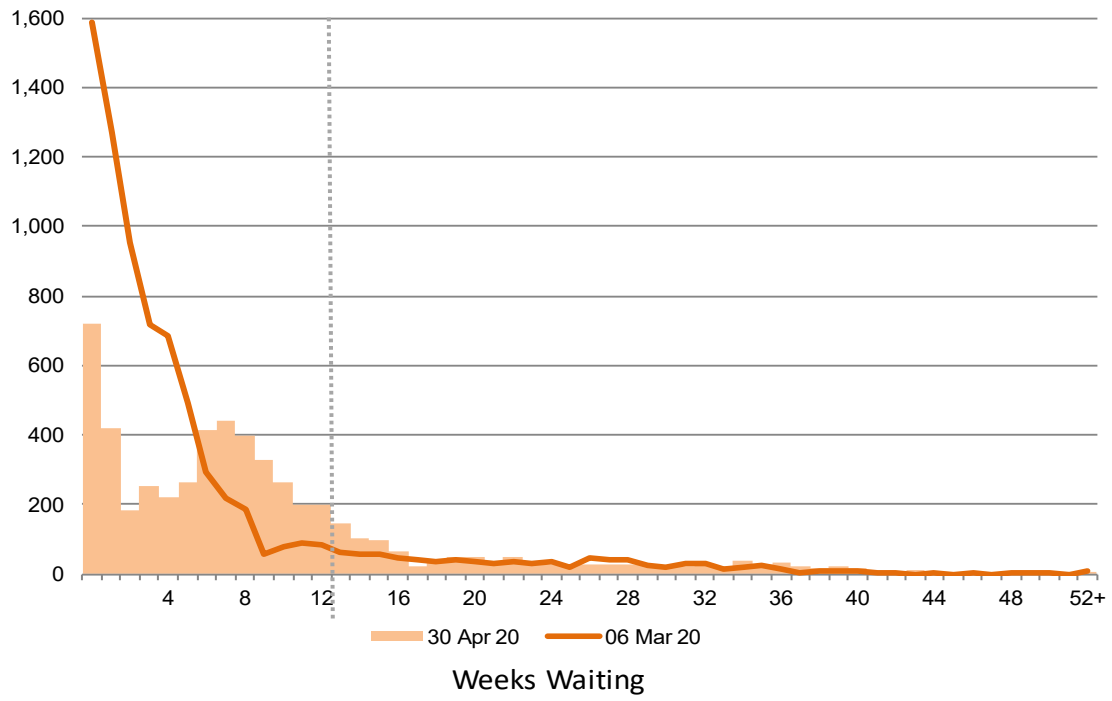
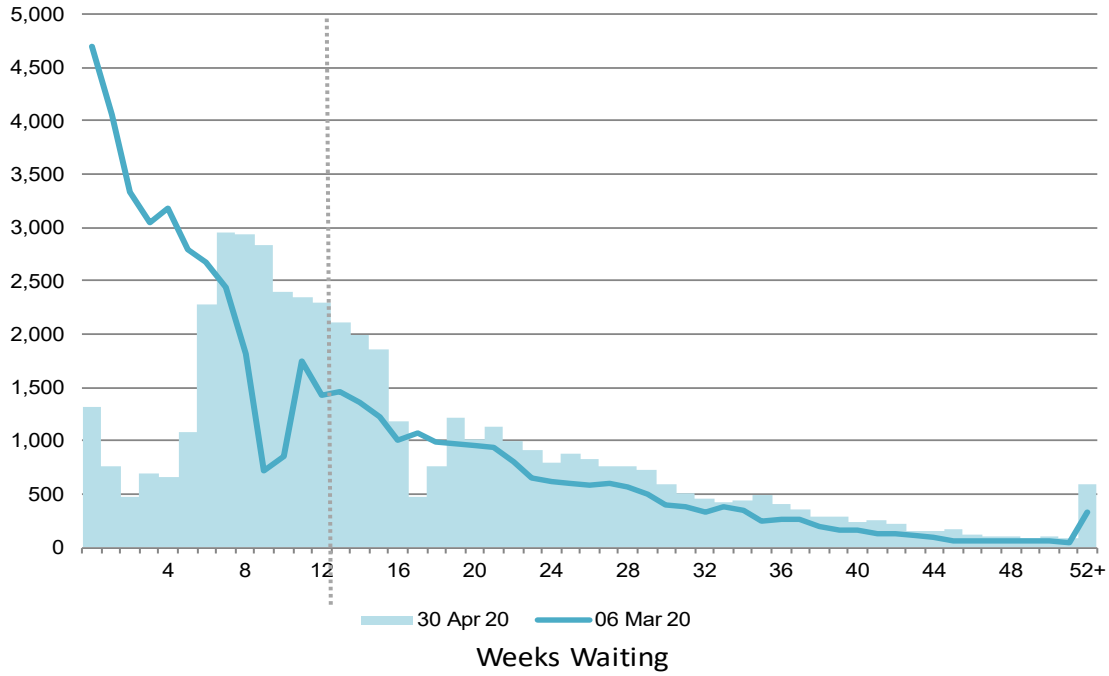
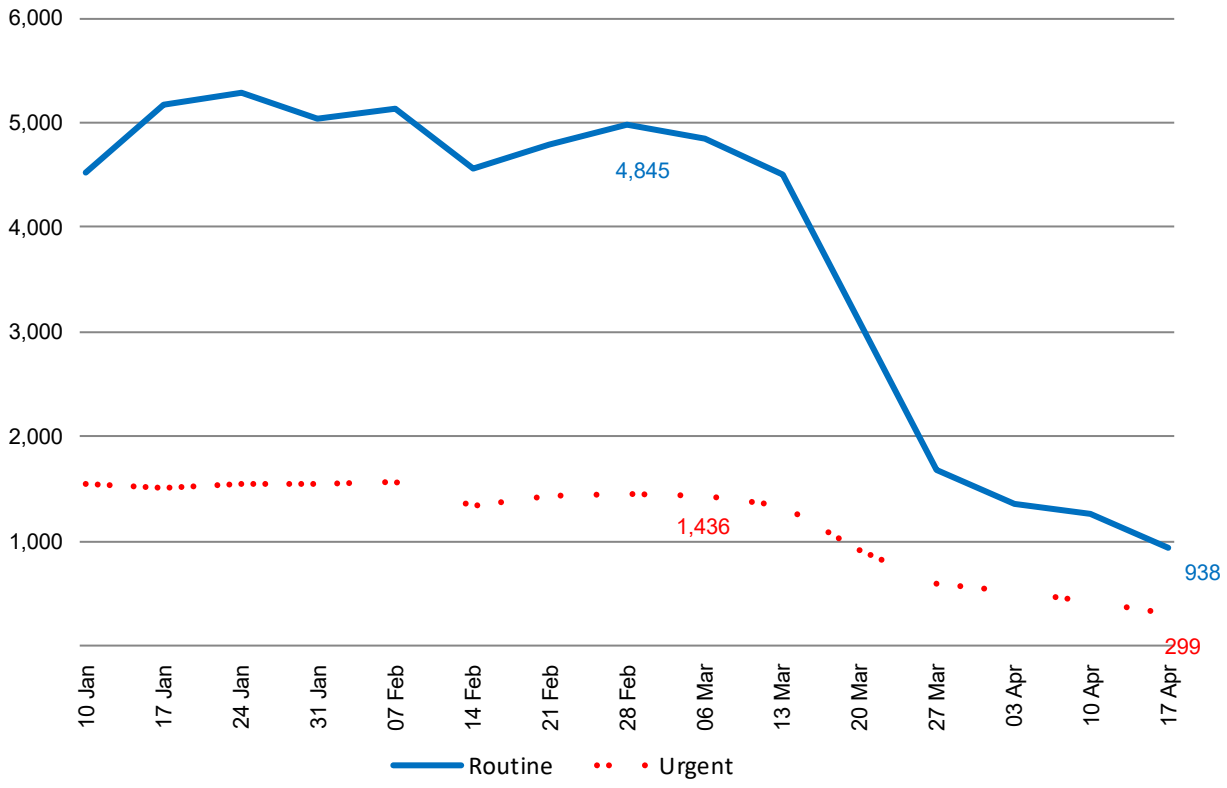


**Chart 3: OP Length of Wait/Waiting List Shape – All Routine 12 Week Std Patients**




3.14 There have also been significant reductions in OP additions/referrals since Covid 19. Routine and Urgent additions sharply decreased from mid-March – please see Chart 4 below:-

**Chart 4: OP Additions (excluding Infectious Diseases, which records Covid Tests)**



3.15 **Telephone & Near Me Consultations**

3.16 Out-patient consultations have focussed on Urgent Suspicion of Cancer (USoC), Urgent and return patients, and where clinically appropriate these consultations are being carried out via telephone or Near Me. Where patients are assessed as requiring a face to face consultation this is based on individual risk.

3.17 Between 6th March and 19th April the number of New telephone OP appointments recorded increased rapidly from 6 to 510, and the number of Return telephone OP appointments from 115 to 1,601.

3.18 **Impact on TTG**

3.19 1,200 non-urgent inpatient and day case episodes were cancelled in March, and a similar volume in April.

3.20 The level of cancellations has had an impact on inpatients' length of wait as demonstrated in the charts below. These show that more patients are now waiting longer for treatment. The total impact on >12 week waits will not be clear for some time.

**Chart 5: IP Length of Wait/Waiting List Shape –All 12 Week Standard Patients**

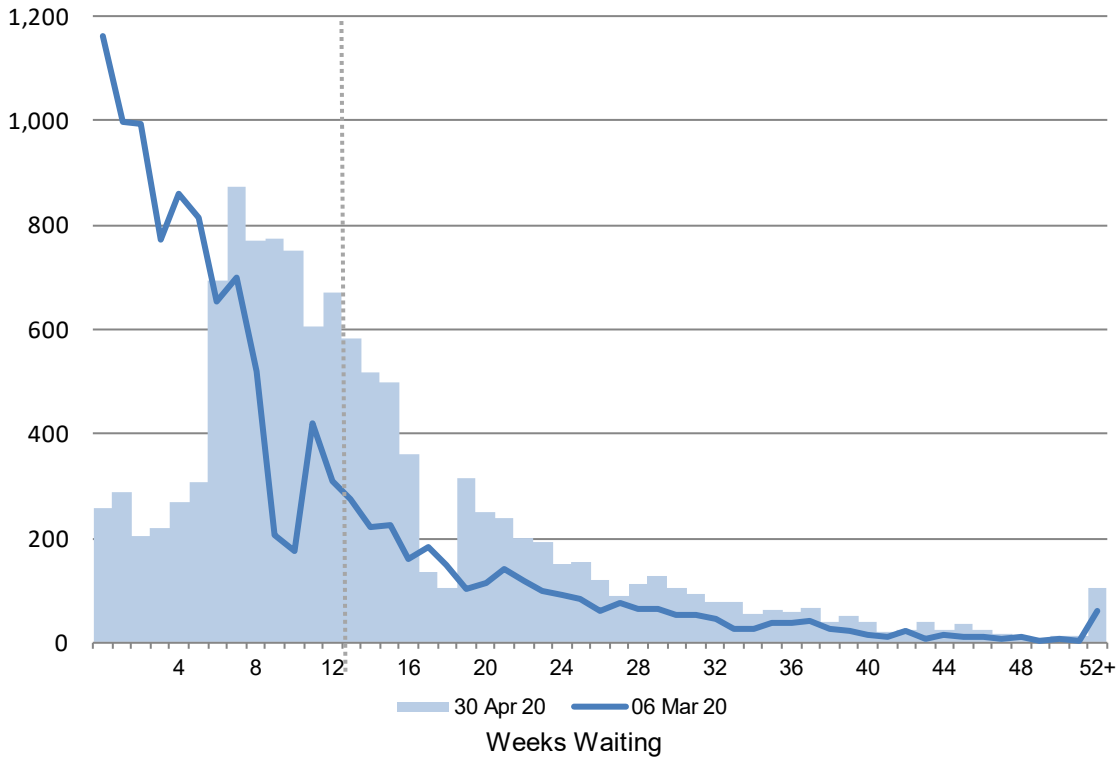


**Chart 6: IP Length of Wait/Waiting List Shape – All Urgent & USoC 12 Week Standard Patients**

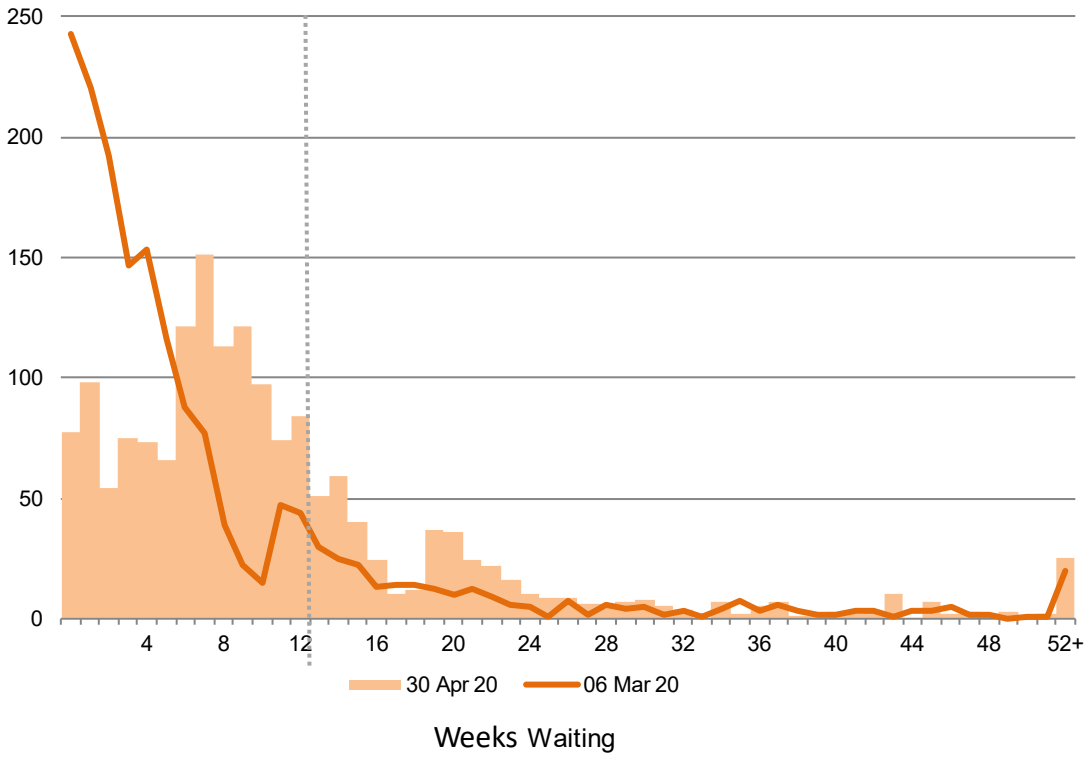
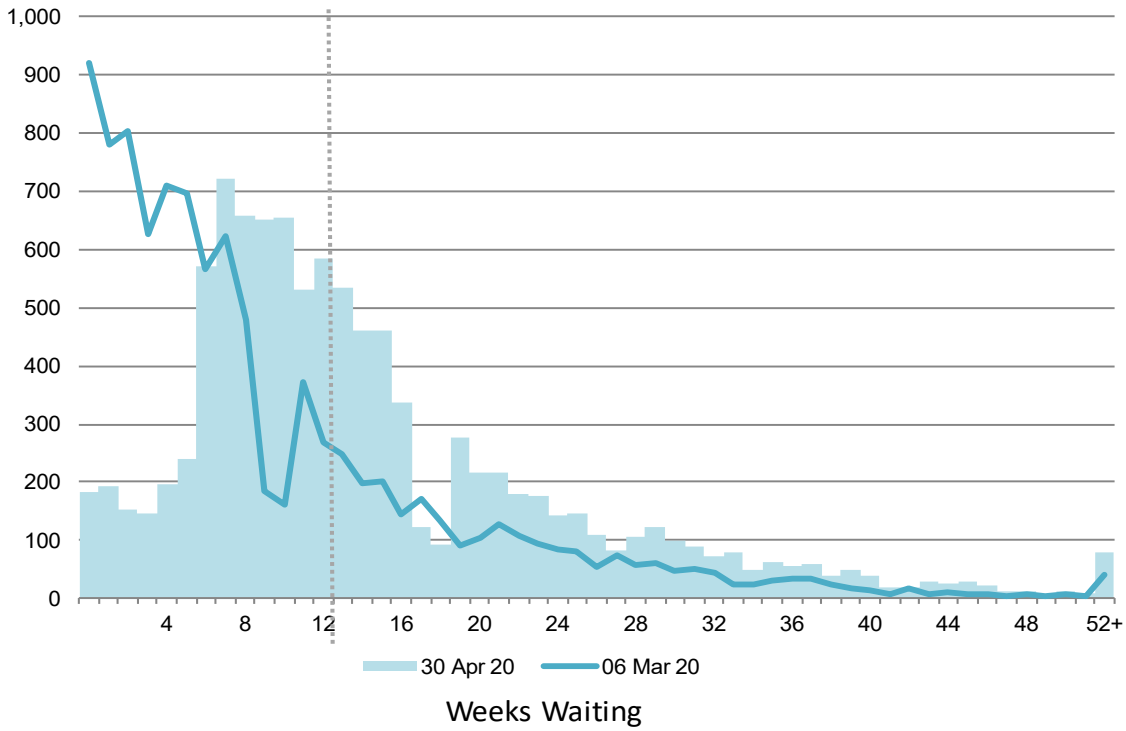
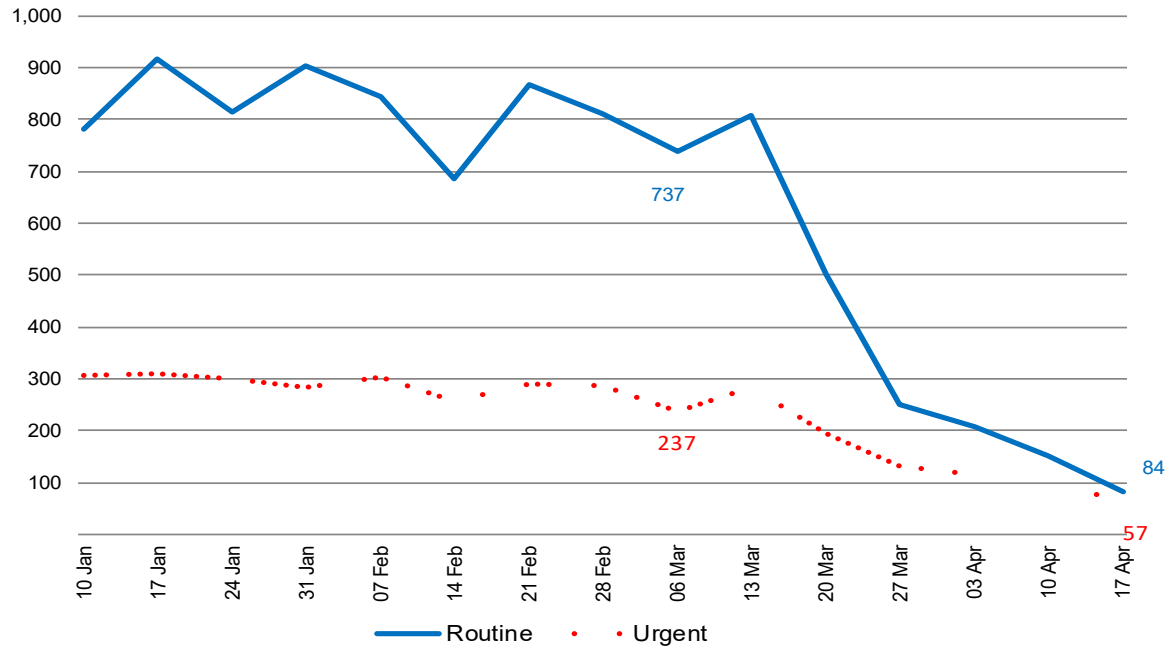



**Chart 7: IP Length of Wait/Waiting List Shape – All Routine 12 Week Standard Patients**




3.21 There have also been significant reductions in additions to the IP waiting list since the impact of Covid 19 – please see Chart 8 below:-

**Chart 8: IP Additions**




3.22 Surgery is focussed on Cancer and priority group 2 patients – defined as requiring surgery within 4 weeks. A high proportion of these patients require access to a critical care bed, and this activity is being balanced with the Covid demand for critical care beds and availability of theatre capacity (critical care expansion is supported in the main from theatre workforce).

3.23 Additional capacity to support some of this urgent demand has been through Golden Jubilee National Hospital (GJNH) for urgent cardiac and thoracic work and SPiRE for colorectal, urology and breast.

3.24 The theatre team have worked with service teams to increase the number of category 2 cases that can be carried out on each acute site, and have a detailed process in place to assess the supporting infrastructure of theatre sessions/ critical care or specialist bed prior to each procedure.

3.25 **Impact on Cancer Performance**

3.26 Cancer activity continues to be a priority for the Board, balancing the risks of efficacy and vulnerability. Urgent Suspicion of Cancer (USoC) referrals have dropped from approximately 350-500 per week to 127 in the week ending 24th April.

3.27 There has been an increase in patients starting hormone therapy and watchful wait treatment options due to current situation.

3.28 Provisional April performance is expected to be approximately 94/95% for 31 day and 81-83% for 62 day performance.

3.29 **Impact on Key Diagnostic Tests**

3.30 Covid cancellations have resulted in significant increases in patients waiting over 6 weeks for key diagnostic tests, as above. Please also see Appendix 1.

3.31 Consultant Radiologists have assessed all referrals booked and un-booked and for those categorised as urgent outpatients, imaging appointments were provided – also for any new urgent referrals. Patients with moderate or high suspicion of malignancy or disease requiring urgent treatment as determined by clinical detail were deemed the most urgent for CT and MRI.

3.32 In addition follow up scanning for cancer treatment has continued when safe for patients to attend, along with antenatal ultrasound.

3.33 **Unscheduled Care 4 Hour Emergency Access Standard (4EAS) Performance**

3.34 NHS Lothian reported compliance to the 4EAS standard of 86.9% for the month of March 2020. This represents a deterioration of <1% increase compared to March 2019. Please see Chart 9 and Table 1 below.

**Chart 9: NHS Lothian 4EAS Performance Jan 19 – Mar 20**

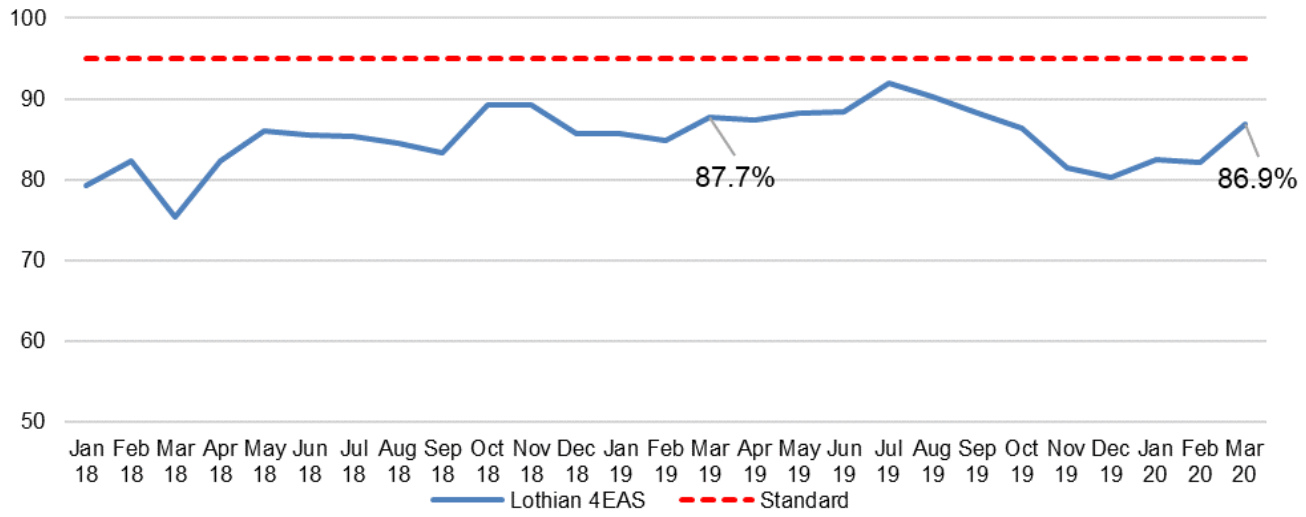



**Table 1: 4EAS Apr 2019 vs April 20 Month to Date (MTD)**

| | Apr 19 | Apr 20 MTD (as at 20/4/20) |
|---|---|---|
| Royal Infirmary of Edinburgh | 81.4% | 95.5% |
| Western General Hospital | 90.1% | 93.6% |
| St John's Hospital | 91.8% | 95.6% |
| Royal Hospital for Sick Children | 95.0% | 97.6% |
| NHS Lothian | 87.7% | 95.6% |

3.35 **Impact of Covid on 4EAS**

3.36 To date demand at each of the Acute sites has dropped considerably due to the Covid-19 pandemic. Daily attendance rates fell by up to 60% following the introduction of lockdown measures in late March to 350-400 attendances per day compared to 800-900 earlier in the month. A fall in all categories of attendance has been seen since with a particularly large fall in minor illness patients. Over the past two weeks activity has started to increase but is still well below historical levels. During this period the 95% 4EAS has been achieved.

3.37 Each of the Acute Sites have designated Red (Covid-19) and Green (non-Covid-19) pathways established to safely cohort patients.

3.38 The 'Call MIA' telemedicine for minor injuries/illness platform commenced on 1st April, allowing patients to be assessed virtually and where clinically required given a planned appointment for attendance. Numbers to date have been 62.

3.39 **Delayed Discharge Performance**

3.40 Table 2 below shows March 19, and 20, and April 20 positions at the time of census for Delayed Discharges and Occupied Bed Days (OBDs). As below the total number of delays has reduced by 20.1% between March 19 and March 20. OBDs have fallen by 14.1% during this same time period. The Covid response of increasing the number of community beds along with focus on Home First has seen a further significant reduction in April.

**Table 2: Delayed Discharges*/ Occupied Bed Days from Census**

| Delays | Mar 19 | Mar 20 | Apr 20 MTD | | Occupied Bed Days | Mar 19 | Mar 20 | Apr 20 MTD |
|---|---|---|---|---|---|---|---|---|
| East Lothian | 10 | 10 | 7 | | East Lothian | 503 | 277 | 101 |
| Edinburgh | 146 | 135 | 68 | | Edinburgh | 4,488 | 4,322 | 935 |
| Midlothian | 43 | 14 | 6 | | Midlothian | 1,237 | 439 | 91 |
| West Lothian | 30 | 24 | 10 | | West Lothian | 1,187 | 1,330 | 141 |
| **NHS Lothian** | **229** | **183** | **91** | | **NHS Lothian** | **7,415** | **6,368** | **1,268** |

*Delayed Discharges (incl. Code 9 Complex delays, excl. Code 100s). Figures produced on 22/4/20.

3.41 **Impact of Covid on Delayed Discharges**

3.42 All cause delays have fallen significantly (health & social care delays) during the pandemic. These have reduced by approximately 200 per day to the lowest levels in years with social care delays down to minimal levels.

3.43 **Immediate Recovery Actions**

3.44 The Covid pandemic response has resulted in a significant backlog of non-urgent patients in outpatients, diagnostics and inpatient services, and this legacy demand needs to be managed along with new routine referrals/ additions in a systematic, equitable process that takes account of on-going social distancing and infection prevention and control guidance. Pathways that include active clinical triage, patient initiated follow up and the optimisation of technology are being developed to reduce the number of face to face consultations where clinically safe to do so.

3.45 The requirement to continue for the foreseeable future with red (Covid) wards and with an expanded critical care footprint has a direct impact on elective capacity - theatre sessions and beds. Quantification of available theatre sessions and Additional capacity through SPiRE and Golden Jubilee National Hospital is helping to mitigate some of the reduced capacity.

3.46 Diagnostic pathways are being reviewed to assess ability to reduce number of unscheduled attendances to plan to help control flow and maintain social distancing requirements.

3.47 Work is underway with GPs on referral guidance and managing patient expectations

around the 'NHS is Open, but we are working differently'.

## 4 Key Risks

4.1 The risks to performance are the on-going requirement to have designated red and green pathways and wards which has a direct impact on productivity and capacity. The required expansion of critical care beds has a direct impact on workforce within theatres as anaesthetic and nursing staff are required for critical care expansion and therefore elective theatre sessions.

4.2 The requirement to have designated Covid red wards will reduce bed footprint available for elective workload.

4.3 Social distancing has a direct impact on the number of patients who can be in waiting areas/ clinical space reducing productivity.

4.4 Activity needs to be fully risk assessed within the context of the phase of pandemic, risk of acquisition, patient choice and availability of capacity.

4.5 Risks of delay in accessing outpatients/ diagnostics/ treatment include:-

- Missed/delayed diagnosis;
- Deterioration of condition.

## 5 Risk Register

5.1 The Corporate Risk Register has a risk specifically associated with the Recovery Programme with reference to a number of linked risks (Risk ID 4820). This will be reviewed in light of the Covid-19 pandemic.

5.2 Covid-19 may also impact performance for patients waiting over 12 weeks for outpatient appointments or inpatient/day case procedures, most significantly as a result of cancelled routine appointments and elective admissions, and reduced referrals. Corporate risk IDs 4191 (Risk that patients will wait longer than described in the relevant national standard and the associated clinical risk), and 3211 (That NHS Lothian will fail to achieve waiting times targets for inpatient/ day case and outpatient appointments) have been updated to reflect this.

5.3 Corporate Risks 3203 (4-hour Target (Organisational)), and 4688 (4 Hour Emergency Access Standard (Patient)), have also been reviewed to consider risks arising from Covid-19.

## 6 Impact on Inequality, Including Health Inequalities

6.1 These proposals could result in the growth of the 'digital care divide' as the move towards virtual health and care may impact on vulnerable groups with limited access to technology. These issues will need to be taken into account in future service models, as well as in light of changing public attitudes to virtual healthcare, by adopting a mixture of traditional and online services.

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

7.1 A proposal to drive Scheduled Care post-Covid recovery has been circulated to NHS

Lothian Directors and IJB Chief Officers and in due course further consultation with staff groups will be taken forward once the immediate pressure of the pandemic response has eased.

## 8 Resource Implications

8.1 There are significant resource implications associated with Covid response, and these are being fully collated via the Finance Team

## Appendix 1. Scheduled Care Performance

Jacquie Campbell
Chief Officer, Acute Services
5 May 2020

## Appendix 1 - Performance

The table below illustrates performance at the end of March 2020:-

### Table 1. Core Recovery Plan Metrics

| Metric | | Mar 2020 | Feb 2020 | Feb 2019 | Annual Change (Mar 20 vs Feb 19) | Target |
|---|---|---|---|---|---|---|
| Delayed Discharges | Standard | 165 | 238 | 267 | -38.2% | 200 |
| | Standard & Complex | 186 | 265 | 304 | -38.8% | - |
| 4 Hour ED Waiting Time | | 86.9% | 82.1% | 84.9% | 2.4% | 95% |
| Outpatient >12 week waiting time [p] | | 20,855 | 21,817 | 27,766 | -24.9% | 18,100* |
| Treatment Time Guarantee [p] | | 3,404 | 3,033 | 2,667 | 27.6% | 3,100* |
| Cancer Waiting Times (62 day target) [p] | | 83.0% | 78.2% | 78.9% | 5.2% | 95% |
| Mental Health & Learning Disability Bed occupancy | | 92.8% | 87.8% | 90.4% | 2.7% | 85-90% |
| CAMHS >18 week target | | 53.9% | 52.5% | 72.9% | -26.1% | 90% |
| Psychological Therapies > 18 week target | | 79.2% | 81% | 79.2% | 0.0% | 90% |
| Paediatrics and St John's | | 4 days a week 24x7 | 4 days a week 24x7 | Closed to inpatients | - | 7 days a week 24x7 |

[p] some is provisional management information and may be subject to small variation.
* 2019/20 AOP Trajectory recently revised upwards from 16,151 and 2,472 for outpatient and TTG respectively.
* Green denotes an improvement >=5%, red deterioration >=5%, and amber no change since Feb 2019.
As at 27/2/20.

## OP Performance against Trajectory

The 2019/20 outpatient trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 12 weeks for a new outpatient appointment.

| | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHSL OP >12 Wks Performance | **24,669** | **24,755** | **24,425** | **24,307** | **24,502** | **25,851** | **25,529** | **24,201** | **23,243** | **23,274** | **22,632** | **21,817** | **20,855** |
| OP Trajectory excl. EDI for 2020_21 | 23,930 | 25,933 | 26,552 | 26,269 | 25,964 | 25,760 | 25,051 | 23,500 | 22,293 | 20,393 | 18,048 | 17,332 | 16,151 |
| OP Revised Trajectory | | | | | | | | | | | | | 18,100 |
| Difference | 739 | -1,178 | -2,127 | -1,962 | -1,462 | 91 | 478 | 701 | 950 | 2,881 | 4,584 | 4,485 | 2,755 |
| % of patients waiting 12 weeks or less for a new outpatient appointment | **64.5%** | **64.9%** | **64.6%** | **64.0%** | **64.6%** | **62.8%** | **62.5%** | **62.0%** | **61.8%** | **61.2%** | **61.5%** | **62.6%** | **62.4%** |

Please note that data provided above is management information and so may differ from published statistics

## IPDC Performance against Trajectory

The 2019/20 IPDC trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 12 weeks for an Inpatient or Day case procedure.

| | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHSL TTG (IPDC) >12 Wks Performance | **2,340** | **2,597** | **2,642** | **2,622** | **2,526** | **2,727** | **2,788** | **2,563** | **2,527** | **2,753** | **2,888** | **3,033** | **3,404** |
| TTG (IPDC) Trajectory | 2,707 | 2,586 | 2,658 | 2,839 | 3,055 | 3,198 | 3,190 | 3,011 | 2,947 | 2,922 | 2,699 | 2,758 | 2,472 |
| TTG (IPDC) Revised Trajectory | | | | | | | | | | | | | 3,100 |
| Difference | -367 | 11 | -16 | -217 | -529 | -471 | -402 | -448 | -420 | -169 | 189 | 275 | 304 |
| % Patients Seen Within 12 Week Treatment Time Guarantee | **73.6%** | **78.4%** | **75.3%** | **74.7%** | **76.6%** | **75.2%** | **74.2%** | **73.5%** | **76.1%** | **77.3%** | **72.9%** | **74.2%** | **80.2%** |

Please note that data provided above is management information and so may differ from published statistics
*Ongoing* Waits

**Gastroenterology Diagnostic Performance against Trajectory**

The 2019/20 Gastroenterology diagnostic trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 6 weeks for a diagnostic procedure.

| | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Upper Endoscopy patients waiting over 6 wks | 1,427 | 1,117 | 759 | 625 | 565 | 504 | 374 | 452 | 585 | 792 | 1,006 | 1,047 | 1,276 |
| Colonoscopy patients waiting over 6 wks | 1,129 | 1,024 | 1,002 | 933 | 753 | 683 | 521 | 701 | 815 | 879 | 931 | 810 | 884 |
| Flexible Sigmoidoscopy (Lower Endoscopy) patients waiting over 6 wks | 785 | 713 | 469 | 340 | 282 | 282 | 297 | 279 | 299 | 332 | 329 | 264 | 331 |
| Gastroenterology Diagnostic Performance | 3,341 | 2,854 | 2,230 | 1,898 | 1,600 | 1,469 | 1,192 | 1,432 | 1,699 | 2,003 | 2,266 | 2,121 | 2,491 |
| Gastroenterology Diagnostic >6 Week Trajectory | 2,901 | 2,260 | 2,196 | 2,034 | 1,844 | 1,719 | 1,794 | 1,619 | 1,444 | 1,269 | 1,094 | 919 | 744 |
| Difference | 440 | 594 | 34 | -136 | -244 | -250 | -602 | -187 | 255 | 734 | 1,172 | 1,202 | 1,747 |

**Urology Diagnostic Performance against Trajectory**

The 2019/20 Urology diagnostic trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 6 weeks for a diagnostic procedure.

| | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Flexible Cystoscopy (Urology Diagnostic) Performance | 349 | 394 | 370 | 323 | 271 | 292 | 340 | 317 | 327 | 362 | 449 | 460 | 599 |
| Urology Diagnostic >6 Week Trajectory | 0 | 435 | 395 | 385 | 415 | 445 | 395 | 345 | 295 | 245 | 195 | 145 | 95 |
| Difference | 349 | -41 | -25 | -62 | -144 | -153 | -55 | -28 | 32 | 117 | 254 | 315 | 504 |

**Radiology Diagnostic Performance against Trajectory**

The 2019/20 Radiology trajectories and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 6 weeks for a Radiology scan.

| Specialty Radiology - CT Lothian | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CT Performance | 32 | 63 | 101 | 101 | 97 | 98 | 112 | 108 | 85 | 97 | 268 | 151 | 203 |
| Trajectory >6 weeks | 8 | 50 | 80 | 100 | 80 | 60 | 40 | 20 | 0 | 0 | 0 | 0 | 0 |
| Difference | 24 | 13 | 21 | 1 | 17 | 38 | 72 | 88 | 85 | 97 | 268 | 151 | 203 |

| Specialty Radiology - MRI Lothian | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MRI Performance | 103 | 137 | 114 | 87 | 194 | 204 | 260 | 393 | 446 | 588 | 765 | 472 | 448 |
| Trajectory >6 weeks | 0 | 200 | 250 | 150 | 250 | 200 | 150 | 50 | 0 | 0 | 0 | 0 | 0 |
| Difference | 103 | -63 | -136 | -63 | -56 | 4 | 110 | 343 | 446 | 588 | 765 | 472 | 448 |

For General Ultrasound the Trajectory was 0 for each month from July 2019 inclusive onwards. However, a small volume of breaches occurred between July and March 2020, with a cumulative total of 70 for this period.

There were 5 breaches in total for Barium Studies across the year.

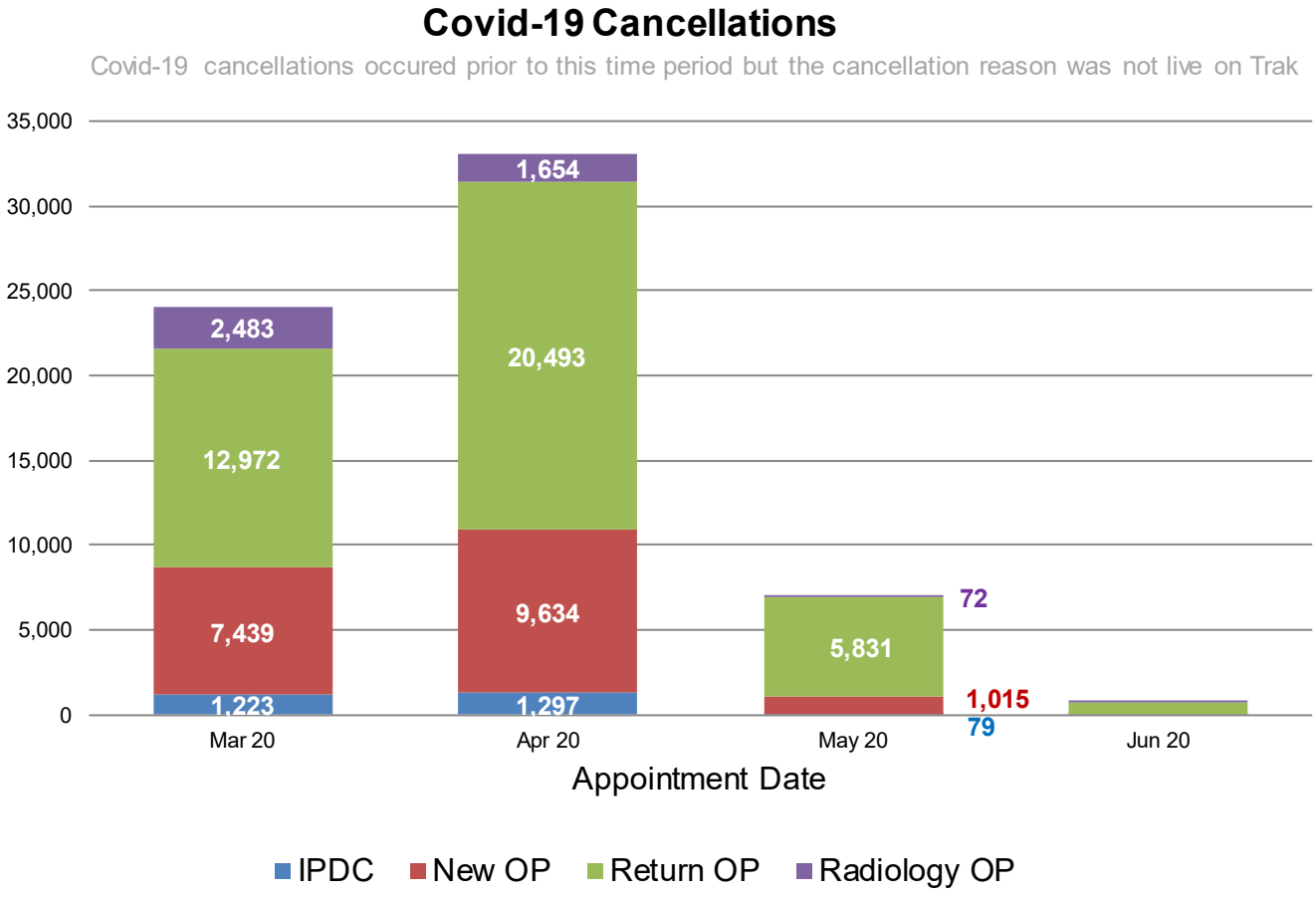
**Cancer Performance** The following tables detail 31 and 62 day cancer performance against trajectory using management information.

| 31 Day performance | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
| Urological | 94.5% | 86.4% | 92.9% | 91.2% | 81.7% | 86.4% | 92.2% | 89.4% | 85.9% | 90.3% | 97.1% | 98.5% | 92.2% |
| Colorectal (screened excluded) | 85.7% | 82.9% | 76.7% | 78.3% | 73.3% | 78.1% | 88.6% | 90.3% | 83.3% | 96.3% | 77.4% | 81.5% | 87.1% |
| Colorectal (screened only) | 100.0% | 100.0% | 55.6% | 100.0% | 87.5% | 20.0% | 83.3% | 72.2% | 77.8% | 55.6% | 55.6% | 80.0% | 100.0% |
| Melanoma | 91.7% | 100.0% | 100.0% | 95.7% | 100.0% | 88.9% | 100.0% | 93.8% | 97.9% | 100.0% | 100.0% | 100.0% | 85.7% |
| Breast (screened excluded) | 98.1% | 97.1% | 97.5% | 97.5% | 100.0% | 100.0% | 100.0% | 100.0% | 98.1% | 97.5% | 97.0% | 97.1% | 98.0% |
| Breast (screened only) | 100.0% | 78.1% | 91.1% | 95.1% | 97.1% | 100.0% | 100.0% | 96.6% | 97.7% | 96.9% | 71.1% | 100.0% | 97.7% |
| Cervical (screened excluded) | 100.0% | 75.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 66.7% |
| Cervical (screened only) | 100.0% | 100.0% | n/a | 100.0% | 100.0% | 100.0% | n/a | 100.0% | n/a | n/a | n/a | n/a | n/a |
| Head & Neck | 100.0% | 100.0% | 100.0% | 100.0% | 93.1% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.2% | 100.0% |
| Lung | 93.2% | 95.2% | 100.0% | 93.9% | 98.6% | 94.9% | 94.9% | 98.5% | 100.0% | 100.0% | 96.3% | 100.0% | 100.0% |
| Lymphoma | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Ovarian | 100.0% | 66.7% | 100.0% | 100.0% | 85.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 83.3% | 100.0% |
| Upper Gastro-Intestinal (GI) | 97.7% | 96.4% | 95.1% | 100.0% | 100.0% | 97.3% | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 100.0% | 100.0% |
| All Cancer Types | 95.3% | 91.1% | 93.9% | 94.5% | 92.2% | 92.2% | 96.2% | 94.3% | 95.2% | 96.1% | 90.7% | 96.2% | 96.2% |
| All Cancer Types Trajectory | 92.9% | 92.6% | 92.8% | 92.5% | 94.7% | 94.4% | 93.7% | 94.7% | 94.8% | 94.8% | 94.6% | 95.1% | 94.9% |
| Difference | 2.4% | -1.5% | 1.1% | 2.0% | -2.5% | -2.2% | 2.5% | -0.4% | 0.4% | 1.3% | -3.9% | 1.1% | 1.3% |

| 62 Day performance | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 |
| Urological | 50.0% | 51.4% | 45.2% | 51.7% | 61.3% | 48.8% | 47.8% | 77.1% | 50.0% | 67.7% | 70.6% | 71.4% | 58.1% |
| Colorectal (screened excluded) | 55.6% | 37.5% | 61.9% | 41.7% | 55.0% | 54.5% | 38.1% | 61.1% | 60.0% | 68.8% | 64.0% | 44.4% | 75.0% |
| Colorectal (screened only) | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 10.0% | 5.9% | 22.2% | 11.1% | 55.6% | 35.7% | 50.0% |
| Melanoma | 80.0% | 75.0% | 72.2% | 82.4% | 90.9% | 66.7% | 94.8% | 89.7% | 93.6% | 100.0% | 100.0% | 100.0% | 100.0% |
| Breast (screened excluded) | 90.6% | 95.7% | 73.9% | 84.0% | 75.9% | 95.8% | 92.9% | 95.7% | 85.3% | 100.0% | 87.0% | 80.0% | 90.9% |
| Breast (screened only) | 100.0% | 97.1% | 95.7% | 97.7% | 90.2% | 100.0% | 97.2% | 97.0% | 95.8% | 100.0% | 100.0% | 100.0% | 100.0% |
| Cervical (screened excluded) | 100.0% | 0.0% | 100.0% | 100.0% | 75.0% | 100.0% | 100.0% | 25.0% | 0.0% | n/a | 100.0% | 33.2% | 50.0% |
| Cervical (screened only) | 100.0% | 0.0% | n/a | 0.0% | n/a | 0.0% | n/a | 0.0% | n/a | 0.0% | n/a | n/a | n/a |
| Head & Neck | 100.0% | 100.0% | 88.9% | 100.0% | 73.3% | 88.9% | 100.0% | 91.7% | 100.0% | 100.0% | 88.9% | 100.0% | 85.7% |
| Lung | 92.9% | 90.5% | 76.2% | 93.3% | 90.5% | 82.1% | 83.3% | 82.4% | 87.5% | 84.0% | 100.0% | 100.0% | 82.8% |
| Lymphoma | 100.0% | 66.7% | 100.0% | 75.0% | 50.0% | 100.0% | 83.3% | 100.0% | 66.7% | 33.3% | 100.0% | 33.3% | 100.0% |
| Ovarian | 100.0% | 0.0% | 40.0% | 75.0% | 100.0% | 100.0% | 33.3% | 100.0% | 100.0% | n/a | n/a | 100.0% | 50.0% |
| Upper Gastro-Intestinal (GI) | 90.5% | 100.0% | 90.9% | 100.0% | 92.3% | 94.7% | 94.7% | 92.9% | 93.1% | 94.4% | 96.2% | 95.5% | 100.0% |
| All Cancer Types | 79.3% | 74.3% | 70.6% | 78.0% | 75.4% | 75.8% | 78.5% | 78.9% | 80.8% | 83.8% | 85.2% | 78.2% | 83.0% |
| All Cancer Types Trajectory | 89.5% | 78.0% | 81.8% | 81.5% | 82.8% | 84.2% | 81.2% | 82.1% | 84.0% | 84.1% | 84.1% | 88.1% | 88.3% |
| Difference | -10.2% | -3.7% | -11.2% | -3.5% | -7.4% | -8.4% | -2.7% | -3.2% | -3.2% | -0.3% | 1.1% | -9.9% | -5.3% |

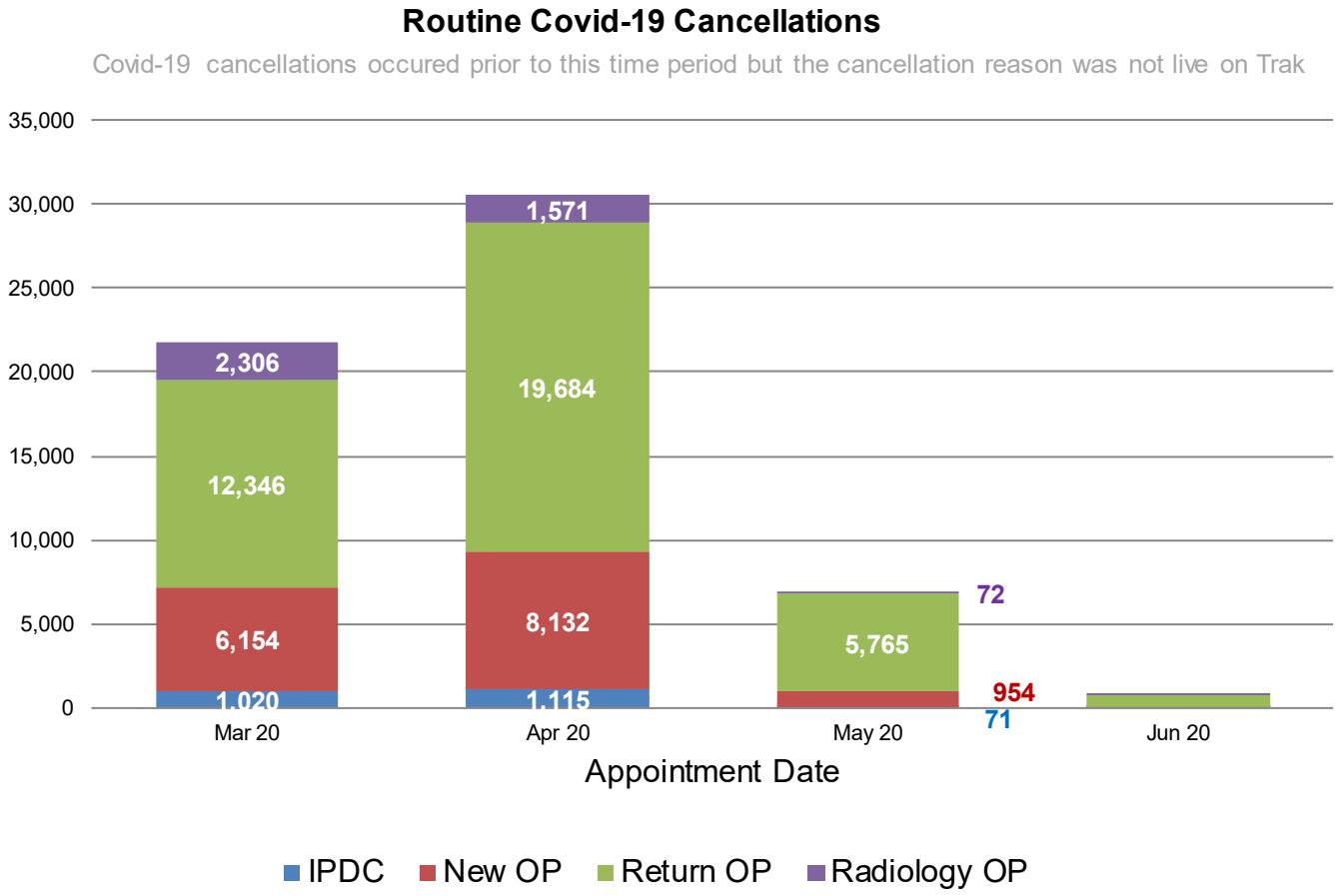
## Cancellations

| All | | | | |
|---|---|---|---|---|
| | **Total** | **Mar 20** | **Apr 20** | **May 20** |
| **IPDC** | **2,606** | **1,223** | **1,297** | **79** |
| New OP | **18,152** | 7,439 | 9,634 | 1,015 |
| Return OP | **40,005** | 12,972 | 20,493 | 5,831 |
| Radiology OP | **4,211** | 2,483 | 1,654 | 72 |
| **Total OP** | **62,368** | **22,894** | **31,781** | **6,918** |



| Routine | | | | |
|---|---|---|---|---|
| | Total | Mar 20 | Apr 20 | May 20 |
| **IPDC** | **2,213** | **1,020** | **1,115** | **71** |
| New OP | **15,303** | 6,154 | 8,132 | 954 |
| Return OP | **38,491** | 12,346 | 19,684 | 5,765 |
| Radiology OP | **3,951** | 2,306 | 1,571 | 72 |
| **Total OP** | **57,745** | **20,806** | **29,387** | **6,791** |

| Urgent | | | | |
|---|---|---|---|---|
| | Total | Mar 20 | Apr 20 | May 20 |
| **IPDC** | **393** | **203** | **182** | **8** |
| New OP | **2,849** | 1,285 | 1,502 | 61 |
| Return OP | **1,514** | 626 | 809 | 66 |
| Radiology OP | **260** | 177 | 83 | 0 |
| **Total OP** | **4,623** | **2,088** | **2,394** | **127** |



**NHS LOTHIAN**

Board Meeting
13th May 2020

Director of Improvement

# POST COVID-19: RECOVERY, RENEW AND TILT TO DIGITAL

## 1 Purpose of the Report

1.1 As the Covid-19 pandemic has now peaked with cases and bed numbers in NHS Lothian falling, attention has started to focus on the implications for the health and care sector going forward. One of the main unknowns is how the future disease profile will behave, and the associated implications for maintaining the current level of operational readiness, and when to start 'normalising' health and care delivery.

1.2 Whilst it may still be a few of weeks away, especially whilst there remain significant challenges in terms of care home provision, testing and PPE supplies, it is important to be prepared and plan early for the recovery period in line with good resilience planning guidance. This paper sets out an overarching framework, as well as a proposed approach for progressing the recovery and renewal process.

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

## 2 Recommendations

2.1 Approve the proposed way forward in relation to the Recovery and Renew process progressed via the Strategy Planning Committee.

## 3 Discussion of Key Issues

### Background

3.1 It has become apparent that the current pandemic situation has resulted in an unprecedented level of change in how day to day health services are delivered, with new patient access channels in place, new ways of working implemented as well as significant efforts to free up clinical capacity in the acute sector.

3.2 This has resulted in some dramatic changes in how services are delivered, for example:

- Emergency Department attendances fell by between 50-60% immediately following the introduction social isolation measures with a shift away from face to face contact to telephone triage through NHS24 and in primary care. The reduction was mainly due to a reduction in minor illness, sporting and recreational injuries as well as attendances by tourists. Over the past two weeks attendance levels have

started to gradually increase, and there remains a small number of four hour target breaches, making it important we learn from what has happened and adapt;

- Delayed discharges have reduced by a similar level given the push to free up hospital beds, with HSCPs increasing the number of patients discharged from mid-March to early April. The number of delays has now stabilised at this new lower level across Lothian for the past few weeks (70-80 standard social care delays);

- In primary care, GPs are triaging the vast majority of patients via the telephone, with a new pathway established for Covid patients who are directed via NHS24 to community hubs, who triage and then admit to hospital as required. There has also been a marked reduction in the number of patients being referred into the acute sector (70-80% depending on the specialty);

- A number of acute specialties have instigated telephone consultations for outpatient services with the number of telephone appointments increasing exponentially during the first few weeks of the pandemic (from under 200 per week in early March to 3,000 per week at the end of March[1]). Video consultation services using 'NHS NearMe' are also being rolled out with strong uptake in early adopters such as dermatology and mental health.

3.3 Going forward it will be important to learn from how these changes were delivered, the impact of robust active clinical triage and assess which of these changes should be embedded into clinical practice and service models going forward. This will involve some monitoring of the current situation as well as understanding the care backlog that will need to be recovered in the future.

**Recovery and Renew Framework**

3.4 This section sets out a framework for recovery and renewal planning, building on the changes that have occurred over the past two months. The framework is broadly aligned with work being progressed nationally, and is based on the assumption that in the short to medium term both Covid and non-Covid activities will need to be run in parallel given the potential of further outbreaks.

3.5 Covid-19 activities: creating a more permanent 'specialty'.

- the Covid-19 service could conceptually be viewed as a specialty on its own right, requiring infrastructure, capacity, budget, staff and leadership within the acute sector;
- it would operate as a single pathway based team with the primary and community input to manage flow into hospital as well as rehabilitation. This would also involve public health input to test, monitor, trace and manage outbreaks as they emerge in the community;
- a planning and resilience capability so it can rapidly respond to future disease states, restock and provide flexibility to ramp up and down capacity.

3.6 Recovery and renew activities: returning to the 'new' normal.

[1] based on text word search of clinical records whilst changes to Trak outcome classifications are put in place

- promote learning from the pandemic, relating to how services have been delivered, how people have managed in a crisis and innovation that has taken place;
- support the workforce with issues associated with personal resilience, and continue to enable and provide leadership for flexible working practices;
- plan for sustainably reintroducing non-Covid activity and consider how to deliver expected performance levels building on changes in clinical practice and service models that have been rapidly adopted during the pandemic; and
- ensure strong financial governance to promote service sustainability into the future.

3.7 At a Scotland level, a number of recovery processes have recently been put in place. Specifically with the health and care sector, two subgroups have been established to look at recovery and renewal. A Recovery subgroup has been established to look at how to reintroduce non-Covid activity, and the sequence and prioritisation of this under the leadership of John Burns, the Chief Executive of Ayrshire and Arran; and a renewal subgroup has been tasked with looking at longer term remobilisation under the leadership of Carol Tannahill, the appointed Scottish Government Director of Recovery. At the time of writing both of these groups were at the point of being established with associated terms of reference and scope documents being drafted.

3.8 The Covid-19 response is currently being delivered through a Gold command structure with input from across the health and care system, and the remainder of the paper sets out how the recovery and renew elements will be progressed within NHS Lothian.

**Forward Programme**

3.9 The overarching thrust of the Covid-19 recovery and renewal process will be to support services return to the 'new normal' learning from the experience of the pandemic situation, and retaining as much as possible of the transformation that has occurred.

3.10 Figure 1 provides a high level overview of the activities that have been undertaken, or that will need to be undertaken. These have been grouped into five themes set across three phases:

- Response: the immediate Covid pandemic response;
- Recovery: actions that are underway to manage the ongoing challenges associated with Covid and to restart other services as the pandemic starts to subside; and
- Renew: the post Covid phase that supports system renewal over a three to six month period.

3.11 The timescales for each phase will depend on how the pandemic progresses but early planning is underway now for both the Recovery and Renew phases.

**Figure 1. Response, Recovery and Renew Activities**

| | 'Covid Pandemic' Response | 'New Covid Specialty' Recovery | 'Post Covid Normal' Renew |
|---|---|---|---|
| **People, Learning, Culture and Engagement** | • Regular staff communications<br>• Mental health and support hotline<br>• Crisis response and team spirit | • Learning and reflection<br>• Post Covid resilience and recuperation<br>• Interim workforce model | • Flexible working practices and revised clinical and non clinical workforce strategy<br>• Wellbeing strategy<br>• Public and staff engagement |
| **Acute configuration and elective capacity** | • Rapid critical care and general bed capacity expansion<br>• Red and green patient cohorts<br>• Cessation of routine elective activity | • Post Covid capacity requirement<br>• Phased restart of elective activity based on clinical risk<br>• Telephone and video consultation ramped up | • Flexible Covid clinical model<br>• Elective programme re-established: active clinical triage, realistic medicine and virtual clinics<br>• Social distancing model normalised |
| **Primary, Community and Unscheduled Care** | • Telephone triage instigated<br>• Covid community hubs created<br>• Delayed discharge reduction<br>• Rehabilitation pathway<br>• Care Home support | • Maintain telephone triage model and restart deprioritised activities<br>• Maintaining community hubs<br>• Maintaining community capacity | • Embedded use of telephone and/or video triage and links with NHS24<br>• Revised unscheduled care pathways<br>• Sustainable community capacity and HomeFirst model |
| **Contingency Planning and Digital First** | • Gold command structure<br>• Supply chain and PPE<br>• Monitoring and forecasting | • Contingency planning<br>• Covid capacity analysis and modelling<br>• Restocking PPE and refresh pandemic strategic approach<br>• Financial recovery | • Revision of demand and capacity forecasts and refresh of STP<br>• Digital first delivery<br>• Review of financial plan, investments and capital priorities |
| **Public Health and Inclusion** | • Pandemic incidence management<br>• Public health messaging<br>• Testing capacity expansion | • Community testing strategy<br>• Shielding maintained<br>• Plan to restart key public health programmes | • New models for inclusion health and screening programmes<br>• Ongoing shielding approach<br>• Public health recovery, health inequalities and health intelligence |

3.12 The programme of work across the health and care system required to deliver the non-Covid related renewal activities is set out below. Work is already progressing in a number of these areas, and will accelerate over the next few weeks as the Covid response phase ramps down.

*People, learning, culture and engagement*

3.13 This work will be wide ranging and progress a number of elements at the appropriate time (given many staff are actively engaged in caring for Covid-19 patients), including:

- active learning from key participants in the Covid-19 effort including 'debrief' interviews with 20-30 key leaders of the response effort, as well as a larger structured evaluation of staff experience;
- small scale local evaluation of recent changes in care models, for example, patient and staff feedback in relation to the use of telephone and video consultations;
- participation or support for national initiatives such as evaluations/research into the impact of Covid-19;
- continued support for personal resilience and wellbeing measures for staff;
- changing the culture of the workplace, streamlining decision making processes, reducing face to face meetings and embedding virtual and flexible working practices;
- plan a larger scale public engagement strategy across Lothian, setting out how the 'new normal' will influence the way health services are delivered, ensuring alignment with any Scottish Government messages.

*Elective programme*

3.14 This will involve implementing a phased plan to reintroduce outpatient, diagnostics, inpatient and day case activity based on capacity planning for Covid and non-Covid patients, as well as a clinical assessment of risk. It will be underpinned by active clinical triage, realistic medicine, technology and new service models. It will document what is happening now, short term plans to re-establish services and in due course require revised waiting time trajectory analysis in relevant services.

*Digital First*

3.15 To support the restart and redesign of the elective programme and other services this work will consider how to embed, accelerate and sustain a digital first model for outpatient, primary care, mental health consultations and other relevant areas. The aim will be to enhance patient experience, support the delivery of access targets and minimise social contact. The scope would be broader than the use of video consultation, and relate to the use of technology to support service transformation. It should involve a structured approach to developing the case for change, have clinical leadership, specified technology requirements and an associated business case(s).

*Community Capacity*

3.16 Delayed discharges have reduced significantly during the Covid-19 pandemic and it will be important to sustain this position, to ensure capacity is available in the acute sector in case of further Covid surges. In parallel, it will be important to understand what capacity is required in the community to continue to manage Covid related work and links with the Care Home sector. This work will consider what further capacity is required in the community and care sector, establish a baseline level of activity and funding to sustain the current discharge position across a range of health and care services. It will also consider how redesigned care models, telehealth and other improvements can support people closer to home;

*Unscheduled Care Pathway*

3.17 This work will continue to plan in advance of Winter 2020, to embed HomeFirst principles whilst learning from the changes instigated as a result of Covid-19. In particular, how changes in primary care and the community hub model, alongside greater integration across NHS24 and the flow centre can provide alternative care pathways and models of care. This will build on lessons learnt from the reduction in Emergency Department attendances as there is a window of opportunity to assess what changes can be instigated.

*Public health and inclusion*

3.18 This work will support improvements in health, health inequalities and inclusion, associated with the short and longer term effects of the pandemic taking a pan public sector perspective linking across the private and the third sector. This will involve the reestablishment of public health screening programmes, health improvement initiatives and inclusion programmes, as well as the ongoing shielding programme. This will be closely aligned with the work of Public Health Scotland.

**Programme governance and next steps**

3.19 Work will be progressed across all of these areas feeding into the Board's strategic priorities, investment priorities and annual planning processes. Key proposals are set out below.

3.20 A whole system approach working with all HSCPs will be needed given the range and extent of issues to be addressed.

3.21 Planning should remain flexible, and align with Covid-19 requirements given the potential for further waves of infection. Where possible dedicated Covid and non-Covid teams will be required not to dilute focus.

3.22 It is proposed that the initial planning timeframe for this should be focused on Winter 2020/21.

3.23 Individual work packages will be progressed by tactical groups, these meetings will be virtual where possible, and build on learning from the more agile management style adopted during the Covid response.

3.24 An overarching Recovery and Renewal group will be established to progress the work programme, reporting into the Strategic Planning committee of the Board.

3.25 Clinical leadership is important and a virtual clinical reference groups will be established to guide the programme as required.

## 4 Key Risks

4.1 The primary risk to this work relates to the future progression of the Covid-19 pandemic as the recovery and renewal phase are predicated on the pandemic easing allowing a phased restart of activities. It will be important to maintain the momentum of change associated with the Covid response to allow innovation and new ideas.

4.2 Involvement and engagement with national programmes will be required to minimise risks associated with the alignment with the national agenda. In particular, it is not known how the Scottish Government's performance management framework will influence this programme of work.

## 5 Risk Register

5.1 The Corporate Risk Register will need to be refreshed in the light of the COVID-19 pandemic and updated to reflect ongoing work around recovery and renewal.

## 6 Impact on Inequality, Including Health Inequalities

6.1 A number of the Digital First proposals could result in the growth of the 'digital care divide' as the move towards virtual health and care may impact on vulnerable groups with limited access to technology. These issues will need to be taken into account in future service models, as well as in light of changing public attitudes to virtual healthcare, by adopting a mixture of traditional and online services.

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

7.1 A number of proposals have been set out to involve people who use our services in evaluating the impact of changes instigated as part of the Covid response, as well as for further public consultation. These proposals will be developed over the coming weeks.

## 8 Resource Implications

8.1 There are no immediate resource implications, in the longer term there are likely to be financial implications and these will be estimated as this work is progressed. Where investment requirements are identified, appropriate business cases will be prepared for approval.

Peter Lock
Director of Improvement
5th May 2020

**NHS LOTHIAN**
Board Meeting
13th May 2020

Executive Director, Nursing, Midwifery and AHPs; Executive Lead for REAS and Prison Healthcare: HAI Executive Lead

## HEALTHCARE ASSOCIATED INFECTION (HAI) UPDATE

### 1 Purpose of the Report

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

### 2 Recommendations

The Board is recommended to take moderate assurance from the information provided in this paper, and to:

- Accept the progress against local delivery plan standards for the year 1st April 2019 - 31st March 2020:

    - *Staphylococcus aureus* Bacteraemia (SAB): The performance standard has been met. The incidence for SAB is 12.4 (n=123) against a target of 13.2 healthcare associated episodes (or less) per 100,000 bed days (<133 episodes approx).

    - *Clostridioides difficile* Infection (CDI): The performance standard has been met. The Incidence for the year ending 31 March 2020 as per HPS surveillance programme reporting criteria is 11.9 (n=118) against a target incidence of 12.3 healthcare associated episodes (or less) per 100,000 bed days (<125 episodes approx).

    - *Escherichia coli* Bacteraemia (ECB): The standard for 2019/20 has not been met. The target for 2019/2020 was to achieve an incidence of 32.5 healthcare associated episodes (or less) per 100,000 bed days (<330 episodes approx). Incidence for the year ending 31 March 2020 is 34.8 (n=345).

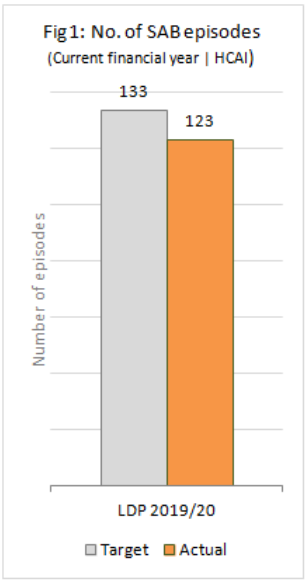
- Note the investigations and outcomes arising from a small number of possible infection incidents in Department Clinical Neuroscience (Western General Hospital), Neonatal Unit (Royal Infirmary of Edinburgh), and Ward 2 Royal Hospital for Sick Children.

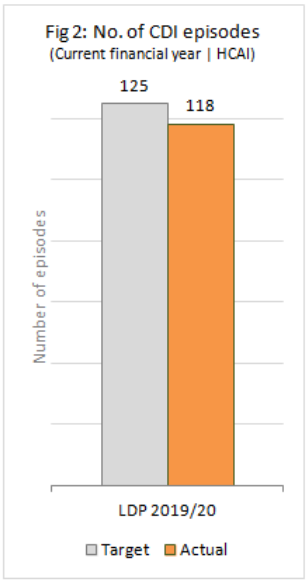
- Accept the impact on Infection Prevention and Control Services routine work programmes to support activities associated with the pandemic novel Coronavirus (COVID 19) on Infection Prevention Control. (Appendix 1).

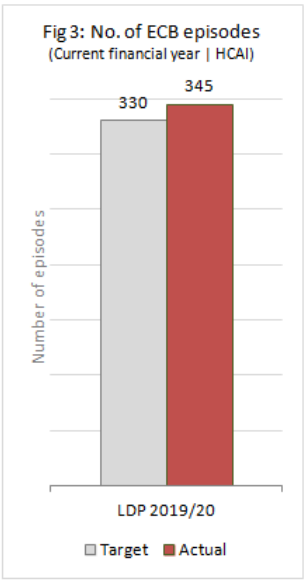
- Acknowledge whilst mandatory surveillance programmes have been paused until further notice incidences of SAB, CDI, and ECB will continue to be reported to Health protection Scotland (HPS)

## 3 Discussion of Key Issues

3.1 Progress against Local Delivery Plan Standards 31 March 2020




3.2 *Staphylococcus aureus* Bacteraemia: NHS Lothian's interim LDP target for 2019/2020 was set to achieve an incidence of 13.2 healthcare associated episodes (or less) per 100,000 bed days (<133 episodes approx). Incidence for the year ending 31 March 2020 (at time of reporting) is 12.4 (n=123). Therefore, the LDP for 2019/20 has been met.

The incidence of healthcare associated infections considered as preventable for the period April 2019 to March 2020 have reduced in comparison to previous year. 49 of the 123 (40%) compared to 74 out of 138 (54%) for the same period in 2018/19.

NHS Lothian has seen a reduction in PVC related SAB for the period April 2019 to March 2020 (n=13) compared to the same period in 2018/19 (n=22). NHS Lothian continue to roll out and reinforce Aseptic Non Touch Technique (ANTT) training relating to optimise care of vascular access devices to minimise vascular access device related SAB.

3.3 *Clostridioides difficile* Infection: NHS Lothian's interim LDP target for 2019/2020 was set to achieve an incidence of 12.3 healthcare associated episodes (or less) per 100,000 bed days (<125 episodes approx). Incidence for the year ending 31 March 2020 (at time of reporting) is 11.9 (n=118). Therefore, the LDP for 2019/20 has been met.

Exposure to antibiotics with recognised association with CDI continues to contribute to cases. The Antimicrobial Management Committee (AMC) and microbiologists continue to highlight the risks of prescribing 4C antimicrobials.

Reinforcement of the need to isolate and manage patients with loose stools in accordance with the NHS Lothian Loose Stool Policy continues through clinical teams and infection control committees.

3.4 *Escherichia coli* Bacteraemia (ECB): NHS Lothian's performance target for 2019/2020 was to achieve an incidence of 32.5 healthcare associated episodes (or less) per 100,000 bed days (<330 episodes approx). Incidence for the year ending 31 March 2020 (at time of reporting) is 34.8 (n=345). Therefore, the LDP for 2019/20 has not been met.

The specific source (using HPS surveillance categories) for most of the healthcare associated ECB was urinary catheter related (24%; n=82); infection in the lower urinary tract (19%; n=64), hepatobiliary infections (19%; n=65); and sources classified as "other" (15%; n=52). For a proportion of the cases (5%; n=18) data collectors were unable to establish the specific source of the ECB.

The ECB data for NHS Lothian is influenced by its provision of specialist tertiary care for hepatobiliary and urological surgery. Majority of these cases were deemed unpreventable on review although classified as healthcare associated using HPS definitions. Hepatobiliary infections include community gallstones/gallstones in bile duct, inflammation of the gallbladder amongst others. Intra-abdominal infections include community onset Necrotising enterocolitis, appendicitis, malignancy amongst others. There is ongoing further detailed investigation of the hepatobiliary and intra-abdominal sources to better understand these categories and to consider how these can be prevented.

NHS Lothian continues to encourage the reduction of urinary catheter use and optimise care and management of all devices. Future plans to trial cholorhexidine wash prior to catheter insertion needs investigation.

3.5 Incident Investigation:

Western General Hospital Department of Neurosciences - *Pseudomonas aeruginosa*: In total 5 neurosurgical patients were associated with acquisition of *Pseudomonas aeruginosa* with DCN since February 2019. No new patient cases have been identified since December 2019.

A robust programme of water sampling and reactive estates works to identify and address any positive outlets in the ward areas will continue until the move, now confirmed to take place in May 2020.

- Royal Infirmary of Edinburgh Ward 110 (Neonatal Unit) - Extremely resistant *Escherichia coli*: Two babies tested positive for the same strain of extremely resistant *Escherichia coli* blood stream infections in the Neonatal Unit at the Royal Infirmary of Edinburgh in December 2019 . The incident management and clinical teams undertook a full review of environment and practice developing a comprehensive improvement programme. There have been no further incidents reported and the incident management team has stood down and the Neonatal management team continue to monitor progress and sustainment on actions.

- Royal Hospital for Sick Children Ward 2 (Haematology Oncology)– *Pseudomonas aeruginosa*: In November 2019 routine sampling identified a single outlet positive for *Pseudomonas aeruginosa* in Ward 2, and four positive outlets in Critical Care. All remedial work to address this was completed in conjunction with ongoing water sampling. A look back exercise as part of incident management confirmed there

were no associated clinical infections at this time. On 31st December 2019 one incident for *Pseudomonas aeruginosa* in a child in ward 2 who had been in hospital for more than 48 hours was identified.

The reference laboratory testing indicated that the pseudomonas types was a common one and found in both environmental isolates as well as from patient. Results of water testing carried out via the estates department show at several time points during the child's admission were negative for pseudomonas. It was therefore not possible to determine a definitive source of this infection. The patient is well and has been discharged home. There are no ongoing issues or outstand actions relating to water quality in ward 2.

3.6 Royal Hospital Children & Young People Department Clinical Neurosciences: Work is ongoing and on schedule. It is anticipated the hospital will open in autumn 2020 The impact of the COVID 19 pandemic and social distancing on the works is being monitored.

3.7 Pandemic Novel Coronavirus SARS-CoV-2/COVID-19: Scottish government confirmed on 2nd April 2020 Scotland is in a period of sustained transmission for SARS-CoV-2/COVID-19. Based on information available to Health Protection Scotland (HPS) at 09:00 on 22/04/2020 there have been 7, 365 tests carried out in NHS Lothian for COVID-19, of those 1, 515 (20.6%) were laboratory confirmed positive cases. 184 of the COVID-19 positive patients have subsequently died (Data source: HPS COVID-19 Epidemiological Summary for Scotland).

Health Protection Scotland (HPS) continues to update its guidance for health protection teams and healthcare practitioners as the situation evolves, as well as providing guidance for non-healthcare settings including schools, places of detention, and separate guidance for social care settings. This is challenging at times as the guidance is based on Public Health England and publications are not provided to NHS Scotland ahead of public release. Updating internal NHSL Lothian guidance is under constant review to ensure the correct information is available to assist the organisation management of the pandemic.

NHS Lothian has developed a Framework on the use of PPE. This has been discussed and agreed with the Strategic Oversight Group. Given the precarious nature of PPE this will remain a 'live' document and reviewed each time there is any national change in guidance related to PPE. However there is a daily PPE Huddle, chaired by the Executive Nurse Director with representation from the whole system and this provides assurance/reassurance that there is appropriate stock available to support safe delivery of care. This Huddle also includes a staff side representative which is important given the mixed and confused messages at times re access and use of PPE.

Infection Prevention and Control Services reviewed routine activities and in conjunction with the temporary suspension of mandatory surveillance programmes released resources to support, the clinical and management teams manage the response to COVID-19 in Lothian hospitals. Incident reports are submitted daily to Lothian Analytical Services have established tableaux dashboards to support the

monitoring of incidents and impact on services. Clinical Services have established patient pathways for confirmed and suspected cases.

Reports are submitted to HPS daily for any clusters occurring out with these pathways to monitor the ongoing impact on patients and services. The information provides cumulative figures on these clusters for suspected and confirmed cases in patients and staff as well as any related deaths. HPS collate this information from Boards and report to Scottish Government.

Public Health Team and Emergency Planning and Business Continuity are leading on the wider Lothian programme of control measures.

## 4 Key Risks

The key risks associated with the recommendations are:

- The ECB data for NHS Lothian is influenced by its provision of specialist tertiary care for hepatobiliary and urological surgery. Further detailed analysis of the risk factors within these two large clinical specialties is needed to meet the revised target.
- There is a potential risk of missed incidents due to the focus on the pandemic. Actions to continue monitoring are outlined in appendix 1.
- There is risk to ensuring compliance with most up to date pandemic guidance due to the fluidity of situation, subsequent changes to guidance and time required to operationalise the guidance for staff.

## 5 Risk Register

The Healthcare Associated Infection Corporate Risk Register 1076 has been reviewed and is graded as high reflecting the impact of COVID 19 as well as the risks of Healthcare associated infections

## 6 Impact on Inequality, Including Health Inequalities

Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. They require increased interventions and therefore have increased contact with healthcare services.

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

Patients affected by the incidents in section 3.1 have been kept informed as part of professional candour.

There is patient public representation on the Community and NHS Lothian Infection Control Committees. Information leaflets are available to patients for a number of healthcare associated infections including *Clostridioides difficile*. Patients are kept informed by clinical care teams.

## 8 Resource Implications

The excess cost of each episode of hospital acquired and healthcare associated infection is variable, depending on increased length of stay and additional treatment requirements.

There are additional costs associated with the pandemic and increased requirement for personal protective equipment in accordance with national and local guidance.

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24/04/2020
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HAI Appendix 1: Temporary Changes to IPCT Activities

| AREA | ACTIVITIES changes from 25/3/20 | IMPACT | PLAN |
|---|---|---|---|
| **Surveillance** | Surgical Site Infection (SSI) | Mandatory and voluntary surveillance has been paused until further notice by SGHH&SCD & HPS. | ***Paused*** until further notice |
| | Routine Intensive Care Unit (ICU) surveillance | | ***Paused*** until further notice |
| | Staphylococcus aureas bacteraemia (SAB) | Scottish Health boards are still required to submit the number of CDI, ECB and SAB case numbers together with the origin of infection. Until further notice, the submission of other data items included in the enhanced or extended surveillance has become voluntary. This will allow health boards to report on case numbers and to establish whether cases are healthcare or community associated. | **Report *case numbers & origin of infection* for Quarterly Epidemiological Data Official Statistics**<br>Janathan Danial (Clinical Scientist) will ensure data for March 2020 has been completed in ECOSS to enable the end of year data to be completed<br><br>From April 2020 until further notice, the Donald Saunders (Infection Prevention and Control Support Worker) will complete the origin of infection information in ECOSS. Donald has the required access to ECOSS, Trak and Apex and has been provided with the current surveillance protocol. Janathan has run through the information on ECOSS with Donald and the Scientists will be available to provide further guidance if required.<br><br>Option: Scientists together with the Consultant Microbiologists will review all SAB cases at the end of the month to identify any key issues that need to be reported. This process will require the use of Trak and Apex integration. |
| | Escherichia coli (ECB) | | **Report *case numbers & origin of infection* for Quarterly Epidemiological Data Official Statistics**<br>From April 2020 until further notice, the Donald Saunders (Infection Prevention and Control Support Worker) will complete the origin of infection information in ECOSS. Donald has the required access to ECOSS, Trak and Apex and has been provided with the current surveillance protocol. Janathan has run through the information on ECOSS with Donald and the Scientists will be available to provide further guidance if required. |

| | | |
|---|---|---|
| | Clostridioides difficile infection (CDI) | **Report *case numbers & origin of infection* for Quarterly Epidemiological Data Official Statistics**<br>The Scientists together with the Consultant Microbiologists will review all CDI cases at the end of the month to identify cases for de-notification and any key issues that need to be reported. This process will require the use of Trak and Apex integration.<br><br>Janathan Danial (Clinical Scientist) will ensure data for March 2020 has been completed to enable the end of year data to be completed.<br><br>From April 2020 until further notice, Scientists will generate a list of C. difficle toxin positive patients. Donald Saunders (Infection Prevention and Control Support Worker) will determine and record the origin of infection for each case.<br><br>If during the course of their role, the IPCNs identify any relevant information to assist the review of cases, they should provide the relevant information to the Scientists. |
| | This programme has not been paused<br>MDRO screening KPI | The Scientists together with the Consultant Microbiologists will review all CDI cases at the end of the month to identify cases for de-notification and any key issues that need to be reported. This process will require the use of Trak and Apex integration.<br>The Surveillance Team will undertake first review of all downloads, review open cases and where appropriate escalate or close. Clinical Scientists will review and validate data. |
| **COVID-19 enhanced surveillance programme** | | ***Dedicated surveillance of COVID- 19 infections specifically*** .<br>• Report Ventilator Associated Pneumonia (VAP) and other infections associated with COVID-19.<br>Extra surveillance resource will be required to support this enhanced surveillance in ICU |

| | | | |
|---|---|---|---|
| **Reports** | Monthly Infection reporting | | The monthly reporting of CDI, SAB and ECB cases will continue to be reported using the Monthly Healthcare Associated Infection Report and Clinical Management Group (CMG) reports.<br>The number and origin of infection information for CDI, SAB and ECB cases will continue to be fed into the Quarterly Epidemiological Data Officials Statistics. This will enable health boards and HPS to continue identifying trends, exceptions and to take immediate mitigating action where necessary.<br>Monthly reporting of infection data from April 2020 was hopefully going to be migrated to the new Infection Service Dashboard. This project may be delayed due to other priorities, however if this is the case, the existing Chart Generator will continue to be used. |
| | Mortality Reviews | Mortality reviews for CDI and SAB patients has been suspended until further notice. | The Infection Prevention and Control Team will monitor patients who have died and tested positive for SARS-CoV2 (COVID-19) but no formal case reviews will be required.<br>The Surveillance Team will review Mortality database, enter death certificate data to IC Net and if appropriate close the review. |
| **Meetings** | | Suspended | |
| | | | |
| **ICNET** | Open case reviews | Open case reviews require to continue | The Surveillance Team will regularly review IC Net reports & close cases where the patients have been discharged home. |
| | Pseudomonas alerts | These still require to be updated | The Surveillance Team will continue to review and close or pass on to IPCT for further investigation as per flowchart. |
| | TRAK & MDRO alerts | These still require to be reviewed | The Surveillance Team will copy & paste into action log. They will alert IPCT if further action or advice required for new cases. |
| | HL7 upgrade | Tempoary suspended, impacts on real time data not available from TRAK | |
| | | | |
| **Education TBP** | | Transmission Based Precautions Education Sessions across RIE WGH and St John's sites scheduled for April May and June cancelled. | Will be rescheduled for later in the year once returned to normal activity levels. |

| | |
|---|---|
| **Planning meetings** | Education Group Monthly meetings also stopped until normal activities resumed. |
| **Band 6 Development days** | Suspended |

| | | | |
|---|---|---|---|
| **Audits** | Snapshot<br>In depth<br><br><br>Pilot SICPs<br>SICPs audits QiDS | These have been suspended from Feb<br>Were initially to be prioritised<br>Annual audits first priority, then 18 month frequency ones by risk<br>2 yearly ones not a priority<br>Work suspended due to clinical activity<br>Work suspended due to clinical activity | Snapshots will only be done if required as part of a PAG or IMT<br>All suspended unless required as part of an IMT |
| | | | |
| **HAI SCRIBE** | Project and Refurbishment work across NHSL | Decreased IPCT capacity to support project and refurbishment work due to clinical acitivity during COVID pandemic | Advice from the Scottish Government that hospital construction sites are essential, Risk assessments are to be prepared by construction companies in order to establish a safe systems of work allowing them to re-start work on sites. HAI Scribe Lead Advisor will where possible continue to provide urgent advice and attend teleconference meetings subject to clinical activity |
| | | | |
| **Shared drive** | Reconfiguration | Work suspended due to other critical clinical need | |
| | | | |
| **Web page** | Upgrade | Redesign o f web pages currently on hold. Critical updates continue to support staff with current IPC advice. | Work will be picked up once normal activity levels resume. |
| | | | |
| **Policy** | | Reviews on hold. Critical Policy will continue to be reviewed, guidance will be updated to reflect significant changes in National guidance but routine review not happening. | Priority activity to be resumed once normal activity levels achieved. |
| | | | |
| **Meetings** | | Number of service meetings cancelled and wider organisation meetings supported by IPC representatives | Weekly teleconferences arranged for specific groups IPCT senior managment team, IPCNs, IPCNs and ICDs |

**NHS LOTHIAN**

Board
13 May 2020

Executive Director of Nursing, Midwifery and Allied Health Professionals

# REVIEW OF THE INTEGRATION SCHEMES

## 1 Purpose of the Report

1.1 The NHS Board is a party to four integration schemes with the local authority for each area. Those schemes led to the establishment of the four integration joint boards ('IJBs') in Lothian. The law requires the parties (the NHS Board and the local authority) to carry out a review of the integration scheme within five years from when the Scottish Ministers approved the scheme.

1.2 This report explains that the parties will not be able to complete the review of the schemes in time, and invites the Board to agree that the reviews should be postponed.

1.3 With regard to Our Priorities for Continuous Improvement, this report relates to the following priorities:

- 'Increase activity aimed at preventing people developing health issues or becoming unwell'. ('Improving the Health of the Population')
- 'Support integrated whole-system working across health and social care.' ('Achieving Value and Sustainability')
- 'Learn from all attempts to make improvements and share that learning with others'. ('Achieving Value and Sustainability')

Any member wishing additional information should contact the Executive Director of Nursing, Midwifery and Allied Health Professionals in advance of the meeting. (alex.mcmahon@nhslothian.scot.nhs.uk)

## 2 Recommendations

The Board is recommended to:

2.1 Agree to pause the process to review the integration schemes in Lothian with the four local authorities.

2.2 Agree to carry out the review of the integration schemes at an appropriate later date, when the reviews can be effectively completed.

## 3 Discussion of Key Issues

3.1 The Public Bodies (Joint Working) Scotland Act 2014 sets out the process to review the integration scheme.

3.2 The first step is a review under Section 44 of the Act to identify whether any changes to the scheme are necessary or desirable. As part of that review the parties have to carry out a formal consultation. For the Lothian schemes, the reviews would have to be completed by 27 May 2020 (for East Lothian, Edinburgh, and Midlothian) and 17 June 2020 (for West Lothian).

3.3 Given the circumstances of COVID-19, it is not possible to complete the four Section 44 reviews within the timescale. The NHS Board and the four local authorities are dedicating their attention to dealing with the pandemic.

3.4 Management had started the process of reviewing the integration schemes before COVID-19, working with colleagues in the local authorities and health & social care partnerships. This had identified the opportunity to simplify the content of integration schemes. The law largely prescribes which functions the Board and the local authority has to delegate, as well as some of the standard content of the schemes. As well as the standard content, the review identified the possibility of simplifying non-standard content, so as to give the parties more flexibility to adapt when circumstances change, without recourse to the full formal process.

3.5 Nevertheless the review work to date did not identify a fundamental problem with the integration schemes. The parties and the IJBs can continue to function, and management and staff will continue to work together. A review of the integration scheme is not critical to the operation of the health and social care system.

3.6 There have been discussions with West Lothian Council management and City of Edinburgh Council management on the specifics, and similar are scheduled with Midlothian Council and East Lothian Council. West Lothian have formally paused from their perspective, and City of Edinburgh management are, in principle, supportive. All have expressed a preference for a joint letter to Government colleagues to support.

## 4 Key Risks

4.1 The Board's Risk Management Policy states that '.the Board expects employees to give greater priority to managing and reducing risks associated with the safety of people, the experience of people who receive care, and the delivery of effective care'. There is a risk that diverting resources to attend to the legal requirement to carry out a formal review of an integration in the near future, could mean that management are not following the Board's risk management policy which leads to unintended harm.

4.2 By not carrying out a Section 44 review by the given deadlines (see Section 7 below) the Board will not be following the law. There is a risk that the Board will be held to account for this decision, however there is no legal penalty such as a fine.

4.3 If the parties attempted to carry out a Section 44 review while under pressure in the given circumstances, then there is a risk that the review is not carried out properly and the potential benefits of any review would be lost.

## 5 Risk Register

5.1 IJBs are responsible for a range of 'integration functions' which relate to many risks on the Board's corporate 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. However both the NHS Board and the IJBs have responsibilities to address inequalities, so it is important that any review of the integration schemes is carried out properly.

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

7.1 Given that a lockdown is in place, it would not be possible to carry out a meaningful consultation, even if the organisations had the capacity to do so.

7.2 The preferred approach is to defer the Section 44 reviews to a later date, when they can be carried out properly.

7.3 If following a Section 44 review, the parties agreed that it was necessary or desirable to change the integration scheme, they must then follow Section 46 of the Act to vary the scheme. Section 46 includes a further consultation processes on the proposed changes, and the parties must take into account the consultation views when finalising the scheme. The Act does not set a timeline to complete the requirements of Section 46. So even if a Section 44 review was carried out, it could be some considerable time before a revised integration scheme is in place.

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**8 Resource Implications**

8.1 The process of reviewing integration schemes does require resources (management and staff time) to complete. At the moment the priority is responding to COVID-19.

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21 April 2020
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**NHS LOTHIAN**

Board Meeting
13 May 2020

Director of Finance

# ROYAL HOSPITAL FOR CHILDREN AND YOUNG PEOPLE AND DEPARTMENT OF CLINICAL NEUROSCIENCES – PROJECT UPDATE

## 1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board takes assurance from the progress made towards the opening of the new RHCYP and DCN building.

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

## 2 Recommendations

2.1 The Board is recommended to accept:

2.1.1 Significant assurance that the facilities and the service are ready for DCN migration to Little France to commence on 11 May.

2.1.2 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 discussion.

2.1.3 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.

## 3 Discussion of Key Issues

### Implementation of NSS review findings

3.1 All actions related to water quality, drainage, electrical safety and medical gases in the RHCYP & DCN have been addressed and closed off. Water quality tests have given the building a clean bill of health, with zero outlets tested showing pseudomonas.

3.2 All ventilation checks and improvements except the critical care and haematology / oncology ward works have been carried out. Air handling units for these two areas are the subject of the high value change and supplemental agreement discussed below.

3.3 With confirmation from the Scottish Government that RHCYP & DCN is an essential construction project, contractors continue on site whilst practising Covid 19 conditions for safe working. This includes distancing of personnel, which is mitigated through work in smaller teams over different shifts, however may yet result in a delay to the programme. The impact is being monitored with our contractors.

3.4 Fire safety enhancement works are completed in DCN and underway in RHCYP, due to be completed by the end of July.

3.5 In CAMHS a number of changes, including fire safety enhancements, are programmed for completion in October 2020.

**DCN Migration**

3.6 With the completion of all outstanding works in DCN, the contractor had cleaned and handed over these facilities by 1st May 2020.

3.7 In agreement with the Cabinet Secretary, the first phase of DCN migration will take place from 11-13 May 2020. Outpatient clinics, neurophysiology and diagnostic radiology will be moved from the WGH to the new site, along with the related office and administrative functions.

3.8 DCN will see the first outpatients in their new facility on 13 May. At present, due to Covid-19, appointments on site will be for on urgent neuro patients, including stroke and ophthalmology clinics. The full outpatient service will be ready and established in their new site when it is possible to resume all clinic activity.

3.9 A move of inpatient services is not advisable whilst the hospitals, and particularly critical care, are responding to Covid-19. It has been agreed that the remaining DCN services – wards, critical care, theatres and interventional radiology – will migrate when Covid-19 demands reduce. This is a complex piece of work because of the co-dependencies of each service and the demands to respond to Covid-19; the date at which this can be achieved is unknown yet. NHS Lothian is committed to transferring DCN as soon as it is safe for patients and staff, so that they can all benefit from their new, purpose built- home.

3.10 This phasing of DCN moves, as opposed to the plan for a whole-service move in July 2019, reflects the pressures faced by the system at present. Starting the moves on 11 May 2020 is supported by the staff in neurosciences, radiology, theatres and anaesthetics and critical care.

3.11 To supplement the experienced Clinical Management Team for DCN, and to provide leadership in bedding in with IHSL and Bouygues, a fixed-term term interim Site Director has been appointed. Tim Montgomery will be taking on this part-time role until the Director of Women's and Children's Services moves onto site with RHCYP and CAMHS.

**High Value Change 107 – Ventilation Remedials and Fire Enhancements – and Supplemental Agreement 2**

3.12 Following approval of the commercial principles by the Board on 8th April 2020 and then the Oversight Board for the project on 9 April 2020, the Cabinet Secretary confirmed that NHS Lothian can proceed to signing the Supplemental Agreement on conclusion of negotiations.

3.13 Formal contracts to document the design, construction and operation of the new ventilation works required at the hospital are near finalisation. There remain some points of commercial detail to be agreed between the parties. These are expected to

have been closed out by the date of the Board meeting, when a verbal update will be provided.

3.14 IHSL have confirmed that the order for the air handling units was placed on 1 May, however they have also informed the Oversight Board for the project that because of the complexities involved and the impact of COVID-19, it is possible that changes will have to be made to the works programme and its delivery.

3.15 Discussions are underway to establish a revised programme to allow a full handover as close to the autumn timeline as possible and we will update the June Board meeting on progress.

**Contract Management Processes**

3.16 The Board are putting in place a team to manage the contract during its steady state operational phase. The team will consist of the current Contract Manager, whose team will be augmented by two members of NSS staff who have extensive experience of PPP-type contract management and assurance. The NSS personnel will provide support for the remainder of 2020 while the project transitions from its current position to the steady state, with particular focus on planned maintenance and reactive maintenance processes, and on reporting and monitoring functions.

3.17 At the same time, the Board is in the process of identifying two members of staff who will form a permanent part of the team and who will take up their posts while NSS staff are still present to allow effective handover and skills and knowledge transfer.

3.18 A Business Partner, reporting directly to the Director of Finance, will oversee the transition, provide a link between the contract management team and the project and commissioning teams, and with Tim Montgomery in particular, and liaise with IHSL at a senior level to facilitate the transition to ensure that effective performance management processes are in place.

3.19 Support from NSS and SFT will continue throughout this period, with a focus on development of effective ongoing contract management, assurance and monitoring processes.

3.20 The contract management structure for this project forms part of a wider ongoing exercise to review and strengthen the Board's overall capacity to manage its ten PPP-type contracts.

## 4 Key Risks

4.1 Moving DCN during the current pandemic means that the migration programme has had to be split into phases. The service are confident that the outpatient service moves, in light of current reduced activity, can be achieved by mid May, however, the follow-up of inpatient services is dependent on critical care capacity and therefore Covid-19 demands on that service. The Medical Director and Chief Operating Officer will review the activity and confirm the remainder of the DCN moves as soon as it is possible and safe.

4.2 As described to the Board in April 2020, there is a risk that the overlapping of construction, commissioning and validation processes impacts on compliance sign-off

of the finished works. This is being managed through working closely with contractors on the specification and design of the air handling units.

## 5 Risk Register

5.1 The impact of the delays to moving into RHCYP & DCN is included on the corporate risk register (risk 4813). This is regularly updated with evidence of the management actions taken to mitigate the risk, which remain satisfactory.

## 6 Impact on Inequality, Including Health Inequalities

6.1 There is no impact on equality arising from the matters outlined in this paper.

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

7.1 NHS Lothian has met its responsibilities to involve people in the Reprovision of RHCYP, DCN and CAMHS services. No further duty for public involvement has arisen regarding the issues in this paper.

## 8 Resource Implications

8.1 Funding for commissioning has been set aside within the financial plan and detailed budgets are being worked through with the project team, for commissioning, migration and decommissioning costs, including impact of phasing moves over a longer period now.

8.2 NSS support for the implementation and knowledge transfer for contract management is provided at no cost.

8.3 Identification of NHS staff to support contract management will require backfill. Further detail of the resource plan will be brought forward to Finance and Resources Committee as soon as possible.

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5 May 2020
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**NHS LOTHIAN**

Board Meeting
13th May 2020

**Director of Finance**

# COVID-19 MOBILISATION PLANS & FINANCIAL OUTTURN UPDATE

## 1 Purpose of the Report

1.1 This paper provides an update to the Board on the NHS Lothian COVID-19 Mobilisation Plans and financial implications. The paper also provides an update on the year end outturn considered by the Finance and Resources Committee at its April meeting.

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 a robust system of financial governance and cost control is being implemented in relation to COVID-19 with the Strategic Management Group receiving regular financial updates.
- **Accept** as a source of **significant assurance** that the Finance and Resources Committee has considered the year end outturn and accepted significant assurance on the achievement of a breakeven outturn for 2019/20, subject to External Audit.

## 3 Discussion of Key Issues

### Covid-19 Mobilisation Plans

3.1 Maintenance of sound financial governance and cost control is imperative when planning for and responding to the COVID-19 pandemic. Decision making needs to be rapid but within an effective control environment with escalation for further discussion and agreement as required.

3.2 Health Boards and Integration Authorities have been asked by the Scottish Government (SG) to prepare mobilisation plans detailing how they are dealing with the impact on health and social care of the COVID-19 pandemic.

3.3 These plans are continually being reviewed as the pandemic develops and the Health Board is required to report weekly to the SG on the updated financial impact of the plans. As part of the monitoring there is a requirement to report what decisions have been made locally, highlighting any decisions with a financial impact of more than £1m as these require to be approved by the SG before they can proceed. This is shown in further detail in Appendix 1. Further work is underway between the SG and Boards on due diligence and to allow funding to be allocated.

3.4 Covid related activity has stabilised across Scotland with Lothian seeing a levelling in demand both for general beds and ICU capacity. NHS Lothian is now required to consider options relating to capacity which is not required for COVID activity at this stage.

3.5 The Director of Finance and Deputy Director of Finance have now met with Chief Officer for Acute Services, Director of Facilities and all the Chief Finance Officers of the IJBs to discuss their mobilisation plans and the stages of implementation reached. All areas have been asked to undertake the following:

- Review local plans based on the current bed modelling being undertaken;
- Consider the options to pause or continue any of the plans currently being implemented or not yet progressed;
- Ensure that, for those plans that are live, the resources are being optimally utilised.

3.6 These review meetings will continue as a matter of routine and will form a key element of financial governance.

**Financial Impact of COVID-19**

3.7 All Boards are submitting regular financial returns to the Scottish Government. These include both modelled and some actual costs.

3.8 The actual costs for 19/20 are being finalised, however the 20/21 costs are still estimated at a very high level and will be refined through time as actual costs are captured. It is also vital to capture the effect of the pandemic on ongoing costs and to assess where other costs have reduced i.e. slippage on investments and reduction in elective surgery.

3.9 A summary of the key areas which will influence actual spend are as follows:

- **Additional cost of externally provided services** – This is an estimate of the additional costs to external providers to cover the increased costs for PPE, staff sickness, increased recruitment costs, agency workers, and other costs as resulting from COVID-19.

- **Acute Beds** – These costs are currently being modelled on a higher level of ITU beds for the year and a number of general COVID beds being sustained for a period of time. Work continues to understand the bed requirements going forward.

- **Delayed Discharge Reduction** – These costs are those associated with relocating existing and expected future delayed patients to release capacity in acute hospitals. Costs will include the provision of additional care home beds, care at home costs and other support costs to avoid delays.

- **Additional Bed Capacity/Costs (Community Hospitals)** – the additional cost of expanding bed capacity within community hospitals. The majority of the additional beds being created within East Lothian Community Hospital and a small amount in Midlothian Community Hospital.

- **Additional Cost from Contract Rate Uplift** - The additional costs to East Lothian, Edinburgh and Midlothian IJBs as a result of applying a Local Living Wage uplift over and above allocated SG funding. West Lothian IJB had planned for this level of increase as part of their annual budget setting.

- **Temporary and Supplementary Staffing Costs** – The numbers of returners, student nurses and medics is in the process of being finalised and the cost established.

- **Payments to GP Practices -** Scottish Government has already agreed some additional funding for GP practices remaining open over Easter. It is likely that any additional funding for GP practices will be agreed centrally.

3.10 We will continue to work with SG and Board colleagues to develop the costing methodology to ensure a consistent and accurate presentation of Covid related spend compared to available resources. This will include review of resources that are now not being utilised.

**FINANCIAL OUTTURN 2019/20**

3.11 The Finance and Resources Committee received a summary update on the year end outturn at its April meeting. The Committee agreed to accept **significant assurance** that NHS Lothian will deliver a balanced financial position for the 19/20 financial year, with a £619k underspend reported at this time. A fuller update will be provided to the May F&R meeting.

## 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 mobilisation plans 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 There are no specific resource implications arising from the recommendations contained within this paper.

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**Appendix 1 – NHS Lothian plans requiring SG Approval**

A summary of all the plans and projected costs requiring approval are:

- **Acute –** Provision of PPE, either locally sourced or ordered via PECOS and a financial commitment to NHS Lothian - **£1,976k pa, this is currently being implemented so retrospective approval required;**

- **Acute -** Additional labs testing costs estimated based on current projections of activity at **£1,808k pa, this is currently being implemented so retrospective approval required;**

- **Edinburgh IJB** – Purchase of 20 Beds from Care Concern to build capacity and reduce delayed discharges - **£1,293k pa , retrospective approval required;**

- **Edinburgh IJB –** Estimate of additional costs to external providers to cover the additional costs for PPE, staff sickness, increased recruitment costs, agency workers, and other costs as resulting from COVID-19- **£24,396k pa;**

- **Edinburgh IJB –** Additional cost from Contract Rate Uplift - **£4,700k pa;**

- **East Lothian IJB –** Scale up of activities at ELCH, providing an additional 24 beds reducing delayed discharges - **£2,131k pa;**

- **East Lothian IJB –** Estimate of additional costs to external providers to cover the additional costs for PPE, staff sickness, increased recruitment costs, agency workers, and other costs as resulting from COVID-19- **£4,908k pa;**

- **Midlothian IJB** – Recruitment of 50 wte carers to support additional capacity to bolster team absences and provide additional care hours - **£1,293k retrospective approval required;**

- **Midlothian IJB –** Opening of a palliative care ward in MCH to support palliative care patients within a community setting, 19 bed - **£1,067k retrospective approval required;**

- **Midlothian IJB –** Estimate of additional costs to external providers to cover the additional costs for PPE, staff sickness, increased recruitment costs, agency workers, and other costs as resulting from COVID-19- **£3,875k pa;**

- **West Lothian IJB –** Estimate of additional costs to external providers to cover the additional costs for PPE, staff sickness, increased recruitment costs, agency workers, and other costs as resulting from COVID-19 - **£1,500k pa**