NHS Lothian Board

Wed 01 December 2021, 09:30 - 12:30

MS Teams

Agenda

09:30 - 09:35
5 min

1.
Welcome

Verbal *John Connaghan*

09:35 - 09:37
2 min

2.
Apologies for Absence

Verbal *John Connaghan*

09:37 - 09:40
3 min

3.
Declaration of Interests

Verbal *John Connaghan*

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 Lesley.H.MacDonald@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

09:40 - 09:45
5 min

4.
Items proposed for Approval or Noting without further discussion

Decision *John Connaghan*

4.1.
Minutes of Previous Board Meeting held on 06 October 2021

For Approval *John Connaghan*

06-10-21 Public Board Minutes (draft to board).pdf (19 pages)

4.2.
Audit & Risk Committee Minutes - 23 August 2021

For Noting *Martin Connor*

23-08-2021 ARC Minutes to Board.pdf (6 pages)

4.3.
Healthcare Governance Committee Minutes - 07 September 2021

For Noting *Patricia Donald*

07-09-21 HCG Minutes to Board.pdf (8 pages)

4.4.
Finance and Resources Committee Minutes - 25 August and 29 September 2021

For Noting *Angus McCann*

FR 25-08-21 Minutes signed internet.pdf (5 pages)
29-09-21 F&R Minutes to Board.pdf (2 pages)

4.5.
Staff Governance Committee Minutes - 28 July 2021

For Noting *William McQueen*

SGC 28-07-2021 Minutes (signed).pdf (7 pages)

4.6.
Edinburgh Integration Joint Board Minutes - 20 August and 28 September 2021

For Noting *Angus McCann*

Edinburgh IJB Minutes 20-08-2021.pdf (6 pages)
Edinburgh IJB Minutes 28-09-2021.pdf (3 pages)

4.7.
West Lothian Integration Joint Board Minutes - 21 September 2021

For Noting *Bill McQueen*

WL IJB Minutes 21-09-2021.pdf (8 pages)

4.8.
Midlothian Integration Joint Board Minutes - 26 August and 09 September 2021

For Noting *Carolyn Hirst*

Midlothian IJB Minutes 26-08-2021.pdf (10 pages)
Midlothian IJB Special Meeting Minutes 09-09-2021.pdf (5 pages)

4.9.
East Lothian Integration Joint Board Minutes 16 September 2021

For Noting *Peter Murray*

East Lothian IJB Minutes 16-09-2021.pdf (7 pages)

4.10.
Public Health Partnership and Place Teams

Information *Dona Milne*

Public Health Partnership and Place Teams V0.1.pdf (4 pages)

4.11.
Appointment of Members to Committees

For Approval *John Connaghan*

1 December 21 Board appointments report (revised 181121).pdf (2 pages)

4.12.
Climate Change Annual Report

Information *Jim Crombie*

Board Paper page cover template NHS Lothian Climate Change Report 2020-2021.pdf (1 pages)
NHS Lothian Board Paper Climate Change Report 2020 2021.pdf (4 pages)
2020-2021 Carbon Emissions Report_Final.pdf (13 pages)

4.13.
Initial Agreements

4.13.1.
Initial Agreements - Reprovision of Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU) & Reprovision of Integrated Mental Health Rehabilitation and Low Secure Centre

For Approval *Tracey McKigen*

REH Campus Re-developement Board Paper 1 page cover template.pdf (1 pages)
REH Board Cover Paper Nov 2021 (1).pdf (4 pages)
Learning Disability and IDAIPU IA June 2021 v1.14.pdf (53 pages)
Rehabilitation and Low Secure IA June 2021 v1.17.pdf (50 pages)

4.13.2.
Initial Agreement - Reprovision of Critical Care Ward 20 at the Western General Hospital

For Approval *Jacquie Campbell*

Ward 20 1 page cover template_181121_v2.pdf (1 pages)
Board Paper-Ward 20_181121.pdf (4 pages)
Appendix 1 Reprovision of Critical Care Ward 20 at the Western General Hospital Initial Agreement.pdf (43 pages)

4.14.
Performance Oversight Board: Progress Update

Information *Pete Lock*

Peformance Oversight Board_NHS Lothian Board Update_Dec 21_Cover Paper.pdf (1 pages)
Peformance Oversight Board_NHS Lothian Board Update_Dec 21_vFINAL.pdf (11 pages)

4.15.
Vaccinations Update (Covid and Flu)

Information *Fiona Ireland*

2021-12 Board Flu and Covid Vaccine Programme Cover Sheet.pdf (1 pages)
2021-12 Board Flu and Covid Vaccine Programme Update.pdf (15 pages)

Items for Discussion

09:45 - 09:50
5 min

5.
Board Chair's Report - December 2021

Verbal *John Connaghan*

09:50 - 10:00
10 min

6.
Board Executive Team Report - December 2021

Discussion *Calum Campbell*

BET Report Appendices available in Admincontrol Meeting folder

- BET Report 1 December 2021.pdf (23 pages)

10:00 - 10:05
5 min

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

Verbal *John Connaghan*

10:05 - 10:25
20 min

8.
NHS Lothian Board Performance Paper

Discussion *Jim Crombie*

- Board Paper Performance_December 2021 Final.pdf (37 pages)

10:25 - 10:40
15 min

9.
Lothian Strategic Development Framework Progress Update

Discussion *Colin Briggs*

- LSDF Board 1-page cover paper.pdf (1 pages)
- December Board LSDF cover final.pdf (3 pages)
- The Lothian Strategic Development Framework COMPLETE DRAFT 2 submitted 19xi21 3.pdf (18 pages)

10:40 - 11:00
20 min

10.
Remobilisation Plan 4

Discussion *Colin Briggs*

Separate RMP4 Appendices 1-6 available in Admincontrol Meeting Folder

- RMP4 Board 1-page cover paper.pdf (1 pages)
- December Board RMP4 cover final.pdf (2 pages)
- Appendix 1 - RMP4 Final + Appendices 1-6.pdf (296 pages)
- Appendix 2 - NHS Remobilisation Plans 2021-22 - RMP4 - Feedback Letter to NHS Lothian - Nov 21.pdf (3 pages)

11:00 - 11:10
10 min

Break

John Connaghan

11:10 - 11:25
15 min

11.
NHS Lothian Pharmaceutical Care Plan

Discussion *Dona Milne*

- NHS Lothian Pharmaceutical Care Service Plan Board Paper.pdf (72 pages)

11:25 - 11:35
10 min

12.
September 2021 YTD Financial Position

Discussion *Susan Goldsmith*

- Financial position 1-page cover Board 1 December 21.pdf (1 pages)
- NHS Lothian 2122 finance report - Board 1 December 2021.pdf (7 pages)

11:35 - 11:45
10 min

13.
National Whistleblowing Standards - Quarter 2 Performance Report

Discussion *Janis Butler*

- Whistleblowing 1-page cover paper - December 2021.pdf (1 pages)
- 211201 NHSL Whistleblowing Performance Cover Report final.pdf (2 pages)
- Q2 April - September 21_22 Whistleblowing Performance Report Final.pdf (10 pages)

11:45 - 11:55
10 min

14.
Corporate Risk Register

Discussion *Tracey Gillies*

- Board Corporate Risk Register Paper 1 Dec 2021 - Cover Page.pdf (1 pages)
- Board Corporate Risk Register Paper 1 Dec 2021 Draft.pdf (24 pages)

11:55 - 12:00
5 min

15.
Any Other Business

Verbal *John Connaghan*

12:00 - 12:05
5 min

16.
Reflections on the Meeting

Verbal *John Connaghan*

12:05 - 12:06
1 min

17.
2022 Board Meeting Dates

For Noting *John Connaghan*

2022
09 February 2022
06 April 2022
22 June 2022 (annual accounts)
03 August 2022
05 October 2022
07 December 2022

LOTHIAN NHS BOARD

Minutes of the meeting of Lothian NHS Board held at 9.30am on Wednesday 06 October 2021 using Microsoft Teams.

Present:

Non-Executive Board Members: Mr M. Hill (Vice-Chair)(Chairing); Mr M. Connor; Dr P. Donald; Ms C. Hirst; Mr A. McCann; Mr P. Murray (from 9:45am); Mr W. McQueen; Dr R. Williams; Cllr J. McGinty; Mr J. Encombe; Prof. S. Chandran; Cllr S. Akhtar; Cllr G. Gordon and Mr E. Balfour

Executive Board Members: Mr C. Campbell (Chief Executive); Miss T. Gillies (Executive Medical Director); Mrs S. Goldsmith (Director of Finance); Ms D. Milne (Director of Public Health and Health Policy) and Miss F. Ireland (Interim Executive Director, Nursing, Midwifery & AHPs).

In Attendance: Mr J. Crombie (Deputy Chief Executive); Mrs J. Butler (Director of HR & OD); Mrs J. Campbell (Chief Officer, Acute Services); Dr J. Long (Director of Primary Care); Mrs J. Mackay (Director of Communications & Public Engagement); Mr P. Lock (Director of Improvement); Mr C. Briggs (Director of Strategic Planning); Ms T. McKigen (REAS Services Director); Ms A. White (Chief Officer, West Lothian HSCP); Ms A. Macdonald (Chief Officer, East Lothian HSCP); Ms M. Barrow (Chief Officer, Midlothian HSCP); Ms J. Anderson (Unison Branch Secretary NHS Lothian); Ms J. Stonebridge, Consultant in Public Health (Item 63); Mr A. Payne (Head of Corporate Governance) and Mr C. Graham (Secretariat Manager).

Apologies for absence: Mr J. Connaghan; Cllr D. Milligan and Ms K. Kasper.

52. Declaration of Financial and Non-Financial Interest

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

53. Chair's Introductory Comments

53.1 Mr Tom Waterson Condolences

53.1.1 The Chair advised that it was with sadness that he had to report the death of Mr Tom Waterson.

53.1.2 He commented that Mr Waterson had started working in the NHS in Lothian in 1989 as a Porter at the old RIE on Lauriston Place. Mr Waterson very quickly became a NUPE Shop Steward, going on to become the Branch Secretary of NUPE and held this position until the merger of COHSE, NUPE and NALGO into what we now know as UNISON. In 2005 the UNISON Lothian Health Branch was formed and Mr Waterson had been its only Branch Chair in all that time.

53.1.3 Mr Waterson had also held the position of Chair of the UNISON health committee (a pan-Scotland Role) since 2005 and in that time made a significant contribution across the NHS in Scotland, being instrumental in improving the position for lower paid staff by the removal of Agenda for Change band 1. Mr Waterson was a member of many tripartite committees and groups with employer's and government officials and had been a very prominent trade unionist and advocate for removing social injustice.

53.1.4 Mr Waterson had been very proud to be invited as a judge on the annual Daily Record Scottish Health Awards, where the UNISON Lothian Branch had sponsored the Team of the Year Award for many years.

53.1.5 Mr Waterson became Employee Director (and Non-executive Board member) in August 2020 and had been very well respected in that role, working closely with all trade unions and senior leaders across the organisation to improve staff and patient experience.

53.1.6 The Board expressed its condolences to Mr Waterson's family at this time.

53.2 Executive Director Nursing, Midwifery & AHP's

53.2.1 The Chair reported that Professor McMahon had now stepped down from the Board to become the Interim Chief Nursing Officer for NHS Scotland. This was a nine-month secondment from 4 October 2021 to 3 July 2022. The following individuals would become the Interim Director (and an executive Board member) for the following periods.

- Fiona Ireland – 4 October 2021 to 3 January 2022.
- Gillian McAuley – 4 January 2022 to 3 April 2022.
- Pat Wynne – 4 April 2022 – 3 July 2022

53.2.2 Miss Ireland was the Chair of the Area Clinical Forum and a non-executive member of the Board. Consequently, she will temporarily stand down as a non-executive while she is an executive Board member. Mr Eddie Balfour, vice-chair of the Area Clinical Forum, was therefore welcomed as non-executive Board member from 4 October 2021 to 3 January 2022.

Items for Approval

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

54.1 Minutes of Previous Board Meeting held on 04 August 2021 – Minutes were approved.

54.2 Audit & Risk Committee Minutes – 21 June 2021 – Minutes were noted.

54.3 Healthcare Governance Committee Minutes – 27 July 2021 – Minutes were noted.

54.4 Finance & Resources Committee Minutes – 14 July 2021 – Minutes were noted.

54.5 Edinburgh Integration Joint Board Minutes – 22 June 2021 – Minutes were noted.

54.6 West Lothian Integration Joint Board Minutes – 29 June and 10 August 2021 – Minutes were noted.

54.7 Midlothian Integration Joint Board Minutes – 17 June 2021 – Minutes were noted.

54.8 East Lothian Integration Joint Board Minutes – 24 June 2021 – Minutes were noted.

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

- Re-appoint Lorraine Cowan as the registered nurse non-voting member of East Lothian Integration Joint Board for the period from 5 December 2021 to 4 December 2024.
- Appoint Linda Yule as the registered nurse non-voting member of West Lothian Integration Joint Board for the period from 6 October 2021 to 5 October 2024.
- Nominate Jock Encombe as a voting member of West Lothian Integration Joint Board for the period from 1 December 2021 to 31 July 2022.
- Appoint Katharina Kasper as a member of the Remuneration Committee with effect from 6 October 2021.
- Appoint Angus McCann as the Chair of the Finance & Resources Committee with effect from 1 November 2021.
- Appoint Dr Patricia Donald as the Chair of the Healthcare Governance Committee for the period 4 October 2021 to 3 January 2022.

54.10 NHS Lothian Board and Committee Dates Schedule 2022 - The Board approved the schedule of Board and committee meeting dates of 2022.

54.11 End Poverty Edinburgh (EPE) Annual Progress Report - The Board noted the update on the progress made across many of the EPC recommendations. The Board also noted that many of the actions relate to child poverty. The completed Edinburgh Local Child Poverty Action Report would be submitted for Board approval in the near future.

Items for Discussion

55. Board Chair's Report – October 2021

55.1 The Chair referenced the correspondence received last week from the Scottish Government, confirming that the NHS in Scotland would remain on emergency footing until 31 March 2022. Primary focus would remain on responding to current service pressures during the period ahead and not to expect to open any new programmes of work unless there were identified as priority. The necessary assurances would be provided to the Scottish Government and Minsters that NHS Lothian was responding to the current pressures and winter challenges ahead. The Board agenda this morning was testament to that focus.

56. Board Executive Team Report – October 2021

56.1 The Board noted the Board Executive Team report.

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

57.1 **Audit and Risk Committee** - Mr Connor delivered an update on two recent internal audit reports that have only achieved limited assurance, in relation to Estates and Consort Invoicing. These were being progressed with support from Audit and Risk Committee. There was an ongoing review of estates and work was underway to update structures with Consort and to recruit people with appropriate PFI and PPP contract management experience.

57.2 **Edinburgh Integration Joint Board (IJB)** - Mr McCann stated that the IJB had agreed to move forward with actions for the bed base review to develop the right types of bed in the right numbers due to current constraints in service and lack of intermediate care capacity. Mr Campbell supported the IJB strategic decision, but stressed that it was important to have details of the implementation plan confirmed before any capacity was taken out the system. The implementation plan, critical path and key milestones had been requested by the health board.

57.3 **Healthcare Governance Committee** - Miss Ireland reported from the September meeting. There had been two issues flagged to raise at to the Board's attention, these had been the Did Not Attend (DNA) Policy and the good news about the care planning functionality on the Trak system for adult services named the "Model Ward". There would be follow up analysis and a paper to Healthcare Governance committee from management, looking at the profile/characteristics of patients that do not attend appointments.

57.4 **Finance and Resources Committee** - The Chair reported on three items from the August and September meetings:

- The development of a project team and director appointment for the National Treatment Centre at St John's Hospital had been welcomed and it had been envisaged that this would now accelerate and progress planning and design in relation to the Centre.
- A report had been received on the Royal Infirmary of Edinburgh (RIE) Commercial Business Case and contract management resource. It had been noted that work was ongoing to ensure that the RIE continued to be fit for purpose and to continue to manage the remaining years of the contract in the best interest of the people of Lothian.
- There had been an update on the Scottish Hospital Inquiry and inquiry information requests. There had also been an extraordinary Finance and Resources Committee meeting on 29/09/2021 to approve the Board's response to request for information #2 and the narrative around request for information #1.

58. Lothian Strategic Development Framework

58.1 Mr Briggs introduced the report updating the Board on progress in developing the Lothian Strategic Development Framework (LSDF).

58.2 Mr Briggs outlined the process adopted for developing the LSDF and how the development of the Framework would look to answer the questions around improving population health through working with people and improving performance against an unstable baseline, through collaboration between NHS Lothian and the Integration Joint Boards. The Board noted the need to be conscious of the fact that the full impact of the pandemic was still to be known and this is why this was a framework rather than a detailed plan.

58.3 Mr Briggs explained that the framework was based on five key pillars – unscheduled care; scheduled care, primary care, mental health and children and young people. Relationships with NHS Lothian's partners were important as many of the plans would be for IJBs to direct NHS Lothian and local authorities to deliver. There was also the link to national work to consider and there would be cross cutting areas across all five pillars e.g. cancer.

58.4 The work around NHS Lothian becoming an anchor institution was also part of the LSDF and there were headline priorities that needed to be made more explicit to partners and the public such as becoming an increasing digital organisation.

58.5 Workforce constraints also had to be considered. As discussed at the Planning, Performance and Delivery Committee in September, there were issues around the demographic challenge and an ageing population which means there were not enough young people joining the workforce, which had impacts in nursing and care roles locally and nationally.

58.6 Mr Briggs confirmed that there would be a twenty page Strategic Framework ready for further discussion at the Board Strategic Away Day on 27/10/2021 and that the Royal Society for Arts, Manufactures and Commerce (RSA) were working with NHS Lothian to put together a representative group of citizens to work with us to design a formal consultation

58.7 Mr McQueen asked about workforce and concerns in many areas nationally that there may not be sufficient workforce. Mr Briggs confirmed that workforce issues would be part of the consultation stage of the framework and that nationally he was chairing the Directors of Strategic Planning Group and it was clear that NHS Lothian were ahead of the curve in grappling with many of these challenges. There had been a lot of work by thought leaders in this area, looking at opportunities such as the ability of technology to extend working lives and understanding what alternative workforces are out there, including use of the third and independent sectors.

58.8 Mrs Butler added that the workforce issues were well understood both locally and nationally and work at all levels was ongoing. Opportunities at both ends of the spectrum were being considered such as Retire and Return and Early Careers Programmes (Earn, Learn, Progress). The national health care academy had also stood up training programmes as part of a once for Scotland approach.

58.9 Dr Donald asked about the more effective use of volunteers. Mr Briggs commented that volunteering would be aligned to the framework as part of what NHS Lothian did going forward , whilst recognising thatvolunteer skills were not a direct replacement for nursing for example.

58.10 Miss Ireland added that the Edinburgh and Lothians Health Foundation volunteering programme and strategy were due to be reviewed for 2023 to 2028 and that service areas were now actively identifying help they required from volunteers, but again this was not a replacement for substantive posts.

58.11 Mr McCann and Dr Williams both made comment about the importance of communication and articulating to public and patients the changes of how services will be delivered in future. Miss Gillies added that there would be an area of sensitive language around communication. Most people are able to understand benefits when they are more abstract but when these become more personal there can be a reverting to previous ways doing things.

58.12 Mr Briggs stated that there would also have to be influencing of national communications to avoid messages in different directions and that there were no better advocates to demonstrate change than our own staff. Mr Briggs referred to a recent BBC Scotland news article involving Penicuik Medical Practice.

58.13 The Board agreed to the recommendations in the report, to

- Note the outline of the process to date;
- Note the headline proposals for change;
- Agree the process for further development of the consultation draft.

59. NHS Lothian Board Performance Paper

59.1 Mr Crombie introduced the report recommending that the Board discuss and review the current performance position of key metrics relevant to the Lothian Performance Recovery Programme and Remobilisation Plans. The detail in the report was to end of August 2021.

59.2 The Board noted that following the recent Active Governance Session for Board Members a revised presentation of data was being developed for the December Board Meeting, this would include the recommended format and run charts.

59.3 Mr Crombie reiterated that the NHS in Scotland remains on an emergency footing and that NHS Lothian's Gold Command structure was in place providing the highest level of oversight and reviewing the whole system position twice per week. The multiagency Gold Command had also been triggered and there were daily conversations between Mr Campbell and members of the Scottish Government.

59.4 It was important to note that in terms of data and indicators, front door attendances were now at a level which exceeded pre-Covid winter activity and we were not yet in winter. The spectre of Covid remained, having a very real impact on capacity across the system, in primary care, emergency departments, inpatients and in the rehabilitation and care environments.

59.5 Mr McQueen asked about fixed term posts in Psychology Therapies and CAMHS not being attractive to potential applicants and the balance between numbers of fixed term and permanent posts. Ms Mckigen clarified that both fixed term and permanent posts were being continually recruited and the majority of posts were now permanent with NHS Lothian deciding to advertise on a recurring basis, in order to improve the prospects of recruitment.

59.6 Mr Murray commented that the ability to achieve sustainable performance improvement may require operating outside normal parameters such as with the Covid additional powers.

59.7 Mr Campbell responded that national group conversations had been around increased public awareness in relation to health and social care need. Lots of people think Covid has peaked and is coming down but the winter impact, Flu, RSV, Flu and Covid vaccination programmes and continued requirements to isolate will have a massive impact on demand and on securing the workforce to cope with this. Increased communication was required to reinforce messages that if people need to come to us then fine, but if they don't need to come, then to try and use another means to get the care required.

59.8 Mr McCann asked about unscheduled care and the redesign of the urgent care programme. Mr Crombie confirmed that there was a varying impact being seen from the redesign. This was early days in the development of the programme but there was a continued focus on efforts around messaging and signposting, concentrating more on awareness of alternative options and how to support individuals as well as reducing demand on acute services.

59.9 Mr Campbell added that the challenge with redesign of urgent care was the ability of NHS24 to handle calls quickly and this could be frustrating for the public. Nationally, clearer redirection from A&E was being looked at. There needed to be a more assertive approach to people coming to the wrong door, in order to try and drive a change in culture.

59.10 Mrs Goldsmith emphasised that in terms of performance there remained an underlying capacity gap in the core finance position. The Chair added that this was important to keep in mind, but it should not be seen as finance putting a stranglehold on achieving performance. It was recognised this was a difficult situation to report.

59.11 Mr Crombie highlighted that whilst it was easy to get lost in the numbers and detail of the challenges in the report, it should be recognised that Lothian teams across health and social care continue with outstanding efforts and dedication in these challenging times. The Board commended this statement and passed on thanks to all staff for their continued efforts in challenging times.

59.12 The Board agreed the recommendations in the report:

- The Board acknowledges the supporting performance infrastructure in place which provides formal assurance on a wider set of metrics aligned to Board priorities through existing committees.
- The Board recognises the performance challenges detailed in this paper including; exacerbated pre-existing performance issues and dips in performance following the impact of Covid-19 and current measures.
- The Board considers the clinical reprioritisation exercise undertaken on all inpatient and day case waiting list patients and the focus on maintaining and improving performance in order of clinical priority and longest routine waits.
- To note the PPDC draft work plan is due to commence to further enhance coordinated and aligned performance reporting across the system.
- If further deeper dives are requested by the Board, these are addressed in separate reports to maintain the structure of the core performance report.

60. CAMHS Improvement Recovery and Renewal Plan

60.1 Ms McKigen provided a briefing on key context and progress in relation to improving performance against the CAMHS LDP Access Standard and the associated programme of work and key improvement actions to strengthen the clinical governance and improve the effectiveness of services.

60.2 Ms McKigen reported that CAMHS currently remained on escalation for not meeting the CAMHS Standard. A Recovery Plan had been submitted to Scottish Government in July 2021 and this had now been accepted and was moving to the implementation stage. Key factors within the Recovery Plan included an increase in workforce, redesign of individuals working roles and introducing a full CAPA (Choice and Partnership Approach) clinical system model. These changes would take between 6 and 12 months to fully implement.

60.3 The Board noted that the roll out would start with the North and South Edinburgh CAMHS teams as these had the largest referral numbers. It was expected that an improvement in North Edinburgh would be seen later in October and in South Edinburgh from November. The roll out would then move to East and West Edinburgh teams.

60.4 Ms McKigen added that there would be a 24/7 unscheduled care service introduced once all staff had been recruited. It was hoped this would take pressure off A&E, particular out of hours at St John's Hospital and also prevent some onward referrals. There would also be investment in Tier 2 services and work on single points of contact for primary care to redirect Tier 3 and Tier 4 services where historically all referrals had been.

60.5 Supervision and support would be required to implement all these changes and there was support from organisational development. Most posts were now permanent, having reviewed turnover. There was minimal risk even if funding from Scottish Government were to be non-recurring.

60.6 Mr Murray asked about effective signposting to alternatives and what could be done to help with this. Ms Mckigen stated that a communication strategy would be part of the recovery plan work with members of the public and young people. Third sector organisations were now also coming back on stream following the pandemic and there would be an increase in direct funding from the Scottish Government to support the work of Tier 2 services.

60.7 Dr Williams asked about children and young people who are referred internally for a specific treatment/intervention but would not now be reported as part of the Public Health Scotland CAMHS LDP standard as waiting for treatment to commence (e.g. Dietetics, Eating Disorder Development Team (EDDT), CAMHS Assertive Outreach Team (CAOT) and Day Programme.

60.8 Ms Mckigen explained that these people were already in the service for PT or nursing intervention, internal referral to dietician for example. They would normally be on a waiting list for CAMHS with a standard support full package of care so would not now be added onto another waiting list to add to their journey.

60.9 Dr Williams then asked about the reporting and monitoring of patient outcomes. Ms Mckigen confirmed that there was national benchmarking against outcomes and a national specification that is reported against in terms of outcomes, deliverables, and patient satisfaction. CAPA had been welcomed by patients and families along with a high use of Near Me which patient surveys had indicated was preferred in certain circumstances. The Chair suggested that Healthcare Governance Committee would be the appropriate place to scrutinise quality outcome issues. Ms Mckigen would take this forward for CAMHS and Psychological Therapies.

60.10 Mr McCann asked about recruitment of staff and whether this was new recruitment or moves from other areas in Lothian or Scotland. Ms Mckigen confirmed that there was a mixture of some Lothian or Scotland staff as part of development opportunities along with recruitment of new psychology staff from England.

60.11 Mr McQueen asked about impact on inequalities and long waits for treatment. Ms Mckigen stated that inequalities in long waits had not been looked at specifically but this work would start once a more stable position for CAMHS and PT had been achieved. Schools did have a direct link for advice as did General Practice. Cllr Akhtar added that it would be helpful to see the impact of different interventions as a standalone paper. Ms Mckigen would bring back appropriate updates to the Board.

60.12 The Board accepted the recommendations in the report, to:

- Acknowledge the levels of improvement to date and continuing progress in relation to key trajectories and performance against the CAMHS LDP Access Standard.
- Note that the Scottish Government are aware and content that CAMHS is following the detailed Recovery and Renewal Plan that was submitted to them and recently approved.
- Note the strategic aims of the NHS Lothian CAMHS Recovery and Renewal Plan align with the Boards CAMHS 2021 Project.
- Endorse the NHS Lothian CAMHS revised waiting list trajectory and the assumptions made therein.
- Note that in future those children and young people who are referred internally for a specific treatment/intervention will not be reported as part of the Public Health Scotland CAMHS LDP standard as waiting for treatment to commence (e.g. Dietetics, Eating Disorder Development Team (EDDT), CAMHS Assertive Outreach Team (CAOT) and Day Programme.
- Endorse and accept the requirements for recurrent funding to ensure that the additional 23 WTE required to clear the core mental health waiting list can be recruited on a permanent basis.
- Note the associated investments secured from the Mental Health Recovery and Renewal Fund that will be applied against the delivery of the National CAMHS Service Specification and Transition Care Planning standards for children, young people, and families in Lothian.
- Note the key risks around urgent referrals.

61. Psychological Therapies Performance Report and Recovery plan

61.1 Ms McKigen described the performance of psychological therapies (PT) against the LDP Access Standard and outlined the associated initiatives to strengthen clinical governance, improve the effectiveness of services and updated on progress with the current recruitment plan.

61.2 The Board noted that the PT position was similar to CAMHS in terms of escalation and working with the Scottish Government on the recovery plan. The plan put in place had been agreed with Scottish Government, NHS Lothian Corporate Management Team and the Health and Social Care Partnerships' Chief Officers as PT was a delegated service.

61.3 In terms of trajectory there was an overall reduction in numbers and people waiting over 18 weeks although there were still some people waiting a very long time. This included people who had been offered Near Me consultations but were holding out for face to face appointments. The Board noted that July 2021 had seen a slight shift off trajectory due to increased demand from East Lothian and this was being monitored.

61.4 Ms Mckigen added that work with teams to introduce sustained, monitored job plans was ongoing and there was Organisation Development support again to support this. The tables in the paper detailed the position against the trajectory, also including an increasing availability of group work face to face and an increased number of people a clinician would see in a month, but this was not yet to the benchmarked level.

61.5 The Chair asked about additional funding requested from the Scottish Government. Ms Mckigen confirmed that funding was in place for this year but this was not yet recurring and would be picked up in discussions with the Head of Performance at the Scottish Government.

61.6 Cllr Akhtar asked about expected demand and any increase in demand levels. Ms Mckigen stated that apart from the small increase last month in East Lothian, an increase in demand had not been seen. When planning the trajectory the impact of Covid had not been know so the approach had been to go with a reasonable demand level for the recovery plan.

61.7 Mr McCann asked about the implementation of a digital platform for group work, such as MS Teams or Near Me. Ms Mckigen clarified that there would be a pilot around this which NHS Lothian has requested to be part of but at the moment the issues around a digital platform for group work were not resolved.

61.8 The Board agreed the recommendations in the report:

- To recognise the steady improvement with the reduction of the total number of patients waiting in total and over 18 weeks for psychological therapy in Adult Mental Health Services with increased accountability and performance management; the overall performance is on track with the trajectory.

- To note the reduction in planned capacity offered in July associated with the change of service model in Edinburgh to Thrive, which has happened earlier than expected, as well as higher than expected demand levels in East Lothian and a coding TRAK error in West Lothian. While this caused a slight variation to the numbers expected to be waiting for psychological treatment, the performance over August is bringing the trajectory back on track.
- To support the TRAK work required to allow services to make use of Patient Focused Booking (PFB), with scheduled activity for taking on new patients, associated patient allocation and booking systems. A manualised version of PFB is currently in place.
- To note the recruitment in place for staff being offered fixed term contracts as part of the waiting list initiative; there remains a gap in recruitment of experienced applied psychologists to Band 8A fixed term posts.

62. August 2021 Financial Position

62.1 Mrs Goldsmith provided an update to the Board on the financial position at Period 5 for NHS Lothian. The paper set out the financial impact from Covid-19 in the first five months and provided an update on the main core pressures in year.

62.2 The Board discussed the CAMHS and PT financial position, the Board's Core and Covid positions; additional funding to support primary care around covid booster and flu vaccination programme; NRAC funding and assumptions around Scottish Government funding. Mr Crombie highlighted the importance of attracting revenue and capital funding to support services such as the new National Treatment Centre coming to St John's Hospital. The success of the Board around the Scottish Government supporting the full business case for the reprovision of the Eye Pavilion were also to be commended.

62.3 There was also discussion on acute drugs spend; new drugs funding source and the introduction of electronic prescribing. The Board asked Mrs Goldsmith to provide a detailed report to the Finance and Resources Committee so better understanding of systems could be obtained.

62.4 The Board accepted the recommendations in the report and that, based on information available at this stage and assumptions around additional funding, NHS Lothian continues to provide limited assurance on its ability to deliver a breakeven position in 2021/22.

63. Drug Related Deaths

63.1 Ms Milne invited Ms Stonebridge to outline the report on drug related deaths (DRD) across Lothian. Information on current rates and trends was provided, the national and local priorities were summarised and current and proposed future actions were set out. The Board noted that DRD was a highly topical area and a key public health issue, with DRD often masking greater harm in society.

63.2 Ms Stonebridge explained that the 2020 data showed a similar position to 2019. The NHS Lothian position against the overall Scotland picture showed an increase which was not at the level of other health boards. However numbers were still high and there was a lot happening across the system in Lothian to address the increase, including great partnership working with the third sector and those with lived experience. There was a strong performance in relation to the medication assisted treatments standards and good benchmarking. Greater detail was provided through reporting to the Healthcare Governance Committee.

63.3 The Board noted there was a strong governance structure in NHS Lothian with the Pan Lothian Drug Harm Oversight group having a link to the Health and Social Care Partnerships, as well as links with children's partnerships and child poverty action groups.

63.4 The Chair recognised the amount of work in the area of DRD and asked whether there was enough visibility of DRD issues at Integration Joint Boards, with these Board being responsible for the strategic planning of services in this area. Ms Stonebridge confirmed that the perception from the Drug Harm Oversight Group was that there was excellent engagement and that the Edinburgh IJB Chief Officer chaired the executive Drug, Alcohol, Upstream Prevention group.

63.5 There was discussion on workforce demand and issues with buildings from where services were delivered. Ms Stonebridge stated that the buildings issue was an area where estates can help further. Current provision is not sufficient to allow expansion or development of services. This is a very important agenda and a conversation on how estates can help to support this would be welcomed.

63.6 The Board agreed the recommendations in the report:

- Clinical service delivery **-** The greatest area of risk for achieving the Medication Assisted Treatment (MAT) standards by April 2022 is associated with clinical treatment. The Board should request a more detailed report providing an assessment of these issues to be considered, in the first instance, by the Healthcare Governance Committee. There are specific concerns in relation to workforce capacity (development and retention), access to suitable buildings from which to deliver specialist services and appropriate therapies for the most vulnerable which must be trauma informed.
- Data flows and health intelligence **-** The Board should continue to support health intelligence dedicated to enhancing a partnership approach to consistent data gathering, information governance and timely follow-up for all non-fatal overdoses (NFO's) (including those who are homeless and registered with the Access Practice) and frequent attenders at A&E.
- Governance and oversight **-** It is recommended a twice yearly update on DRD reporting and associated work be presented either to the Board or delegated committee. The Board also recommended that a report be taken to each of the four Integration Joint Boards for visibility of the issues.
- Early intervention and prevention **-** It is recommended that the Board support capacity building amongst NHS Lothian staff to reduce the stigma

and improve understanding of problematic drug use and associated behaviours. This could consider the updating and extension of mandatory training modules for staff on how to respond to an overdose and the use of naloxone.

64. NHS Lothian as an Anchor Organisation

64.1 Ms Milne updated on progress toward developing the Board's corporate objective to developing its Anchor Institution status. The Board noted that this work supported action to address inequalities and working with partners gave opportunities to make a difference.

64.2 Ms Milne reported that she was chairing the anchors programme board and there had been enthusiastic and positive discussions with people seeing the potential impact small changes can make. There had also been a lot of work as an employer around living wage accreditation; partner conversations around housing supply and improving affordable housing. There would be further work with capital, estates and engagement with private sector partners to look at further reducing inequalities and improving outcomes.

64.3 The Board noted that evidence form the Edinburgh and Lothians Health Foundation and Kings Fund show a need to be ambitious with this work and to look for the biggest impact that can be made. Ms Milne planned to bring more concrete recommendations around actions to take back to a future Board meeting.

64.4 The Board agreed that it had been briefed on progress towards developing its role as an Anchor Institution as part of its work on pandemic remobilisation and tackling inequalities. The governance arrangements for this work through the Corporate Management Team and Planning, Performance and Development Committee were noted.

65. National Whistleblowing Standards - Quarter 1 Performance Report

65.1 Ms Butler provided the Board with details of the first quarterly report produced under the National Whistleblowing Standards. The Board noted that the Standards had been launched on 01/04/2021 and they were for use by anyone employed in health services. There was a two stage process and if staff remained unsatisfied, they had the right to go to the independent national whistleblowing officer.

65.2 NHS Lothian had developed its infrastructure to support the Standards and progress the implementation. Work also continued with Primary Care Contractors used by NHS Lothian, but this process was slower. Governance arrangements were through the Board's Staff Governance Committee and cases coming through were also being monitored. There had been six cases under the new standards, four were closed in the quarter and two carried over due to the complexity of the cases. NHS Lothian had flagged an issue to SPSO and Scottish Government early on that it would not always be possible to close out cases at stage 2 in 20 days. Communication with the whistle blower was key in this and these mechanisms had been effective in

Lothian.

65.3 The Board noted the work to date on the roll out of the Whistleblowing Standards across all staff and contractor groups; Noted that further work was required and the continued need to promote and publicise the Standards; Noted the content of the attached Quarter 1 Performance Report and Noted that from Quarter 3 onwards Performance Reports would include figures from Primary Care Contractors.

66. Regional Health Protection Service

66.1 Ms Milne outlined the report recommending that the Board supports the strategic direction proposed for Health Protection services in the East Region. The Board noted that there had been a lot of discussion around this and the experiences of Boards working together during the pandemic had emphasised the importance and value of such linkages.

66.2 Ms Milne explained that the timescale was for the new model of service delivery to be agreed by December 2021 with the new integrated function starting from April 2022. The bulk of services was ready for this and teams in each of the Board areas had been informed and consulted.

66.3 There was discussion on staffing and IT interoperability. Ms Milne confirmed that work on governance arrangements was ongoing but learning was being taken from other regional services as to how to manage and host these. There would be a need for fewer employees but Health Protection was an area that had not been particularly well resourced prior to the pandemic and there were a number of people who had indicated they would retire in the next 12 months, so no-one was expected to be adversely affected. There had been appropriate HROD consultation with staff and partnership had also been involved.

66.4 In relation to IT, Health Protection use the same clinical management system in all Boards and it was hoped this could be adapted to manage this new service. Miss Gillies added that there was already a clinical viewer system in place between Lothian, Fife and Borders that could be extended to Forth Valley. Ms Milne stated the important thing was to identify any issues and have the IT system working properly from day one.

66.5 The Board accepted the recommendation in the report that NHS Lothian, Fife, Forth Valley and Borders would work towards implementation of a regional model for Health Protection services which would deliver a resilient, sustainable regional service that maximised the skills of the workforce, reduced duplication and made provision for surge capacity and mutual aid should it be required.

67. Winter Plan (This item was taken together with Item 68.)

67.1 Mr Briggs briefed the Board on the actions being taken to plan and prepare for winter. The Board noted that there had been an in-depth session on Winter Planning and RMP4 held on 04/10/2021.

67.2 The paper outlined the fragile position and challenges likely to be seen this coming Winter and included a checklist for the Board to use against best practice. The paper also included the individual plans that services would be putting in place to support the Winter Plan. The Board noted that as part of the leadership support, Gold Command and Regional Resilience Partnership structures were already place.

67.3 Mr Briggs added that, while there was no one thing alone that would make the huge difference for NHS Lothian, the measures recently announced by the Cabinet Secretary would help stabilise the care sector. This would not be quick ,but this was the right direction and welcomed.

67.4 The Board recognised that the winter position would be a challenging one and it was important to remain conscious that each of the performance numbers represented an individual having a sub optimal experience.

67.5 Mr Murray asked why winter was treated differently to any other part of the year as the challenges were well known. Could staff not be brought in on the long term knowing there would be available funding later in the year. The Chair commented that the winter situation would be exacerbated this year with the pandemic recovery. Mr Campbell stated that there was a Winter Plan as there was an activity spike around adverse weather and that pandemic recovery required recurring investment not just staff for winter. Mrs Goldsmith made the point that there was a financial plan for winter each year, with agreement on how to use finding and this could be tailored in line with intelligence.

67.6 Dr Williams pointed out that in winter there was normally a peak in demand and a trough in capacity, however over the past two years there had been long term demand and capacity issues. The term Winter Plan may be misleading and it was not clear after winter if there was a confidence of returning to 'normal'. There would be the need for action plans to mitigate risks. Mr Briggs accepted this point and added that this winter more people would be going out as pre-pandemic and this would mean having to deal with other diseases (colds, flu, norovirus, RSV) as well as Covid. One of the most challenging things for the Lothian Strategic Development Framework was not knowing when 'normal' would return.

67.7 Mr Campbell clarified that although reassurance could be taken that it was believed that there was a robust plan in place that would be monitored closely, only limited assurance could be taken at this stage as the additional demand part was unknown and that this would be the most challenged Winter the NHS had known.

67.8 Mr McCann asked about other challenges through winter such as the ability to meet surge capacity and if there was any expected services affected by the COP26 event in November. Mr Campbell confirmed that he had met with Police, Fire, Directors of Public Health and Local Authority Chief Executives to discuss COP26. It was hoped that this would go smoothly but there was awareness of significant lobbies who may undertake protest, blocking roads

etc. This introduced additional pressure into the system at a time where there was little spare capacity to cope.

67.9 The Chair stated that there was a huge amount of work and analysis behind the winter planning and this was a testament to whole system working. The Board agreed to the recommendations in the report, to:

- Note the context the Lothian system is working within;
- Note the actions already underway to mitigate system pressures;
- Note the additional actions planned for the winter period;
- Note that the actions will be updated constantly through the winter period;
- Agree that the Board can only take limited assurance that the system will be able to respond to additional pressures during the winter period.

68. Remobilisation Plan 4

68.1 Mr Briggs outlined the report recommending that the Board note progress in developing Remobilisation Plan 4 (RMP4), covering the period 1st October 2021 to 31st March 2022. The paper clarified the discussion with the Scottish Government and the Board noted that the draft RMP4 had been sent to Scottish Government on 30/09/2021.

68.2 Mr Briggs explained that discussions on RMP4 were expected to continue in October/November with a view to finalising this in November and bringing RMP4 back to the Board on 01/12/2021.

68.3 The Board agreed to the recommendations in the report, to:

- Note the purpose of RMP4;
- Note that an accompanying paper to this Board meeting outlines the winter planning actions that form a key underpinning for RMP4;
- Note the discussions with Board members informing RMP4;
- Note that a draft version of RMP4 is under discussion with the Scottish Government;
- Agree that the final version of RMP4 should be brought to the December meeting of the Board for final agreement and to facilitate publication on the Board's website.

69. National Care Service Consultation

69.1 Mr Briggs introduced the report informing the Board of the current Scottish Government consultation on the proposal for a National Care Service, and to agree the process to prepare an organisational response to the consultation.

69.2 The Board noted that there would be more detailed discussion on this topic at the Board strategy away day on 27/10/2021. The closing date for consultation responses was 02/11/2021. Mr Briggs would be working with the Chair, Mr Campbell and Mr Payne to pull together the response process for NHS Lothian.

69.3 The Board agreed the recommendations in the report, to:

- Note the parameters of the consultation;
- Note the high level summary of proposals;
- Note the issues flagged in internal analysis;
- Agree the process for concluding a response on behalf of NHS Lothian

70. Corporate Risk Register

70.1 Miss Gillies outlined the paper reviewing NHS Lothian's Corporate Risk Register (CRR) and associated processes to ensure it remains fit for purpose.

70.2 Miss Gillies reported that the final stages of the process to review risk management and make this more dynamic were almost complete with plans to mitigate every risk to the Corporate Management Team. Risk had now been regraded where appropriate or reworded to make risks clearer, the risk around general practice being an example of this. The Board also noted that moving forward there would be more explicit links to risks on the Corporate Risk Register coming through in governance committee papers. These would also signal a clearer link to mitigation plans, level of proposed assurance and an agreed link to progress plans already in place. This approach would make the Corporate Risk Register and actions around it more central and dynamic going forward.

70.3 The Board accepted the recommendations in the paper acknowledging that these followed on from Corporate Management Team discussions on the risk register:

- The reviewed and retitled Sustainability of the Model of General Practice risk remains on the Corporate Risk Register, plus associated gradings and adequacy of control.
- The reviewed Violence & Aggression risk remains under review on the Corporate Risk Register pending the findings of the planned Internal Audit report.
- The Bed Capacity in Acute Mental Health risk be downgraded to moderate and be removed from the Corporate Risk Register.
- The Complaints risk be downgraded to moderate.
- The Care Home risk be downgraded to moderate.

71. Any Other Business

71.1 None.

72. Reflections on the Meeting

72.1 The Chair thanked colleagues for the questions asked and participation in discussions. The Board noted that there were some items to be referred to Committees:

- **Healthcare Governance Committee**
  - CAMHS and Quality of Outcome Reporting work
  - 6 monthly Drug Related Deaths reports

- **Finance and Resources Committee**
  - The acute drugs system analysis

- **Planning, Performance and Delivery Committee**
  - Anchor Institution work

- **Staff Governance Committee and other appropriate committees**
  - Regional Health Protection Service update

73. Next Board Meeting

73.1 The next Board meeting would be held on 01 December 2021.

Chair's Signature ……

Date ……

John Connaghan
Chair – Lothian NHS Board

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee meeting held at 9.30 am on Monday, 23rd August 2021 via MS Teams.

Present:
Mr M. Connor (Chair), Non-Executive, Board Member; Ms K. Kasper, Non-Executive Board Member; Councillor J. McGinty, Non-Executive Board Member and Mr P. Murray, Non-Executive Board Member.

In Attendance:
Ms K. Brooks, Internal Auditor; Mr C. Brown, Azets; Ms J. Brown, Chief Internal Auditor; Ms J. Bennett, Associate Director for Quality Improvement & Safety; Mr C. Campbell, Chief Executive; Mr J. Crombie, Deputy Chief Executive; Ms D. Eardley, Azets; Ms S. Goldsmith, Director of Finance; Ms O. Notman, Head of Financial Services; Mr C. Marriott, Deputy Director of Finance; Mr J. Old, Financial Controller; Mr A. Payne, Head of Corporate Governance; and Miss L. Baird, Committee Administrator.

Apologies:
Mr J. Connaghan, Chairman.

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.

42. Minutes of the previous meeting held on 17th June 2021

42.1 The minutes of the meeting held on 17th June 2021 were accepted as an accurate record and approved.

43. Minutes of the previous meeting held on 21st June 2021

43.1 The minutes of the meeting held on 21st June 2021 were accepted as an accurate record and approved.

44. Running Action Note

44.1 The Committee noted the actions marked complete or items on the agenda for further discussion and those that were not due for consideration detailed within the report.

44.2 Risk Management – The Committee noted that there had been difficulties in getting a date for a workshop with Edinburgh IJB that suited all attendees. The Edinburgh Chief Internal Auditor would continue to pursue a suitable date.

44.3 Audit Scotland: COVID 19 Guide for Audit Committees – Mr Marriott proposed that the development session for members be organised for late October/ early November, to allow the session to be framed around Audit Scotland Annual report. Mr Marriott would set a provisional date for the session, framing the context of discussions with the non-executives and circulate it out with the meeting. **CM**

44.4 Internal audit, Estates (June 2021) – Ms Goldsmith explained that the level of spend for the two companies identified in the Estates audit had been investigated and it was clear that further work around the system of control was required when more than one department was engaging with a supplier. Ms Goldsmith would ask Internal Audit to

consider the additional information and bring a full report on the outcome of these discussions to the November Audit and Risk Committee. **SG/JB**

44.5 The committee accepted the running action note.

45. Corporate Risk Register

45.1 Ms Bennett spoke to the previously circulated report.

45.2 Ms Bennett highlighted progress made in respect of the integration of the risk management structure with the Corporate Risk Register and all levels of risk within the organisation. She noted that the discussion with the Corporate Management Team on 31 August would inform recommendations that would go to the Board on 6 October 2021.

45.3 The Committee discussed the 4-Hour Emergency Access Target risk within the report and what impact if any the redesign of urgent care would have on waiting times. The Chief Executive explained that the programme of redesign was monitored closely, however at this time there was no conclusive evidence that it was having a positive or negative impact on waits.

45.4 The Chief Executive agreed with Mr Murray that there had been a significant amount of investment in the redesign of urgent care and there would need to be a robust, detailed evaluation of the programme to ensure that Boards and NHS 24 were receiving value for money.

45.5 Mr Campbell advised Mr Murray that all Health and Social Care Partnerships had applied for the additional funding for Hospital at Home from the Scottish Government. Mr Campbell agreed to request a report on the scope of work Hospital at Home to identify where and when the money was being spent and share it with Mr Murray out with the meeting. **CC**

45.6 The Committee noted that the risk assurance development session involving committee chairs and NHS Lothian executives had been scheduled for 15th September 2021.

45.7 The Committee noted that the Board approved in June 2021 a number of new and revised corporate risks as summarised in Appendix 1, as part of the risk register review.

45.8 The Committee noted that the GP sustainability and Violence & Aggression risks have been reviewed and will be presented to the Corporate Management Team (CMT) in August 2021 and the Board in October 2021, which completed the review process.

45.9 The Committee noted that a new process has been established to review all corporate risks with executive leads prior to CMT discussions and Board recommendation and that these discussions were summarised in the assurance Table in appendix 1.

45.10 The Committee accepted the report.

46. Internal Audit

46.1 Internal Audit Progress Report – August 2021 – Ms Brown spoke to the previously circulated report that set out the progress on the 2021/22 Plan.

46.1.1 Ms Brown explained that the Complaints Audit had been deferred to allow the team to review the scope and consider the work in respect of the forward-look around complaints

taking place within the organisation. She anticipated that the Complaints Audit would be brought to the October Audit and Risk Committee.

46.1.1 The Committee discussed the recruitment plans within the Internal Audit Team and likelihood of recruiting to the vacancies within the team. Ms Brown explained that she had no concerns about the recruitment process given the current movement within the market. She also took assurance from the contingencies within the Grant Thornton contract, that allow the use of additional internal resource to support the team in the completion of the audit plan. Ms Brown would continue to oversee recruitment to the team with the support of Mr Marriott through their regular programme of meetings.

46.1.2 Ms Brown advised the Committee that Ms Susan Brook would provide cover for Ms Kate Brooks during her maternity leave and attend the Audit and Risk Committee in her place when required.

46.1.3 Ms Brown had considered the follow-up of management actions paper in advance of the August meeting and noted that the number of management actions outstanding was relatively low. She reported that a detailed report would be brought to the October Audit and Risk Committee.

46.1.4 Ms Brown advised the Committee of the different approach that would be applied to the internal audits of Estates and Consort Invoicing and the assurances the approach would provide to the Audit and Risk Committee. The Chair welcomed the new approach for these challenging audits and proposed that those audits would remain on Committee's agenda as standing items until all actions had been signed off.

46.1.5 The Committee accepted the report.

46.2 Property Transactions Monitoring – Ms Brooks presented the Property Transactions Monitoring report that undertook an annual review of the property transactions that concluded in 2020/21.

46.2.1 The Committee took significant assurance from the report, noting that there was 1 low level finding in relation to the timely completion of the property certifications. It was noted that the low level finding had been accepted by management and included within the action plan.

46.2.2 The Committee accepted the report.

46.3 COP26 – Responding to Emergencies – Ms Brooks presented the report that reviewed the preparedness of NHS Lothian to respond to emergencies in the context of the upcoming COP26 event.

46.3.1 It was noted that the audit had identified that there were clear controls in place but there had been some areas of improvement required. Action identified had been accepted my management and incorporated into a detailed action plan.

46.3.2 Mr Campbell confirmed that the adoption of NHS Lothian's Major Incident procedures by the local authorities had been discussed with the Chief Officers and recorded in the Corporate Management Team minute. He recognised that the lack of formal confirmation that the Chief Officers would accept the major incident procedures if an incident was declared had been an oversight and action will be taken to address this.

46.3.3 The Committee accepted the report.

47. Counter Fraud Activity

47.1 Mr Old presented the previously circulated report. He noted that since the June meeting there had been 1 intelligence alert and 4 referrals, and 9 operations were ongoing.

47.2 The Committee welcomed the re-establishment of the Counter Fraud Action Group and noted the introduction on a 'Once for Scotland' basis of the Government Functional Standard GovS 013: Counter Fraud from April 2022.

47.3 Mr Old reported that there had been some enquiries around the resale of Personal Protective Equipment etc. but these had not materialised within Lothian. He explained that overall there had been no significant increase in referrals around Covid or Covid related activities.

47.4 The Committee accepted the report as a briefing of the current status of the counter fraud activity.

47.5 The Committee agreed that the report provides a moderate level of assurance that all cases of suspected fraud were accounted for and appropriate action had been taken.

47.6 The Committee accepted the report.

48. Corporate Governance

48.1 Progress Report on the Estates Audit – Ms Brown reported that Ms McMillan had taken a robust project management approach and implemented a detailed tracker to monitor the actions to address the recommendations within the internal audit report. She welcomed this approach and the good actions that had already taken place.

48.1.1 Mr Crombie provided an overview of the progress against the recommendations, drawing attention to the formal establishment of the Senior Management Team for Estates and Facilities that would oversee and drive responses to the recommendations within the Internal Audit report. He refenced clear links with the Internal audit team and welcomed their support as the actions are taken thought to conclusion.

48.1.2 The Committee questioned the broader impact of the audit on the organisation and whether this report could be used as a benchmark for other corporate functions. Mr Crombie and Ms Goldsmith had discussed linkages identified in the other internal audit that crossed out of Facilities and Estates into Finance and Procurement and as part of the framework for this, lessons would be shared with colleagues.

48.1.3 Mr Crombie reported the approach taken had also been shared with Ms Campbell, Chief Officer Acute Services and that would be subject to their consideration going forward.

48.1.4 The Committee discussed the culture within Estates and Facilities and how this could be refreshed going forward. Members took assurance from the Organisational Development workstream within the Senior Management Team and how actions identified would be fed into a wider plan for the Estates and Facilities division.

48.1.5 Mr Crombie assured the Committee that the audit had a constructive and helpful impact on the Facilities and Estates Team. He reported that the leadership had reflected on the vulnerabilities that had been evidenced by the internal audit and expressed a commitment to resolve these through the Senior Management Team.

48.1.6 Mr Crombie advised that the recruitment of a new Director of Estates was progressing and the interviews would be held in September. He anticipated that the change in leadership would also allow a refresh of the team culture an re-establish a strategic footprint of what the division's priorities would be.

48.1.7 The Committee noted that Ms Goldsmith and Mr Payne had met with key members of the Estates team to provide support as they develop systems of control from critical systems including fire prevention, ventilation etc and the level of assurance this would bring going forward.

48.1.8 The Committee agreed to accept moderate assurance from the approach taken to monitor the progress via the Internal Audit Sub-Group.

48.1.9 The Committee agreed to accept the actions detailed within the report that would be considered closed off by 31 August 2021 by the Estates and Facilities Senior Management Team.

48.1.10 Members acknowledged the Internal Audit Team would undertake further monitoring and follow-up audits of the implementation of these actions and the outcome of these would be provided at the November Audit and Risk Committee.

48.2 Consort Invoicing Internal Audit Report – Mr Marriott provided an overview of the report on the established process to implement the recommended actions in the Consort Invoicing Internal Audit Report.

48.2.1 Ms Goldsmith recognised that placing reliance solely on one department for all technical aspects of the contract and the authorisation had been a mistake. She confirmed going forward Estates and facilities would have a technical due diligence around the management of contract and the business element would site within finance.

48.2.3 The Committee accepted the progress made to date in implementing the agreed recommendations in the internal audit report.

48.2.4 The Committee acknowledged the revised implementation leads and timelines for some of the recommendations and welcomed the update that would be provided at the October meeting.

49. External Audit

49.1 NHS Lothian – Annual Audit Report to the Board and the Auditor General for Scotland – Mr Eardley presented the previously circulated report, drawing the Committee's attention to the findings and conclusions from the report. He explained that the report concluded the audit of NHS Lothian for 2020/2021 with an unqualified opinion.

49.1.1 The Committee received assurance that the minor matters in relation to the accounts including the resolution of the PPE accounting adjustments had been concluded and signed off.

49.1.2 The Chair welcomed the informative report recognising that sustainability would be a challenge for all Boards but, overall the report reflected well on NHS Lothian and the practices of the finance team.

49.1.3 Mr Murray questioned whether financial sustainability would be a feature of the strategic plan and the PPDC agenda in the coming months. Ms Goldsmith assured the Committee

that Finance were working on drawing out the balance between value for money and financial sustainability thought the development of the finance strategy and the Oversight Board and will present this to the Board. The Committee recognised that this would be picked up through the Finance and Resources Committee as the owner of the risk within the Corporate Risk Register.

49.1.4 In response to Mr Murray's question Mr Eardley acknowledged it was difficult for the External Auditor to make the correlation to identify that the more resources you have the more you can put into treatment time guarantees and therefore it is more likely you can achieve the targets. He acknowledged the interdependencies between value-for-money performance and financial sustainability and would reflect on how as external auditors they could draw this out in future reports.

49.1.5 The Committee accepted the report.

50. Any Other Competent Business

50.1 There were no other items of competent business for consideration.

51. Reflections on the meeting

51.1 The Chair noted that he would update the Board on the internal audits of Estates and Facilities and Consort invoicing at its meeting in October. He would liaise with Mr Payne and Ms Goldsmith around the nature of the update in advance of the meeting.

52. Date of Next Meeting

52.1. The next meeting of the Audit and Risk Committee will be held on Monday 22nd November 2021 at 9.30 a.m. via Microsoft Teams.

Chair approved 22.11.2021

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 1.00pm on Tuesday 7 September 2021 by video conference.

Present: Ms F. Ireland, Non Executive Board Member (chair); Dr P. Donald, Non Executive Board Member; Councillor G. Gordon, Non Executive Board Member; Ms C. Hirst, Non Executive Board Member; Ms K. Kasper, Non Executive Board Member; Mr S. Kerr, Patient and Public Representative; Ms J. Keys, Patient and Public Representative; Ms F. Lloyd, Patient and Public Representative; Ms L. Rumbles, Partnership Representative.

In attendance: Mr C. Campbell, Chief Executive; Ms J. Campbell, Chief Officer Acute Services; Ms J. Craig, Director of Midwifery; Ms S. Gibbs, Quality and Safety Assurance Lead; Ms T. Gillies, Medical Director; Ms Y. Lawton, Head of Strategic Planning and Performance, West Lothian; Ms G. McAuley, Nurse Director Acute Services; Ms A. MacDonald, Chief Officer East Lothian Health and Social Care Partnership; Ms J. Macrae, Associate Nurse Director; Ms T. McKigen, Service Director Royal Edinburgh Hospital and Associated Services; Professor A. McMahon, Executive Nurse Director; Dr D. Milne, Director of Public Health and Health Policy; Ms J. Morrison, Head of Patient Experience; Ms S. Muir, Services Manager, Edinburgh Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Ms J. Proctor, Chief Officer, Edinburgh Health and Social Care Partnership; Mr A. Short, Women's and Children's Service Director; Ms F. Stratton, Chief Nurse Midlothian Health and Social Care Partnership; Professor A. Timoney, Director of Pharmacy; Ms F. Wilson, Head of Health, West Lothian Health and Social Care Partnership.

Apologies: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Mr J. Connaghan, Board Chairman; Mr J. Crombie, Deputy Chief Executive; Mr J. Encombe, Non Executive Board Member; Ms M. Hughes, Chief Nurse West Lothian Health and Social Care Partnership.

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.

25. Minutes from Previous Meeting (27 July 2021)

25.1 The minutes from the meeting held on 27 July 2021 were approved as a correct record.

25.2 The updated cumulative action note had been previously circulated.

26. Patient Story

26.1 Mr Kerr read out feedback from Patient Opinion from a patient on a waiting list for surgery who required pain relief. The patient struggled to make contact with the

service either by telephone or email and was disappointed when an appointment was later offered for 4 weeks' time.

26.2 An administrative process for keeping in touch with patients on the waiting list was in place, using letters compiled through the TRAK system. Ms Morrison noted that it was important to keep in touch and reassure patients even when they were being asked to wait longer.

27. Matters Arising

27.1 Healthcare Governance Committee Workshop

27.1.1 The date for the workshop was being arranged and this would be circulated once confirmed.

27.2 Gender Based Violence Practitioner

27.2.1 Professor McMahon advised that he was in discussion with Public Health regarding the appointment of a practitioner. Currently the work was being covered by two experts in the area working in Maternity Services and Prison Healthcare.

27.3 National appointment letters for cervical screening

27.3.1 Dr Milne advised that the report had not yet been released but that she would follow this up.

28. Emerging Issues

28.1 System Pressures

28.1.1 Professor McMahon noted the extreme pressures currently being experienced in NHS Lothian regarding capacity and patient flow, partly due to staffing pressures and noted that this pressure had not improved. The staff absence rate was higher than usual. 450 new graduate nurses would start in the next month which may provide some improvement. Higher acuity procedures were being prioritised and some non urgent elective surgery was having to be cancelled at this stage. A meeting was scheduled the next week with MPs and MSPs to discuss these pressures.

29. Annual Assurance Reports

29.1 Women's Services Assurance Report

29.1.1 Ms Craig presented the previously circulated paper. Members noted the very positive 'being open' work which had been discussed previously.

29.1.2 This paper had been reviewed by the Patient and Public Representatives Group. Mr Kerr noted the lack of reference to any engagement with women over the service development. Ms Craig advised that a lot of engagement work had been done with families and details of this would be added in the next report.

29.1.3 Regarding the Best Start Programme, Ms Craig advised that there were 76 recommendations, one of which was described in the paper. An extension of 2 years to complete the recommendations had been given by the Scottish Government.

29.1.4 The creation of the Clinical and Management groups across the service was noted and it was queried whether these were management or governance functions, if the latter it was noted that the current construct might require review to provide appropriate oversight.

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

29.2 East Lothian Health and Social Care Partnership Annual Report

29.2.1 A paper had been previously circulated and Ms MacDonald gave a presentation.In response to a question about the sustainability of primary care Ms MacDonald advised that there was an improvement plan, an extensive multi disciplinary team approach and that data on general practice activity was available and was supplied to general practices regularly.

29.1.2 In response to the data on pressure ulcers Professor McMahon directed the committee to the Tissue Viability annual report and advised that there had been investment in tissue viability nurses to support the partnership services and the care home team.

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

29.3 Edinburgh Health and Social Care Partnership Annual Report

29.3.1 A paper had been previously circulated and Ms Proctor gave a presentation.

29.3.2 Ms Kasper gave the background of a whistleblowing concern raised about the SMART centre in October 2020, which was upheld in January 2021 following investigation and external review. In April 2021 the SMART centre requested funding and a discussion of governance arrangements in response to the recommendations in the report. However, there had been little improvement in performance, with the longest waiting time for service users in Scotland. Ms Proctor advised that a business case was needed for investment in the service. The governance questions were due to the fact that the service was a consortium delivered in collaboration with NHS Borders and NHS Fife. A paper would be discussed at the next Corporate Management Team meeting laying out what had been done in response to all seven recommendations from the report and what the next steps would be. Ms Proctor agreed to also report back to the Healthcare Governance Committee in November 2021 giving an update on all all of the recommendations. **JP**

29.3.3 In response to a question about engagement with the public regarding the proposal to change the use of care homes and reinvest in a new model of care, Ms Proctor advised that a paper would be submitted to the Integration Joint Board in October 2021 with a bed base review. Four care homes were now no longer usable and the decision would be around how to provide care at these sites. Concerns had been raised in the community. The team was meeting with trade unions each week and

there would be further community consultation and discussion with the aim of showing what would be improved for Edinburgh residents.

29.3.4 It was noted that the plans for a changed model of care in care homes was not only for a reduction of beds but for a change in bed use. For instance some nursing homes were not able to provide care for residents with complex needs who required 24 hour nursing care and who therefore remained in acute beds. The plan was to change this.

29.3.5 Dr Donald raised concern about the challenges in community services and the capacity to deliver safe, effective, person centred care, given high levels of District Nursing vacancy. Dr Donald also sought assurance around the single point of access through the Flow Centre.

29.3.6 Ms Proctor advised that some work was done on pressure ulcer adverse events and improvement work was starting with all Health and Social Care Partnerships in collaboration with the Lead Tissue Viability Nurse.

29.3.7 Members accepted the recommendations laid out in the paper. Limited assurance was accepted for the SMART centre, with a further update addressing all the recommendations of the SMART centre external review at the next meeting.

29.4 Midlothian Health and Social Care Partnership Annual Report

29.4.1 A paper had been previously circulated and Ms Stratton gave a presentation. An increase in adverse events from March 2021 was noted. Ms Stratton advised that the main concern was the delay in investigating these and noted that the increase may be caused by violence and aggression reports around one or two individuals in the Rossbank unit. The level of harm reported had not increased.

29.4.2 Ms Stratton also advised of extensive Quality Improvement works that were ongoing. It was noted that the new software 'outnav' was being used to describe patient outcomes in Substance Misuse Services and staff were pleased with how this was working.

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

29.5 West Lothian Health and Social Care Partnership

29.5.1 A paper had been previously circulated and Ms Wilson gave a presentation. In response to a question about supporting access to the digital services in an area where inequalities in access to technology may be higher, Ms Wilson advised that more work was needed on this and the service had so far been focussed on taking the opportunity to develop the use of technology to improve access.

29.5.2 The supporting documentation with the paper highlighted a 10% reduction in the length of stay to 6.5 days and a 3% reduction in bed days through the efforts within the partnership to provide community services. This was noted as a significant achievement in effective and person centred care.

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

29.5.4 It was noted that there was close working between all four Health and Social Care Partnerships which allowed experiences to be shared. The Chief Officers met regularly and nursing and medical teams met in professional groups. NHS Lothian Gold group included all four partnerships and discussed capacity problems across all tiers. The Board Sub Committee the Planning Performance and Development Committee was a planning group that included all four partnerships.

29.5.5 There was a discussion about NHS Lothian's governance role regarding the Health and Social Care Partnerships. NHS Lothian was responsible for healthcare delivery and the Health and Social Care Partnership reports gave assurance on the healthcare services delivered by them to ensure oversight. The governance arrangements within the Health and Social Care Partnerships and Integration Joint Boards identified the key risks which were brought to this Committee.

30. Person Centred Culture

30.1 Patient Experience and Feedback

30.1.1 Ms Morrison presented the previously circulated paper. A decision was made regarding the change in the level of risk later in the meeting – see section 35 of this minute. Members accepted the remaining recommendations laid out in the paper.

30.2 Person Centred Care Model Ward Project Implementation

30.2.1 A paper had been previously circulated and Ms McAuley gave a presentation on the work taken forward in the adult wards across acute and community hospitals. The transferability of the work to other specialties including childrens, maternity, mental health and community was being pursued. Members commended this work but amended the recommendations laid out in the paper to moderate assurance overall until the person centred care planning tools and processes were in place in all areas.

30.3 Patient non attendance at appointments

30.3.1 Ms Campbell presented the previously circulated paper. Members welcomed the detailed consideration of the data. The next steps were engagement with GP practices and direct engagement with patients and the wider community. A report would also be brought to the Board on this. Members accepted the recommendations laid out in the paper. **JCa**

31. Safe Care

31.1 Healthcare Associated Infection Update

31.1.1 Professor McMahon presented the previously circulated paper. It was noted that it had been a national decision to pause the mandatory surgical site infection surveillance, but noted that other routine data collection continued and any incidence of infection would be investigated.

31.1.2 A recent incident in the neonatal department was highlighted and the Committee were advised that an Incident Management Team had been convened and had met the

previous day. Decontamimation and deep cleaning actions were underway to mitigate any further incidence.

31.1.3 It was noted that adherence to standard infection control precautions required constant reinforcement to reduce risk when staff where under pressure.

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

31.2 Immunisation Programmes Updated Governance Structure

31.2.1 Dr Milne presented the previously circulated paper. The revised arrangements were already in place. Members accepted the recommendations laid out in the paper.

31.3 Statutory Organisational Duty of Candour

31.3.1 Ms Gillies presented the previously circulated paper, noting that the numbers of fewer than five in the report would be redacted before publication. Members accepted the recommendations laid out in the paper and approved the report for publication.

32. Effective Care

32.1 Cancer Services

32.1.2 Ms Gillies presented the previously circulated paper. The staffing situation was difficult and there was focus on deploying staff in the areas most needed. Ms Gillies gave assurance that patient care was safe and effective despite the significant pressures.

32.1.3 Members accepted the recommendations laid out in the paper and accepted limited assurance.

32.2 Stroke Care

32.2.1 The chair welcomed Dr Coull to the meeting and he presented the previously circulated paper. He noted that appendix 1 in the paper laid out the reasons that performance had fallen compared to other Scottish Health Boards, which redeployment of staff of all disciplines to other areas and the use of stroke wards to look after covid patients from March 2020. It was hoped that improvements could be made in the next year. Improvements had already been made that month in aspirin administration; the apparent reduced performance at the Royal Infirmary may have been partly due to the fact that auditors were not able to enter the wards due to covid restrictions and aspirin may have been given but not recorded.

32.2.2 Regarding the risks around capacity and access to the stroke unit due to delayed discharge, Dr Coull advised that a lot of work had been done to improve the skills of community staff so that more rehabilitation could be done closer to home rather than in acute sites.

32.3 REAS Governance – Adult Inpatient Services

32.3.1 The chair welcomed Ms McKigen to the meeting and she presented the previously circulated paper. It was noted that availability of inpatient capacity had been a key risk and was one of the reasons for the Board's escalation. Members were pleased to see the work done so far and acknowledged there was more to do.

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

32.4 Update to response on Paediatric Audiology Ombudsman Report

32.4.1 Ms Gillies presented the previously circulated paper. A significant amount of work had been done and the paper laid out the timescales for completion of the actions required by the Ombudsman. The final report would lay out the responses to all the actions.

32.4.2 Ms Gillies confirmed that cohorts for the study would be identified by the external assessors as agreed by the Ombudsman and would follow the criteria laid out.

32.4.3 Members accepted the recommendations laid out in the report.

33. Exception Reporting Only

Members noted the following previously circulated papers:

33.1 Sexual Health and Blood Borne Virus Programme Board Annual Report;
33.2 Blood Transfusion Annual Report;
33.3 Controlled Drug Team Annual Report;
33.4 Information Governance Annual Report;
33.5 Tissue Viability Annual Report.

34. Other Minutes: Exception Reporting Only

Members noted the following previously circulated minutes:

34.1 Policy Approval Group, 24 August 2021;
34.2 Organ Donation Sub Group, 15 June 2021.

35. Corporate Risk Register

35.1 Ms Gibbs presented the previously circulated paper. A meeting would take place on 15 September 2021 to discuss better management of assurances given on the risk register. Ms Gillies advised that all risks were now discussed at the Corporate Management Team meetings and prior to each meeting the executive lead for each risk would discuss the mitigations in place with the risk owner. This would make the risk register more dynamic and reflective of current positions.

35.2 A recommendation had been made in the Patient Experience and Feedback report at this meeting for the risk level for complaints to be reduced. This would be discussed at the Corporate Management Team where evidence of an improved position would be presented. **AMcM**

35.3 Members accepted the recommendations laid out in the paper.

36. Reflection on the Meeting

36.1 The report on patient non attendance at appointments was already due to be presented at the Board. It was agreed that the update on the positive progress on the model ward implementation would also be raised. **FI**

36.2 Ms Rumbles noted that from her experience in working with staff in various areas of the organisation that the significant amount of work being done at executive level to ensure and improve staff wellbeing during a time of unprecedented pressures should be recognised.

37. Date of Next Meeting

37.1 The next meeting of the Healthcare Governance Committee would take place at **1.00pm** on **Tuesday 9 November 2021** by video conference.

38. Further Meeting Dates

38.1 The meeting dates for 2022 were to be confirmed.

Chair Approved 16.11.21

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 25 August 2021 by videoconference.

Present: Mr M. Hill, Non Executive Board Member (chair); Councillor S. Akhtar, Non Executive Board Member; Ms S. Goldsmith, Director of Finance; Mr A. McCann, Non Executive Board Member; Mr B. McQueen, Non Executive Board Member; Councillor G. Gordon, Non Executive Board Member.

In Attendance: Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Mr B. Currie, Project Director (item 27.2 and 27.4); Mr M. Gallaher, Business Consultant (item 27.5); Ms T. Gillies, Medical Director; Mr I. Graham, Director of Capital Planning and Projects; Dr J. Hopton, Programme Director, Facilities; Mr C. Marriott, Deputy Director of Finance; Ms A. Milburn, Service Manager (item 27.3); Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes).

Apologies: Professor J. Connaghan, Board Chair; Professor A. McMahon, Executive Nurse Director.

Chair's Welcome and Introductions

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

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

26. Committee Business

26.1 Minutes and Actions from Previous Meeting (14 July 2021)

26.1.1 Members accepted the minutes from the meeting held on 14 July 2021 as a correct record, subject to a correction to the attendance list.

26.1.2 The updated cumulative action note had been previously circulated. Updates discussed would be included in the action plan circulated before the next meeting.

27. Capital

27.1 Property and Asset Management Improvement Plan Update

27.1.1 Mr Graham presented the previously circulated paper. Regarding the two primary care proposals due to increase in population noted at item 3.3.2 in the paper, Mr Graham advised that these were with the Scottish Government for funding agreement. If funding was identified there would be notification in the next six to eight weeks, but if no funding was identified these would be likely to be put on hold rather than rejected. In this case the Board would make a decision as to whether to identify funding in the interim to go ahead with the works. Ms Goldsmith advised that the

Scottish Government were working on a longer term national plan based on a broader assessment of Scottish infrastructure rather than waiting for Boards to come forward with proposals.

27.1.2 Mr McQueen and Mr McCann had met with Mr Graham and capital planning colleagues regarding the review of the business case documentation and were supportive of the proposal not to focus on costs at the initial agreement stage due to the likelihood of subsequent changes.

27.1.3 The proposed strategic framework would set out the requirements and the priorities for the next five or more years, using a set of criteria. Ms Goldsmith advised that engagement with the Integration Joint Boards on priorities and primary care population pressures was proving effective. Chief Officers of the Health and Social Care Partnerships were part of the strategic framework process.

27.1.4 More information about public sector collaboration initiatives for primary care facilities as at paragraph 3.3.2 in the paper was requested with some examples in the next update. **IG**

27.1.5 Members accepted the business case for the Lauriston Building Combined Pharmacy. The wording in the recommendations in the paper would be revised to reflect this as Mr Payne had advised that the Committee was not able to delegate approval for this business case. Members accepted the other recommendations laid out in the paper and accepted moderate assurance on the delivery of the PAMIP programme.

27.2 <u>National Treatment Centre Next Steps</u>

27.2.1 Ms Goldsmith, Mr Currie and Mr Crombie presented the previously circulated paper. The development of a project team and director for this project was being progressed. Mr Graham was working on a structure for capital plans which would identify which delivery and assurance resources would be made available for projects. Mr Currie would remain in the role of senior project director working with new project managers for each capital project, including the Eye Pavilion and the National Treatment Centre. In the meantime Mr Currie was acting as project director of the National Treatment Centre.

27.2.2 Mr Crombie noted that engagement with clinical teams who would be using the building was key, but that external advisory roles were also required for building planning and technical requirements. The focus would be on the overall service need, informed by patient and professional needs.

27.2.3 Members accepted the recommendations laid out in the paper.

27.3 <u>Gynaecology Ambulatory Care Suite, St John's Hospital</u>

27.3.1 The chair welcomed Ms Milburn to the meeting and she presented the previously circulated paper. The proposal was to reduce inpatient beds at St John's Hospital from 10 to 6 to support more outpatient work. The procedures identified were less likely to require inpatient recovery and therefore could take place in outpatient

theatres. This would free up space for less complex inpatient cases to move from the Royal Infirmary which would in turn allow them to focus on more complex cases.

27.3.2 It was noted in the paper that some stakeholders did not take part in the engagement over the proposal but Ms Milburn advised that those who had not attended the engagement sessions had been contacted separately for comments and no concerns were raised.

27.3.3 Members accepted the recommendations laid out in the paper and approved the standard business case.

27.4 Scottish Hospitals Inquiry Update

27.4.1 Ms Goldsmith presented the previously circulated paper. It was agreed that the response to the second Request for Information to the Inquiry should be approved by members of the Committee prior to the next scheduled meeting. **AP**

27.4.2 It was noted that there were two strands of information being provided to the Inquiry, the documents requested as evidence, and narratives with NHS Lothian's interpretation of the events as witnesses, which also refer to original documents as evidence for the interpretation. It was agreed that for assurance purposes the Committee only required to review those documents that were part of the narrative of NHS Lothian's interpretation of events.

27.4.3 The review of the documents for identification of those needed to respond to the Inquiry was being carried out using search software which reduced the number of documents to be reviewed. Mr Currie and Mr Graham and former members of the project team then reviewed these documents for inclusion.

27.4.4 Members accepted the recommendations laid out in the paper.

27.5 Royal Infirmary of Edinburgh – Commercial Business Case

27.5.1 Ms Goldsmith presented the previously circulated paper which was commercially confidential. She advised that a member of the Scottish Government finance team had been engaged on NHS Lothian's process and had been briefing the head of finance at the Scottish Government.

27.5.2 A paper had previously been shared with the Scottish Government explaining why management issues had not been previously identified, and this paper would also be shared with the Committee. **SG**

27.5.3 Ms Goldsmith advised that as well as increasing contract management resource, additional resource was also being put into estates services with a working group to investigate any concerns raised and monitor any rectification required. This allowed oversight on what work needed to be done and enabled the team to work with Consort to deliver this. Regular reporting on the implementation of this model would be through this Committee, with reporting on wider strategy to the Board.

27.5.4 Members accepted the recommendations laid out in the paper and supported the proposed approach.

27.6 Assurance, Quality and Business Case Framework

27.6.1 Ms Goldsmith and Mr Graham presented the previously circulated paper. Members were supportive of the work being done and accepted the recommendations laid out in the paper, accepting moderate assurance at this stage.

28. Revenue

28.1 Financial Position – July 2021

28.1.1 Mr Marriott presented the previously circulated paper. He noted that £8.9 million of efficiency savings had been identified but not yet delivered due to Covid mitigations. It was acknowledged that there were ongoing pressures on delivering efficiency savings.

28.1.2 Members accepted the recommendations laid out in the paper and accepted limited assurance on the ability to reach a breakeven position at year end.

28.2 Finance Risk 3600

28.2.1 Mr Marriott presented the previously circulated paper. A submission would be made to the Finance Oversight Board in November regarding the status of this risk, and this would include the costs of recovery and remobilisation. Mr Payne advised that the risk would be focused on areas that could be mitigated regarding financial sustainability. There would also be reference to other risks such as clinical care and recovery, but these would be updated separately.

28.2.2 It was suggested that the wording of the risk be revised to ensure it referred to wider implications of financial and service sustainability and not only the risks associated with population growth.

28.2.3 Members accepted the recommendations laid out in the paper. A further paper would be brought back to the meeting in November following discussion at the Finance Oversight Board. **SG**

29. Sustainability

29.1 Sustainability Update

29.1.1 Ms Hopton presented the previously circulated paper. Ms Hopton noted the need for the relationship between PFI projects and the sustainability programme to be considered, and the need to ensure that sustainability needs were considered as part of building design.

29.1.2 Members accepted the recommendations laid out in the paper.

30. Committee Business

30.1 Reflection on the Meeting

30.1.1 It was agreed that the following items would be raised at the next Board meeting: update on the Scottish Hospitals Inquiry; progress on the National Treatment Centre; and the Royal Infirmary Commercial Business Case.

31. Date of Next Meeting

31.1 The next scheduled meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 13 October 2021**. An extraordinary meeting would also be held at **9.30** on **Wednesday 29 September 2021**.

32. Meeting Dates in 2021

32.1 Further meetings in 2021 would take place on the following dates:
- 17 November 2021.

Signed by the Chair

FINANCE AND RESOURCES COMMITTEE

Minutes of the extraordinary meeting of the Finance and Resources Committee held at 9.30 on Wednesday 29 September 2021 by videoconference.

Present: Mr M. Hill, Non Executive Board Member (chair); Councillor S. Akhtar, Non Executive Board Member; Ms S. Goldsmith, Director of Finance; Mr A. McCann, Non Executive Board Member; Mr B. McQueen, Non Executive Board Member.

In Attendance: Mr C. Campbell, Chief Executive; Mr J. Crombie, Deputy Chief Executive; Mr B. Currie, Project Director; Mr C. Marriott, Deputy Director of Finance; Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes).

Apologies: Councillor G. Gordon, 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.

33. Scottish Hospitals Inquiry – Response

33.1 Ms Goldsmith presented the previously circulated paper which accompanied the draft response to the Inquiry's Request for Information No.2 and on Question 6.3 of Request for Information No.1 and invited comments on the draft response.

33.2 Mr McCann had previously submitted some suggested formatting and grammar corrections to the document which had been accepted. Some further formatting, clarification and interpretation amendments and revisions to the document were proposed and agreed.

33.3 Ms Goldsmith agreed to discuss the proposed changes and revisions with the CLO and revise the response accordingly. The response was due to be submitted to the Inquiry Team on 1 October 2021.

33.4 Subject to these changes to the document, members accepted the recommendations laid out in the paper, accepted significant assurance and agreed that Ms Goldsmith could submit the revised document to the Inquiry. Members thanked Ms Goldsmith and Mr Currie and their teams for their hard work in bringing such a dertailed and comprehensive response together.

34. Date of Next Meeting

34.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 13 October 2021**.

35. Meeting Dates in 2021

35.1 Further meetings in 2021 would take place on the following dates:
- 17 November 2021.

Chair Approved 17.11.21

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 9.30 on Wednesday 28 July 2021 via Microsoft Teams.

Present: Mr W. McQueen, Non-Executive Board Member (Chair); Ms J. Clark, Partnership Representative; Ms T. Gillies, Medical Director; Ms C. Hirst, Non-Executive Board Member; Ms K. Kasper, Non-Executive Board Member; Ms C. McDowall, Partnership Representative; Professor A. McMahon, Executive Nurse Director.

In attendance: Mr J. Crombie, Deputy Chief Executive; Ms K. Davidson, Senior Clinical Pharmacist (observing); Ms J. Duncan, Head of Recruitment; Ms R. Kelly, Deputy Director of Human Resources; Ms H. Greig, Workforce Development Administrator; Ms B. Pillath, Committee Administrator (minutes).

Apologies: Ms J. Campbell, Chief Officer, Acute Services; Ms H. Fitzgerald, Partnership Representative.

Chair's Welcome and Introductions

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

11. Youth Network

11.1 The chair welcomed Ms Greig to the meeting and she gave a verbal presentation. There were 90 members of the youth network on the distribution list and although engagement had decreased during the last year it was expected that this would improve again when meetings in person were possible. Mr Crombie had met with the youth network and noted the importance of getting young people involved with the NHS to improve workforce for the future.

11.2 Ms Butler noted that all the networks were currently at an early stage and were analysing the data and trends to identify areas for improvement for staff experience. In the future this data and the networks could also be used to identify improvements to patient experience.

12. Minutes and Action Note of the Previous Meeting of the Staff Governance Committee held on 26 May 2021

12.1 The minutes from the meeting held on 26 May 2021 were approved as a correct record.

12.2 Members noted the previously circulated updated cumulative action note.

13. Matters Arising

13.1 Equal Pay Statement

13.1.1 In relation to item 4.4.3 of the minutes of the meeting on 26 May 2021, Ms Kelly advised that GP salaries were at an average hourly rate of £31 for female and £41 for male salaried GPs. The discrepancy was due to the fact that many female GPs were younger and are further down on the national salary scale, and many male GPs were older and had moved from the old Trust fund salary on protected pay.

13.2 Workforce Report – Agency Hours

13.2.1 In relation to item 6.2.2 of the minutes of the meeting on 26 May 2021, Ms Kelly advised that the costs of agency staff hours had increased because of additional agency hours worked due to the vacancy rate amongst bank staff. The spend had decreased again in more recent reports.

14. Staff Experience

14.1 Advancing Equalities Staff Network Action Plans – Update

14.1.1 Ms Kelly presented the previously circulated paper. Ms Butler noted that in order to support the networks and allow them to contribute to policy, there may be ways for executive and non executive directors to get involved.

14.1.2 The leadership network was voluntary for staff and there were around 500 members. For the system wide leadership, over 120 members of staff are identified as leaders.

14.1.3 Ms Kelly advised that the intranet was up to date with information about the networks and how to join them, and more work would be done on raising awareness among staff. Each of the networks had their own branding.

14.1.4 In response to a question about measuring the outcomes and impact of the staff network plans, Ms Butler advised that the networks were at the early stage of considering recruitment data and employee relations case work for any differences in outcome for different groups of staff. This work would lead to the development of an employment matrix which could then be used as a baseline for measuring any improvement. Ms Hirst suggested that it would be useful to collect data from an early stage on outcomes and qualitative measures.

14.1.5 Members accepted the recommendations laid out in the paper.

14.2 Whistleblowing Report

14.2.1 Ms Kelly presented the previously circulated paper. Ms Kasper added that Board was in a good position in terms of implementation of the whistleblowing requirements and that it was good that early work was being done with primary care practices. The next step would be to document the process and to put into place processes to ensure that the data returned was analysed and used for organisational learning. Demonstrating that whistleblowing had made a positive impact would encourage those with concerns to come forward.

14.2.2 It was noted that regarding the risk section of the paper, the risk that if robust methods for considering staff concerns and feedback were not in place then any problems with staff actions in acute or primary care areas would not be resolved and this would affect the morale of staff should also be stated.

14.2.3 The connection between staff governance and patient safety was noted. There were regular discussions about the remit cross over between the Healthcare Governance Committee and the Staff Governance Committee so that relevant issues were shared. All incidents were also discussed at the Patient Safety and Experience Action Group at executive level and it would be decided there if consideration was required at a Governance Committee.

14.2.4 So far there had been 8 whistleblowing cases. Each case closure was signed off by the nurse director and the medical director who could raise any concerns at the Healthcare Governance Committee and share outcomes as appropriate.

14.2.5 Members accepted the recommendations laid out in the paper and accepted moderate assurance that processes were in place for NHS employed staff to raise concerns and limited assurance that these processes were in place in primary care practices.

14.3 Speak Up Report

14.3.1 Ms McDowall presented the previously circulated paper. She advised that turnover amongst the speak up advocates was due to maternity leave, secondments and staff taking new roles, and was not a concern. Staff picked up cases as and when they had capacity but continued to engage and to promote speak up throughout.

14.3.2 There were currently 25 speak up advocates but there were plans to engage with the staff networks to try to increase the diversity of this group.

14.3.3 Engagement with the speak up process varied across areas and more work was required to ensure that new managers were updated on this by engaging with different management meetings and the leadership group. An induction programme for new managers which stopped at the time of covid in March 2020 would be restarted and this would include speak up.

14.3.4 In response to a question as to whether there was an overall system to analyse and learn from all patient and staff feedback including complaints, grievances, whistleblowing and speak up, Ms Gillies advised that the this role was carried out by the executive team at the Patient Safety and Experience Action Group (PSEAG) which looked at clinical and feedback data along with internal and external assurance reports and individual cases, analysing trends. Concerns were then brought to the governance Committees. The PSEAG meetings were also minuted.

14.3.5 Members accepted the recommendations laid out in the paper.

14.4 iMatter update

14.4.1 Ms Kelly presented the previously circulated paper. The information in the paper about participation from different areas was available to directors who could focus on encouraging participation in the relevant areas.

14.1.2 Members accepted the recommendations laid out in the paper.

15. Assurance and Scrutiny

15.1. Corporate Risk Register
Management of Violence and Aggression Risk 3455

15.1.1 Professor McMahon presented the previously circulated paper. It was noted that the problem with a lack of new work based advisors coming forward for the programme was limited to certain areas and would be followed up.

15.1.2 It was noted that the identicom devices were one part of the support and protection that is available for staff, and they were rarely activated. More detail would be available on the use of these devices in the internal report.

15.1.3 Staff were asked to report all violence and aggression incidents of any level of harm on Datix and there had been no evidence of any increase in incidents associated with staffing pressures currently either on Datix or from feedback received on walkarounds.

15.1.4 It was suggested that the risk profile given in the paper should include the risk to staff as well as the risk of being found non compliant.

15.1.5 Members accepted the recommendations laid out in the paper and accepted moderate assurance on the processes in place and limited assurance on the implementation of the actions.

Nursing Workforce Safe Staffing Risk 3828

15.1.6 Professor McMahon gave a verbal update. The highest pressures were at St John's Hospital with over 30 beds closed over the past few weeks due to lack of staffing. Some beds had also been closed at the Western General Hospital and there were also pressures at the Royal Infirmary.

15.1.7 The vacancy rate was similar to usual. The sickness rate went up to 7.7% but was reducing again. The need for staff to self isolate as community covid contacts was adding pressure and staff had been reluctant to take on extra shifts through bank and agency. Staff were being moved to different areas to ensure appropriate skill mix but staff were tired; management had reported some staff refusing to move or going off sick. There was a similar situation across the UK and in NHS Scotland, in other sectors as well as health.

15.1.8 Staffing pressures would be discussed at a private session of the Board the next week and were being monitored at whole system Gold meetings three times per week currently.

15.1.9 A Scottish Government policy statement recommended that staff identified as covid contacts who had been fully vaccinated, were asymptomatic and had received a negative test result could return to work, but this was voluntary until 9 August 2021. 467 band 5 nursing posts and 50 band 5 midwifery posts would be filled on 6 August 2021. Around 40 staff would be starting on the band 4 support staff training programme in September 2021. The volunteer programme was going well.

15.1.10 The nursing vacancy rate was normally around 5% in Lothian, which was a better position than many other boards. Recruitment was mainly of newly graduated nurses once per year. The Scottish Government were in discussion about increasing nursing training places, but this would be a longer term investment with nurses become qualified four years later.

15.1.11 Ms Butler advised that international recruitment was now being actively pursued specifically for theatres where there was a vacancy rate of 8.6%. The recruitment team was working with the Yeovil NHS Trust in England who had experience in international recruitment. The Scottish Government was also putting in place a National Workforce Sustainability Centre for international recruitment, but this would not be ready for some time.

15.2 Health and Safety Assurance

15.2.1 Ms Gillies presented the previously circulated paper. Regarding the need for improvement in investigation of adverse events Ms Gillies advised that the quality directorate supported training; the assurance team were now giving that support and improvement was expected. This would focus on analysis of why incidents happened rather than what happened.

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

15.3 Occupational Health and Safety Annual Report

15.3.1 Ms Gillies advised that this paper would be resubmitted to the next meeting. **TG**

15.4 Physiological Services

15.4.1 Ms Gillies presented the previously circulated paper. The audiology audit and actions would be completed before moving on to the next stage which would include consideration of engagement with the relevant bodies including Partnership. In England physiologists were a CQC registered workforce which had different mandatory standards than Healthcare Improvement Scotland.

15.4.2 Quality management in the department varied by role and some was internal. Regarding the risk laid out in the paper, Ms Gillies advised that the complaint revealed that there was no robust governance and it was therefore unclear what the risk was and what improvements were required. This was complex as it was regarding specialist interpretation of tests where the team had learned from one another without external input but were expert in this area. The risk was held by

Children's Services and Ms Gillies agreed to check whether this was cited on the risk register. **TG**

15.4.3 Following the outcome of the audit a further paper would be brought to this Committee focussing on training, recruitment and retention and support for physiologists in practice. A paper on the clinical aspects would also be brought to the Healthcare Governance Committee, which had already received a background paper. **TG**

15.4.4 Members accepted the recommendations laid out in the paper with the replacement of recommendation 2.3 to 'review existing quality management systems and make proposals for improvement.'

15.5 Staff Governance Monitoring Framework

15.5.1 Ms Kelly presented the previously circulated paper. Members accepted the recommendations laid out.

16. Sustainable Workforce

16.1 East Regional Recruitment Transformation

16.1.1 Ms Duncan presented the previously circulated paper. The job evaluation process had gone well and tax issues with some staff pay were resolved quickly. Members accepted the recommendations laid out in the paper and asked for an update on progression at the end of the year. **JB**

16.2 Workforce Report

16.2.1 Ms Kelly presented the previously circulated paper. The report was in a new format and included extra information on bank and agency staffing.

16.2.2 There was now limited organisational level reporting for LearnPro following the purchase of an additional function on the software. This showed that compliance with the fire safety mandatory training was at 57% and healthcare associated infection mandatory training at 60%. Clinical staff were to be asked to focus on these two areas while non clinical staff would focus on improvement in compliance overall. Staff would also be asked that frequency of appraisals for both groups return to usual following the pause during covid.

16.2.3 Members accepted the recommendations laid out in the paper.

17. For Information and Noting

Members noted the following previously circulated papers for information:

17.1 Staff Governance Work Plan 2021/22;
17.2 Staff Governance Assurance Statement 2021/22;
17.3 Minutes of the Workforce Planning and Development Programme Board held on 25 May 2021.

18. Reflections on the Meeting

18.1 There would be further discussion regarding the crossover of remit between the Healthcare Governance Committee and the Staff Governance Committee by the chairs of these groups.

19. Date of Next Meeting

19.1 The next meeting of the Staff Governance Committee would take place at 9.30 on Wednesday 20 October 2021.

20. Further Meeting Dates in 2021

20.1 Meetings would take place on the following dates in 2021:
- 15 December 2021.

Signed by Chair
20-10-2021

Edinburgh Integration Joint Board

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 17 August 2021

Held remotely by video conference

Present:

Board Members:

Councillor Ricky Henderson (Chair), Angus McCann (Vice-Chair), Sam Abushal (substituting for Ian McKay), Councillor Robert Aldridge, Bridie Ashrowan, Colin Beck, Carl Bickler, Heather Cameron, Councillor Phil Doggart, Christine Farquhar, Helen FitzGerald, Councillor George Gordon, Ruth Hendery (from item 2 onwards), Kirsten Hey, Martin Hill, Jackie Irvine, Grant Macrae, Jacqui Macrae, Allister McKillop, Moira Pringle, Peter Murray and Richard Williams.

Officers: Matthew Brass, Sarah Bryson, Nikki Conway, Tom Cowan, Tony Duncan, Rachel Gentleman, Beth Hall, Angela Ritchie and Hazel Stewart.

Apologies: Ian Mackay, Councillor Melanie Main, Judith Proctor and Emma Reynish.

1. Appointments to the Edinburgh Integration Joint Board and Committees

The Board was presented with a report informing members of changes in membership.

Decision

1) To note that the NHS Lothian Board had agreed to reappoint Richard Williams as a voting member of the Joint Board, with effect from 1 August 2021.

2) To note that the NHS Lothian Board had agreed to appoint Siddharthan Chandran as a voting member of the Joint Board, with effect from 1 August 2021.

3) To appoint Siddharthan Chandran as a voting member of the Strategic Planning Group and the Performance and Delivery Committee.

4) To appoint Emma Reynish as a non-voting member of the Joint Board and to the Performance and Delivery Committee.

5) To re-appoint Ian McKay and Jacqui Macrae as non-voting members of the Joint Board.

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

2. Bed Based Care – Phase 1 Strategy

The Board agreed to hear three deputations from Unison, Edinburgh Trade Union Council and Unite.

2.1 – Deputation – Unison

The deputation made the following key points:

- Concerns were expressed regarding the public consultation and whether the IJB could undertake such activity.
- Concerns regarding the unknown outcome for staff – including not offering voluntary early retirement – were expressed. A full breakdown of staff destinations after care home closures was requested to be presented at the next Board meeting.

2.2 – Deputation – Edinburgh Trade Union Council

The deputation made the following key points:

- The deputation hoped to receive a full response to questions and points raised through their deputation at the June Board meeting in the report presented to the September meeting. Most significantly, they requested a breakdown of the lessons learnt from Covid-19 and how these would help inform the process of moving patients to different homes.
- Concerns were expressed over the lack of will to engage in public consultation, and requests were made to follow good practice consultation and include Trade Unions as well as the public and staff directly.
- The deputation asked the Board to consider the impact of making radical changes to the social care setting in Edinburgh at a time where the national social care system was under review.

2.3 – Deputation – Unite

The deputation made the following key points:

- Concerns were expressed regarding the lack of public consultation up to this point, with decisions being made without any form of engagement.

The lack of appetite for public consultation was noted to be of concern of Unite and the staff represented.

- The deputation requested that – although recognising Care at Home was the preferred option as we emerged from Covid-19 – that care home care remained an option to families.

2.4 Report by the Chief Officer, Edinburgh Integration Joint Board

The Board was presented with an update report on the progress of the bed based care (phase 1) activities. Specifically, the Board was updated on the points that were agreed to be addressed after the June Board meeting, which were to be undertaken before any final decision was made. These included; a final Integrated Impact Assessment (IIA), engagement with trade unions, consultation with key stakeholders, an investment plan for Care@Home services, and an update on workforce planning.

Decision

1) To note the progress made since the last meeting on 22 June in response to the amendment in relation to item 7.1 Bed Based care – Phase 1 Strategy, which includes the updates on:
    - The actions requested by the EIJB as set out in the amendment;
    - Data and modelling;
    - Potential public consultation requirements.
2) To commit to a public consultation exercise once the legal advice had been received.
3) To circulate legal advice specifically relating to the IJB undertaking public engagement once received.
4) To include Climate Change specialists in the IIA stakeholder groups.

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

3. Minutes

The minute of the Edinburgh Integration Joint Board meeting held on 22 June 2021 was presented to the Board for approval as a correct record.

Decision

To approve the minute of the Edinburgh Integration Joint Board of 22 June 2021 as a correct record.

4. Rolling Actions Log

The rolling actions log updated to August 2021 was presented to the Board.

Decision

1) To agree to close the following actions:

- Action 2 – Edinburgh Integration Joint Board Risk Register – Referral from the Audit and Assurance Committee.
- Action 3 – Financial Update.

2) To note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted)

5. Royal Edinburgh Hospital – Initial Agreement for the Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit and the Initial Agreement for an Integrated Mental Health Rehabilitation and Low Secure Unit

The Board was asked to support an Initial Agreement (IA) for The National Intellectual Disability Unit (NIDAIPU) and an Integrated Mental Health Rehabilitation and Low Secure Unit prior to submission to the Scottish Government.

The Royal Edinburgh Hospital (REH) Modernisation Project was initially approved by the EIJB in May 2018 and the Strategic Planning Group supported an interim report in March 2020 which included a reduction in learning disability beds from 15 to 10.

Moving forward, the EHSCP would continue to support the REH Programme Board in the furtherment of the business case.

Decision

1) To note the reduction in LD bed numbers from 15 to 10.

2) To approve the IAs at appendices 1 and 2 to the report by the Service Director Strategic Planning.3) To acknowledge the continued involvement of EHSCP officers in the development of the business case.

4) To circulate an updated Appendix 2 to Board members as soon as possible.

5) To circulate a briefing before the next meeting of the Board to address issues raised with the Initial Agreements.

(Reference – Report by the Head of Strategic Planning, EHSCP, submitted)

6. 2030 Climate Strategy

The Board heard a presentation on the draft 2030 Climate Strategy for Edinburgh from the Policy and Insight team of the City of Edinburgh Council. The slides provided members with an overview of the activity Council partners could get involved in to help contribute to the overall goal of achieving Net Zero by 2030, as well as several case studies where different Council partners had already contributed to these plans.

Decision

To note the presentation.

7. Financial Update

The financial performance of delegated services for the first three months of the year was presented to the Board. The report gave members an overview the financial position of both the Council and NHS Lothian as at June 2021, with the Council reported to have an overall overspend of £4.5m, and NHSL reported to have a £0.1m overspend. Members noted that efforts were ongoing to achieve financial balance.

Decision

1) To note the financial position for delegated services to 30 June 2021.

2) To note that additional funding would be recognised once the Scottish Government has considered the mobilisation plans submitted.

3) To note the ongoing tripartite discussions, led by the Chief Officer, to deliver financial balance.

(Reference – Report by the Chief Finance Officer, Edinburgh Integration Joint Board, submitted)

8. Financial Regulations – Referral from the Performance and Delivery Committee

Following consideration at the Performance and Delivery Committee Meeting in June 2021, the Financial Regulations were presented to the Board for adoption. The refreshed Regulations were more tailored to the needs of the EIJB and shifted from a more Council-based approach as adopted in previous years.

Decision

To adopt the Financial Regulations as laid out in the Appendix to the report.

(Reference – Performance and Delivery Committee of 9 June 2021, item 7; report by the Chair, Performance and Delivery Committee, submitted)

9. Annual Review of Standing Orders

The Board were presented the EIJB's Standing Orders for review. To be reviewed annually, the Board noted the Standing Orders remained fit for purpose and allowed sufficient flexibility for both physical and virtual meetings.

Decision

1) To note that the Standing Orders of the Integration Joint Board remained fit for purpose and to agree that no changes require to be made.

2) To note that the next annual review of the Standing Orders would be presented to the IJB in August 2022.

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

10. Committee Updates

A report was presented which provided an update on the work of the IJB committees which had met since the last Board meeting. In addition to the summary report, draft minutes of the Audit and Assurance Committee, Clinical and Care Governance Committee, Performance and Delivery Committee and the Futures Committee were submitted for noting.

Decision

To note the update and the draft minutes of the IJB Committees.

11. Mobile Workforce Solution for Homecare and Reablement

The Board resolved that the public be excluded from the meeting during consideration of the item of business on grounds that it involved the disclosure of exempt information as defined under Standing Order 5.9.

The Board were asked to approve the mobile workforce solution for homecare and reablement. The solution of using Totalmobile would support service redesign, increase efficiency and act as a catalyst to improve system wide performance.

Decision

1) To approve the business case which identified Totalmobile as the recommended solution to supersede the legacy system Webroster.
2) To approve the accompanying CR218 (Option 2) Microsoft Licencing for frontline workers.
3) To note that key performance measures were identified but more work was required to gather baseline data and develop a detailed evaluation framework.
4) To instruct the Chief Officer to work with colleagues in the City of Edinburgh Council to secure the required capital funding.
5) To issue the direction to City of Edinburgh Council attached at Appendix 1 to the report by the Chief Officer.

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

Edinburgh Integration Joint Board

Minute

Edinburgh Integration Joint Board

2.30pm, Tuesday 28 September 2021

Held remotely by video conference

Present:

Board Members:

Councillor Ricky Henderson (Chair), Angus McCann (Vice-Chair), Councillor Robert Aldridge, Bridie Ashrowan, Colin Beck, Carl Bickler, Heather Cameron, Councillor Phil Doggart, Christine Farquhar, Helen FitzGerald, Councillor George Gordon, Ruth Hendery, Grant Macrae, Jacqui Macrae, Allister McKillop, Peter Murray, Moira Pringle, Judith Proctor, Emma Reynish and Richard Williams.

Officers: Matthew Brass, Jane Brown, Jessica Brown, Andrew Coull, Ann Duff, Tony Duncan, Rachel Gentleman, Elisa Giannulli and Hazel Stewart.

Apologies: Kirsten Hey, Martin Hill, Jackie Irvine and Ian Mackay

1. Bed Based Care – Phase 1 Strategy

The Board agreed to hear three deputations from Unite, Edinburgh Trade Union Council and Unison.

1.1 – Deputation – Unite

The deputation made the following key points:

- The deputation requested that the Board suspend any decision on the four care homes noted in the report until after the public consultation.
- The deputation requested that the Board ensured the consultation would be undertaken in an open and meaningful manner that can help to shape future proposals.
- More work was requested to complete impact assessments on those who have protected characteristics or of a socioeconomic disadvantage.

- The deputation requested that the Board ensured care providers that staff would benefit from fair pay and fair conditions moving forward.

1.2 – Deputation – Edinburgh Trade Union Council

The deputation made the following key points:

- The deputation requested that the EIJB ask the City of Edinburgh Council to carry out the consultation on their behalf.
- Concerns were raised over the EIJB's ability to undertake a consultation as they would not consider staff or public concerns.
- Concerns were raised over the shift from public to private sector care due to their poor reputation for working conditions.

1.3 – Deputation – Unison

The deputation made the following key points:

- The deputation proposed that the EIJB should immediately recruit nursing staff for Drumbrae, which would allow HBCCC patients to fill the vacant beds in the home and would still allow Liberton Hospital to close as planned as well as reduce HBCCC in remaining NHS units.
- The deputation requested that the EIJB abandon the closure of Ferryfield House which could accommodate the mentioned 68 HBCCC patients and allow Ellen's Glen and Findlay House to provide intermediate care.

1.4 – Report by the Chief Officer, Edinburgh Integration Joint Board

The Board was presented with an update on the work completed in order to aid decision making on the Bed Based care (phase 1) proposals. The report presented members with the outcomes of; Integrated Impact Assessments, engagement with Trade Unions, consultation with key stakeholders, community infrastructure and investment plan, demand profiling, modelling and projections, workforce planning, and the public consultation requirements.

Decision

1) To decommission the residential care model provided at Drumbrae Care Home and direct the re-provisioning of Hospital Based Complex Care (HBCCC) services within that facility.
2) To decommission intermediate care beds currently provided at the remaining wards at Liberton Hospital and to direct the re-provisioning of these within a reconfigured number of beds within the remaining HBCCC estate.
3) To decommission HBCCC beds provided at Findlay House and Ellen's Glen House and direct the re-provisioning of these within the former residential care home facility in Drumbrae.
4) To commission Intermediate Care beds within the bed base remaining at Ellen's Glen House and Findlay House.

5) To decommission the HBCCC beds provided at Ferryfield House, noting this will enable a withdrawal from the lease at intended break point and decommission the service provided there by October 2023.
6) To request an update to the October meeting of the EIJB on the extent of the consultation exercise including the engagement with relevant stakeholders.
7) To agree that the Chair and Vice-Chair would lead on providing regular updates to Board members on the consultation exercise and explore the possibility of circulating these updates to wider, interested parties including the staff, patients and families at Drumbrae Care Home.
8) To agree to establish a semi-formal arrangement between the Chair, Vice-Chair and the Trade Unions in order to maintain a discourse surrounding the formulation of the consultation framework.
9) To ensure throughout the work of the Bed Base Care Strategy that the continued modelling of population care needs is taken to provide assurance and assist with decision making for future of the EIJB.

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

3. Membership Proposal – Referral from the Strategic Planning Group

The Board was presented with a referral report from the Strategic Planning Group on the proposal to appoint a representative of the Edinburgh Association of Community Councils (EACC) to the Group.

Decision

To agree to continue the report to the October 2021 Board meeting in order to seek further information on how the Edinburgh Association of Community Councils would involve, represent and communicate to communities throughout Edinburgh.

(Reference – Strategic Planning Group of 18 August 2021, item 4; Report by the Chair, Strategic Planning Group, submitted)

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within VIRTUAL MEETING ROOM, on 21 SEPTEMBER 2021.

Present

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

Non-Voting Members – Karen Adamson, Lesley Cunningham, Elaine Duncan, David Huddlestone, Jo MacPherson, Alan McCloskey, Patrick Welsh and Alison White

Apologies – Steven Dunn and Ann Pike

In attendance – Colin Briggs (NHS Lothian), Neil Ferguson (NHS Lothian), Hamish Hamilton (West Lothian HSCP Business Partner), Carol Holmes (NHS Lothian), Lorna Kemp (Project Officer), Yvonne Lawton (Head of Strategic Planning and Performance), Tracey McKigen (NHS Lothian), James Millar (Standards Officer), Greg Stark (NHS Lothian), Fiona Wilson (Head of Health) and Linda Yule (Chief Nurse)

The Chair thanked Harry Cartmill for chairing the IJB for the past two years and for his guidance in anticipation of the Chair rotation on 21 September 2021.

1 DECLARATIONS OF INTEREST

There were no declarations of interest made.

2 MINUTES

The Board approved the minutes of its meeting held on 10 August 2021.

3 MINUTES FOR NOTING

a The Board noted the minutes of the West Lothian Integration Joint Board Audit Risk and Governance Committee meeting held on 17 June 2021.

b The Board noted the minutes of the West Lothian Integration Joint Board Strategic Planning Group held on 27 July 2021.

4 MEMBERSHIP & MEETING CHANGES

The IJB agreed the following:

- To appoint Karen Adamson to the IJB as non-voting member (replacing Rohana Wright) as of 1 August 2021.
- To appoint Lesley Cunningham to the IJB as non-voting member

(replacing Caroline McDowall) as of 3 September 2021.

- To reappoint Ann Pike to the IJB as non-voting member as of 3 October 2021.
- To appoint Lesley Cunningham to the Audit, Risk and Governance Committee and the Strategic Planning Group.
- To appoint Katharina Kasper as Strategic Planning Group Chair.

5 UPDATE ON TEMPORARY CLOSURE OF ST MICHAELS HOSPITAL & STAFFING PRESSURES

The Board considered a report (copies of which had been circulated) by the Head of Health providing a situational update relating to the temporary closure of St Michael's Hospital in August 2021. The report also outlined future decision-making proposals for St Michael's by taking into account the ongoing, wider bed-based review of current and future demand that was part of the transformation work commenced in May 2021. Additionally, the report provided an assurance to the IJB that options were being fully evaluated through an assessment framework that included detailed data analysis.

It was noted that the most important aspect of the process going forward was to communicate its decision-making process to the public, staff and stakeholders. Officers were asked to provide an update at the November IJB meeting.

Decision

1. To approve the terms of the report.
2. An update report to be presented at the November meeting of the IJB.

6 MENTAL WELFARE COMMISSION REPORT: AUTHORITY TO DISCHARGE

The Board considered a report (copies of which had been circulated) by Greg Stark, Senior Development Manager, presenting the Mental Welfare Commission Report: *Authority to Discharge*.

It was recommended that the Board note the contents of the report.

Decision

To note the terms of the report.

7 INITIAL AGREEMENTS TO SUPPORT DEVELOPMENT OF ROYAL EDINBURGH CAMPUS

The Board considered a report (copies of which had been circulated) by Colin Briggs, Director of Strategic Planning, NHS Lothian seeking approval to take forward Initial Agreements for developments at the Royal Edinburgh Hospital Campus, Edinburgh. The specific proposals had been developed with the WLHSCP management team and the capacity identified had been calculated by the WLHSCP management team. These proposals included: Provision of low-secure/rehabilitation capacity for people receiving inpatient treatment for mental illness; Provision of inpatient capacity for people with learning disabilities, who cannot be cared for in the community.

It was recommended that the Board:

1. Note the strategic case outlined in the initial agreement, and how this linked to the WLIJB vision for future care in this area;

2. Note the collaborative work undertaken by the WLHSCP team and NHS Lothian to identify the required capacity;

3. Note the work undertaken to develop models and capacity for future delivery of care and support within West Lothian; and

4. Agree that NHSL should progress this case.

Decision

To approve the terms of the report.

8 NATIONAL CARE SERVICE CONSULTATION RESPONSE

The Board considered a report (copies of which had been circulated) by the Project Officer providing an overview of the Scottish Government's consultation *A National Care Service for Scotland* and providing a proposed response to the consultation for discussion. The Board was asked to carefully consider whether the proposed response reflected the collective view of the Board and to draw attention to any section that should be revised if a collective response was agreed to be submitted.

It was recommended that the Board:

1. Note that the Scottish Government was consulting on the development of a National Care Service for Scotland which was anticipated to be operational by March 2026;

2. Note that the deadline for the submission of responses to the consultation had been extended to 2 November 2021;

3. Note that a proposed response had been drafted following the Board's Development Session on 6 September and in consultation with colleagues in the council and the partnership;

4. Note that the scope of the National Care Service (NCS) outlined

within the consultation extended beyond the recommendations of the Independent Review of Adult Social (IRASC);

5. Note that the proposals outlined within the consultation document would have significant implications for IJB's, councils, health boards and local accountability; and

6. Discuss the proposed response and agree if a collective response should be submitted to the consultation on behalf of the Board.

After discussion, it was agreed that a small working group comprising the Chair, Vice Chair, one elected member, one NHS Lothian member and two non-voting members to be formed to consider a response to the consultation. The group would request an extension to the consultation deadline and another draft would be prepared for either the IJB to sign off at its November meeting or for the Chief Officer to finalise and approve response under delegated powers if no deadline extension was granted.

Decision

1. To approve the terms of the report.

2. A working group to be formed to consider a response to the consultation.

3. A request for extension to the consultation deadline to be sent to the Scottish Government.

4. The Chair and Vice Chair to prepare another draft for the IJB to sign off at its November meeting; if no extension granted, the Chief Officer to finalise and approve the response under delegated powers.

9 UNACCEPTABLE ACTIONS POLICY

The Board considered a report (copies of which had been circulated) by the Project Officer presenting a draft Unacceptable Actions Policy for approval as required by the Scottish Public Services Ombudsman's (SPSO) new Model Complaints Handling Procedure, adopted by the Board in August 2021.

It was recommended that the Board:

1. Note that the Board adopted the SPSO's new Model Complaints Handling Procedure (CHP) on 10 August 2021;

2. Note that an Unacceptable Actions Policy was required to be developed in line with the Model CHP; and

3. Agree the proposed Unacceptable Actions Policy and approve its publication alongside the Board's revised CHP.

Decision

To approve the terms of the report.

10 LOCAL CODE OF CORPORATE GOVERNANCE - REVIEW

The Board considered a report (copies of which had been circulated) by the Standards Officer reviewing the Board's Local Code of Corporate Governance as instructed in September 2019.

It was recommended that the Board:

1. Note the present structure and content of the Local Code of Corporate Governance and the process followed for its use in governance reporting;

2. Note that the Code had been last reviewed in September 2019 when the Board had instructed a further review in 2021/22;

3. Consider and review the Code and in particular agree the following recommendations which were endorsed by the Audit Risk & Governance Committee on 7 September 2021:

a) To agree that there were no changes required to the standards in the Code or its overall structure and content;

b) To continue the practice of monitoring progress on governance issues and populating the Code through the integrated senior management team (paragraph 4);

c) To continue the practice of reporting the populated Code once each year and progress on governance issues twice each year to the committee to inform the annual governance statement (paragraph 6); and

d) To agree any future review of the Code be carried out by the committee as part of the annual governance reporting process rather than conducting and reporting a separate periodic review, with the committee's conclusion reported to the Board as part of the annual report on the Board's accounts and external audit report (paragraph 7).

Decision

To approve the terms of the report.

11 AUDIT OF THE 2020/21 ANNUAL ACCOUNTS

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer advising members on the outcome of the 2020/21 audit and providing a summary of the key points arising from the Auditor's Annual Report.

It was recommended that the Board:

1. Consider the Auditors' 2020/21 Annual Audit Report including the management action plan;

2. Note that the Audit, Risk and Governance Committee had reviewed the Annual Accounts and Annual Audit report on 8 September 2021 and had no recommendations for the Board; and

3. Agree the audited 2020/21 Annual Accounts for signature.

Decision

To approve the terms of the report.

12 2021/22 FINANCE MONTH 4 UPDATE AND QUARTER 1 FORECAST

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2021/22 budget forecast position for the IJB delegated health and social care functions reflecting the outcome of the Quarter 1 monitoring.

It was recommended that the Board:

Consider the forecast outturn for 2021/22 taking account of delivery of agreed savings;

Note the currently estimated financial implications of Covid-19 on the 2021/22 budget; and

Note that further updates on the 2021/22 budget position and progress towards achieving a balanced budget position would be reported to future Board meetings.

Decision

To note the terms of the report.

13 CHIEF OFFICER REPORT

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

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

Decision

To note the terms of the report.

14 STRATEGIC COMMISSIONING PLAN UPDATE

The Board considered a report (copies of which had been circulated) by the Head of Strategic Planning and Performance providing an update in relation to strategic commissioning plans and offering assurance to the IJB over progress being made.

It was recommended that the Board:

1. Note progress with the actions detailed in strategic commissioning plans; and

2. Be assured by the progress being reported and where actions were falling behind or at risk be satisfied that planning and commissioning leads were taking appropriate action.

Decision

To note the terms of the report.

15 WEST LOTHIAN CARER STRATEGY PROGRESS UPDATE

The Board considered a report (copies of which had been circulated) by Pamela Main presenting a West Lothian Carer Strategy progress update and reporting how funding from the Carers (Scotland) Act was being utilised.

It was recommended that the Board:

1. Note the content of the report; and

2. Approve the suggested spending options of the Carer (Scotland) Act remaining funding as outlined in section 5.

During discussion, it was noted that efforts should be maximised to ensure carers were aware of all support available to them, and it was agreed that a further progress report would be presented at the November IJB meeting.

Decision

1. To approve the terms of the report.

2. A further progress report to be brought to the November IJB meeting.

16 INTERIM PERFORMANCE REPORT

The Board considered a report (copies of which had been circulated) by the Chief Officer providing a quarterly performance report based on the

latest data available on the Core Suite of Integration Indicators and social care benchmarked data.

It was recommended that the Board note the content of the performance report and confirm assurance.

Decision

To note the terms of the report.

17 IJBS AS CATEGORY 1 RESPONDERS

The Board considered a report (copies of which had been circulated) by the Chief Officer providing information of the inclusion of the IJB as a Category 1 Responder in line with the Civil Contingencies Act 2004 and reporting on the requirements that this inclusion involved.

It was recommended that the Board:

1. Note the information in this paper and be assured that the established governance and management systems were in place to support the Board as a Category 1 Responder; and

2. Agree that the Chief Officer could continue to manage the necessary arrangements relating to this Act on behalf of the Board.

It was agreed that the Chief Officer's report would henceforth include an annual update demonstrating how the IJB had carried out its statutory obligations as responder.

Decision

1. To approve the terms of the report.

2. The Chief Officer's report to include an annual update demonstrating how the IJB has carried out its statutory obligations as responder.

18 WORKPLAN

A workplan had been circulated for information.

Decision

To note the workplan.

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 26 August 2021	2.00pm	Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Carolyn Hirst (Chair)	Councillor Derek Milligan (Vice Chair)	Jock Encombe
Cllr Catherine Johnstone	Angus McCann	Cllr Jim Muirhead
Cllr Pauline Winchester		

Present (non-voting members):		
Morag Barrow (Chief Officer)	David King (Interim Chief Finance Officer)	Hamish Reid (GP/Clinical Director)
Wanda Fairgrieve (Staff side representative)	James Hill (Staff side representative)	Fiona Stratton (Chief Nurse)
Johanne Simpson (Medical Practitioner)	Fiona Huffer (Head of Dietetics)	Keith Chapman (User/Carer)
Lesley Kelly (Third Sector)		

In attendance:		
Mairi Simpson (Integration Manager)	Jill Stacey (Chief Internal Auditor)	Jamie Megaw (Strategic Programme Manager)
Roxanne King (Business Manager)	Debbie Crerar (Lead Physiotherapist)	Sandra Bagnall (Macmillan Programme Manager)
Sandra Wright (Clerk)		

Apologies:		
Tricia Donald	Grace Cowan (Head of Primary Care and Older Peoples Services)	

Midlothian Integration Joint Board

Thursday 26 August 2021

1. Welcome and Introductions

The Chair, Carolyn Hirst, in welcoming everyone to this virtual Meeting of the Midlothian Integration Joint Board, expressed her gratitude and thanks to outgoing Chair, Councillor Catherine Johnstone. She also extended a warm welcome back to David King who would be undertaking the role of Chief Finance Officer on an interim basis whilst Claire Flanagan was on maternity leave.

2. Order of Business

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

3. Declarations of interest

No declarations of interest were received.

4. Minute of previous Meetings

4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 17 June 2021 were submitted and approved as a correct record

4.2 The Minutes of Meeting of the MIJB Strategic Planning Group held on 19 May 2021 were submitted and noted.

4.3 The Minutes of Meeting of the Audit and Risk Committee held on 10 June 2021 were submitted and noted.

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.1 Lothian Strategic Development Framework (LSDF) – Update by Carolyn Hirst, Chair With reference to paragraph 4.2 of the Minutes of the Special Meeting held on 11 March 2021, when the Board had received a presentation from Rebecca Millar, Strategic Program Manager NHS Lothian regarding the strategic development framework which	Agreed that the Chair respond on behalf of the Midlothian IJB that in principle the Board endorsed the direction of travel, but require more time to work on its strategic plan to have a clearer understanding on how this will fit with the NHS Lothian strategic plan before a fuller response could be provided.	Chair	

Midlothian Integration Joint Board

Thursday 26 August 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
looked at their planning strategy for the next 5 years, the Chair advised that she had received a letter asking the Midlothian IJB to endorse a number of 'fixed points' or assumptions underpinning the Framework and to provide clarity on some points relating to future IJB commissioning ambitions by no later than the end of August 2021. The Midlothian Strategic Planning Group had given some consideration to this at their meeting on 11 August – a paper and presentation which was provided to the SPG meeting would be circulated to all Board Members following today's meeting. The intention was to give further regard to the LSDF at a future Board meetings alongside the work on progressing the Board's Strategic Plan. The SPG's view had been that whilst broadly endorsing the fixed points, more time and information was needed before a response could be provided with respect to the detail requested about commissioning. Additionally, Scottish Government had recently published an NHS recovery plan. It set out key actions for the next 5 years aimed at addressing backlogs in health and increasing capacity by 10% by committing £10b in targeted investment for the recovery and renewal of the Scottish Health Service.			
5.2 Chief Officers Report This report provided a summary of the key service pressures and service developments which had occurred during the previous months across health	(a) Noted the issues and updates arising from the Chief Officers Report. (b) Agreed that Jock Encombe be appointed as a member of the Audit and Risk Committee.		

Midlothian Integration Joint Board

Thursday 26 August 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
and social care as well as looking ahead at future developments. Having heard from the Chief Officer, Morag Barrow in amplification of her report, the Board discussed arrangements for the continuing used of Gorebridge Leisure Centre as a vaccination centre, particularly now that the Covid Booster and Seasonal Flu programme was underway. Members also gave consideration to the vaccination programme itself, in particular the inclusion of the younger age groups. With regards the likely impact that seasonal illness/covid would have on staff numbers, arrangements were in hand as part of the Winter Plan to ensure that, as far as it was possible to do so, services would continue to be provided safely. With regards to support for carers, Members were advised that H&SC continued to work closely with partners and also that a large scale survey led by Vocal was underway targeting unpaid carers. It was hoped that this would lead to the carer action group being re-establishing thereby ensuring carers' voices were heard. The report also provided updates on several other issues including: • 2022-25 Strategic Plan progress • Annual Report • Chief Finance Officer cover arrangements • IJB Self-evaluation progress • Workforce			

Midlothian Integration Joint Board

Thursday 26 August 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Finally, approval was sought to appoint Jock Encombe as a member of the Audit and Risk Committee as a replacement for Mike Ash.			
5.3 MIJB Audit and Risk Committee Annual Report 2020-21 – Report by Chief Internal Auditor The purpose of this report was to provide Members with the MIJB Audit and Risk Committee Annual Report 2020/21 which set out how the Committee was performing against its remit based on self-assessments carried out in April 2021. The Chief Internal Auditor, Jill Stacey in presenting the Annual Report to the Board summarised some of the key findings and conclusions contained in the Report, which was designed to provide both assurance to the Board and actions for the Committee to improve its effectiveness. Following which she responded to Members questions and comments.	(a) Approved the MIJB Audit and Risk Committee Annual Report 2020/21; and (b) Noted the increased focus which would be put on risk.		
5.4 IJB Performance Management – Report by Morag Barrow, Chief Officer The purpose of this report was to request the use of MIJB general reserves to fund a fixed term Performance team to develop, implement and monitor performance against the MIJB Strategic Plan and Directions. The report advised that a significant amount of work had been commissioned to develop performance	(a) Agreed to the establishment of a performance group to report into the MIJB (non-statutory initially); and (b) Agreed to resource an additional Programme Manager and Data Analyst to develop, implement and monitor reporting to MIJB from the general reserves.		

Midlothian Integration Joint Board

Thursday 26 August 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
management and reporting infrastructure within the HSCP. This was to support data driven decision making around service development and transformation and also to support a more robust performance reporting overview to the MIJB. In order to develop performance reporting and monitoring further, it was requested that a separate Performance Group be established, supported by an additional Programme Manager, to develop the performance reporting structure for the monitoring of the MIJB Strategic Plan and annual Directions issued to NHS Lothian and Midlothian Council. The Board in considering the proposals detailed in the report discussed the potential use of reserves to drive forward projects to meet strategic ambition and also the need to ensure that the proposed development of a separate performance group did not detract from the Board's own performance monitoring responsibilities nor lead to an over reliance on performance information, to the detriment of such information being appropriately used to help inform good future decision making.			
5.5 Improving the Cancer Journey – Service Update – Report by Sandra Bagnall, Macmillan Programme Manager The purpose of this report was to share information on the progress made by Improving the Cancer Journey (ICJ) service, a Macmillan-funded programme for the Lothians, which went live in March 2021.	(a) Noted the progress made to date. (b) Noted the approach taken to align ICJ with an existing service in Midlothian. (c) Welcomed the monitoring and evaluation plans.		

Midlothian Integration Joint Board

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
The report explained that the service supported people's non clinical needs following a cancer diagnosis and was also open to carers. It currently brings funding of £295,000 into Midlothian, which has been used to secure two additional Practitioners to join Thistle's Wellbeing Service. In addition, a part-time Project Manager was employed and along with the Programme Manager, who support the planning, implementation and service monitoring and evaluation. The funding was secured for four years. Macmillan Programme Manager, Sandra Bagnall in speaking to the report provided the Board with an overview of the progress which had been made since going live in March 2021 and what this contributed to Midlothian. Referrals had increased, with 84% of people referred engaging with the service. Data shows that 70% of people were over the age of 60, with 70% female, under a half were in treatment with 16% having a palliative diagnoses.	(d) Noted the expectations for the service in the first year of operation.		
5.6 IJB Improvement Goal – Report by Jamie Megaw, Strategic Programme Manager The purpose of this report was to update the Board on progress towards achieving the current IJB performance goals and using OutNav to improve understanding of system impact on outcomes. Jamie Megaw was heard in amplification of the report and thereafter responded to Members questions and comments.	(a) Noted the performance against the IJB performance goals; (b) Noted progress to establish an outcomes-focused performance approach in the HSCP; and (c) Agreed to general practice being the subject of a future Development Workshop session.		

Midlothian Integration Joint Board

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Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
The Board in discussing the report, considered the impact of Covid on some services not just in practical terms but also it terms of the public's perceptions. One area which appeared to be affected more that most in this regard was GP practices, who although they had remained open throughout the pandemic were having to deal with a misconception that GPs were closed and face to face appointments were no longer provided. Certainly some aspects had changed, such as the way in which appointments were booked, however the fundamental service itself had not changed. The Board debated whether there was perhaps a communication issue, there being a feeling that mixed and inconsistent messages were not helping the situation. After further discussion, it was felt that this would probably be best dealt with at a Development Workshop session.			
5.7 Long Covid Support in Midlothian – Report by Debbie Crerar, Lead Physiotherapist The purpose of this report was to provide an update to the Board with regards to support for Long Covid in Midlothian. Debbie Crerar, advised that there were a number of different pathways in place in Midlothian where people could access support, but that numbers so far were relatively low. It was highlighted that this may	Noted the service provision for people with Long Covid in Midlothian.		

Midlothian Integration Joint Board

Thursday 26 August 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
change in time, as the long term health impacts of Covid became clearer. This was therefore an ongoing piece of work that would continued to be developed linking in with other services as appropriate.			
5.8 Clinical and Care Governance Group - Report by Fiona Stratton, Chief Nurse The purpose of this report was to provide assurance to the Board regarding the Care and Clinical Governance arrangements within Midlothian Health and Social Care Partnership and to provide an update on the work of the Clinical and Care Governance Group. Chief Nurse, Fiona Stratton was heard in amplification of the report, highlighted in particular the work that had been undertaking at Midlothian Community hospital and the progress made with Lothian accreditation and care assurance standards, where the two wards undertaking there second round had improved their grades.	Noted and approved the contents of the report.		
5.9 The Mental Welfare Commission – Authority to Discharge: Report into decision making for people in hospital who lack capacity – Report by Mairi Simpson, Integration Manager The purpose of this report was to ensure that Board Members were aware of the actions being taken within Midlothian following the most recent Mental Welfare	(a) Noted the content of the report. (b) Noted the Action Plan and that updates on progress against the Plan would be brought to the Board.	Integration Manager	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Commission (MWC) report - Authority to Discharge: Report into decision making for people in hospital who lack capacity. The Board, having heard from Integration Manager Mairi Simpson, who responded to Members questions and comments, considered the report and Action Plan.			

6. Private Reports

No private business to be discussed at this meeting.

7. Any other business

Winter Planning: Noted that there was concern moving into the winter months of how services would cope with the normal winter challenges coupled with the ongoing pressure of Covid and that the Winter Plan would be the subject of a future report. As part of these plans the possible use of reserves on a non-recurring basis had been identified and with the Board's agreement in principle, the Chief Officer proposed bring forward a more detail report to the Special Board meeting on 9 September 2021.

After discussion, the Board agreed to support the principle of reserves being used in this way, subject to a more detailed report. In response to a further point regarding aids and adaptations referrals, the Chief Officer advised that steps were being taken to try and speed up the aids and adaptation process.

I**ndependent Review of Adult Social Care**: Noted that this, along with the newly developed handbook for IJB Members, would be discuss at the next Development Workshop session on 9 September 2021.

8. Date of next meeting

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

- Thursday 9 September 2021 2pm Special Midlothian Integration Joint Board/Development Workshop.
- Thursday 14 October 2021 2pm Midlothian Integration Joint Board

The meeting terminated at 16:19.

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 9 September 2021	2.00pm	Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Carolyn Hirst (Chair)	Cllr Derek Milligan (Vice Chair)	Tricia Donald
Cllr Jim Muirhead	Angus McCann	Cllr Catherine Johnstone
Cllr Pauline Winchester		

Present (non-voting members):		
Morag Barrow (Chief Officer)	David King (Interim Chief Finance Officer)	Fiona Stratton (Chief Nurse)
Wanda Fairgrieve (Staff side representative)	Fiona Huffer (Head of Dietetics)	Marlene Gill (User/Carer) (substitute for Keith Chapman)
Lesley Kelly (Third Sector)		

In attendance:		
Roxanne King (Business Manager)	Mairi Simpson (Integration Manager)	Andrew Henderson (DSO – Observing)
Mike Broadway (Clerk)		

Apologies:		
James Hill (Staff side representative)		

Midlothian Integration Joint Board

Thursday 9 September 2021

1. Welcome and introductions

The Chair, Carolyn Hirst, welcomed everyone to this virtual Special Meeting of the Midlothian Integration Joint Board.

Prior to the commencement of the formal business, the Board, having heard from the Chair, and Wanda Fairgrieve, both of whom paid warm tribute to Tom Waterson who had sadly passed away earlier in the day, paid its respects by observing a minute's silence.

2. Order of Business

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

3. Declarations of interest

No declarations of interest were received.

4. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
4.1 2020/21 Audited Annual Accounts – Report by Chief Officer. The purpose of this report was to present for the Board's approval the Audited Annual Accounts for 2020/21. The report explained that as a statutory body, the IJB was required to produce a set of annual accounts at the end of its financial year (31 March). These accounts were then reviewed by the IJB's external auditors who report their opinion of the IJB's annual accounts to the IJB's Audit and Risk Committee. The Independent auditors have given the accounts an 'unqualified' opinion which means that they meet the	(a). Noted the report of the Independent Auditor and requested the Chief Finance raise the issue of the need to endure the correct use of terminology and the Board's disappointment at amber rating for Value for Money; and (b). Approved the IJB's Annual Accounts 2020/21 and make appropriate arrangements for the document to be signed electronically.	Chief Finance Officer	

Midlothian Integration Joint Board

Thursday 9 September 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
requirements of the regulations and give a fair and true view of the IJB's financial position in 2020/21. The accounts are required to be signed off by 30 September and signed by the Chair of the IJB, the Chief Officer of the IJB, the Chief Finance Officer of the IJB and the Independent Auditor. The Independent Auditors reported their views to the meeting of the IJB's Audit and Risk Committee on 2 September 2020. The IJB's Audit and Risk Committee was satisfied with the report of the Independent Auditor and recommended that the Annual Accounts are approved by the IJB. The Chief Finance Officer in presenting the Annual Accounts to the Board summarised the key findings and conclusions contained in the Annual Audit Report and made particular reference to plans to address issues around Financial Sustainability and Value for Money. He also made mention of the interchangeable used of the terms 'Integrated Joint Board' (IJB) and 'Health and Social Care Partnership' (HSCP), which given that they were two distinctly separate bodies was not always appropriate. There then followed a general discussion on the Annual Accounts during which both Morag Barrow and David King provided clarity on a number of issues in response to Members questions and comments. With regards the amber rating for Value for Money the Board expressed its disappointment that the			

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
decision to exercise powers granted by the Coronavirus (Scotland) Act 2020 to delay publication of the Annual Performance Report for 2020/21, had adversely impacted on this rating.			
4.2 Support to the 2020-21 Winter Plan – Report by Chief Officer. The purpose of this report was to seek the release of £756,000 from the IJB's general reserves to allow the Midlothian Health and Social Care partnership to appoint 20.00 WTE additional Healthcare Support workerd and 1.00 WTE additional admin member of staff. These staff would provide additional support to the HSCP's services during the winter. The report explained that every year, NHS Lothian working with its partners in the IJBs and the Councils prepared a Winter Plan. The Plan was designed to ensure that any additional pressures on the NHS that arise from winter and its impact on the population are matched with the appropriate additional resources. It was clear from early indicators that given the continuing impact of the Covid pandemic that this winter was likely to prove very challenging The Board, having heard from Chief Officer, Morag Barrow, acknowledged the difficulties to recruit on a temporary basis (a one-year contract) and welcomed the decision of NHS Lothian Gold Command to accept the financial risk of appointing these staff on a permanent basis. With regards whether the number involved would be enough to meet the anticipated	Agreed that the IJB will release c. £756,000 of funds from its general reserve over 2021/22 and 2022/23 to allow the HSCP to recruit the additional staff required.	Chief Officer	

Midlothian Integration Joint Board

Thursday 9 September 2021

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
requirements, the Chief Officer explained that the proposed number of staff was based on their best estimates,, and whilst due to the unprecedented nature of the situation it was impossible to be absolutely certain, the position would be kept under close review.			

5. Private Reports

There were no private reports for consideration at this meeting.

6. Any other business

The Board, having noted that this would be Fiona Huffer's last IJB meeting as she would shortly be taking up a new post in West Lothian, joined with the Chair in expressing their thanks to Fiona for all her hard work in support of the Midlothian Integration Joint Board over the years, and wishing her well in her new role.

7. Date of next meeting

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

- Thursday 14 October 2021 2pm Midlothian Integration Joint Board
- Thursday 11 November 2021 1.30pm* Development Workshop
  (Please Note Carefully the earlier start time)

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

The meeting terminated at 2.42pm.

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 16th SEPTEMBER 2021
VIA DIGITAL MEETINGS SYSTEM

Voting Members Present:
Mr P Murray (Chair)
Councillor S Akhtar
Dr P Donald
Councillor N Gilbert
Councillor S Kempson
Dr R Williams
Councillor F O'Donnell (Items 5 – 9)

Non-voting Members Present:
Ms L Cowan
Mr D King
Ms J Tait
Dr C Mackintosh
Mr I Gorman
Mr T Miller
Dr J Turvill

Officers Present from NHS Lothian/East Lothian Council:
Mr P Currie
Ms C Johnston
Ms L Kerr
Ms J Ogden-Smith
Ms C Goodwin
Mr M Kennedy
Ms G Neil

Others Present:
Ms E Scoburgh, Audit Scotland

Clerk:
Ms F Currie

Apologies:
Ms F Ireland
Ms A MacDonald
Ms M McNeill

Declarations of Interest:
None

The members agreed to a change in Agenda order; Item 3 was taken first.

3. CHAIR'S REPORT

Peter Murray informed members of a communication with stakeholders on 1st September 2021 notifying them of the relocation of staff from the Edington Hospital in North Berwick to the East Lothian Community Hospital (ELCH) in Haddington. This action was in response to specific and significant pressures and was designed to ensure the continuity of services within the county. The position was to be reviewed after 12 weeks.

Mr Murray said that he had received a number of communications from individuals regarding the lack of consultation prior to this decision being taken. His response had been that this was a highly unusual set of circumstances which had required urgent action to avoid the situation worsening. This had limited the opportunity for and type of consultation with stakeholders. He said that the subsequent social media response had been concerning and disappointing, as well as being unhelpful to colleagues who were taking difficult decisions to ensure continuity of services and staff safety. He referred in particular to a petition which had been raised suggesting that the Edington Hospital was in line for closure. He assured IJB members that the Edington Hospital was not being closed. He encouraged members to support health and social care staff by countering any inaccurate comments or reports.

The Chair invited Iain Gorman to outline the reasons behind the decision to relocate staff. Mr Gorman provided details of some of the key challenges which had been facing the Health & Social Care Partnership (HSCP) and warned that these challenges were becoming more acute. He referred to increasing COVID-19 cases and the associated pressures on frontline services and the long-term impact on staff who had been dealing with the pandemic for over 18 months. Although the HSCP was working with partners across the sector, it was struggling to manage the pressure and the need to keep key services running. The decision to relocate staff had come from a need to consolidate staffing and maintain services in as safe as way as possible.

Mr Gorman also outlined the pressures facing the Care at Home service and the additional implications for the HSCP and individual care packages if external care providers struggled to deliver their contracted hours. He praised the work of staff to implement the COVID-19 vaccination programme but highlighted proposals to begin vaccinating 12-15 year olds, as well as delivering booster jabs and the winter flu jab programme, as further challenges to resources over the coming months. He advised members that the HSCP had alerted the Scottish Government to their current situation and that they would continue to manage current and future pressures as well as possible.

The Chair asked members to contact Mr Gorman if they had any questions on this issue. He added that it was important to present the decision relating to Edington Hospital within a broader context. He acknowledged the strength of feeling to maintain local services and also the need for Edington Hospital to be part of a broader analysis of care services. However, he wanted to emphasise that the current crisis, and the subsequent decision to relocate staff from Edington Hospital, was separate to that discussion.

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN IJB ON 24th JUNE 2021 (FOR APPROVAL)

The minutes of the meeting on 24th June 2021 were approved.

2. MATTERS ARISING FROM THE MINUTES OF 24th JUNE 2021

The following matters were raised:

Item 8: Dr Richard Williams said he had raised a question regarding his membership of the Change Board and sought advice as to whether his participation was as a GP was appropriate, or whether he was there as a member of the IJB. Mr Murray agreed to seek advice and respond to Dr Williams directly.

Sederunt: Dr Jon Turvill and Mr Thomas Miller left the meeting.

4. CHANGES TO THE MEMBERSHIP OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

The Chief Officer had submitted a report seeking the Integration Joint Board's (IJB) agreement to changes in its non-voting membership.

The Clerk presented the report outlining the background and recommendations.

The Chair asked that a letter of thanks be sent to Paul White expressing the IJB's appreciation for his contributions during his tenure as Third Sector representative. He welcomed the new members and offered his thanks to those members continuing for a further term of office.

The vote was taken by roll call and all of the recommendations were approved unanimously.

Decision

The IJB agreed:

(i) that, with effect from September 2021, Maureen Allan would replace Paul White as a non-voting member and Third Sector representative on the IJB.

(ii) the re-appointment of Dr Jon Turvill and Thomas Miller as non-voting members of the IJB for a further term of office; and

(iii) the appointment of Dr Claire Mackintosh as a non-voting member, to replace Prof. Emma Reynish, effective from August 2021.

Sederunt: Dr Turvill and Mr Miller re-joined the meeting. Mr David King left the meeting.

5. INTERIM APPOINTMENT OF CHIEF FINANCE OFFICER

The Chief Officer had submitted a report updating the IJB on the proposals for the recruitment of the Chief Finance Officer/Section 95 Officer to cover a period of maternity leave.

The Clerk presented the update which followed on from the report considered at the IJB's meeting on 24th June 2021. The recommendation of this report was that the IJB approve the appointment of David King as Interim Chief Finance Officer.

The vote was taken by roll call and the recommendation was approved unanimously.

Decision

The IJB approved the appointment of David King as Interim Chief Finance Officer for the period of Claire Flanagan's maternity leave.

Sederunt: Mr King re-joined the meeting.

6. EAST LOTHIAN IJB 2020/21 ANNUAL AUDIT REPORT

Esther Scoburgh presented the 2020/21 ELIJB Annual Audit Report.

Ms Scoburgh advised members that the report and the ISA 260 (Report Charged to Those with Governance) had been presented to the IJB's Audit & Risk Committee on 14th September and had been agreed and recommended to the IJB. She outlined the content of the audit report which included reviews of the annual accounts; financial management and sustainability; governance transparency and Best Value; as well as the 2020/21 action plan and significant audit risks. The auditors proposed an unmodified opinion meaning that the accounts presented were true and fair and that there were no material misstatements noted in 2020/21. The report also recommended that the medium term financial plan and budgets were revisited to factor in the increased COVID-19 costs and funding and its impact.

She indicated that, as a result of rapid changes in the financial position at year end, a further updated report would be provided showing the finalised position. This would not alter the content of the message but rather provide improved clarity/transparency in the auditors' reporting. She drew members' attention to examples of good practice highlighted in the report and advised that these had been shared with the Audit Scotland national NHS overview team.

Ms Scoburgh referred members to the recommendations contained in the 2020/21 action plan and confirmed that the auditors were satisfied with management responses. She highlighted the key risks identified and the national reports which may be of relevance to IJB members. Finally, she thanked officers for their assistance during the year and in the preparation of this report.

Mr King welcomed the report noting in particular the comments regarding medium term financial planning. He said he was currently working on a post-COVID version of the IJB's 5 year financial plan and this would be brought to the IJB's October meeting along with a report on how to deliver a balanced financial plan.

Dr Richard Williams observed that the audit report was very clearly set out and understandable. He viewed the 'unqualified' audit opinion as meaning that the financial information provided to the IJB during the year was both robust and timely. He thanked the Chief Finance Officer and colleagues for their diligence.

Dr Patricia Donald stated that as chair of the Audit & Risk Committee she was always very impressed by the quality of reporting and level of assurance given, as well as the work done by officers. She also offered her thanks.

The Chair said he would pass on these comments to Ms Flanagan, who was currently on maternity leave, but who had been instrumental in preparing the 2020/21 accounts. He also welcomed the report and noted that the examples of good practice being shared nationally were a further testament to the work of local colleagues. He commented on the challenges of financial planning and said that change would be essential if the IJB was to balance its budget in the medium term.

7. 2020/21 AUDITED ANNUAL ACCOUNTS

The Chief Finance Officer had submitted a report presenting the IJB's annual accounts for 2020/21.

Mr King presented the report advising members that the accounts had been considered and recommended for approval by the IJB's Audit & Risk Committee at its meeting on 14th September. He also advised that the accounts would be signed by Councillor Shamin Akhtar, who latterly held the post of Chair in 2020/21, as the current Chair had been appointed from 1st April 2021.

In response to a question from Councillor Akhtar, Mr King indicated that during the pandemic there were a number of services which were postponed and which had resulted in cost savings. Following remobilisation, these services had restarted and the associated savings were no longer being achieved. This had resulted in increased financial pressures which would be likely to continue in the current financial year. He agreed to provide Councillor Akhtar with a more detailed update following the meeting.

The Chair actively encouraged members to read the accounts, if they had not already done so, as they provided a very good summary of the IJB's work during the previous financial year. He referred in particular to the management commentary which included a thank you to staff across services for their hard work and dedication during such a challenging period. He echoed those thanks resoundingly, on behalf of all IJB members.

The vote was taken by roll call and all of the recommendation was approved unanimously.

Decision

The IJB, having noted the report of the independent auditor, agreed that the annual accounts for 2020/21 could be signed electronically on behalf of the IJB by the Chair, the Chief Officer and the Interim Chief Finance Officer, following approval of the accounts at the IJB's Audit & Risk Committee meeting on 14th September 2021.

Sederunt: David King left the meeting.

8. NATIONAL CARE SERVICE CONSULTATION

The Chief Officer had submitted a SBAR report updating members on the national consultation underway concerning the establishment of a National Care Service and inviting members to consider how to formulate the IJB's response to the consultation.

Paul Currie presented the report outlining the background to the consultation exercise, its scope and some issues of particular interest to IJB members. He referred to the previous request for members' comments and said that 2 responses had been received initially and that he was now seeking approval to set up a development session in early

October. This event would allow members to consider the consultation and what is happening more widely and to formulate the IJB's response. He added that some IJBs had not put forward a response to the consultation as they could not reach a consensus. However, in his opinion, a range of views should not preclude the IJB from providing a constructive response to the consultation.

Dr Donald supported the opportunity to have further discussion on the issues and to formulate a response. She said that the IJBs and HSCPs both had relevant expertise in integration and it was right that they should be participating in this consultation.

The Chair expressed concern about the lack of recognition of the previous 5 years of endeavour on the part of IJBs. He said it would be important to highlight and reflect on good practice as well as responding to the current proposals. He also encouraged members to attend one of the information sessions being held by the Scottish Government as these provided useful background on the consultation.

Councillor Fiona O'Donnell said she was happy to support the recommendations in the report but queried the best way to respond to wider issues such as community justice and children's' services.

Judith Tait advised that that East Lothian Council was preparing its own response to the consultation which would cover these areas. It was undertaking a range of meetings with key services in order to prepare a draft response and there would be a briefing session for Councillors on 12th October to discuss this document. She added that the message from the Scottish Government was that they wanted to hear from as many people as possible. Responses were being encouraged in a range of formats and need not necessarily follow the consultation response proforma.

Councillor Akhtar also welcomed the recommendations in the report and the work to extend the deadline to the consultation. She said that everyone had the same aim – to improve outcomes for health and social care – and she encouraged as many people as possible to comment on the sections of the consultation which were relevant to them.

The vote was taken by roll call and all of the recommendations were approved unanimously.

Decision

The IJB agreed:

i. That a development session would be arranged in late September/early October to provide IJB members with an opportunity to discuss the implications of the NCS consultation for health and social care services in East Lothian and more widely; and
ii. That the outputs of any development session should be used to prepare an East Lothian IJB response to the consultation on the establishment of a National Care Service.

9. COMMUNITY TRANSFORMATION PROGRAMME, ADULTS WITH COMPLEX NEEDS OVER 65

The Chief Officer had submitted a report updating the IJB on the progress of the Community Transformation Programme for over 65s and seeking approval for the recommendations set out in the report; which were agreed at the Strategic Planning Group meeting on 8th September 2021.

Christine Johnston presented the report reminding members of the actions agreed by the IJB at its June meeting. She advised that discussions had subsequently taken place with Older People's Day Centres and additional new investment had been agreed to develop outreach support until 2023. However, in considering the longer term 4 year public contract framework, a number of risks and issues had been highlighted and, as a result, it was recommended that the existing funding for the centres should be continued until 31st March 2023. She added that additional actions had been recommended to mitigate any risks and to address the concerns of colleagues in procurement and legal services. Ms Johnston also updated the members on the proposals for a Meeting Centre in Musselburgh.

Ms Johnston responded to questions from members on demonstrating Best Value and the implications of a light touch application process.

Councillor Akhtar said she had been meeting with the Association of Day Centres and she felt that they would welcome this report. She referred to the range of work being done to support carers and service users and said she had agreed to circulate examples of good practice to IJB members. Ms Johnston offered to help collate some examples for circulation.

The Chair said that the report demonstrated a constructive response to the concerns raised and comments made by stakeholders during the engagement process. He felt that the proposals were being taken forward in a very measured way.

The vote was taken by roll call and all of the recommendations were approved unanimously.

Decision

The IJB agreed to:

i. Note the background;
ii. Note the risks and issues in commissioning Older People's Day Centres and approve the proposed approach set out in the report;
iii. Approve the mitigating actions set out in the report; and
iv. Note the update on the Meeting Centre proposal and approve the further development of the Public Social Partnerships approach set out in the report.

Signed .....

Mr Peter Murray
Chair of the East Lothian Integration Joint Board

NHS LOTHIAN

Board Meeting
01 December 2021

Director of Public Health and Health Policy

PUBLIC HEALTH PARTNERSHIP AND PLACE TEAMS

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress with the formation of the new Public Health Partnership and Place teams and the local working arrangements in each area.

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

2 Recommendations

2.1 The Board is asked to note the progress with the development of this new, focused approach to addressing the wider determinants of health.

3 Discussion of Key Issues

3.1 The Board has been updated previously about the progress of the NHS Lothian Public Health review and organisational change process. The organisational change process is now complete and recruitment to unfilled vacancies has begun.

3.2 There is a Partnership and Place team for each local authority area. Each of the four Partnership and Place teams is led by a Public Health Consultant and the four teams vary in size according to the population that they serve. The structure of the teams is shown in appendix 1. The teams will work with partners to shape and influence strategic planning and develop strategies to tackle the wider determinants of health.

3.3 Place-based approaches provide opportunities for whole system working to improve population health and tackle health inequalities. Each team is in the process of negotiating a local work plan which will bring together national public health priorities with key local issues highlighted during discussions with colleagues in health and social care partnerships, community planning partnerships and wider stakeholders. The teams' work plans will be focused on reducing inequalities through tackling the wider determinants of health including poverty, income maximisation, employability, housing, and education.

3.4 The teams will take a lead role in delivering on NHS Lothian's responsibilities linked to the Community Empowerment (Scotland) Act 2015. The Director of Public Health and the Deputy Director of Public Health are the NHS Board Executive representatives on each Community Planning Partnership (CPP) Board. Each Partnership and Place team are actively involved in local community planning structures.

3.5 The public health teams have specific responsibility for producing Local Child Poverty Action Reports alongside local authority colleagues. There are already plans in place to strengthen NHS Lothian input into these plans (outlined in the paper to Performance, Planning and Development Committee (03 November 2021).

3.6 Each public health team will work closely with the Integration Joint Board and Health and Social Care Partnerships. In particular, they will contribute to the strategic planning function and Joint Strategic Needs Assessments.

3.7 Health intelligence will be provided by the new Public Health Intelligence Team working alongside Lothian Analytical Services and Locality Information Support Teams. The teams are working on a Public Health dashboard which will be developed iteratively with the first module available from early 2022. The first module will include data about life expectancy, key morbidity and mortality data, population statistics and, importantly, data about wider determinants of health such as education, employment and income. All data will be presented by partnership area as well as at a Lothian wide level.

3.8 The Lothian public health survey is currently being commissioned and it is expected to be undertaken in the first half of 2022. This survey will measure the wider impacts that the pandemic has had on the health of the population and will provide a more granular understanding of health inequalities than we are able to get from national data sets.

3.9 The Partnership and Place teams provide a link between NHS Lothian's Anchor Institution Programme Board and local community wealth building strategies. NHS Lothian as an anchor will play a key role in employment, income maximisation, public service provision and sustainable development of the built environment.

3.10 Place-based approaches are key to tackling health inequalities and supporting Covid recovery. As CPPs renew Local Outcomes Improvement Plans (LOIPs) and IJBs look at their Strategic Plans in the wake of the pandemic, Lothian's public health resource is now better configured to engage meaningfully with delivering these plans.

4 Key Risks

4.1 Recruitment is underway to complete these new teams, capacity is increasing but will be limited until all posts are filled.

5 Risk Register

5.1 None at this stage.

6 Impact on Inequality, Including Health Inequalities

6.1 These teams have been developed to ensure a greater focus on tackling health inequalities. An impact assessment of the new public health structure was undertaken as part of the organisational change process.

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

7.1 Not applicable at this stage as this paper provides an update on progress.

8 Resource Implications

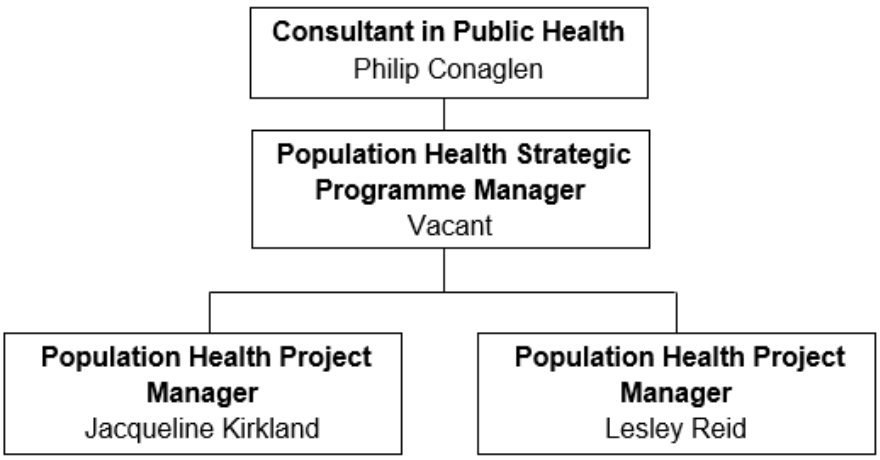
8.1 None at this stage.

Katie Dee
Deputy Director of Public Health and Health Policy
9th November 2021
Katie.Dee@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Partnership and Place Team Structures

East Lothian:



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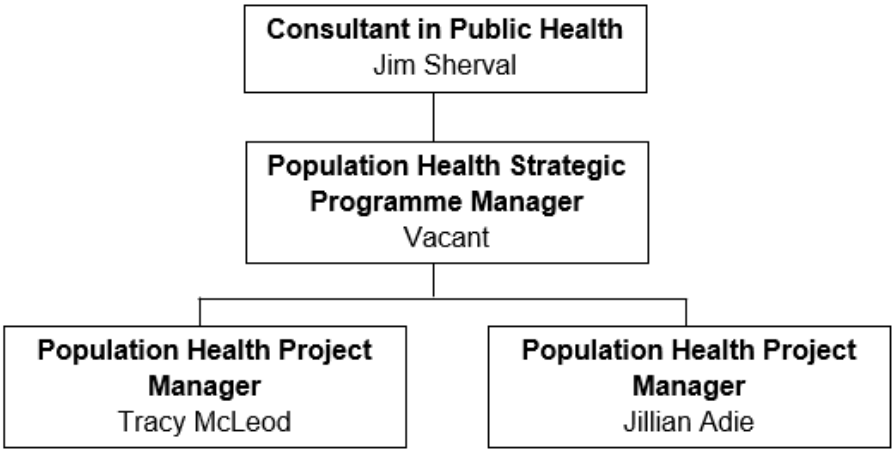

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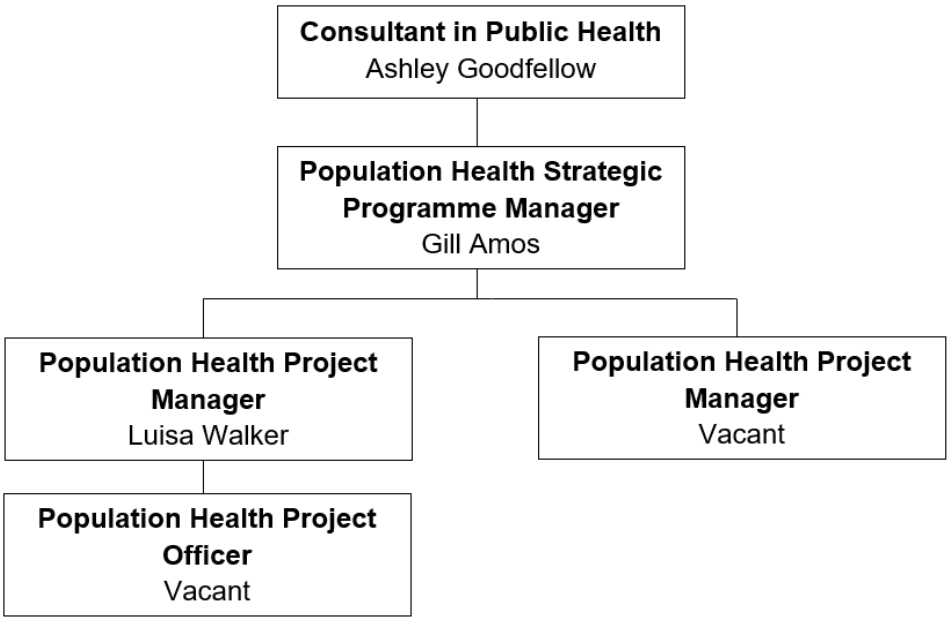
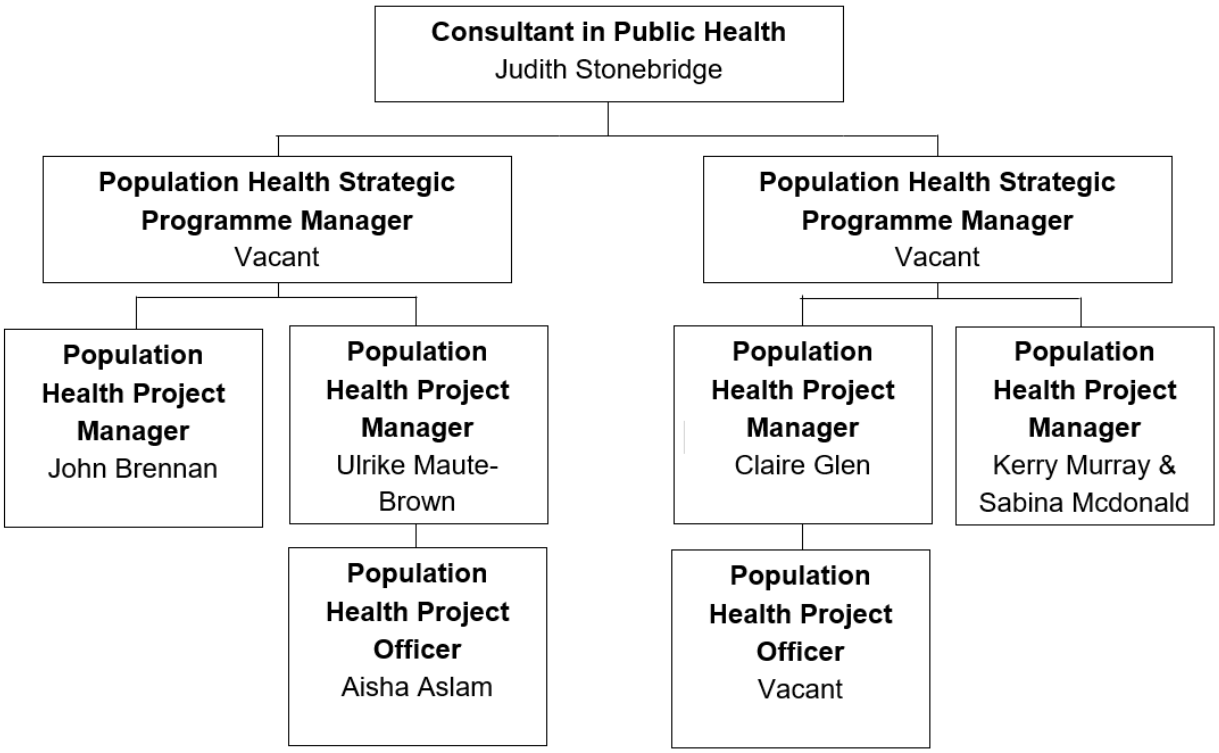


Edinburgh:



NHS LOTHIAN

Board
1 December 2021

Chair

APPOINTMENT OF MEMBERS TO COMMITTEES

1 Purpose of the Report

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

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

2 Recommendations

The Board is recommended to:

2.1 Appoint Peter Murray as the Board's vice-chair from 1 December 2021.

2.2 Appoint Giovanna di Tano as a non-contractor pharmacist member of the Pharmacy Practices Committee from 1 December 2021 to 30 November 2024.

2.3 Re-appoint Bill McQueen as a member of the Pharmacy Practices Committee for the period from 3 October 2021 to 31 January 2024.

3 Discussion of Key Issues

Board Vice-Chair

3.1 Following a selection process, the Cabinet Secretary has determined that Peter Murray should become the Board's vice-Chair. Peter will take over that position from Martin Hill. The Board is recommended to appoint Peter Murray as the Board's vice-chair from 1 December 2021.

Pharmacy Practices Committee

3.5 The Lothian Area Pharmaceutical Committee met on 7 October 2021 and agreed to nominate Giovanna di Tano as a non-contractor pharmacist member of the Pharmacy Practices Committee. The Board is recommended to appoint Giovanna di Tano as a non-contractor pharmacist member of the Pharmacy Practices Committee.

3.6 The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 (as amended) require the chair to be someone who is a Board member and not be, nor previously have been (nor an employee of) a doctor, dentist, ophthalmic optician or pharmacist. Bill McQueen's 3-year appointment as a member of the Committee ended on 2 October 2021. In the interests of ensuring continuity of the Committee's

business, it is recommended that the Board re-appoint Bill McQueen as a member of the Pharmacy Practices Committee from 3rd October 2021 to 31 January 2024.

4 Key Risks

4.1 A committee or an IJB 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. Public involvement is not required.

8 Resource Implications

8.1 This report contains proposals on the membership of committees and integration joint boards. 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.

8.2 The Board now has several vacancies in its membership, and this adds to the workload of the remaining members to service the meetings of the Board, its committees and the IJBs. The Scottish Government has started a public appointment process to recruit new non-executive members, with the aim of them being in place by Spring 2022.

Alan Payne
Head of Corporate Governance
18 November 2021
alan.payne@nhslothian.scot.nhs.uk

Meeting Name: Board **Meeting date: 1 December 2021**

Title: NHS Lothian Climate Change Report 2020-2021

Purpose and Key Issues of the Report:					
DISCUSSION	X	DECISION		AWARENESS	X

All public bodies are required to submit an Annual Climate Change report with a focus on Green House Gas emissions. The current report for the financial year 2020 -2021 was prepared in May 2021 and reviewed and approved at NHS Lothian Finance and Resources Committee in June 2021 for submission to the NHS Board.

Given the growing requirements on NHS Boards in relation to the Climate Emergency and Sustainability, it is important that the NHS Board gives consideration to this report.

The key points to note are:

- The limitations of the report: it reports on emissions in scope 1 and 2 of the Green House Gas Protocol and these emissions typically account for only 20-30% of the overall NHS carbon footprint
- NHS Lothian has sought to increase the scope of reporting in line with the NHS Lothian Sustainable Development Framework, including medical gases and in this report some key commodities relevant to the circular economy. The report contains brief information of key activities in relation to the Sustainable Development Framework for the reporting period but there has been substantial progress in the current year.
- The core metrics in this report are now reported quarterly as part of the NHS Lothian performance report submitted to the Planning, Performance and Development Committee

Recommendations:

The NHS Board

- Note the overall reduction of 1.6% in NHS Lothian carbon emissions.
- Note the significant reduction of 30% in carbon emissions from transport and the opportunity to plan to maintain or better this reduction in 2021-2022 in line with a Green Recovery.
- Note that for the first year the report is publicly available on the NHS Lothian Website in line with the Board's commitment to the Edinburgh Climate Compact.

Author: Jane Hopton **Date: 18th November 2021**	**Director: Jim Crombie** **Date: 18 November 2021**

LOTHIAN NHS BOARD

Board Meeting
1st December 2021

DEPUTY CHIEF EXECUTIVE

NHS LOTHIAN CLIMATE CHANGE REPORT 2020-2021

1 Purpose of the Report

1.1 The purpose of this report is to present the Mandatory Climate Change Report for 2020-2021 and identify the main implications and next steps in the context of the Climate Change Duties (Reporting) of Public Bodies.

2 Recommendations

NHS Lothian Board

2.1 Note the overall reduction of 1.6% in NHS Lothian carbon emissions.

2.2 Note the significant reduction of 30% in carbon emissions from transport and the opportunity to plan to maintain or better this reduction in 2021-2022 in line with a Green Recovery.

2.3 Note that for the first year the report is publicly available on the NHS Lothian Website in line with the Board's commitment to the Edinburgh Climate Compact.

3 Discussions of Key Issues

3.1 NHS Lothian has been required to submit an annual climate change report since 2007. The submission of the Mandatory Climate Change report is a requirement of the Climate Change Act Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015. Reports for the previous financial year are required to be submitted by November of the following year, but as per the 2019-2020 report the Sustainable Development Management Group have brought forward the reporting cycle.

3.2 The letter from Cabinet Secretary for Environment, Climate Change and Land Reform 3rd March 2021 **Public Sector Leadership and the Global Climate Emergency** set the requirement for a just transition to a 75% emissions reduction by 2030 (from baseline) and Scotland's world leading goal of net zero emissions by 2045.

3.3 The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Amendment Order 2020 sets out that public bodies will be required to provide in their annual reports how the body will publish progress and targets – a requirement from April 2022 onwards[i].

3.4 The Climate Change Report is report is designed as a publicly available document, to meet the commitments above, our commitments to the Edinburgh Climate Compact and to ensure that our wider partners understand the opportunities for, and responsibilities of, NHS Lothian in contributing to Climate Action. It has informed our engagement with the Draft Edinburgh Climate Strategy 2030 (currently out for consultation).

3.5 The Carbon Emissions report for 2020-2021 and commentary and analysis is in appendix 1. The report focuses on the reporting requirements of the Climate Change Act and is not an update on the Sustainable Development Framework and Action Plan in full, though as with previous years the report seeks to extend the scope of reporting of carbon emissions.

3.6 Key points to note are that the emissions reported on represent only around 20-30% of the total health service carbon footprint and NHS Lothian are seeking to increase the scope of reporting year on year across more of the whole carbon footprint.

3.7 In this report we have sought to include some data and estimates of carbon impact in relation to the Circular Economy, providing information from Warp-it the reuse portal and on consumption of commodities known to have significant climate impact and items of significant concern to staff, namely textiles[1] (uniforms including gloves, headwear and outerwear and linen including scrubs) and disposable foam and plastic drinking and medicine cups. Despite the potential impact of these products, there is no structured environmental reporting on these so the data presented must be interpreted with caution.

Further considerations and implications of the reported data

3.8 The report shows a positive trajectory and overall reduction of **101,391** Tonnes CO_2, 62%, from 1989/1990 national targets baseline (buildings only) with the requirement to reach a 75% reduction over the next 9 years (2030).

3.9 The three largest sites (RIE, WGH & SJH) account for **62%** of buildings emissions, the ten largest account for 92%.

3.10 It should be noted that PFI properties now account for 50% of our expenditure on energy. The energy performance at RIE has been known to be poor for some time, but even new builds are showing poor energy efficiency. Contract mechanisms to enforce energy efficiency and sustainability are very poor and a strong approach to sustainability in contract management will be required to deliver a trajectory to 75% reduction by 2030 and net zero by 2045.

3.11 A key next step is to ensure there are carbon pathways in place for the three main sites. Work at the WGH has already commenced through the Energy Infrastructure Project. The recent installation of a new energy centre at SJH provides a good basis for building a pathway. A more significant challenge is in relation to RIE and RHCYP/DCN and the intention is to commission a high level strategic review of opportunities in the coming year.

3.12 The impact of Covid on travel and ways of working is evident in the report of emissions from transport, particularly the reduction in grey fleet mileage of circa 30% and a potential new baseline. This reduction represents a saving of around £100k per month and consideration should be given to reinvesting to maintain and improve on this new baseline.

3.13 In the current year Liftshare registered 14 new members (only 554 members registered since 2007 and only 32 current Liftshare teams).

3.14 Medical gases added to 2018/2019 submission, not previously reported. Contributing 8,344 CO_2. The reduction in emissions this year has been a real success. This is attributed to the highly engaged staff group that have identified the impacts, opportunity and pioneered the change activities.

3.15 Waste figures show an decrease of 20 Tonnes CO_2. Significant concerns remain over data quality, in part due to clinical contingency, and accessibility of meaningful waste data

[1] Globally around 87% of textiles are disposed of through landfill or incineration although 90% of the clothing waste disposed of in landfill can be re-useable or recyclable and still has 70% of its useful life. The carbon savings of reuse/recycling of textiles is second only to aluminium in terms of carbons savings from re-use/recycling (textiles 1.8 to 8.0 tonnes CO2e and aluminium 9-12 tones CO2e) compared with recycled steel, dense plastic, waste electric and electronic equipment.

to support management of change in waste management and reduction at site and service level. Work on the NHS Lothian waste dashboard is underway.

4. Key Risks

4.1 The key risks are:

- that NHS Lothian will fail to meet the requirement of a 75% reduction in carbon emissions by 2030
- that NHS Lothian will fail to maintain the reduction in carbon emissions from transport.
- availability of capital to meet the targets

5. Risk Register

5.1 There are currently no implications for NHS Lothian Risk Register.

6. Impact on Health and Other Inequalities

6.1 There are no specific implications of this report for Health or Other Inequalities.

6.2 NHS Lothian will require to ensure that future actions to reduce Green House Gas Emissions support the principles and requirements of Just Transition towards a fairer and greener Scotland. Areas of likely concern are in relation to changes in ways of working (remote working, transport and access) and models of care (digital) to ensure that access is fair to all staff and patients.

7. Involving People

7.1 The report will be available to the public. A webinar on the report is planned for 1st July to communicate the report to staff and to engage staff in the next steps.

8. Resource Implications

8.1 The resource implications pertain to achieving the future pathway to net zero.

Jane Hopton
Programme Director Facilities
Daniel Mill
Senior Project Manager Sustainable and Technical Development
Ian Mackenzie
Greenspace and Health Strategy Manager
Jan Cassels
Senior Data Analyst – Sustainability
23 June 2021

[i] The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Amendment Order 2020 sets out that public bodies will be required to provide in their annual reports:

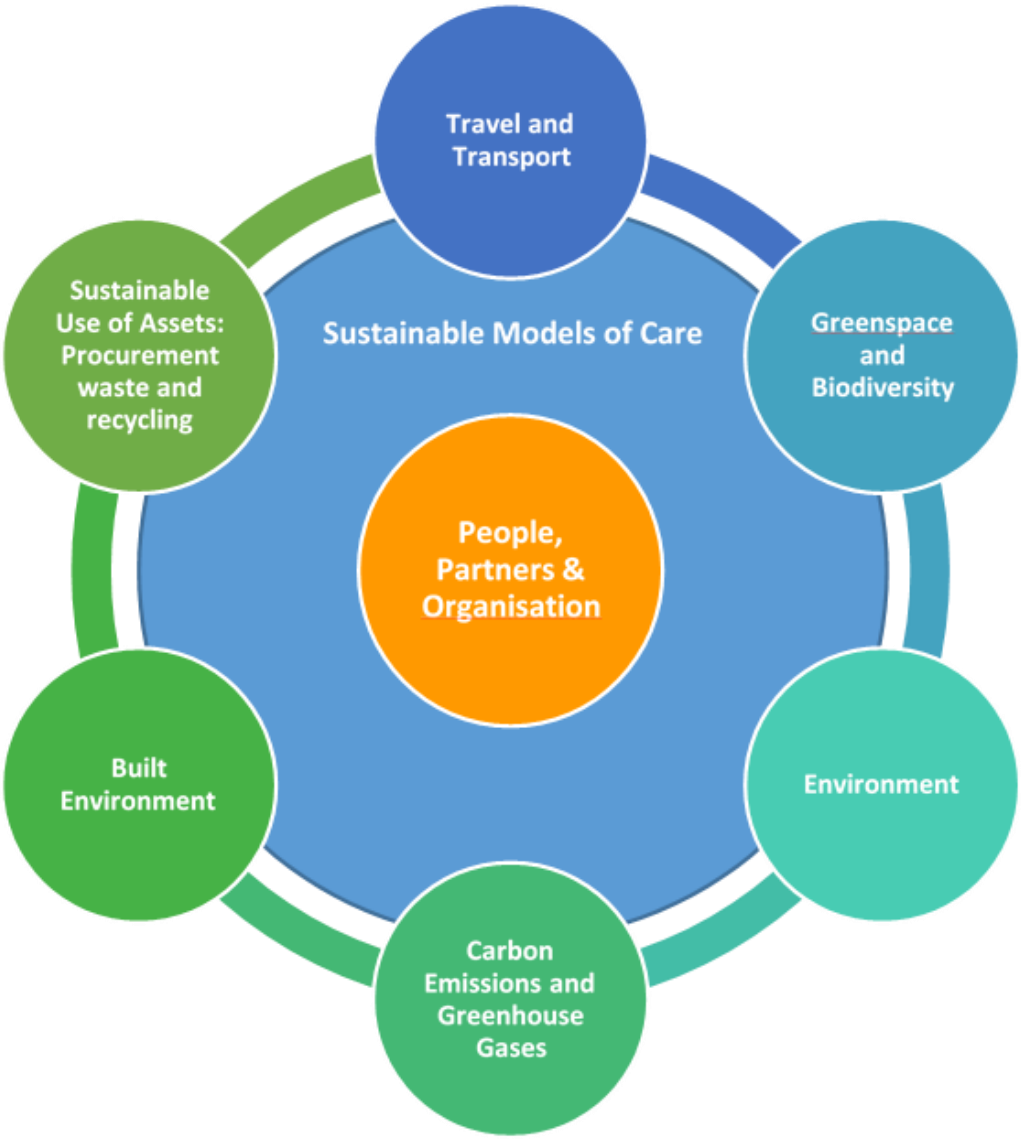
- where applicable, the body's target date for achieving zero direct emissions of greenhouse gases, or such other targets that demonstrate how the body is contributing to Scotland achieving its emissions reduction targets;
- where applicable, targets for reducing indirect emissions of greenhouse gases;
- how the body will align its spending plans and use of resources to contribute to reducing emissions and delivering its emissions reduction targets;
- how the body will publish, or otherwise make available, its progress to achieving its emissions reduction targets; and
- where applicable, what contribution the body has made to helping deliver Scotland's Climate Change Adaptation Programme.

The new requirements apply from the report year ending on 31 March 2022 onwards. Further detailed guidance will be issued by the Scottish Government by April 2021.

Our NHS
Our People
Our Planet

NHS Lothian

2020-2021 Carbon Emissions Report



Sustainability Overview

NHS Lothian launched our new **Sustainability Development Framework and Action Plan** in December 2020, to guide our journey to net zero by 2045 and our commitment to the UN Sustainability Goals.

Incorporating a new and broader approach, the Framework not only provides direction on reducing the climate impact of NHS activity but also looks at our role as advocates and partners for wider change

The NHS Lothian Framework gives us a strong vision and clear ambitions. Our urgent task now is to harness the commitment and enthusiasm of our staff, patients and partners to take action for change.

The **Biodiversity Audit and Natural Capital Assessment** which is the first of its kind in Scotland, was completed in April 2021 and provides a comprehensive analysis of the NHS Lothian estate to guide action and a baseline from which to measure our future progress

5 webinars were delivered by the Sustainability Group during the last year and attended by over **350 people**. These included events on Greenspace and Biodiversity, Sustainability and Pharmaceuticals, and The New Normal – sustainability and COVID 19 recovery. A monthly series of webinars is planned for the coming year

NHS Lothian is a founder signatory of the **Edinburgh Climate Compact**, which will support the radical reduction in Edinburgh's greenhouse gas emissions and contribute to a green recovery for the city

NHS Lothian emissions for 2020/21 are **67,758** Tonnes CO_2, a reduction of **2,883** from 2019/2020.

Over **350 staff** have signed up to our Sustainability Network and site-based events were held at the WGH and RIE before lockdown Consultation session have been held with NHS volunteers and young people's groups

Our work on **Anaesthetic gases** is leading nationally on reporting standards and mitigation measures. This year's significant improvement has been driven by highly engaged clinical teams with access to sound evidence

A **Sustainability Communications Strategy** has been developed and continuously improved during the year, providing a guide for communication with staff and wider partners and the public during this challenging year

111 Electric Fleet Vehicles on the road and **2 eBikes**, an increase of 71 vehicles from last year, with 49 charge points installed.

Phase 1 of the Western General Energy Infrastructure project on-site, starting our Carbon Pathway transition for a major acute site.

Purpose of this Report

Managing and reducing our emissions is essential to reduce our impact on the environment, effectively manage resources, contribute to actions on climate change and show leadership.

This 2020/21 Carbon Emissions Report gives detail on emissions associated with the operations of NHS Lothian. The Scottish Government has adopted an ambitious new target to reduce emissions by 75% by 2030 – the toughest statutory target of any country in the world. While only buildings data is available over this period, a reduction of 63% is positive.

Annual reporting has been required since 2007/08 when a Carbon Management Plan was developed to formalise our strategy and activities in reducing carbon emissions. Activity on emissions has historically focused on utilities (buildings), waste and transport.

Carbon Emissions Overview

Addressing carbon emissions and greenhouse gases is fundamental to addressing climate change and delivering services in a sustainable manner. Establishing targets and systems that provide continuous monitoring is paramount to shaping our actions and tracking our progress. NHS Lothian has calculated and reported emissions from traditional energy and fuel sources since 2008. We continue to improve the collection and utilisation of data to better understand the hotspots, opportunities, impacts and trends. We also recognise the need for understanding and engaging on the wider impact of our operations, through our partners and supply chain.

Our Aim: Contribute to national net-zero targets through reducing carbon emissions and other Green House Gases.

We continue to recognise the wider contribution that services have on the environment and need to broaden our scope of measurement. For the first time, the 2018/19 report included emissions from Anaesthetic Gases and these emissions are included in the current report.

The addition of a wider range of emissions sources in our reporting increases the challenge but is essential if we are to embed sustainability across the whole organisation and harness the enthusiasm and determination of the widest range of our staff. The current report shows a dramatic reduction of emissions from anaesthetic gases by 15% compared to last year achieved as a result of the enthusiasm and leadership shown by clinical staff. The current report represents a further step.

This year we are the first board in Scotland to include an estimate of the carbon sequestered by our estate in the report.

Overall there has been a reduction in emissions from last year, by 2,883 Tonnes of CO_2, with reductions across anaesthetic gases, waste and travel. There have been increases in emissions from buildings, with continued impact of the double running of the RHSC and RYCYP & DCN sites. Added to this the WGH aged plant is contributing and highlights the importance of the Energy Infrastructure project that is ongoing.

Glossary

RIE – Royal Infirmary of Edinburgh

CO_2 – Carbon Dioxide

RHSC – Royal Hospital for Sick Children

RYCYP & DCN – Royal Hospital for Children and Young People

WGH – Western General Hospital

SJH – St John's Hospital

kWh – Kilowatt Hours (measurement of energy)

EV – Electric Vehicles

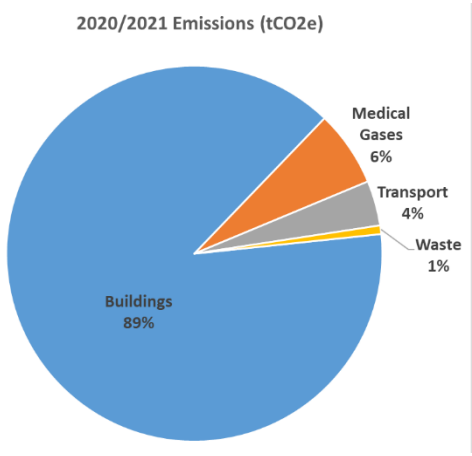
T – Tonnes

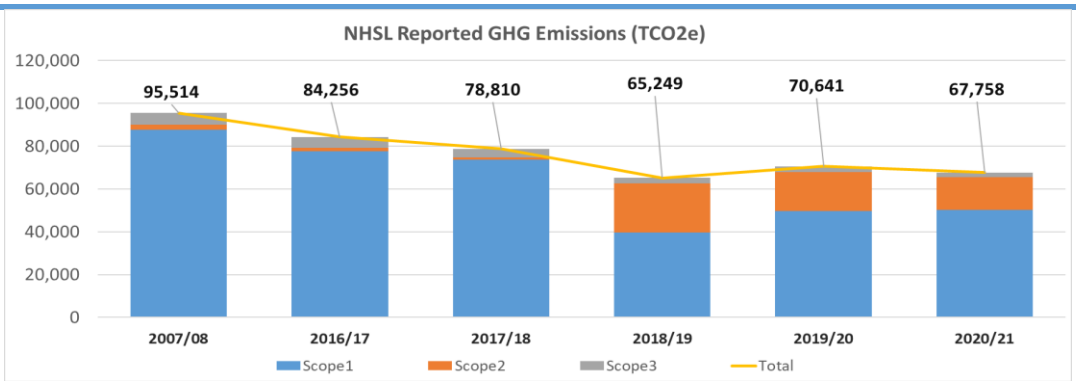
Kg – Kilograms

Carbon Emissions

Key Stats

- Overall decrease of **2,883** Tonnes CO_2 from 2019/2020 report.
- Overall reduction of **103,029** Tonnes CO_2, 63%, from 1989/1990 national targets baseline (buildings only).
- **Buildings** - reduction of 843 Tonnes CO_2 (-1.4%)
- **Medical Gases** - reduction of 811 Tonnes CO_2 (-15.3%)
- **Transport** – decrease of 1,136 Tonnes CO_2 (-30%)
- **Waste** – decrease of 20 Tonnes CO_2 (-3.7%)





Year	2007/08	2016/17	2017/18	2018/19	2019/20	2020/21
Scope 1	87,800	77,569	73,744	39,786	49,814	50,273
Scope 2	2,302	1,611	1,059	22,783	18,057	15,373
Scope 3	5,412	5,076	4,007	2,680	2,770	2,112
Total	**95,514**	**84,256**	**78,810**	**65,249**	**70,641**	**67,758**
Annual Performance						
Reduction %		5.2%	6.5%	17.2%	-8.3%	4.1%
Reduction TCO2		-4,663	-5,446	-13,561	5,392	-2,883
Baseline Performance						
Reduction %		11.8%	17.5%	31.7%	26.0%	29.1%
Reduction TCO2		-11,258	-16,704	-30,265	-24,873	-27,756

Commentary

- Buildings are the most significant emissions source, based on current emissions scope. The high proportion of emissions associated with the major acute sites (RIE, WGH and SJH) account for 62% of the total buildings emissions, the top 10 account for 92%.
- Medical gases added to 2018/2019 submission, not previously reported. Contributing 6.5% of our CO_2 emissions. There has been year on year reductions in emissions this year which has been a real success. This is attributed to the highly engaged staff group that have pioneered the change activities.
- Waste figures show a decrease of 20 TCO_2. Progress has been made but concerns remain over data quality. While a small contributor to carbon, this is an important area for action from a sustainability perspective.
- Transport emissions have decreased by 1,136 Tonnes CO_2. Approximate mileage reduction of 9.3 million km. Covid-19 impacts on services and changes to ways of working have driven the change, and sets a new baseline.
- NHS Lothian is the first board in Scotland to deliver a biodiversity, climate change and nature-based health benefits assessment of the natural capital assets (habitats) of their estate. We have established a base line of carbon sequestration, air quality regulation and biodiversity.

Buildings

Key Stats

- Buildings - reduction of **843** TCO_2 (-1.4%)
- Gas consumption increased by over 10.9 million kWh's (2,000 TCO_2, +4.7%)
- Electricity consumption has reduced by over 4.2 million kWh's (1,067 TCO_2, -6.0%)
- The **three largest sites** (RIE, WGH & SJH) accounts for **62%** of buildings emissions, the ten largest account for 92%.
- The three largest sites are equivalent to **16,328** average homes electricity and **12,620** gas consumption.
- The total across all sites are equivalent to **22,916** average homes electricity and **20,025** gas consumption

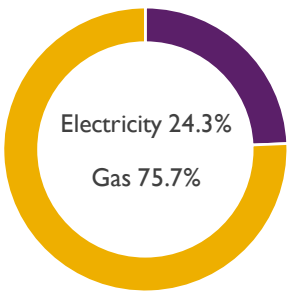
Energy Consumption				2019-2020		2019-2021	
	2018/19	2019/20	2020/21	Variation	% Change	Variation	% Change
Electricity	76,460,580	70,671,451	66,455,966	-5,789,129	-7.6%	-4,215,485	-6.0%
Gas	174,886,735	229,425,868	240,304,959	54,539,133	31.2%	10,879,091	4.7%
Water	833,796	1,494,105	1,091,963	660,309	79.2%	-402,142	-26.9%

NHS Lothian: All sites

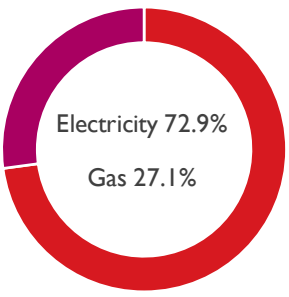
Utility Overview: Apr-20 - Mar-21

	Energy Usage (kWh/Mth)		Energy Cost (£/Mth)		CO_2 Emissions (TonnesCO_2/Mth)	
Month	Electricity	Natural Gas	Electricity	Natural Gas	Electricity	Natural Gas
Apr-20	6,329,257	21,116,588	£924,013	£369,154	1,462.8	3,867.7
May-20	6,259,954	17,739,052	£913,895	£310,109	1,446.8	3,249.1
Jun-20	6,302,847	15,048,357	£920,157	£263,071	1,456.7	2,756.3
Jul-20	6,376,503	13,268,331	£930,911	£231,953	1,473.7	2,430.2
Aug-20	6,255,515	13,385,118	£913,247	£233,994	1,445.8	2,451.6
Sep-20	6,501,499	15,581,698	£949,159	£272,394	1,502.6	2,853.9
Oct-20	6,696,349	20,350,872	£977,605	£355,768	1,547.7	3,727.5
Nov-20	7,008,369	24,150,367	£1,023,157	£422,189	1,619.8	4,423.4
Dec-20	6,969,206	26,358,798	£1,017,440	£460,796	1,610.7	4,827.9
Jan-21	6,260,063	27,275,497	£913,911	£476,822	1,446.8	4,995.8
Feb-21	6,697,611	23,921,762	£977,789	£418,193	1,548.0	4,381.5
Mar-21	6,112,649	23,593,374	£892,390	£412,452	1,412.8	4,321.4
Total	**77,769,822**	**241,789,814**	**£11,353,676**	**£4,226,895**	**17,974.2**	**44,286.2**

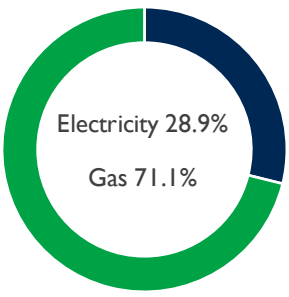
Usage Breakdown



Cost Breakdown



CO_2 Breakdown



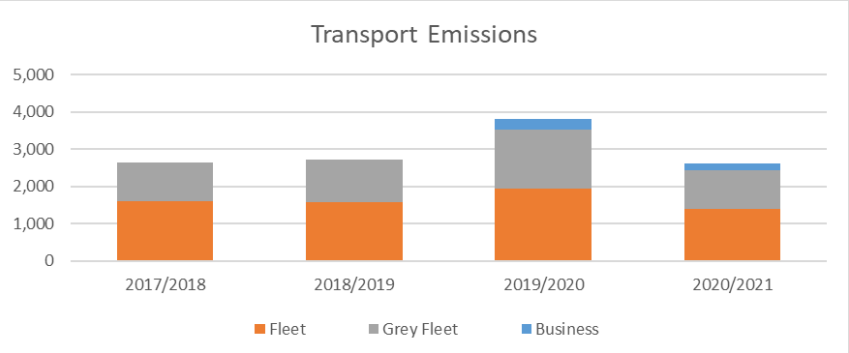
Commentary

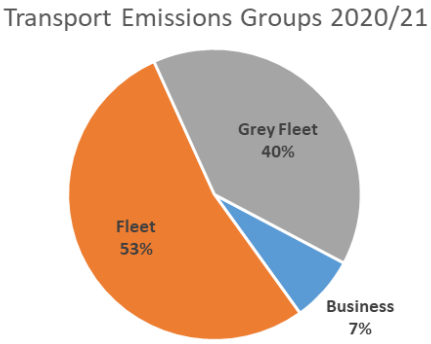
- The reduction in carbon emissions from buildings of 843 TCO_2, is due to a reduction in emissions from electricity based on lower demand and lower grid carbon factor, while there has been an increase in demand and associated emissions from natural gas.
- The difference in figures for electricity and gas shown in the two tables is due to a difference in invoiced utilities and reportable emissions. In-line with international standards we deduct energy consumption associated with external organisations operating within our property boundaries. The vast majority is apportioned to the University of Edinburgh who have large footprints at the RIE and WGH. Other partners include City of Edinburgh Council and West Lothian Council, all of which report their emissions under the same regulations.
- There is likely an impact of Covid-19 on energy consumption but this cannot be fully understood, due to complexity in the operational patterns of demand. There is an expected reduction in some areas due to lower service use but this could be counteracted by changes in ventilation, increased IT server demands and hot water consumption for cleaning.
- Electricity consumption is shown to have reduced year on year. Even with increased floor area, the change is positive. A high proportion is due to the effective operation of the Combined Heat and Power system at St John's Hospital. Other factors will include improvements to lighting through maintenance replacements, more efficient IT and more recently the increase in working from home.
- Gas has significantly increased over this period, in part due to the Combined Heat and Power system at St John's Hospital, as this system generates electricity on-site using network supplied gas. These systems provide substantial energy cost savings but due to the continued reduction in the grid electricity factor there is now a negative impact on carbon.
- Double running of RHSC and RHCYP buildings are contributing to higher emissions. Both sites within top 10 energy consumers, but there is an expected improvement in future years when the RHSC is decommissioned.
- The table above shows the high proportion of emissions associated with the major acute sites. The RIE, WGH and SJH account for 62% of the total buildings emissions. The 10 shown above account for 92%.

Transport

Key Stats

- Transport - decrease of **1,136** TCO_2 (-30%)
- 111 Electric Fleet Vehicles on the road, an increase of 71 vehicles from last year and 2 new eBikes.
- 49 EV Charge points installed, an increase of 45 from last year.





Transport	Consumption		Emissions (tCO2e)			
			2019/20	2020/21	Variation	% Reduction
Diesel (Fleet)	433,513	litres	1,562	1,089	473	30.3%
Car - petrol (Grey fleet)	3,207,893	km	799	559	240	30.0%
Car - diesel (Grey fleet)	1,506,986	km	409	254	156	38.0%
Petrol (Fleet)	132,842	litres	378	291	87	23.0%
Average Car* (Grey fleet)	1,224,082	km	364	210	154	42.3%
Car - hybrid (Grey fleet)	58,799	km	9	7	2	18.6%
Taxi - Business	3,476	km	123	1	123	99.4%
Train - Business	302,305	km	87	12	74	85.6%
Air - Business	10,798	km	56	3	53	95.0%
Bus - Business	76,932	km	39	9	29	75.9%
EV's - Business	18,898	kWh		4	-4	n/a
EV's - Fleet	41,343	kWh		10	-10	n/a
Taxi - Business	785,147	km		166	-166	n/a
Total			**3,825**	**2,616**	**1,210**	**31.6%**
* Unknown Fuel						

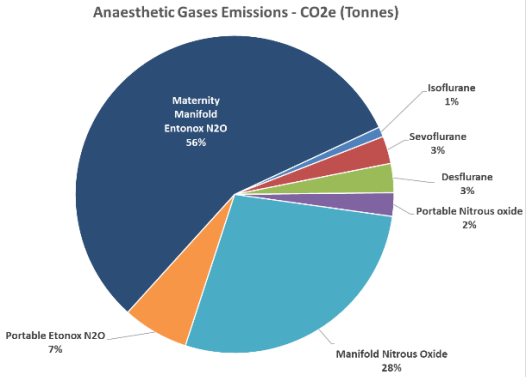
Commentary

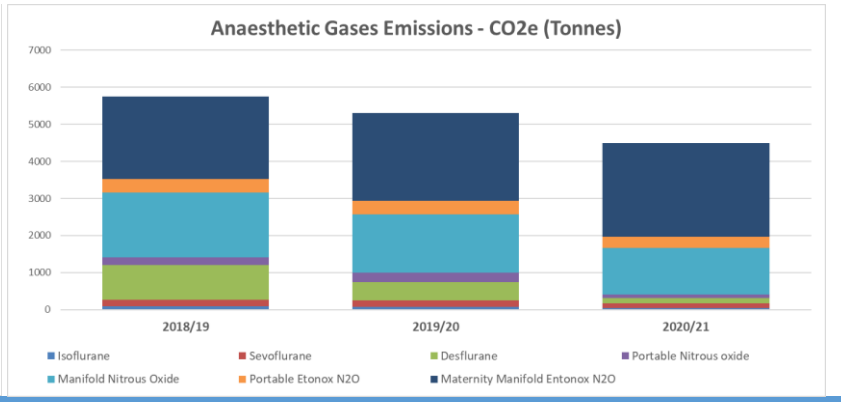
- Overall there has been a significant decrease in transport emissions, across most identified groups.
- There has been a significant decrease in the mileage and associated emissions from Grey Fleet of approximately 2,912,181 km. A reduction of travel across the grey fleet would be expected due to the impact of Covid-19, but a decrease of 33% can also be attributed to measures such as increased use of video conferencing and Near-me consultations that need to be maintained.
- The table above shows a comparison of emissions against 2019/20 for comparison against the previous year. Transport data is collated through a variety of sources, including expenses returns and is therefore based on available indicators to convert costs to distance. Further investigation is being undertaken to check the data, and improve for future reports and trend analysis.
- COVID 19 has brought rapid progress in the roll out of technology and organisational development to support remote working and consultations.
- Significant progress on transition of the fleet to Electric Vehicles and support infrastructure.

Anaesthetic Gases

Key Stats

- Medical Gases - reduction of **811** TCO_2 (-15%)





	CO2e			2019-2020		2020-2021	
Gas	**2018/19**	**2019/20**	**2020/21**	**Variation**	**% Change**	**Variation**	**% Change**
Isoflurane	87.2	72.5	45.8	-14.7	-16.8%	-26.7	-36.8%
Sevoflurane	182.3	179.3	125.5	-3.1	-1.7%	-53.7	-30.0%
Desflurane	929.3	492.6	133.1	-436.7	-47.0%	-359.5	-73.0%
Portable N2O	207.7	243.1	107.3	35.4	17.1%	-135.8	-55.9%
Manifold N2O	1747.2	1582.4	1248.0	-164.7	-9.4%	-334.5	-21.1%
Portable Entonox	369.5	361.1	300.7	-8.4	-2.3%	-60.3	-16.7%
Manifold Entonox	2229.7	2372.1	2532.1	142.4	6.4%	160.0	6.7%
TOTAL	**5753**	**5303**	**4493**	**-450**	**-7.8%**	**-811**	**-15.3%**
N_2O	4554	4559	4188	4.7	**0.1%**	-370.6	**-8.1%**

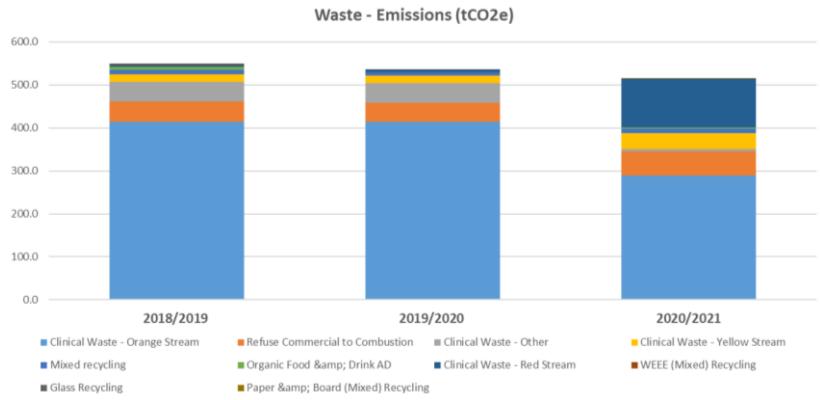
Commentary

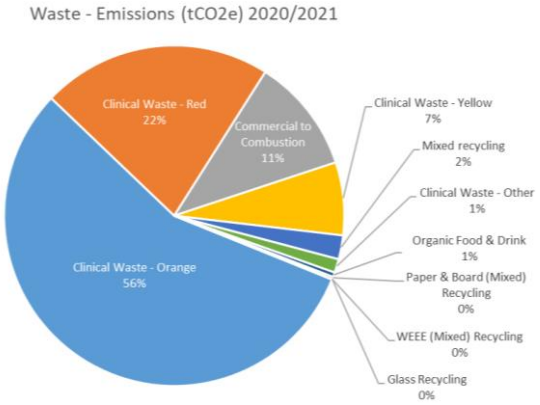
- The significant reduction in emissions associated with Medical Gases has again been driven by the clinical teams through engagement of local and national networks.
- Further investigation is required to understand the impact of clinical events on the consumption, to determine actual efficiency savings.
- The success is attributed to a highly engaged group based on sound evidence and recognition of the high environmental impact of anaesthetic gases.
- The key activities have been focused on minimising the use of Desflurane through use of lower emission alternatives with no clinical impact. This has resulted in a 15.3% reduction from the previous year. There is also a substantial reduction in emissions from Nitrous Oxide. Evidence and feedback will be sought to understand the activities and communicate the success throughout NHSS and beyond.
- Further improvements are considered possible and being investigated across multiple service lines, with the changes realised over the last 12 months there is a high level of confidence in further reductions.
- Data for 2018/19 corrected due to errors in gas emissions factors advised by national agency.

Waste

Key Stats

Waste - reduction of **20 TCO_2** (-2%)





Waste	Emissions (tCO2e)			
	2019/20	2020/21	Carbon Reduction	% Reduction
Clinical Waste - Orange Stream	414	288	126	30%
Refuse Commercial/Industrial to Combustion	44	56	-12	-29%
Clinical Waste - Other	46	7	40	86%
Clinical Waste - Yellow Stream	17	36	-19	-110%
Mixed recycling	8	12	-4	-47%
Organic Food & Drink AD	0	2	-2	n/a
Clinical Waste - Red Stream	5	113	-107	-1,986%
WEEE (Mixed) Recycling	*	0	0	n/a
Glass Recycling	*	0	0	11%
Paper & Board (Mixed) Recycling	*	1	-1	30%
Totals	**535**	**514**	**20**	**2%**

Commentary

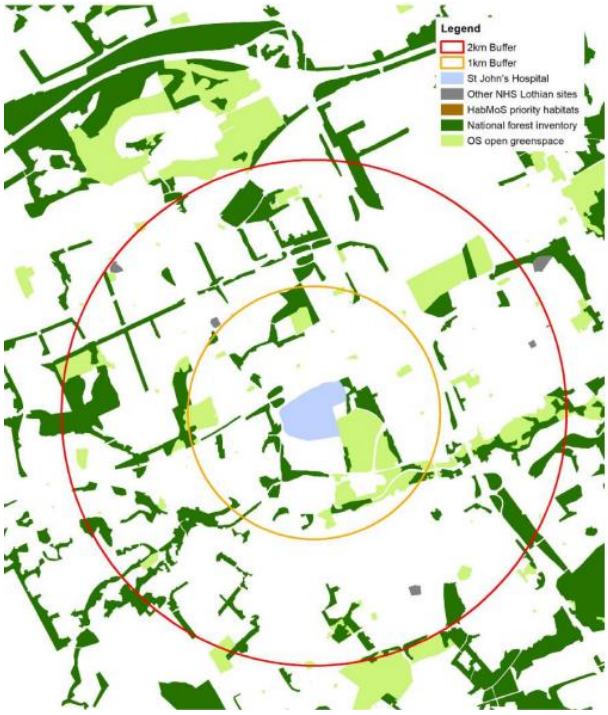
- Clinical Waste remains the highest emissions source, predominately due to intensive treatment method. Clinical waste data for last reporting year is of poor quality, but has significantly improved in 2020/21.
- Waste data continues to be challenging and typically has the lowest certainty and availability. The historic lack of concise data did not allow trend analysis and granular understanding.
- While waste is a very small portion of total emissions, around 0.7%, waste is recognised as a high priority based on feedback from frontline staff during sustainability engagement events.

Greenspace and Biodiversity

Key Stats

- We have established a base line of carbon sequestration, air quality regulation and biodiversity.

Carbon capture	2020/21	
	Annual physical flow	Annual monetary flow £(2020)
Carbon sequestration by greenspace (tCO2e/year)	282	£19,501
Air quality regulation tPM2.5/year	0.98	£225,993
Biodiversity units	484	N/A



Commentary

- NHS Lothian is the first board in Scotland to deliver a biodiversity, climate change and nature-based health benefits assessment of the natural capital assets (habitats) of their estate. The images and table above are drawn from this work.
- The flows of carbon sequestration and air pollution regulation were quantified across the estate and their monetary value estimated
- The valuation of these ecosystem services is key to providing full cost–benefit analyses, most importantly of changes to the estate that may reduce or increase the habitat types that perform the services.
- The values can be affected by changes in the built environment on a site, or simply by new grounds maintenance practices such as reduced mowing. Recommendation are currently being considered on how these flows can be increased.

Areas for Development

Scope 3 Emissions

Greenhouse gas emissions are categorised into three groups or 'Scopes' by the most widely-used international accounting tool, the Greenhouse Gas (GHG) Protocol. Scope 1 covers direct emissions from owned or controlled sources. Scope 2 covers indirect emissions from the generation of purchased electricity, steam, heating and cooling consumed by the reporting company. Scope 3 includes all other indirect emissions that occur in a company's value chain.

These include;

- Purchased goods and services
- Business travel
- Employee commuting
- Waste disposal
- Use of sold products
- Transportation and distribution (up- and downstream)
- Investments
- Leased assets and franchises

There are a number of benefits associated with measuring Scope 3 emissions. For many companies, the majority of their greenhouse gas (GHG) emissions and cost reduction opportunities lie outside their own operations. By measuring Scope 3 emissions, organisations can:

- Assess where the emission hotspots are in their supply chain;
- Identify resource and energy risks in their supply chain;
- Identify which suppliers are leaders and which are laggards in terms of their sustainability performance;
- Identify energy efficiency and cost reduction opportunities in their supply chain;
- Engage suppliers and assist them to implement sustainability initiatives
- Improve the energy efficiency of their products
- Positively engage with employees to reduce emissions from business travel and employee commuting.

Circular Economy

NHS Lothian Sustainable Development Framework and has a focus area on Sustainable Use of Assets, Waste and Recycling and an action to Engage with National Procurement and Zero Waste Scotland to support changes which accelerate the move to a circular economy in health care.

This annual Climate Change Report seeks to make a start on reporting on the Circular Economy in health care by including data from Warp-it resource re-distribution network of which NHS Lothian is a member and on some indicative commodities.

Warp-it

Our Annual Reuse Report from the portal is as below.

Membership 1,072 in total with 52 new members, 181 active members and 19 partners in current year

Avoided procurement and waste charges	£13,192
Amount of waste diverted	987kg
Amount of carbon emissions avoided	3194 kg CO2

To give some perspective on these figures, in the current year we will replace our birthing beds and bassinettes, offering the equipment to charities through Warp-it.

The Warp-it value of the bassinettes represents a cash saving or charitable donation of £31,116, a carbon saving of 21,900kg CO_2 and avoidance of 8000kg of waste.

This does not represent the full extent of NHS Lothian's activities in relation to re-use – our eHealth and medical physics departments have arrangements in place to donate obsolete equipment to charities and the decommissioning of RHSC has sought to ensure that opportunities for recycling is maximised, however there is currently no organisational overview of practice or accounting for the wider contribution to re-use.

Indicative commodities

Textiles

NHS Scotland disposes of 1,230 tons of textile waste per year, based on NHS Lothian NRAC share of 14.96% would give an estimation of NHS Lothian disposing of 184 tonnes of textiles per year.

Based on the carbon footprint of 9.52kg per tonne of Polyester (most NHS lines are poly) an estimate of our CO_2 foot print for textiles would be 1,752kg CO_2 per annum. Bottom up data on the carbon foot print of our textile products is not currently available.

Linen and scrubs (Laundry orders)

Year	Items	Carbon	Cost	Waste tons	Waste cost
2019-2020	146,190	Not known			
2020-2021	192,310	Not known			

Uniform items including gloves and shoes (two main suppliers)

Year	Items	Carbon	Cost	Waste kg	Waste cost
2019-2020	56,479	Not known	£423K	Not known	Not Known
2020-2021	62,701	Not known	£637K	Not known	Not known

If returned to linen rooms uniforms are shredded and disposed of in the general waste.

Other disposable items

Medicine cups

Year	Items	Carbon	Cost	Waste kg	Waste cost
2019-2020	3,703,800	Not known	£26,678	Not known	Not Known
2020-2021	3,258,600	Not known	£23,554	Not known	Not known

Foam insulated cups

Year	Items	Carbon	Cost	Waste kg	Waste cost
2019-2020	218,000	Not known	£3428	Not known	Not Known
2020-2021	194,000	Not known	£3563	Not known	Not known

Cup plastic water

Year	Items	Carbon	Cost	Waste kg	Waste cost
2019-2020	759,000	Not known	£6,999	Not known	Not Known
2020-2021	3,161,200	Not known	£29,288	Not known	Not known

What next?

This report has outlined the significant progress made this year both in reducing our carbon emissions and in strengthening the organisation to make gains in sustainable development in the coming period. Our Sustainable Development Framework and Action Plan lays out the urgency, scope and focus of the action we need to take. Priorities in the coming year will include

- Producing an NHS Lothian Climate Adaptation and Mitigation Strategy to ensure that NHS Lothian is prepared to deal with the effects of climate change and has plans to in appropriate adaptation and mitigation measures
- Strengthening our staff engagement across NHS Lothian with increased site-based sustainability networking and sustainability support for clinical care networks
- Expanding internal and public facing communications
- Building Lothian wide partnerships and networking with statutory and voluntary organisations to address sustainable development goals in tandem with related areas such as inequalities and COVID recovery
- Building on the progress made with data collection and analysis to provide detailed evidence of action needed and progress made
- Making progress in ensuring that sustainable development outcomes are integrated in all NHS Lothian planning and reporting processes

Meeting Name: Board **Meeting date: 1 December 2021**

Title: Initial Agreements for the Royal Edinburgh Hospital Campus Re-development

Purpose and Key Issues of the Report:

DISCUSSION		DECISION		AWARENESS	√

To share the Initial Agreements for the next stage of the Royal Edinburgh Hospital Campus re-development with the NHS Lothian board for awareness. One focusses on services for people with an intellectual disability requiring hospital admission and a national service for adolescents with intellectual disability requiring hospital admission (with an initial estimated cost of £27.9m). The other focusses on creating capacity for low secure mental health rehabilitation in NHS Lothian as well as re-providing inpatient mental health rehabilitation (with an initial estimated cost of £49.8m).

Both cases are aligned with IJB, NHS and Scottish Government strategies to both reduce inpatient care and transfer resources to community based services and to deliver care as close to people's homes as possible. The cases have been supported by the 4 Lothian IJBs, PPDC and F&R.

The drivers behind the need for change and then main issues facing these two services are:

- There is currently no Mental Health low secure provision in the Lothian area
- There is no National Intellectual Disability Adolescent Inpatient Unit
- There are changes in local and national strategies which cannot be achieved in existing facilities
- The current buildings do not support the model of care services wish to strategically deliver

Recommendations:

That the board notes that the two IAs for the REH Campus re-provision will be submitted to the Scottish Government Capital Investment Group for consideration.

Author: Nickola Jones **Date: 18/11/2021**	**Director: Tracey McKigen** **Date: 18/11/2021**

NHS LOTHIAN

Board Meeting
1 December 2021

Calum Campbell, Chief Executive NHS Lothian

INITIAL AGREEMENT - REPROVISION OF INTELLECTUAL DISABILITY AND NATIONAL INTELLECTUAL DISABILITY ADOLESCENT INPATIENT UNIT (NIDAIPU) & INITIAL AGREEMENT - REPROVISION OF INTEGRATED MENTAL HEALTH REHABILITATION AND LOW SECURE CENTRE

1 Purpose of the Report

1.1 The purpose of this report is to provide assurance to the NHS Lothian Board that appropriate consideration has been given to the Initial Agreements (IAs) for the Reprovision of Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU) and the Reprovision of Integrated Mental Health Rehabilitation and Low Secure Centre, ensuring alignment with Board strategy, and recognising and seeking to address the most significant challenges and opportunities.

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

2 Recommendations

2.1 The NHS Lothian Board are recommended to take assurance from the Lothian Capital Investment Group (LCIG), that appropriate consideration has been given to the IAs for the Reprovision of Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU) and the Reprovision of Integrated Mental Health Rehabilitation and Low Secure Centre including the key issues and risks identified below.

2.2 The NHS Lothian Board are recommended to approve the IAs with a view to progression to the Scottish Government Capital Investment Group.

3 Discussion of Key Issues

3.1 The Masterplan for the Royal Edinburgh Campus has previously been presented and supported at both LCIG and the Lothian Planning, Performance and Development Committee (PPDC). The submission of these two IAs represents the initial priority projects in development in support of this Masterplan.

3.2 The drivers behind the need for change and then main issues facing these two services are:

- There is currently no Mental Health low secure provision in the Lothian area
- There is no National Intellectual Disability Adolescent Inpatient Unit
- There are changes in local and national strategies which cannot be achieved in existing facilities
- The current buildings do not support the model of care services wish to strategically deliver

3.3 Collectively, these issues result in poor patient and relative experience and present a challenge for staff.

3.4 A core team has been established to support this project, led by Tracey McKigen, Service Director for Royal Edinburgh and Associated Services (REAS).

3.5 A detailed exercise has been undertaken to understand the service requirements for both services, this work has been completed in collaboration with stakeholders and their feedback has been incorporated in the development of the IAs. This work underpins the options appraisals, which have been updated from the previous IA approved for the site, acknowledging the different needs and environment.

3.6 The Initial Agreements were approved LCIG in September 2021 and PPDC and F&R in November 2021. The IAs have also been approved by the four Lothian IJBs.

3.7 The project supports the Corporate Objectives of NHS Lothian:

- **Improve Quality, Safety and Patient Experience** - the current facilities present an environment where it is challenging to provide services to patients. These projects seek to address these issues by providing an environment where patients can receive care in a more dignified and respectful manner including reducing the need for restraint and requirement for 1:1 observations. The provision of a Low Secure Unit within Mental Health will allow patients to be closer to home and families, rather than being in an out of area placement.
- **Improve the experience of our staff** – the current facilities present a challenge for staff and currently make it difficult for staff to provide the care and treatment that patients require. This effects staff morale and job satisfaction, which is resulting in high vacancy rates. By creating a suitable care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention.

4 Key Risks

4.1 There are interdependencies between both these cases in relation revenue funding, should both cases be progressed concurrently this risk would be mitigated. If the projects were to be progressed separately, specifically progression of the Intellectual Disability service first, this would result in a revenue gap of £583k until budgets could be released on completion of the Integrated Mental Health Rehabilitation and Low Secure Centre project.

4.2 The project team will be following the formal process for engagement with NHS Scotland Assure. As a recent addition to the assurance framework for projects this engagement could impact project programme or cost in a way that has not been fully quantified in the present IA.

4.3 If approved, the project will have its own risk register developed, including design, construction, contract, and post-contract risks.

5 Risk Register

5.1 No changes to NHS Lothian's corporate risk register have been identified as a result of these projects.

6 Impact on Inequality, including Health Inequalities

6.1 This paper does not include any policy changes which might impact unfairly on different sectors of the wider community served by NHS Lothian; however, an integrated impact assessment will be developed through the Business Case process should the IA be approved.

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

7.1 The individual proposals outlined here all bring the duty to inform, engage, and consult, so these actions are being taken forward by the core group with wider engagement with Service, Medical, Nursing, Estates, Facilities and Partnership (staff side) colleagues.

8 Resource Implications

Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU)

8.1 The estimated capital cost for the preferred option is £27.9m. Construction costs for the preferred option were estimated using a sqm rate provided from the independent quantity surveyors, which were given as a range, the upper of which has been assumed.

8.2 Optimism bias has been included at 34% of all costs, to reflect the stage of this project and the unquantifiable uncertainties surrounding it.

8.3 Annual revenue costs for the preferred option identified a funding gap of £583k, the projected gap can be managed through the projected underspend on the out of area budget until the out of area budget can be released in full on a recurring basis (following completion of the Low Secure Mental Health unit for NHS Lothian).

Integrated Mental Health Rehabilitation and Low Secure Centre

8.4 The estimated capital cost for the preferred option is £49.8m. Construction costs for the preferred option were provided by independent quantity surveyors through a Pathfinder process which then informed the Strategic Support Report. This involved exploring, in parallel with the architectural design development, opportunities for reducing the energy consumption of the proposed 60-bed Unit.

8.5 Optimism bias has been included at 25% of all costs, to reflect the stage of this project and the level of design already carried out.

8.6 Annual revenue costs show gap of £5.3m, however there is a £5.9m planned release of funding from the out of area budget in total which will offset this. The release from the out of area budget is achieved from the creation of a Low Secure Mental Health facility on the Royal Edinburgh Campus.

8.7 The planned release of out of area budgets underpins both planned developments on Campus - Learning Disabilities and Mental Health Low Secure and Rehabilitation. Overall, both initial agreements present a joint financial gap of £5.9m which is equivalent to the planned release from the out of area budget. In totality once the out

of area budget has been released both initial agreements are affordable on a recurring basis.

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20 November 2021
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List of Appendices

Appendix 1: Initial Agreement - Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU)

Appendix 2: Initial Agreement - Integrated Mental Health Rehabilitation and Low Secure Centre

Intellectual Disability and National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU)

NHS Lothian

Initial Agreement

Project Owner: Nickola Jones

Project Sponsor: Calum Campbell

Date: 20/10/2021

Version: 1.14

Version History

Version	Date	Author(s)	Comments
1.0	13/05/2021	Nickola Jones	Initial draft, pulling together progress to date
1.1	25/05/2021	Nickola Jones	Updating IA Title, developing case
1.2	27/05/2021	Nickola Jones	Updating Case based on service discussions and options appraisal
1.3	28/05/2021	Nickola Jones	Review and update of case
1.4	04/06/2021	Scott Taylor	Review and update of case
1.5	10/06/2021	Nickola Jones	Review and update of case
1.6	14/06/2021	Nickola Jones	Review and update of case
1.7	15/06/2021	Nickola Jones and Steve Shon	Review and update of case
1.8	16/06/2021	Nickola Jones	Review and update of case
1.9	16/06/2021	Laura Smith/Hamish Hamilton	Updates to Economic Case & Financial Case
1.10	20/07/2021	Laura Smith	Review and update of Financial Case
1.11	22/07/2021	Nickola Jones	Review and update of case
1.12	26/07/2021	Nickola Jones	Review and update of case
1.13	27/07/2021	Nickola Jones	Review and update of case
1.14	20/10/2021	Laura Smith	Review and update of case

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1. Executive Summary

1.1 Purpose

Intellectual Disability services are currently delivered on the Royal Edinburgh Hospital (REH) site from outdated, clinically challenging accommodation. As described in the Initial Agreement (IA) for an initial 2 bedded facility for the NIDAIPU, currently there is no inpatient intellectual disability facility in Scotland for young people over the age of 12 with mental health needs.

This IA makes the case for the development of an intellectual disability campus on the Royal Edinburgh Hospital Site. The campus would deliver high quality care for those requiring inpatient treatment as well as being a hub for training, learning and development in the area of managing patients with an intellectual disability with complex behavioural and mental health needs both within and out with hospital.

The campus will include 17 beds for the Lothian's and Borders Intellectual Disability patients and 4 beds for the national IDAIPU, as specified by National Services Scotland (NSS) and the Scottish Government.

1.2 Background and Strategic Context

This IA follows on from the implementation of Phase 1 of the Royal Edinburgh Hospital campus re-development. It seeks to build on knowledge gained from the first phase and to provide high quality facilities for those with an intellectual disability receiving inpatient care for their mental health. This case also incorporates 4 beds to implement the Scottish Government's ambition to provide inpatient care in Scotland for adolescents with mental health needs and an intellectual disability.

The case aligns with all current Scottish Government and local strategies and has been included in the four Lothian IJB Strategic Plans for 2019-2022.

Inpatient care for those with an intellectual disability is a delegated function in Lothian, which means that the four Lothian IJBs are responsible for setting the direction for the future. Therefore, the Royal Edinburgh Project Board has worked closely with colleagues from across the four Lothian IJBs to create a joined-up plan for Adults with intellectual disability.

The IJBs have agreed on a reduced bed number for adults with intellectual disability from a current funded capacity of 37 to 17 beds. This includes 2 beds for NHS Borders. The breakdown across the IJBs is as follows:

Table 1: Reduced Bed Numbers

IJB	New Bed No:
Edinburgh	10
West	2
East	2
Midlothian	1
Lothian	**15**
NHS Borders	2
TOTAL	**17**

1.3 Need for Change

The current accommodation in Lothian for patients with intellectual disability requiring inpatient admission is not fit for purpose. The ward environment does not meet care standards such as providing en-suite facilities, and sharing bathrooms presents problems with regards to dignity for this patient group. The ward environment makes it challenging for staff to safely manage patients, which has an impact on both patient's recovery and staff morale and wellbeing. There is a lack of therapeutic space for patients, making it difficult for them to practice the life skills required to go home, and to receive 1:1 therapy in a private environment. The need for change is further described throughout this case, supported by direct feedback from patients receiving treatment within the wards in June 2021.

The impact of not having access to dedicated assessment and treatment inpatient facilities for adolescents with intellectual disability and mental health needs in Scotland are:

- Children and young people remained in distress and under-treated at home or in unsuitable units, sometimes with high use of sedative medication and restraint
- Due to delays in admission and not admitting, families were highly stressed, managing severe self-injury, aggression and destructive behaviours in their children. Families managing changes in medication and other treatments in crisis stages at home.
- Dislocation from family and local services due to distance when admitted to specialist units in England (however it was noted that better clinical outcomes were achieved).
- Additional costs, nursing costs and ward environmental adaptations to safeguard and manage young people in adult and paediatric ward settings.

1.4 Investment Objectives

The investment objectives for this case are to:

- Shift the balance of care by reducing inpatient beds and developing pathways to support people with long term needs relating to their intellectual disability in residential settings
- Provide adequate space for the delivery of therapeutic activities and spending time with family
- Establish a high quality, safe and robust inpatient services which meet care standards such as providing en-suite bathrooms
- Establish an inpatient environment which provides adequate space for care which enables staff to deliver care in the least restrictive way possible
- Have a facility which meets the current standards for energy efficiency and sustainability
- Embed a realistic and sustainable workforce model using the whole multidisciplinary team (MDT)

1.5 The Preferred Option(s)

The preferred solution was identified as Option 4: New Build for Both Services on REH Site. This was identified as the preferred option because it ranked the highest it both the Non-Financial and the Economic Assessment. Option 4 delivers a greater number of the benefits that have been set out as the criteria for achievement from this project.

It is recommended that NHS Lothian proceeds with this option to Outline Business stage where the implementation of the solution shall be further developed and tested for value for money.

1.6 Readiness to proceed

A benefit register and initial high-level risk register for the project are available from Nickola Jones, Project Owner, on request. 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.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. Section 6.2 outlines the governance support and reporting structure for the proposal and section 6.3 details the project management arrangements.

1.7 Conclusion

This case clearly describes the need for improved accommodation for those with intellectual disability and mental health needs in NHS Lothian, it also describes the case for providing a bespoke 4 bedded facility for adolescents with these needs across Scotland, as requested by the Scottish Government and supported nationally.

The case presents first-hand feedback from those receiving care in the current facilities in NHS Lothian which provides a clear indication of the failings of the current environment. The Scottish Government and IJBs have a strategic direction to care for people in an inpatient setting only when that is the only possible solution. Therefore, when someone does require a hospital admission, it will be because they have a high level of need. The best quality environment is required to ensure those admitted receive the highest quality care, in an appropriate environment and supported by staff who feel valued and well equipped.

Co-locating the national unit with the local unit will create a centre of excellence for supporting people with intellectual disability both in hospital and in the community. It will become more attractive for staff to work in the units because there will be a variety of learning and training opportunities. The environment would be bespoke and fit for purpose and provide dignity to those requiring a hospital admission.

This case is supported by the 4 Lothian IJBs, NHS Borders and Borders IJB and is driven by a genuine desire to provide care for vulnerable patients in the best possible environment to give people the greatest chance of getting better and being able to go home. It is aligned with the ambition to shift the balance of care from hospital to community settings and exhibits NHS Lothian's commitment to this agenda.

2. The Strategic Case

2.1 Existing Arrangements

Intellectual Disability Wards

What is a Learning Disability?

The term learning disability is commonly used in the UK and is synonymous with intellectual disabilities, which is used currently internationally (These are not the same as learning difficulties which is a term that, in the UK, refers to a separate group of specific reading and writing disorders).

Following the recent revisions of international mental health diagnostic classification systems (ICD-11 and DSM-5), the terms Disorders of Intellectual Development or Intellectual Development Disorder are likely to be more widely used in the years ahead. Therefore, this case will use the term 'intellectual disability' or 'ID' throughout.

In Scotland, within the Keys to Life strategy (Scottish Government, 2013), people with learning (intellectual) disabilities are described as having a significant, lifelong, condition that started before adulthood, which affected their development, and which means they need help to:

- understand information;
- learn skills; and
- cope independently.

How many people have an intellectual disability?

About 16,000 school children and young people in Scotland have an intellectual disability. About 26,000 adults in Scotland have an intellectual disability and need support. Around 3,900 (15%) of these adults live in Lothian (Scottish Learning Disabilities Observatory 2021). For any of these needs the level of support will vary. A person with learning disabilities may need:

- occasional or short-term support;
- limited support, for example, only during periods of change or crisis;
- regular long-term support, perhaps every day; or
- constant and highly intensive support if they have complex or other needs which are related.

What does the existing inpatient service do?

The NHS Lothian Intellectual Disability Inpatient Service is designed to accommodate adults (18 years or over) across NHS Lothian with an intellectual disability, presenting with a range of mental health, forensic or behavioural support needs. The principle function of the service is to provide a period of systemic assessment of intense, severe, enduring or unpredictable high-risk behaviours, and

subsequently provide treatment and behavioural support plans to enable patients to live safely within their local community.

There are distinct pathways of assessment and treatment depending upon patient needs. These could be behaviours that challenge, those determined as forensic, or those with mental ill-health concerns which cannot be met within adult mental health services. It is also expected that the service should anticipate the needs of those with dementia.

People with an intellectual disability, with and without co-morbidities, can experience a range of physical disorders, which can add complexity to their presentation. They may require continuous observation, physical intervention and pharmaceutical interventions. Medical and psychiatric expertise is required for accurate diagnoses and effective treatment.

People with ID have higher incidence of preventable disease, divergent disease profile and lower life expectancy than the general population. Generally, this can be attributed to lifestyle factors, ability to identify early signs and manage symptoms of disease, along with chronic conditions that are associated with genetic and congenital disorders. It is also well recognised that people with ID experience a diverse and systemic range of health inequalities, and diagnostic overshadowing with symptoms of preventable disease attributed to their ID.

The intellectual disability service is specialist by nature, operating on a pan-Lothian basis for a specific cohort of patients, addressing specialist needs of the most acute individuals. It is the only NHS Lothian inpatient service of its type.

Model of Care

NHS Lothian provides the inpatient element of care for people with an intellectual disability and has strong links and interdependencies across primary and community care colleagues and intermediate care teams.

GPs, community service providers and intermediate care teams work with individuals in the community to support them at home wherever possible, and if an inpatient stay is required, that they are supported to be discharged home as soon as they can be.

Primary reasons for admission are a) deterioration in mental health state, b) medication review c) increased risk associated with forensic or distressed behaviour. Those receiving care can be described as belonging to three categories:

- Mental Health – presenting needs will be related to new emerging or chronic symptoms associated with schizo-affective disorders or depressive and anxiety disorders. Along with the secondary symptoms of self neglect and poor physical health and psycho-social status.
- Forensic – presenting needs will be related to high risk behaviours which would attract the attention of the criminal justice system such as violence, sexual assault or arson
- Distress behaviours – often associated with autism or other neurodiverse disorders with associate communication concerns and behaviours that challenge

In general, unless the individual can consent to a voluntary period as an inpatient, all patients must meet the psychiatric criteria to require a period of detention under the Mental Health (Care and Treatment) (Scotland) Act 2003. All patients who are detained have an allocated Mental Health Officer (MHO), and all patients have access to NHS Lothian funded Advocacy.

The model of care relies on close partnership working with the centrally funded Intermediate Tier of services: Mental Health Intensive Support Team (MHIST) and the Forensic Assessment and Support Team (FAST), along with the locality-based Integrated Community Learning Disability Teams to ensure appropriate patient progression and flow, supportive of their needs as they change.

The key functions that the intermediate teams provide are:

1) to work with community partners to step up care for a time limited period with additional intensive and assertive interventions to maintain people within their community, and mitigate against admission
2) when an admission to an adult mental health bed is required provide the additional ID expertise and support to enable positive outcome and experiences
3) support discharge planning and to work with community partners to step up for a time limited period with additional intensive and assertive interventions to maintain people within their community

Currently, the model of access to the service is as follows;

- Patients are admitted following community crises by Community Learning Disability Teams (CLDTs) or out of hours by GPs
- They are seen by MIHST, FAST, SBPST if time allows
- Patient flow involves appropriate, timely admission by the current clinical team to the appropriate inpatient area according to clinical need for assessment (forensic, mental illness, challenging behaviour)
- Following assessment and treatment the person should then progress to discharge home in a timely manner

Figure 1: Current Model of Access

The current model is one of “admit assessing”, described above.

Current Ward Establishment

There are currently 38 patients receiving care within the Intellectual Disability service which include patients within the core Royal Edinburgh Hospital site facilities including the William Fraser Centre (WFC) and Islay Centre. Off-site services include Primrose Lodge, Camus Tigh, and Glenlomond. The geographical locations are shown on the map below:

Figure 2: Map of current ward establishment

Current capacity is as follows:

Table 2: Summary of current capacity

Ward	Location	Current Funded Capacity	Current Use
Islay	REH Site	10	11
William Fraser	REH Site	12	13
Carnethy	REH Site	0	2
Primrose Lodge	Midlothian	3	1
Camus Tigh	West Lothian	6	6
Glenlomond	Edinburgh City	5	5
Total		36	38

Glenlomond, Camus Tigh, Primrose Lodge and WFC are all congregate living spaces – each patient has their own bedroom, but living areas and bathrooms are shared. All services have varying levels of security and all are locked using keys.

The Service also has patients currently placed in the REH, St John's Hospital, Midlothian Community Hospital in addition to Regional and National Hospitals. There are currently 7 people receiving care out of area.

Length of Stay

Lengths of stay in the Intellectual disability service are often measured in years, rather than days or months, with low turnover of patients in units, small numbers of admissions and discharges annually through a small number of beds. These long lengths of stay mean that the inpatient units are “home” for patients for several years. The lengths of stay range from 6 months to 10 years.

Currently the service is operating at 130% occupancy and experiencing 30% delayed discharges.

Services for Young People Aged 12-18 with Intellectual Disability and Inpatient Mental Health Needs

Currently there is no NIDAIPU in Scotland for young people over the age of 12. If a young person requires admission to hospital they have to travel to England for treatment or are cared for in an adapted setting which is designed for adults.

Following the completion of the 5 Year Survey of Need for Mental Health Inpatient Care for Children and Young People in Scotland with a Learning Disability and/or Autism, published by Scottish Government (2017), a Short Life Working Group (SLWG) was established to review access to mental health inpatient care for young people in Scotland with learning disability. The group aimed to address three distinct areas:

- To benchmark bed numbers and specification with NHS England
- To identify current expenditure in Scotland and revenue for proposed facility
- To develop a high-level service specification for a Learning Disability Child and Adolescent Mental Health Inpatient Service.

The SLWG concluded that a specialist inpatient unit was required for Scotland. The Directors of Planning asked NSD to undertake an options appraisal exercise to assess and identify the most effective, sustainable and person-centred model of delivery for specialist inpatient mental health care for children and young people with learning disability. The appraisal concluded that a 4 bedded facility was required. Boards were asked to express an interest to host the new facility.

Following a successful bidding process, NHS Lothian is the preferred host for the service. This unit would be located on the Royal Edinburgh Hospital campus alongside new facilities for adult learning disability services.

2.2 Drivers for Change

The following section expands on the need for change as identified in the Strategic Assessment (included in Appendix 1) and describes the anticipated impact if nothing is done to address these needs and why action should be taken now through this proposal.

Intellectual Disability Wards

The following paragraphs are supported by pictures included in Appendix 6.

Inappropriate Physical Environment

The Austin Smith Lord report describes that the buildings in which LD services are currently situated are not fit for purpose. The following paragraphs describe what that means in practice, both for patients receiving care and staff delivering it.

The buildings have shower rooms and toilets located on corridors, which means that if a patient requires support when using these facilities, the door has to be left wide open to enable staff to enter and support that patient, and other staff are required to make sure that no one else currently receiving care within the unit can see them. Due to the nature of this patient group there can be low impulse control and difficulty in communicating which may lead to patients leaving the bathroom in a state of undress, and because the shower opens into a public corridor, there is no privacy for that patient to walk to their room without clothes on. This situation represents a complete lack of dignity for those receiving care and a highly challenging situation for staff to manage, which also means higher levels of staffing. It also represents a lack of freedom for patients to be in a state of undress if they want to be in the privacy of the place in which they are receiving care. The location of the shower rooms and toilets also do not comply with Healthcare Acquired Infection (HAI) standards, which is even more pressing given current requirements to prevent the spread of COVID-19. One patient who did have access to their own shower room (due to their being fewer patients in the ward) said 'I like the shower room and not having to share'. Other patients said:

- 'I can't always use the bathroom when I want to'
- 'I'd like to have my own toilet and shower'
- 'I'd like to have my own bathroom and shower, not having to wait to go to the toilet or shower. It's bad if you have an appointment and you can't get in the shower – it makes you late'
- 'It's not fair that we have to share showers and toilets and you can't always get it when you want it'

The rooms in a large proportion of the LD estate are not wheelchair accessible and there is insufficient room to use hoists and stand aids if patients have physical disability requirements. Additionally, there are risks associated with ligature points due to standard doors being in place. In a new unit there would be doors with sensors which would alert staff if any weight was put on the door.

Supported by the Learning Disability Managed Clinical Network the current services based at REH Campus have been pursuing accreditation with the RCPsych standards[1]. There are fundamental limitations with achieving accreditation related to environmental, deficits and facilities available to patients, families and staff within the current services. only with systemic redesign and direct repurposing of environments will enable successful accreditation.

Patients within intellectual disability wards can also be hyper aware of any flaws associated with their living environment. There have been numerous incidents where there have been small holes in walls which patients have become very interested in and possibly want to try to fix or find out what is behind the wall, they therefore exhibit compulsive behaviours which lead to them picking at the wall and creating

[1] RCPsych Standard - https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-fourth-edition-standards.pdf?sfvrsn=5fce5d7f_2

further damage to the environment. There are also instances where walls are punched and kicked. With a more robust unit, these issues would not arise as often as the walls would be robust enough to withstand damage.

The Islay Centre presents a challenge for staffing because it has three different front doors to enter different parts of the unit. In order to ensure safe staffing levels at night there must be 3 staff nurses to cover each area of the unit as well as two nursing assistants to support each. This means there are 9 staff on each night for 11 patients. A smarter building design would reduce the need for additional staff.

Additionally, there are considerable safety implications of the current ward environment. Due to a lack of flexibility in the clinical space, there are instances where patients who have low inhibition and may remove clothing may also be sharing communal spaces with someone who has been admitted due to forensic reasons such as sexual inappropriateness. This means that there is limited access to shared spaces for some patients and these risks need to be managed by having high staffing numbers who can ensure each patient is safe. Additionally, there are a limited number of exits from the wards meaning that patients must pass the doors of other patients' bedrooms to leave the building. Again, due to the nature of this patient group, there are instances where one patient is unable to leave the building due to another patient requiring support from staff outside of their bedroom door and whereby it could be dangerous for that other patient to pass by. In other instances, it can be challenging for patients to re-enter the ward because the doors into the ward open straight onto the corridor with the doors of the other patients' bedrooms. Again, if there is an event happening for another patient in front of that door, other patients are unable to enter.

Lack of Therapeutic/General Space

Not only is the current accommodation physically challenging for staff to deliver care from, there is a lack of space available to deliver therapeutic activities which will support patients to be able to go home.

There are significant restrictions with regards to therapeutic space available in the wards. Patients are admitted to the LD wards due to significant challenging behaviours which require an intensive period of assessment and therapeutic intervention to enable them to go home and live as independent a life as is possible. It is therefore vitally important that they have access to their usual type of environment in an inpatient setting to practice key skills.

There is currently no therapeutic kitchen where patients can practice skills to support them to go home or for patients to use who are able to prepare their own food. There is no space to do art therapy activities and other OT activities. There is also no indoor space for any physical activity, which can be an important element of a patient's normal day which is currently denied to them in the current inpatient unit. Access to space for physical activity would have a positive impact on the mental and physical health of inpatients with an intellectual disability. Currently, the outdoor space available is situated next to a school playground, so there is a lack of privacy and can be distracting. Patients said:

- 'A kitchen I could use myself would be good for making snacks and meals'
- 'I'd like to be able to make some of my own food. I'd like to have more things to do'
- 'I think a kitchen for patients to use would be good – to keep up your skills and learning new ones making snacks and drinks and meals. I'd like more opportunities to keep active and fit and looking after myself'
- 'I'd like to have a kitchen that I could use to learn how to cook and make meals'

It is extremely challenging to do 1:1 intervention with patients as it is usually inappropriate to conduct therapeutic interventions within a patient bedroom, and the other spaces are communal and

therefore not private. Often this means that OT and Psychological interventions do not happen. Additionally, being able to associate certain spaces with certain activities is often important when supporting people with learning disabilities due to the nature of their condition. There is a requirement for certain sensory elements to be associated with a certain room, for example a bed and dark curtains in the place you go to sleep. This room being used for a purpose other than sleeping can be damaging to patients' understanding of what activity happens where, which can lead to further distress. Additionally, another challenge is access to washing machines. Generally, patients are supported to do their own washing if they are able to as this is an activity they will be doing when they go home, however, some people with an intellectual disability have specific preferences relating to their clothes, and some like to wash clothes every night to be ready to wear again the next morning. There is currently no access to washing machines on the wards. These factors in combination make the lack of therapeutic space detrimental to patient care and increases their length of stay due to an inability to practice skills required for going home.

Feedback from some of the patient's currently receiving inpatient care support this description:

- 'I have used the sitting room for therapy sessions- it's OK. I'd like a better place to meet with visitors'
- 'A big open space for therapy and some more private spaces for meetings with visitors, doctors or lawyers'
- 'There should be an art room and activity room, it would be more peaceful and quieter. I would be able to do my therapy better without people shouting and that'
- 'I mostly use my own sitting room for working with therapists and my support workers and social workers. It would be bad if I didn't have it. It might be good to have a therapy room where you could do groups and that with other people not just on your ward'

There is no private space outwith bedrooms for patients to meet with family members and friends. This means that there can be disengagement with the community in which patient's will be discharged to. This further impedes timely discharge. Patients commented:

- 'Can't watch TV in the sitting room because other patients talk over it so I have to watch in my own room so it can be quite lonely here'
- 'The sitting room is good when people I don't get on with are not around, but mostly I just use my own space'

Patients and staff see the value of being based on the REH site as there are opportunities to practice skills across the site. For example, patients can do garden related activities at the Cyrenians garden and they can practice selecting and purchasing items at the Royal Voluntary Service shop, both of which are safe and understanding environments.

Further to this, the current rooms are not large enough to enable NHS staff to work alongside third sector or private provider staff to train them on how to care for individuals. This is a critical part of the process for discharging people from hospital to home as often people within this patient group have very specific needs and preferences, and it takes time to build knowledge and trust with a new staff team before a patient is able to be discharged from hospital and for the teams to be confident that the community placement will be successful.

Lack of Storage

There is a lack of storage space in the wards, both for patient belongings and for equipment such as hoists and stand aids. People with an intellectual disability sometimes require there to be very

few and specific things in their room and there is currently very little storage space for people's personal belongings to be able to rotate items such as books to ensure they are not all out at once. One patient stated, 'There's not much space for anything here, just your own room'.

Staff Morale and Development

The current environment is damaging to staff morale and wellbeing. Staff often feel that they are managing the environment rather than supporting patients. The requirement for additional staff due to space challenges means that there is less to do for staff on shift and it can feel like they are just trying to keep someone safe rather than delivering treatment and support. It is disheartening for staff to be so restricted in the care they can provide, and they do not feel they are providing the best care possible for their patients. This results in low staff morale which can lead to increased rates of sickness absence and higher staff turnover.

Additionally, there is no space for staff to de-brief together about their approach to patient care. There is a high level of distress for this inpatient group which can often be communicated through self injury or injury to others. This means that it is essential that staff have space to speak to one another about what has happened and how they might approach patient care differently going forwards. For example, a Speech and Language Therapist or Occupational Therapist may be able to work with nursing staff to analyse a situation and formulate an understanding of what may have caused a certain behaviour in order to prevent it from happening again. Without space for this Multidisciplinary Team (MDT) discussion, often these discussions do not happen and therefore the number of instances of violence in the unit is higher than it could be.

The needs for change are summarised as follows:

- The Austin Smith Lord report describes that the buildings in which LD services are currently situated are not fit for purpose. Of particular importance for LD patients is robustness and space, a lack of which can lead to a higher level of restrictions for patients and a lack of dignity. Despite multiple upgrades to current accommodation, they continue to fall short of the needs of service users
- The shift in resource stated in this proposal will mean that those with longer term needs will be cared for in the community, however, those who will require hospital based care will therefore have more challenging needs and will require a robust, high quality, safe inpatient environment, which is also safe for staff to deliver care from
- NHS Lothian's Property and Asset Management Strategy states that the Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant
- There is likely to be increased demand for the service alongside population growth. This service development, alongside the development of sufficient community services, will support a high-quality inpatient service for this population
- Current LD accommodation is located across multiple sites meaning service delivery is more fragmented and high numbers of staff are required
- People want a safe place to live that is a 'home' rather than a hospital. There is currently not enough funding to provide alternative care in a community setting. Reducing the inpatient beds will release funding to enable people with LD currently living in hospital to move back to a community setting

A Joint Vision for the Future

Strategic Planning for LD is delegated to the four Lothian IJBs and over the last 5 years, colleagues from across the four IJBs have worked closely with the inpatient intellectual disability service to establish a joint plan for the future of LD inpatient services. This joint planning was conducted formally through the 'Pan Lothian LD Planning Group' which had a revolving chair across the Lothian IJBs and reported through members to their respective IJBs as well as to the Royal Edinburgh Campus Project Board.

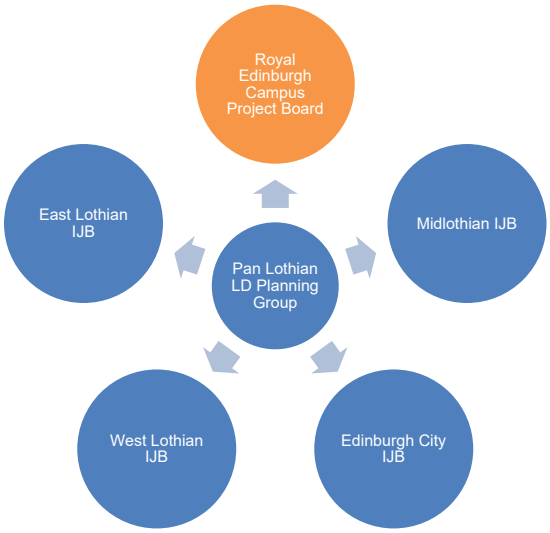

Figure 3: Collaborative Planning

The group has based the future proposals on the outcomes of extensive feedback from people from across Lothian with learning disabilities using inpatient and community services. This is summarised in the Edinburgh IJB Strategic Plan 2018-2021 –

"People with a learning disability continue to seek access to independent lives and to be accepted in their communities. We have taken positive steps towards achieving this, but we need to reshape how we provide support at different levels of engagement... We need to stop people 'living' in hospital and commission housing that can support people in the community. We intend to reshape how people interact with all our partners to better enable them to gain the independence they are entitled to and reinforce the commitment to on-going engagement"

The group has proposed a smaller inpatient intellectual disability service, commissioned by each of the IJBs, supported by robust community alternatives for those with an intellectual disability who have long term and complex needs. The group has worked extensively to assess the needs of those patients currently in hospital who have been there for a long time and have commissioned bespoke services to meet their needs. This proposal has been supported by all the Lothian IJBs and the NHS Lothian Board.

Most current inpatients are residents of Edinburgh and West Lothian. Both Health and Social Care partnerships (H&SCPs) have plans in place to provide a suitable Community response for those people who do not require to be in an inpatient beds and would not meet the criteria for admission if the legislation is to change. Timescales for discharge are as shown below:

Table 3: Planned LD discharges

Integration Authority	Current IP	Planned Discharges	Future IP or	Planned

		2021	2022	OOA	beds
East Lothian	2	0	1	1	2
Edinburgh	33	20	2	11	10
Midlothian	1	0	0	1	1
West Lothian	10	1	9	0	2
Totals	**46**	**21**	**12**	**13**	**15**

In addition, H&SCPS are putting in place several developments to strengthen Community support for this population. All H&SCPs have invested in Positive Behaviour Support training and it is anticipated the continuing focus on developing this across social work, community learning disability teams and commissioned services will impact upon planning to support adults to sustain community placements. Specifically, within each area the following developments are underway:

Edinburgh

- Edinburgh City are working to reduce reliance on the Voluntary Sector to provide community based packages of care and instead recruit staff with additional training in place to help minimise situations whereby packages of care break down with the default position being a hospital admission as a result.
- They have commissioned bespoke community packages of care and accommodation to facilitate discharges for patients currently in hospital to enable the reduction in bed numbers

East Lothian

- Within East Lothian, a new short break provision at Hardgate Court has been developed to support those with more complex needs. This includes an adjoining flat/safe space which can be used in crisis/emergency situations where 24 hours care can be provided utilising internal day services staff in an outreach role.
- In addition, East Lothian are currently developing an Autism Hub in Musselburgh which will provide care at home and housing support for individuals with Autism. The aim of the hub is to offer a community-based accommodation whilst developing a hub of support, information and advice to other providers, professionals and unpaid carers.
- East Lothian are also in the process of developing an enhanced LD service bringing together the ELCLDT and SW staff in to one team to provide specialist health and social care support to adults with Learning Disabilities.

West Lothian

- West Lothian HSCP is taking forward several actions to strengthen community-based support. This includes ongoing review and development of community resources such as the development of 16 tenancies to support individuals with complex care needs. The care delivered within the resource will be commissioned on the basis that POCs can flex as required dependent upon individual need.
- This is complemented by the development of additional core & cluster sites across the authority. The specialist disability framework for commissioned services has been refreshed to bring greater focus on developing Packages of Care that are response to changing need other than defined hours of service delivery.

Midlothian

- There has and continues to be low usage of hospital beds by Midlothian HSCP. Development of Teviot Court complex care service has supported this position. The release of funding will allow Midlothian to further strengthen the community provision to minimise the use of hospital beds.

NHS Borders currently have no adult LD beds and have advised commissioning intent for two in the new facility.

The overall total beds to be commissioned by the 5 IJBs and delivered by NHS Lothian is 17 as outlined in the table below:

Table 4: Summary of beds to be commissioned

IJB	New Bed No
Edinburgh	10
West	2
East	2
Midlothian	1
Lothian	**15**
NHS Borders	2
TOTAL	**17**

Core to the plan is the centralising inpatient LD services on the Royal Edinburgh Campus. This impacts on 3 buildings currently owned by NHS Lothian as follows:

- Primrose Lodge – will be taken over by Midlothian for conversion to a 4 bedded complex physical health facility
- Glenlomond – located directly on the outskirts of the main Royal Edinburgh Campus, potential for future use is being considered by current REAS services
- Camus Tigh – located in Broxburn there maybe opportunities to support with the overall plan for Complex Care provision by West Lothian H&SCP

Future Model of Care

The current model of care and bed base does not align with the strategic direction of IJB's and does not provide fit for purpose inpatient accommodation for people with learning disabilities when they need it. The reduced bed base means that only those with the highest level of need will be admitted to hospital, which creates a further need for the environment to be as safe and supportive as possible, and for staff to feel valued and equipped to deliver care. A new facility would provide the clinical space required to deliver the highest quality of care possible, including multidisciplinary therapeutic interventions and activities to support daily living.

The dependencies between GPs and other teams referring into the service, intermediate care teams supporting individuals at home and community teams caring for people at home or in residential settings have been the focus of the work with the five IJB areas; to ensure that the reduction in bed numbers in the inpatient facility is supported by enhanced community provision. This enhanced provision is described in Chart 1 below and is made up of intensive home support, which involves tenancy based high volume packages of care as well as day treatment facilities.

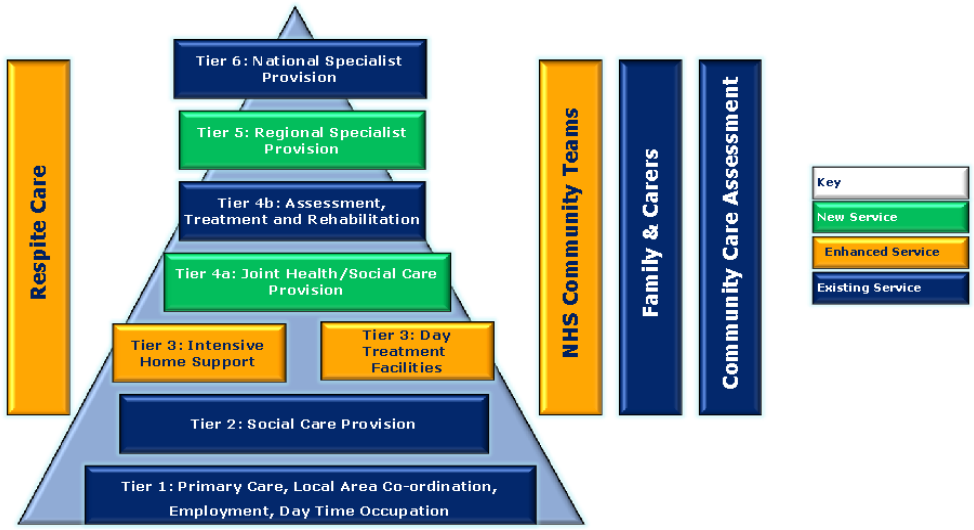

Figure 4: LD Service Tiers

The ambition of the new units will be to enable flexibility for patients to progress from different levels/ models/ types/ spaces of care to facilitate their treatment and progression towards discharge. It aims to use flexibility of staffing across LD disciplines to support key activities and enable continued care from community partners involved with patients who come for admission, involving them in interventions throughout the duration of inpatient admissions.

Establishing a high-quality facility which uses the model of assess to admit will mean that only those with identified, specific needs level of need will be admitted. This will be a benefit to patients, staff, family members and many other stakeholders because inpatient care will only be delivered to those who's needs can only be met within an inpatient setting.

To support this model the community LD teams, intermediate care teams and inpatient teams will work together to undertake initial assessments and formulation to identify and agree achievable outcomes with an admission. Intermediate care teams would be co-located with LD.

Alignment with National and Local Strategy

The Keys to Life is the Scottish Government's ten-year learning disability strategy for 2013 – 2022. It takes a human rights approach to addressing inequalities experienced by many people with learning disabilities. The national 2018-2020 Implementation Framework presents four strategic objectives - A Healthy Life, Choice and Control, Independence and Active Citizenship - to support local partnerships frame priority areas for action. This proposal is aligned with the strategic ambition to: 'Support services that promote independent living, meet needs and work together to enable a life of choices, opportunities and participation. Health and social care support services are designed to meet - and do meet - the individual needs and outcomes of disabled people.' (The Keys for Life Implementation Framework 2019-2021). The Keys to Life states: '*The need for people with learning disabilities to live independently, having the same choice, control and protection as all other citizens of Scotland in terms of the age-appropriate support they receive, is more relevant than ever'.* This proposal supports the realisation of this strategy by shifting the balance of care away from hospital-based services and towards community services. It does this by reducing bed numbers and transferring resources but also by proposing that a new facility is built to meet the specific needs of people with an intellectual disability when they are

admitted to hospital. This will mean that people who are admitted receive the best possible care that enables them to be discharged home or to a homely setting as quickly as possible. This proposal has been developed in partnership with health and social care providers and is supported by extensive community plans.

The Scottish Government policy position set out within the Keys to Life[2] and more recently within the Coming Home Report[3] and the Independent Review of Adult Social Care[4] is clear that people with IOD should access care and treatment within their local community and any admission to hospital requires to be outcome focussed and within as local a hospital to the persons community as possible.

In the Scottish Government's 'Learning/intellectual disability and autism: transformation plan' published in March 2021, there is a commitment to digital inclusion for those with an intellectual disability[5]. The designs which will be developed following approval of this case will incorporate digital elements from the beginning of the design process, ensuring maximum use of technology within the facilities to ensure that when people are in hospital, they are able to communicate well with friends and family.

In addition to these national strategies, there is a pending legislative change which will mean that people with an intellectual disability will only be able to be legally detained in hospital if there is a mental health requirement for their admission. While the service currently focuses on those with mental health needs, there are instances where patients are admitted due to a break down in their packages of care. The shift in resource from hospital to community described in this case will enable NHS and social care services to support people within their own homes more responsively, which should result in more support early and decreased likelihood of a breakdown of support.

The Scottish Government and COSLA's 'Coming Home' Report states that 'The Scottish Government wants to support Health and Social Care Partnerships (HSCPs) to find alternatives to out-of-area placements, and to eradicate delayed discharge for people with learning disabilities'. This case would support the achievement of this goal by improving pathways across NHS Lothian for people with an intellectual disability. Improving the inpatient element of care will mean that there is more appropriate therapeutic and living space for those admitted to hospital, which will mean that they are able to practice and maintain their skills for going home rather than becoming de-skilled while in hospital. This will help to decrease delayed discharges.

The Lothian Hospitals Plan describes the Royal Edinburgh Hospital as one of the four key strategic planning priorities for NHS Lothian alongside the 4 Lothian IJB's and Borders IJB. The 4 Lothian IJB's strategic plans state the intention to support the re-design of the REH campus alongside the development of broader care pathways for people with an intellectual disability. This broader piece of work is focused on ensuring people have access to treatment outwith an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service. The reduction in bed numbers described in this IA aids the realisation of these local aims.

Austin Smith Lord, an architectural practice with extensive masterplanning experience, was commissioned to undertake a study of the REH campus prior to the publishing of the IA in 2011. Their study concluded that most of the existing buildings were not fit for purpose and the majority could not efficiently be converted into single bedroom ward accommodation.

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[2] https://keystolife.info/

[3] https://www.gov.scot/publications/coming-home-complex-care-needs-out-area-placements-report-2018/

[4] https://www.gov.scot/groups/independent-review-of-adult-social-care/

[5] https://www.gov.scot/publications/learning-intellectual-disability-autism-towards-transformation/pages/11/

A key part of NHS Lothian's service delivery is ensuring best use of estate in supporting operational and corporate delivery. To achieve this, the Board has in place a Property and Asset Management Strategy (PAMS). NHS Lothian's current strategy reflects its commitment to improving the healthcare environment whilst reducing the number of hospital and other sites it currently manages, to reduce property expenditure. The Royal Edinburgh Hospital site is a major part of this strategy and its retention has been predicated on the aim to maximise its development potential. This decision has been reviewed through various updates to the site masterplan (most recently in 2019) and it continues to be viable.

The Scottish Government's commitment to deliver a greener, zero carbon Scotland will be pursued through a focus on sustainability in this new development. In this way NHS Lothian will continue to maximise the sustainability of its estate.

Services for Young People Aged 12-18 with Intellectual Disability and Inpatient Mental Health Needs

Evidence for the 5 Year Survey identified that between 2010 and 2014, at least 45 children and young people with intellectual disability required specialist inpatient mental health treatment which was not available in Scotland and were admitted elsewhere as shown below:

- Adult Learning Disability Wards (including secure units) – 30%
- Adult Mental Health Units (including intensive care and secure units) – 28%
- Child and Adolescent Mental Health Units – 16%
- Paediatric Wards – 5%
- Not admitted – 8%
- Specialist Units in England: 13%. Reasons for cross border transfer not being used included distance, lack of bed availability, clinician awareness of option to transfer, cross-border Mental Health Act issues and family refusal.

Of the 45 young people who were admitted from across NHS Boards, 70% of these patients were male; 36 were aged 14-17 years and nine were 13 years or under.

The impact of not having access to dedicated assessment and treatment inpatient facilities in Scotland are:

- Children and young people remained in distress and under-treated at home or in unsuitable units, sometimes with high use of sedative medication and restraint
- Due to delays in admission and not admitting, families were highly stressed, managing severe self-injury, aggression and destructive behaviours in their children. Families managing changes in medication and other treatments in crisis stages at home.
- Dislocation from family and local services due to distance when admitted to specialist units in England (however it was noted that better clinical outcomes were achieved).
- Additional costs, nursing costs and ward environmental adaptations to safeguard and manage young people in adult and paediatric ward settings.

One specialist NIDAIPU for Scotland would provide rapid, planned, safe and effective specialist holistic assessment and treatment closer to home, whilst also acting as a focus to support and build up community learning disability support across Scotland.

The Scottish Government has tasked NHS Lothian with providing a 4 bedded national unit for young people aged 12-18 who have an intellectual disability and a significant mental health need. This has

been supported by the national Chief Executives group and revenue funding on a national basis has been agreed through National Services Division (NSD). As a first step, NHS Lothian is providing a 2-bed facility by refurbishing one of its existing buildings and this case is for the next phase which is to provide a 4 bedded bespoke facility for this patient group. The 2-bed unit is an interim solution and will not provide the bespoke environment with enough therapeutic space and links to wider ID services in the way that the 4 bedded unit will.

The NIDAIPU 4 bedded unit is being included in the wider IA for Adult Intellectual disability wards in NHS Lothian because there are economies of scale by both commissioning the building services together and recruiting and retaining staff. There may also be opportunities for enhanced gym and outdoor space for the 4 bedded unit since it will be co-located with the adult unit. There would be careful consideration on how any shared space would be used given the vulnerability of the young people being cared for within the unit.

The table below summarises the need for change, the impact it is having on present service delivery and why this needs to be actioned now:

Table 5: Summary of the Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
Local and national strategies aim to ensure people have access to treatment out with an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service	The organisation is currently not meeting the strategic goals of the four Lothian IJBs. Therefore, the proposal set out within this IA is to reduce the number of beds within the adult learning disabilities service and transfer investment into community services.	The intention to commission new facilities for people with learning disabilities on the REH campus is stated in the plans of the 4 Lothian IJBs. There is pan-Lothian agreement on this proposal. Reduction in acute hospital beds is required to transfer resource to community alternatives.
There is currently a lack of space for therapeutic activities, including therapeutic interventions, space to practice skills for discharge and space to spend time with family	Poorer outcomes for patients who are admitted to hospital because there is a lack of space to deliver therapeutic activities which would provide them with skills required to be discharged. Patients may also struggle to maintain good links with family and friends as there is no space in the inpatient unit to meet with them.	Patients continue to receive care in environments which do not enhance their treatment and recovery. They may lose some ability to maintain key relationships which may be important to their recovery.
Existing buildings are not fit for purpose and the majority cannot efficiently be converted into single bedroom/bathroom ward accommodation	The organisation is failing to meet requirements such as having single, en-suite rooms. Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older.	The redevelopment is required now to provide a safe, financially sustainable and high-quality environment to those requiring inpatient care for a long-term mental health illness

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
The existing buildings are not safe for staff to deliver care from due to their size and configuration	The organisation is at risk of placing higher levels of restrictions on patients with an intellectual disability and of buildings being unsafe for staff to deliver care from	Staff are under continued pressure to deliver care in a challenging environment. This makes the work highly stressful, which can lead to higher rates of sickness absence and staff turnover
Existing buildings have poor energy efficiency	Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint	Spending on energy is higher than it could be because it is not efficient or sustainable
There are significant workforce challenges, particularly within nursing	High vacancy rate across mental health services	The proposed bed reduction in Adult LD will enable the recruitment of staff for the new 4 bedded NIDAIPU facility. The LD campus will help to attract and retain staff
There is no NIDAIPU in Scotland	Young people over the age of 12 are inappropriately admitted to the wrong hospital settings. Historically they often travelled to England for treatment, however due to reduced capacity in England they stopped accepting referrals from Scotland therefore we no longer have access to these beds.	A SLWG have concluded that a specialist inpatient unit is required for Scotland and this should be located on the Royal Edinburgh Hospital Campus

2.3 Investment Objectives

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

Table 6: Investment Objectives

Effect of the need for change on the organisation	What must be achieved to deliver the necessary change? (Investment Objectives)
Poorer outcomes for patients who are admitted to hospital because there is a lack of space to deliver therapeutic activities which would provide patients with skills required to be discharged. Patients may also struggle to maintain good links with family and friends as there is no space in the inpatient unit to meet with them.	Provide adequate space for the delivery of therapeutic activities and spending time with family
The organisation is failing to meet requirements such as having single, en-suite rooms.	Establish a high quality, safe and robust inpatient services which meet care standards such as

Effect of the need for change on the organisation	What must be achieved to deliver the necessary change? (Investment Objectives)
Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older.	providing en-suite bathrooms
The organisation is at risk of placing higher levels of restrictions on patients with an intellectual disability and of buildings being unsafe for staff to deliver care from	Establish an inpatient environment which provides adequate space for care which enables staff to deliver care in the least restrictive way possible
Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint	Have a facility which meets the current standards for energy efficiency and sustainability
High vacancy rate across mental health services	Realistic and sustainable workforce model using the whole multidisciplinary team (MDT)
Young people and their families sometimes must travel to England for treatment. This is both challenging for the young people and their families in terms of practicalities of visiting and support as well as being less clinically effective as the young person is further from home and therefore their day to day meaningful activities	Development of a dedicated inpatient unit in Scotland.
Young people are being cared for in inappropriate settings such as adult wards. This means that both the staff caring for them and the environment in which they are being cared for are not fit for purpose.	Development of an initial specialist inpatient unit of 4 beds on the Royal Edinburgh Hospital campus, negating the need to use adapted adult LD environments for this service user group.
Adult intellectual disability beds are being used to care for young people, reducing the capacity within the adult LD service which may lead to a delay in admission for an adult requiring hospital care.	
Young people with learning disabilities are being admitted to inappropriate environments which do not have the facilities to meet their educational needs.	Development of an appropriate educational space within the 4 bedded specialist unit, supported by the right educational support.
Young people are being admitted to facilities which are far from their parents and that have no facilities for parents to stay overnight.	Development of dedicated space for young people and their families, including provision for overnight stays for parents.
There is no dedicated centre for excellence for care of young people with learning disabilities in Scotland. This means that there are inconsistent pathways for this group when an inpatient admission is required.	Develop a centre for excellence on both community and inpatient care for young people with learning disabilities. This means that referral for admission to the national unit is only made when there is no other community-based option. It will also be a consistent centre for advice and outreach to support community teams.

2.4 Benefits

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; Efficient: Value and Sustainability

The above investment objectives and the Strategic Assessment (see Appendix 1) have informed the development of a Benefits Register (available from Nickola Jones, Project Owner, on request). 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.

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

1. Make the environment in which patients receive care more dignified and respectful of human rights by providing privacy en-suite bathrooms
2. Improve the environment in which patient receive care to reduce the need for restraint and requirement for 1:1 observations which should reduce reportable incidents
3. The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention
4. Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends
5. The creation of an LD campus on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments. This will make LD in NHS Lothian a more attractive place to work and will help to support the staff we already have to enjoy their roles and continue to work in Lothian
6. A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site
7. There will be a new, high quality, bespoke 4 bedded service for young people aged 12-18 with an intellectual disability with significant mental health needs which will serve the whole of Scotland

2.5 Strategic Risks

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:

- Unable to meet demand;
- Unable to recruit and retain staff;
- Unable to manage the needs of all patients' needs within the space available;
- Inappropriate level of restrictions due to building layout and configuration;
- Inability to meet needs of young adults i.e. 16 to 18yrs old;
- Number and frequency of adverse events is unacceptable; and
- Lack of enough time and resource to plan for new model and redevelopment.

Table 7: Strategic Risks

Theme	Risk	Safeguard
Workforce	High level of staffing required for the NIDAIPU, recruitment to all posts, particularly nursing, will be challenging	The reduction in the bed numbers for Adult LD will release trained staff who will be able to work with adolescent patients
Funding - Capital	NHS Lothian is aware that there is a high level of demand for capital funds across Scotland, therefore there may be challenges securing capital funding	The project team have worked to ensure the proposal presents best value.
Funding - Revenue	IJBs will be required to issue directions to both reduce the bed base and transfer funds to community services	The project team has worked closely with IJB colleagues to ensure the proposal is supported by all four Lothian IJBs
Capacity	This proposal is for a reduced bed base for learning disabilities. The model of care and community provision to support this can be delivered out with this case, however, if not delivered, there is a risk that there will not be enough beds when the new facility is built	The four Lothian IJBs are already working to identify community alternatives for those with learning disabilities currently in hospital who could be cared for in the community.
Training	There is currently no facility for inpatient ID care for those aged 12-18, therefore, additional training will be required to meet the needs of this patient group	There is a well-established Intellectual Disability community team within the CAMHS service, who will lead on the development of the NIDAIPU. They will ensure that staff are appropriately trained.
Green space assets on site	Green space is an important element of treatment for people receiving care on the site. There is a risk that this is compromised as development happens on the site.	The project team are working to ensure there is as minimal disruption as possible as works go forward. Green space is an important consideration within the design of the build and will be incorporated into any plans.

A register of strategic risks is available from Nickola Jones, Project Owner, on request. The risk register was developed at a workshop of key stakeholders in July 2021. A full risk register will be developed for the project at the OBC stage.

2.6 Constraints and Dependencies

The key constraints to be considered are:

- Workforce availability is a key constraint for this case. The availability of sufficient multidisciplinary staff, particularly nursing, for the NIDAIPU is dependent on the reduction in bed numbers in Adult LD, which would release staff to be able to work within the national unit Capital availability may also be a constraint due to a high demand on Scottish Government Capital Finance

The key dependencies to be considered are:

- The proposal to reduce the bed numbers in Adult LD is dependent on community-based developments as alternative places of care for those currently in hospital, these developments are described above
- The proposal is for the upgraded or new LD campus to be built on the site of the existing accommodation for Adult LD. Therefore, any building works may displace patients currently receiving care within the wards. The case is therefore dependent on the provision of alternative community accommodation being available to reduce the inpatient numbers sufficiently that patients can be moved around the existing accommodation as work is undertaken.

3. Economic Case

3.1 Do Minimum/baseline

The table below defines the 'Do Minimum' option, a 'Do Nothing' option is not feasible as the service would still be required and would require building maintenance; therefore, the Do Minimum solution has been selected as a baseline. This is based on the existing arrangements as outlined in the Strategic Case.

Table 8: Do Minimum

Strategic Scope of Option	Do Nothing
Service provision	Learning disabilities inpatient services would continue to be delivered from unsuitable accommodation as described in the 'Current Model of Care' section above
Service arrangements	Intellectual disability services would continue to be delivered by NHS Lothian from the REH and other sites across Lothian
Service provider and workforce arrangements	NHS Lothian would continue to provide staff and services at a higher staffing level than would be required in a bespoke facility
Supporting assets	Standard maintenance work as required to maintain existing standard (backlog maintenance on REH site is circa £16 million)
Public & service user expectations	People receiving care within the intellectual disability wards would continue to receive care in poor quality environments. They may experience a higher level of restriction as a result, leading to poorer clinical outcomes for them as well as having the potential to cause them more harm during their stay in hospital

3.2 Engagement with Stakeholders

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

Table 9: Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
Patients/service users	Patients and service users affected by this proposal include patients receiving care within intellectual disability wards. Their involvement in its development includes being involved with the development of the clinical model through the Patients Council and have provided direct feedback on the current environment through a supported interview conducted by a lead OT in May/June 2021. The impact that this has had on the proposal's development includes additional evidence to support a move towards en suite bathrooms to promote privacy.	Patient / service user groups were consulted on the Initial Agreement and their feedback is included in the Strategic Case and has been incorporated into this proposal.
General public	The general public will not be directly affected by this proposal. There has been public consultation around Phase 1 of the campus re-development and the proposal to develop the intellectual disability inpatient wards on the REH campus has been included in the Strategic Plans of the four Lothian IJBs, which have undergone extensive public consultation.	Outcomes from consultation have not affected this proposal thus far. Further public consultation will be undertaken as the business case develops.
Staff/Resources	Staff affected by this proposal include all the multidisciplinary team required to deliver care within the proposed wards. Their involvement in its development includes being involved with developing the clinical brief.	Staff representatives were consulted on the Initial Agreement their feedback has been incorporated into this proposal.
Other key stakeholders and partners	Other key stakeholders identified for this proposal include health and social care partnerships, IJBs and hub. Their involvement in the development of this proposal includes being members of the Project Board.	Confirmed support for this proposal has been gained through the IA being presented to the four Lothian IJBs following support from the Project Board.

3.3 Long-listed Options

The table below summarises the long list of options identified:

1. **Do Minimum**

2. **Transfer services to wards on an existing NHS Lothian Acute site**

   Accommodate the Adult LD wards and NIDAIPU on another of NHS Lothian's sites – the Western General Hospital, the Royal Infirmary of Edinburgh, St John's Hospital, East Lothian Community Hospital

3. **Transfer services to alternative wards on REH site**

   There is no alternative venue available on the site which could be used for this patient group.

4. **Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU**

   Refurbish existing facilities on the REH site for both Adult LD and the NIDAIPU, currently used by Adult LD.

5. **Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU**

   Refurbishment of current LD facilities for Adult LD and new build facility for the 4 bedded national NIDAIPU.

6. **New Build for both services on the Astley Ainslie Hospital Site**

   The Astley Ainslie Hospital site is also located in Morningside and currently provides rehabilitation services, including the SMART centre. There may be land on this site which could be used for a new build facility.

7. **New Build for both services on the REH Site**

   There is a piece of unused land in close proximity to the current adult intellectual disability facilities which can be used to build a bespoke CAMHS Leaning disabilities inpatient unit with sufficient capacity to include the required additional facilities such as family room, educational suite and the potential to consider shared therapy suites as appropriate. There is also space on site which could be used to build a new, high quality, robust facility for adult LD.

Table 10: Long-listed options

Strategic Scope of Option	Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4 – New Build for both services on REH site
Service provision	Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU.	Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU.	Reduction in LD bed numbers to 17. Creation of 4 beds for NIDAIPU.
Service arrangements	NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'	NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'.	NHS Lothian staff would deliver inpatient LD care on the REH site. Move to a new model of care of 'assess to admit' rather than 'admit to assess'.

Strategic Scope of Option	Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4 – New Build for both services on REH site
Service provider and workforce arrangements	NHS Lothian will continue to be the service provider.	NHS Lothian will continue to be the service provider.	NHS Lothian will continue to be the service provider.
Supporting assets	May have some provision for enhanced therapeutic space, but this will depend on availability of space	May have some access to enhanced therapeutic space to improve treatment and patient care	Treatment would be delivered in a high-quality environment with the least restrictions possible, with access to therapeutic space for treatment and socialisation
Public & service user expectations	Public and service user expectations would be partially met as existing accommodation would be improved and would be supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible	Public and service user expectations would be partially met as existing accommodation would be improved and would be supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible	Public and service user expectations would be met as there would be a top spec intellectual disabilities campus supported by a model of care which prioritises keeping people at home or in a homely setting wherever possible

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

- The transfer of services to wards on alternative NHS Lothian site was discounted due to the existing capacity pressures on the acute sites in NHS Lothian
- The transfer of services to alternative wards on the Royal Edinburgh Hospital site was discounted as there is no alternative accommodation available that would meet the needs of this patient group
- The option to build on the Astley Ainslie Hospital site was discounted because NHS Lothian Hospital's Plan states that NHS Lothian is moving towards only having 4 main hospital sites, one of which is the Royal Edinburgh Hospital site, which makes it the preferred site for any new build

Initial Assessment of Options

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 11: Assessment of options against investment objectives

	Do Minimum	Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4 – New Build for both services on REH site
Advantages (Strengths & Opportunities)	Lower associated costs	Potentially lower associated costs. The ID and NIDAIPU services are refurbished to meet current standards and statuary requirements. Delivers on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU	The ID service is refurbished to meet current standards and statutory requirements. Delivers on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU	Meets Scottish Government health building requirement for the provision of single bedroom with en-suite facilities. Consistent with the benefits register. Newly build Integrated centre comprising of ID and NIDAIPU. Delivers on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU Bespoke new service where staff want to work Optimises energy efficiency and compliance with 0 carbon
Disadvantages (Weaknesses & Threats)	Non-compliance with several current standards and statutory requirements Does not deliver on the requirement for NHS Lothian to provide 4 beds for the NIDAIPU Outdated facilities do not attract new staff to work within	Some non-compliance with several current standards and statutory requirements. Lack of additional therapeutic space which would improve patient outcomes. Facilities without adequate therapeutic space do not help to attract staff	Some non-compliance with several current standards and statutory requirements Lack of additional therapeutic space which would improve patient outcomes. Does not optimise energy efficiency and compliance with 0 carbon	Availability of capital funding

	Do Minimum	Option 2 - Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3 - Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4 – New Build for both services on REH site
	the units Does not optimise energy efficiency and compliance with 0 carbon	Does not optimise energy efficiency and compliance with 0 carbon		
	Does it meet the Investment Objectives (Fully, Partially, No, n/a)?			
Investment Objective 1	Yes	Yes	Yes	Yes
Investment Objective 2	No	No	No	Yes
Investment Objective 3	No	Partially	Partially	Yes
Investment Objective 4	No	Partially	Partially	No
Investment Objective 5	No	No	No	Yes
Investment Objective 6	No	Yes	Yes	Yes
	Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)			
Affordability	Yes	Unknown	Unknown	Unknown
Preferred/Possible/Rejected	Rejected	Possible	Possible	Preferred

3.4 Short-listed Options and Preferred Way Forward

Shortlisted options

From the initial assessment above the following short-listed options have been identified:

Table 12: Short Listed Options

Option	Description
Option 1	Do Minimum
Option 2	Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU
Option 3	Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU
Option 4	New Build for both services on the REH Site

Non-financial benefits assessment

Each of the shortlisted options was assessed against the benefits included in the benefits register available from Nickola Jones, Project Owner, on request. Each of the identified benefits was weighted and following this each of the shortlisted options was scored against its ability to deliver the required benefits. Scoring took place at a workshop with key stakeholder representatives in July 2021.

The results of the benefits assessment are summarised below:

Table 13: Results of Non-Financial Benefits Assessment

#	Benefit	Weight (%)	Option 1	Option 2	Option 3	Option 4
1	Make the environment in which patients receive care more dignified and respectful of human rights by providing en-suite bathrooms	25	1	6	8	10
2	Improve the environment in which patient receive care to reduce the need for restraint and requirement for 1:1 observations	20	0	4	6	10
3	The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention	20	1	5	7	10
4	Patient outcomes will be improved and length of stay will	25	0	0	5	10

#	Benefit	Weight (%)	Option 1	Option 2	Option 3	Option 4
	be reduced due to increased access to spaces where therapeutic activity and activities can be delivered and where they can spend time with family and friends to maintain skills and relationships and meet social care staff.					
5	The creation of an LD campus on the Royal Edinburgh Site will become a centre of excellence which will provide more educational opportunities on site as well as enhancing skills through working within different care environments. This will make LD in NHS Lothian a more attractive place to work and will help to support the staff we already have to enjoy their roles and continue to work in Lothian	5	1	4	7	10
6	A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site	5	1	6	8	10
Total Weighted Benefits Points			55	380	660	1000

From the table above it is noted that the options that will deliver the most benefits is Option 4, which is therefore the preferred option.

Indicative costs

The table below details the indicative whole life costs associated with each of the shortlisted options. For further detail around the determination of the costs see the Financial Case.

The additional assumptions associated with the calculation of the NPV of costs are:

- A discount rate of 3.5% has been used in line with Government guidelines.
- A useful life of 29 years for refurbishment projects (Options 2 and 3), as this is in line with the remaining useful life of the Royal Edinburgh Buildings, a useful life for a new build has been determined as 50 years (Option 4).
- The base date for the proposal is September 2022.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.
- VAT and Inflation are excluded in the NPV calculation – whole life capital costs.

Table 14: Indicative Costs of Shortlisted Options

Cost (£k)	Do Minimum	Option 2	Option 3	Option 4
Capital cost	346	15,314	17,707	27,874
Whole life capital costs	288	12,411	14,350	22,589
Whole life operating costs	223,267	242,845	247,642	318,666
Estimated Net Present Value (NPV) of Costs	**223,555**	**255,256**	**261,992**	**341,255**

Overall assessment and preferred way forward

The table below show the weighted benefit points for each shortlisted option, the NPV of costs and the calculated cost per benefit point. This calculated cost per benefit point has been used to rank the options and identified the preferred way forward.

Table 15: Economic Assessment Summary

Option Appraisal	Option 1	Option 2	Option 3	Option 4
Weighted benefits points	55	380	660	1000
NPV of Costs (£k)	223,555	255,256	261,992	341,255
Cost per benefits point (£k)	4,065	672	397	341
Rank	**4**	**3**	**2**	**1**

The preferred solution was identified as Option 4: New Build for Both Services on REH Site. This was identified as the preferred option because it ranked the highest it both the Non-Financial and the Economic Assessment. Option 4 delivers a greater number of the benefits that have been set out as the criteria for achievement from this project.

It is recommended that NHS Lothian proceeds with this option to Outline Business stage where the implementation of the solution shall be further developed and tested for value for money.

3.5 Design Quality Objectives

Design quality objectives have been developed for the preferred strategic / service option by taking the following steps:

1. An AEDET review of existing property arrangements has been undertaken to set a benchmark score from which change is needed.

2. A second multi-stakeholder AEDET review has been undertaken which has identified the main features the new proposal will need to focus on and has set a target score from which design expectations can be measured

3. Design objectives that explain what the design needs to achieve to improve on the existing arrangements have been outlined in the NDAP Design Statement (available from Nickola Jones, Project Owner, on request).

The AEDET worksheets demonstrate how the target for improvement has been set against the existing arrangements.

4. The Commercial Case

4.1 Procurement Strategy

The indicative cost for the preferred option at this stage is £28m including VAT. It is anticipated that the procurement of the project will be led by NHS Lothian supported by Turner Townsend (technical advisers), Thomson Gray (cost advisers), and Burness Paull (legal advisers).

The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that it will be undertaken in conjunction with Hub South East Scotland Ltd acting as NHS Lothian's development partner.

4.2 Timetable

A detailed Project Plan will be produced for the OBC. At this stage the table below shows the proposed timetable for the progression of the business case and project delivery milestones:

Table 16: Project Timetable

Key Milestone	Date
Initial Agreement approved	December 2021
Hub appointed	January 2021
Outline Business Case approved	March 2023
Planning permission in principle obtained	In place – expires March 2022 – would require extension
Full Business Case approved	September 2023
Construction starts	November 2023
Construction complete and handover begins	March 2025
Service commences	May 2025

5. The Financial Case

5.1 Capital Affordability

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.

Table 17: Capital Costs

Capital Cost (£k)	Option 1: Do Minimum	Option 2: Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3: Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4: New Build for both services on the REH Site
Construction	199	7,429	8,589	13,521
Inflation	8	261	302	475
Professional Fees	-	900	1,041	1,639
Equipment	6	278	321	506
IT & Telephony	2	93	107	169
Contractor Risk	-	675	781	1,229
Optimism Bias	73	3,276	3,788	5,963
Total Cost (excl VAT)	**288**	**12,912**	**14,929**	**23,502**
VAT	58	2,582	2,986	4,700
VAT Recovery	-	(180)	(208)	(328)
Total Capital Cost	**346**	**15,314**	**17,707**	**27,874**

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

- Construction costs for Option 2, 3 and 4 have been estimated using a sqm rate provided from the independent quantity surveyors, which were given as a range, the upper of which has been assumed. Costs for option 1 were provided from the NHS Lothian Estates Manager for the Royal Edinburgh site.
- An inflation allowance of 4%, provided by NHS Lothian's external cost advisors, has been included using a base date of September 2022 and the construction timeline detailed in the Commercial Case. This allowance will need to be further refined as the project progresses due to the volatility in the market currently. The table below includes a sensitivity analysis on Inflationary amount only due to this level of uncertainty.
- Professional fees are assumed to be 10% of the total Capital costs provided or estimated.
- Furniture, Fitting & Equipment has been estimated at 3% of total costs, based on another recent project. This has been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.

- IT & Telephony has been estimated at 1% of total costs, based on another recent project. This has been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.
- Contractor Risk is included at 7.5% as advised by the independent quantity surveyors.
- Optimism bias has been included at 34% of all costs in line with SCIM guidance. The optimism bias calculation is available on request.
- VAT has been included at 20% on all costs. Recovery has been assumed on Professional Fees only – no further VAT recovery has been assumed. VAT recovery will be further assessed in the OBC.

Over the last twelve to eighteen months there has been a decline in the Tender Price Index (TPI) but a sharp rise in the Building Cost Index (BCI). This reflects the difficult economic conditions. This impact was initially felt by main contractors with fixed price contracts and, the cumulative pressure due to increased material prices. The knock-on effect has been transferred to the client side as contractors look to correct or offset the reduction in margin on existing contracts. When pricing new projects, contractors are inflating their prices (or are qualifying tenders) in order to return their margin to a manageable position and to offset the increase in building costs and risk. This will ultimately result in a rise in the TPI which will need to increase to a position above the BCI which could represent a large jump in inflation. It is unknown how long this fluctuation will last and what impact this will have on inflation.

The impact of the COVID-19 pandemic on future projects is still relatively unknown, the capital costs presented do not have an allowance for a programme extension. It would therefore be prudent to consider a possible impact on costs, should the programme have to be extended.

The sensitivity analysis below aims to set out the possible impact on the total project costs should inflation rise or reduce as well as an extension to programme.

Table 18: Inflation & Programme Extension Sensitivity Analysis

	Total Capital Costs (£k)			
Sensitivity Scenario	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Scenario 1: no changes (4%)	346	15,314	17,707	27,874
Scenario 2: inflation percentage doubles (8%) and programme extends (10 weeks) *	359	16,259	18,739	29,278
Scenario 3: inflation percentage halves (2%) no programme extension	340	15,128	17,490	27,532

**extension time and costs have been based on information provided by an external advisor for another project.*

Resources and budget required to develop the case to FBC are currently being considered by the project team.

5.2 Revenue Affordability

The estimated recurring revenue costs associated with each of the short-listed options are detailed in the table below. These represent the total revenue costs required to support the project.

Table 19: Recurring Revenue Costs

Revenue Cost/Funding (£k)	Option 1: Do Minimum	Option 2: Refurbishment of existing facilities for Learning Disabilities and the NIDAIPU	Option 3: Refurbishment of existing facilities for Learning Disabilities and New Build for the NIDAIPU	Option 4: New Build for both services on the REH Site
Inpatient Costs	12,426	4,194	4,194	4,194
Community & Specialist Teams Costs		3,544	3,544	3,544
Community Places		5,271	5,271	5,271
Depreciation	-	528	611	557
NIDAIPU Unit	2,582	2,582	2,582	2,582
Total Annual Revenue Cost	**15,008**	**16,119**	**16,202**	**16,148**
Total LD Service Budgets	10,992	10,992	10,992	10,992
Facilities Budgets	737	737	737	737
West Lothian & Borders Income	697	697	697	697
NHS Lothian Depreciation Budget	-	528	611	557
NHS Lothian NIDAIPU Share (14.8%)	382	382	382	382
NSD NIDAIPU Funding	2,200	2,200	2,200	2,200
Total Annual Revenue Budget	**15,008**	**15,536**	**15,619**	**15,565**
Funding Gap	**0**	**(583)**	**(583)**	**(583)**

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

- Community places have been worked up at individual client level by HSCP managers responsible for commissioning.
- For Inpatient costs, a detailed bottom up exercise has been conducted with the Chief Nurse/General Manager and Clinical Nurse Manager based on nursing requirements for the commissioned level of beds. HSCP commissioners have confirmed they are not supportive of any changes (increases or decreases) to current levels of staff for support services i.e. AHPs, Psychology.
- NSS NSD Funding is equivalent to the estimated costs of the 4 bed NIDAIPU service. The costs of the nationally commissioned service will be funded through the established process of top slicing territorial boards their NRAC share of the total revenue costs of the service.

- The NHS Lothian share of the NIDAIPU service is estimated at £382k. There are currently no adolescent beds in NHS Lothian therefore there is no funding that can be released to offset the NHS Lothian share of the national costs.
- At the April 2021 Corporate Management Team meeting, members supported including the NHS Lothian contribution of the national costs in the financial plan. Therefore, funding of £382k has been assumed in this financial model to offset the NHS Lothian share of the NIDAIPU service.
- NHS Borders income is based on the costs of the two beds they have commissioned.
- West Lothian income is the funding associated with 2 clients currently placed out of area who are to return to community placements (costs of community placements are also included).
- All specialist support teams are assumed to continue in their current form
- Non pays costs are based upon the current William Fraser and Islay ward non costs (LD inpatient wards on REC)
- Facilities costs are based on the Royal Edinburgh Building adjusted for floor area.
- Depreciation is based on a useful life of 29 years for Option 2 and 3, and 50 years for Option 5 and assumed to be funded from the existing NHS Lothian Depreciation funding allocation. Depreciation excluded in Option 1 as already forms part of Depreciation cost for the Royal Edinburgh Buildings.

There are significant double running costs associated with learning disabilities clients moving from inpatient beds to community supported accommodation. Typically, the staff team providing packages of care in the community will begin working with the client 3-6 months before the client is discharged from hospital. Funding from commissioned bed closures cannot be released until beds are closed and NHS staff are redeployed.

There are 33 planned discharges from hospital associated with the learning disability redesign. As described above the cost implications are twofold – the costs of community teams being in place before people are discharged and whilst community costs will happen immediately the release from NHS budgets will occur in phases as beds or facilities are closed. The estimated double running costs associated with the adult learning disability redesign are shown in the table below by financial year:

Table 20: Double Running Costs

	2021/22 £m	2022/23 £m	Total £m
Community team costs (social care)	0.8	0.7	1.5
Delay in hospital budget release (health)	0.1	0.2	0.3
Total double running costs	**0.9**	**0.9**	**1.8**

The costs shown above assume that all discharges take place as planned and that there are no delays in the programme. The cost implications for health (REAS) have been captured as part of the financial planning process for 2021/22.

Discussion is ongoing in partnership with Integration Joint Boards around potential solutions to support the community team double running costs. One such action is the potential application of the community living change fund against these double running costs. The community living change fund totals £3.1m of

nonrecurring funding across the Lothian Integration Joint Boards and was allocated by Scottish Government to support the discharge from hospital of people with complex needs. Whilst the costs shown in the table above are significant, they are one off costs that facilitate the closure of the adult learning disabilities beds as commissioned by the Integration Joint Boards.

Although the Learning Disabilities financial model shows a gap of £0.6m against available funding there is a £5.9m planned release from the out of area budget in total which has not been included. The release from the out of area budget is achieved from the creation of a Low Secure Mental Health facility on the Royal Edinburgh Campus. However, this planned release underpins both planned developments on Campus - Learning Disabilities and Mental Health Low Secure and Rehabilitation. Overall, both initial agreements present a joint financial gap of £5.9m which is equivalent to the planned release from the out of area budget. In totality once the out of area budget has been released both initial agreements are affordable on a recurring basis.

If the Learning Disabilities project progresses first there will be a challenge around release of the out of area budget as patients will still require to be placed out of area for Low Secure Mental Health inpatient care. Current projections for the out of area budget forecasts a £0.6m underspend for the next few years so if Learning Disabilities progresses ahead of the Mental Health and Low Secure and Rehabilitation case the underspend on the out of area placements can be used to balance the Learning Disabilities financial model. This has been agreed with Chief Officers from each of the Lothian Integration Joint Boards.

These have been reviewed and agreed by the Finance Business Partner (Hamish Hamilton, Finance Business Partner (interim) REAS & West Lothian HSCP). These costs have been reviewed in detail with the Chief Finance Officers of each Lothian Integration Joint Board and Chief Officers also receive regular updates on the financial modelling associated with this initial agreement.

Revenue costs will continue to be refined through the OBC process.

5.3 Overall Affordability

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

Funding has been identified for the additional revenue costs from the out of area budget and these have been reviewed and agreed by the Finance Business Partner (interim) Hamish Hamilton and agreed in partnership with Chief Finance Officers of each Lothian Integration Joint Board. The projected gap of £583k can be managed through the projected underspend on the out of area budget until the out of area budget can be released in full on a recurring basis (following completion of the Low Secure Mental Health unit for NHS Lothian).

All costs will continue to be refined through the OBC process.

6 The Management Case

6.1 Readiness to proceed

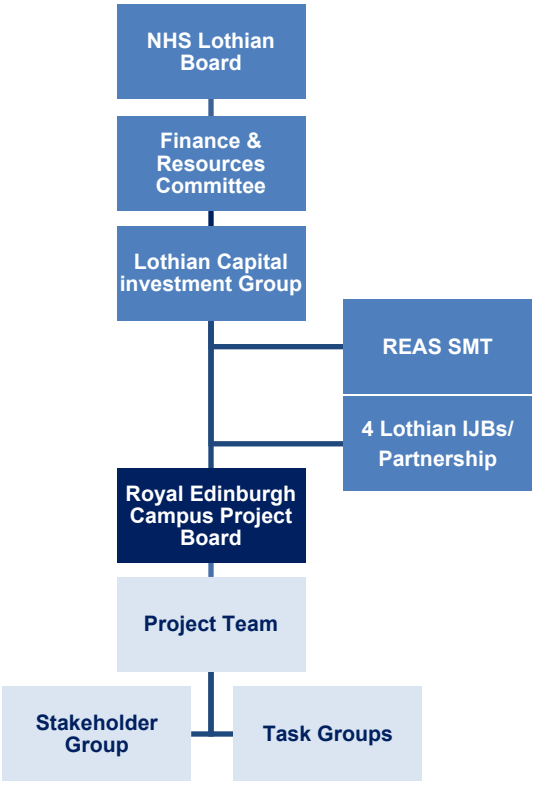
A benefit register and initial high-level risk register for the project are available from Nickola Jones, Project Owner, on request. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. Section 6.2 outlines the governance support and reporting structure for the proposal and section 6.3 details the project management arrangements.

6.2 Governance support for the proposal

Stakeholder engagement is detailed in the Strategic Case and includes information on how members of the proposal's governance arrangements have been involved in its development to date and will 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

The table below identifies key members of the project team and the REH Programme Management Board that will be responsible for taking the project forward; the table includes details of individuals' capabilities and previous experience.

Table 21: Project Management Structure

Role	Individual	Capability and Experience
Senior Responsible Officer, Project Sponsor	Calum Campbell, Chief executive NHS Lothian	Calum, whose background is in nursing, first started working in the NHS in 1984 and was previously the Chief Executive at NHS Borders for five years, before he moved to take charge in NHS Lanarkshire in 2015.

Role	Individual	Capability and Experience
Senior User and Programme Management Board Chair	Tracey McKigen, Services Director, Royal Edinburgh and Associated Services	As Senior User Tracey is accountable for ensuring that requirements have been clearly defined in the Clinical Brief and that the proposed development is fit for purpose and fully meets user needs. Following the principles of PRINCE2, the Senior User has primary responsibility for quality assurance and represents the interests of all those who will use and operate the new facilities. As REAS Service Director, Tracey has a deep understanding of the clinical and support needs of the services delivered from the REH. She has also held a number of other senior management roles in the NHS
Project Owner and Strategic Programme Manager	Nickola Jones, Strategic Programme Manager	Previous experience of NHS capital projects
Project Manager	Steve Shon, Senior Project Manager, Capital Planning	Steve has worked within NHS Capital Planning since 1998 managing and co-ordinating all aspects of the procurement of major new health facilities, from preparation of business cases through to commissioning. In terms of procurement, he has been involved in traditional, D&B, and PFI schemes and is now working on Hub developments, including the redevelopment of the Royal Edinburgh Hospital. Previous projects have ranged from small Learning Disabilities houses, through Care of the Elderly facilities, to the redevelopment of the State Hospital at Carstairs
Capital Finance Support	Laura-Jane Smith	Experience supporting capital investment projects
Finance Business Partner	Hamish Hamilton	Previous experience at Senior Manager level in similar projects
Service Lead	Andrew Watson	Associate Medical Director for the Royal Edinburgh Hospital and Associated Services

Role	Individual	Capability and Experience
Service Lead	Karen Ozden	Chief Nurse for the Royal Edinburgh Hospital and Associated Services
Partnership Representative	To be confirmed	Dependant on appointee

The project's external advisers are:

- Turner and Townsend- Technical Adviser
- Burness Paull - Legal Adviser
- Thomson Gray - Cost Adviser

7 Conclusion

The strategic assessment for this proposal (included in

Appendix 1: Strategic **Assessment**) scored 22 (weighted score) out of a possible maximum score of 25.

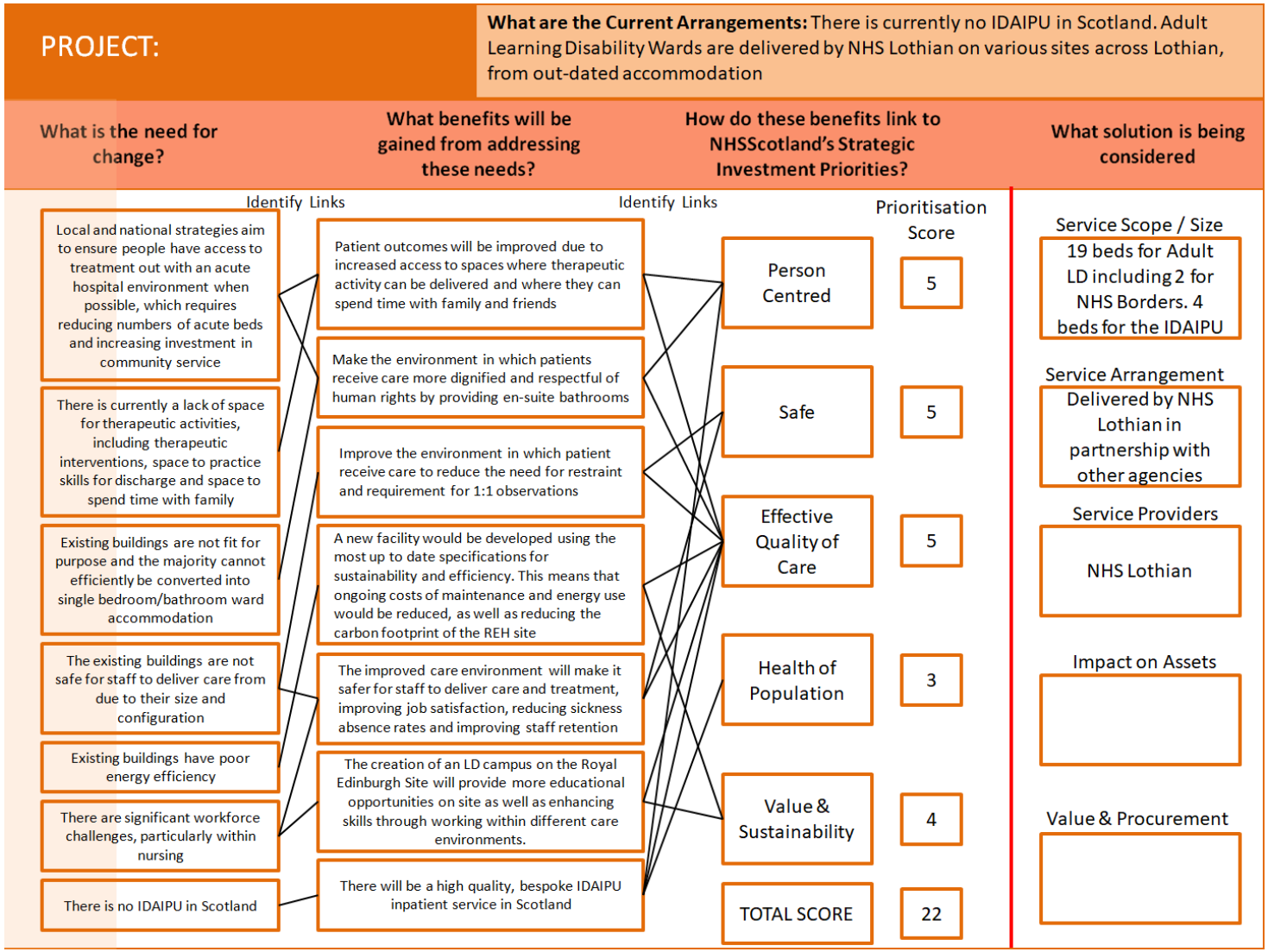
This case clearly describes the need for improved accommodation for those with intellectual disability and mental health needs in NHS Lothian, it also describes the case for providing a bespoke 4 bedded facility for adolescents with these needs across Scotland, as requested by the Scottish Government and supported nationally.

The case presents firsthand feedback from those receiving care in the current facilities in NHS Lothian which provides a clear indication of the failings of the current environment. The Scottish Government and IJBs have a strategic direction to care for people in an inpatient setting only when that is the only possible solution. Therefore, when someone does require a hospital admission, it will be because they have a high level of need. The best quality environment is required to ensure those admitted receive the highest quality care, in an appropriate environment and supported by staff who feel valued and well equipped.

Co-locating the national unit with the local unit will create a centre of excellence for supporting people with intellectual disability both in hospital and in the community. It will become more attractive for staff to work in the units because there will be a variety of learning and training opportunities. The environment would be bespoke and fit for purpose and provide dignity to those requiring a hospital admission.

This case is supported by the 4 Lothian IJBs, NHS Borders and Borders IJB and is driven by a genuine desire to provide care for vulnerable patients in the best possible environment to give people the greatest chance of getting better and being able to go home. It is aligned with the ambition to shift the balance of care from hospital to community settings and exhibits NHS Lothian’s commitment to this agenda.

Appendix 1: Strategic Assessment



Integrated Mental Health Rehabilitation and Low Secure Centre

NHS Lothian

Initial Agreement

Project Owner: Nickola Jones

Project Sponsor: Calum Campbell

Date: 5/9/2021

Version: 1.17

Version History

Version	Date	Author(s)	Comments
1.0	13/05/2021	Nickola Jones	Initial draft, pulling together progress to date
1.1	18/09/2021	Mike Holligan/Andy Wills	Review and update case
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1.16	22/07/2021	Nickola Jones	Review and update case
1.17	05/09/2021	Nickola Jones	Review and update case following Edinburgh IJB feedback

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1. Executive Summary

1.1 Purpose

This Initial Agreement makes the case for providing Low Secure Mental Health Rehabilitation within NHS Lothian for those currently receiving care out of area and to improve facilities for adults receiving general mental health rehabilitation. It sets out the case for a 60 bedded integrated rehabilitation centre that encompasses psychiatric rehabilitation in both low secure and open environments. This would be made up of 24 beds for Low Secure care and 37 beds for Mental Health Rehabilitation.

This is an innovative approach that aims to support people to spend the least possible amount of time in secure care by making the transition to open settings, and onto the community, as easy as possible. Building a unit with layers of shared, rehabilitative spaces that people can transition to as they build their recovery journey will allow that. The relationships built with all members of a person's network including both statutory staff and wider supports will be maintained as people are accommodated in the least restrictive environment. The integration proposed will embed a recovery and rehabilitative focus throughout all areas of the unit and allow this to be maintained throughout a person's stay.

A new facility would address all the current issues described throughout this case and would provide the best possible space to enable optimum rehabilitation and recovery for patients. Additionally, this proposal suggests that the inpatient bed numbers should reduce, and the funding transferred to support community alternatives for those currently in rehabilitation wards who have significant needs, but who are not benefitting from active rehabilitation. Thus, supporting the ambition to shift resources from acute hospitals to community-based resources.

1.2 Background and Strategic Context

This IA follows on from the implementation of Phase 1 of the Royal Edinburgh Hospital campus re-development. It seeks to build on knowledge gained from the first phase and to provide high quality facilities for those receiving Mental Health Rehabilitation and Low Secure care.

The case aligns with all current Scottish Government and local strategies and has been included in the four Lothian IJB Strategic Plans for 2019-2022.

Mental Health Rehabilitation and Low Secure care are delegated functions in Lothian, which means that the four Lothian IJBs are responsible for setting the direction for the future. Therefore, the Royal Edinburgh Project Board has worked closely with colleagues from across the four Lothian IJBs to create a joined-up plan for Adult Rehabilitation and Low Secure care.

The IJBs have agreed on a reduced bed number for Mental Health Rehabilitation from a current funded capacity of 64 beds to 37 beds. The breakdown across the IJBs is as follows:

Table 1: Planned bed numbers – mental health rehabilitation

IJB Area	No. Of MH Rehabilitation Beds Commissioned
West Lothian	0
East Lothian	3.5
Midlothian	3.5
Edinburgh City	30
Total	**37**

The IJBs have also commissioned 23 beds for Low Secure care to facilitate the flexible model of care described above and to deliver people's care as close to home as possible. The breakdown per IJB area is as follows:

Table 2: Planned bed numbers - low secure

IJB Area	No. Of Low Secure MH Beds Commissioned
West Lothian	6
East Lothian	1
Midlothian	1
Edinburgh City	15
Total	**23**

1.3 Need for Change

The 'Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen'[1], published in February 2021, expressed surprise that NHS Scotland spends millions of pounds a year in cross-charges for accommodating people out of area. These out of area placements place people further away from their support networks. The Review advised that Low Secure care should be provided locally, and this case seeks to deliver on this recommendation. There are currently 17 Lothian patients receiving care out of area at a cost of around £200,000 per person. Receiving care out of area has a significant detrimental impact on people's ability to get better and to maintain links to and support from family and friends.

The Adult Mental Health Rehabilitation wards on the Royal Edinburgh Hospital (REH) campus are currently delivered from significantly outdated accommodation. There are a number of issues described in this case which makes the inpatient wards not fit for purpose for this patient group, namely; the lack of single bedrooms with en-suite facilities, the lack of access to outdoor space if patient's require and escort, lack of access to appropriate therapeutic space, lack of access to quiet spaces, poor environment which is not robust and is easy to damage, lack of space to store belongings and various other challenges.

1.4 Investment Objectives

The Investment Objectives for this case are:

- End out of area secure psychiatric care for people in Lothian
- Shift the balance of care by reducing inpatient beds and developing pathways to support people with complex needs in residential settings
- Establish a high quality, safe and robust inpatient services which meet care standards such as providing single rooms with en-suite bathrooms
- Establish high quality facilities which are robust and maintainable
- Have a facility which meets the current standards for energy efficiency and sustainability
- Provide an inpatient environment designed to meet patient and staff safety.
- Provide integral and secure gardens to each rehabilitation and low secure ward areas.
- Provide therapeutic areas that can be accessed with ease by all.
- A clinical environment which supports rehabilitation national evidence based clinical practice.
- Realistic and sustainable workforce model using the whole multidisciplinary team (MDT)

[1] Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen https://www.gov.scot/groups/forensic-mental-health-services-independent-review/

1.5 The Preferred Option(s)

The preferred option is for a New Build facility on the Royal Edinburgh Hospital Site.

This preferred option has been reached following an options appraisal conducted by key representatives of the service and project teams. The Economic Assessment identified the option to build a new facility on the REH as delivering the highest benefit/ cost ratio.

1.6 Readiness to proceed

A benefit register and initial high-level risk register for the project are available from Nickola Jones, Project Owner, on request. 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.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. Section 6.2 outlines the governance support and reporting structure for the proposal and section 6.3 details the project management arrangements.

1.7 Conclusion

This proposal is a significant priority for NHS Lothian and the four Lothian IJBs as it realises national advice to provide Low Secure locally and will improve the quality and dignity of care for patients receiving mental health rehabilitation.

At the centre of this case is a desire to provide the best quality of care to those who require mental health care in NHS Lothian. Having to receive care out of area is detrimental to our patient's wellbeing and recovery, as is receiving care in a poor-quality environment. Additionally, staff should be delivering care from environments that they are proud to work in, not from environments that they must work around. This case provides an opportunity to create an innovative facility which can provide the flexibility required to care for patients in the least restrictive way possible.

This IA makes a compelling case for investment which would further the Scottish Government's ambition to provide parity between physical and mental health care and to provide care as close to home as possible.

2. The Strategic Case

2.1 Existing Arrangements

Adult Mental Health Low Secure

A forensic service comprises of 3 different levels of security: high, medium and low. Whilst high secure is provided at the State Hospital in Carstairs, the Orchard Clinic at the REH provides medium secure forensic care. There is currently no step down / low secure acute forensic provision in NHS Lothian and no capacity to deliver this service within existing arrangements. As a result, Lothian patients either receive this service when required out of area or worst case are unable to access this service at the most clinically appropriate time and their length of stay in medium secure is longer than necessary. The current model of care for low secure services relies on outsourcing to a variety of units with varying care models. The average cost of an out of area low secure placement is approximately £200,000 per person per year.

Patients requiring Low Secure rehabilitation are all detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or Criminal Procedures Act (Scotland) 1995. This patient group has diverse needs, and many will share similar experiences and symptoms of the Mental Health Rehabilitation group described below. Most will have a history of offending behaviour and present significant risks to self and others. This group are likely to have had previous treatment and care in a medium secure psychiatric environment or placed in private secure care as their local NHS board has not had the resources to care and treat these patients with the safety and security that they had required. There is a greater need for environmental, relational and procedural security compared to the mental health rehabilitation and the goal of the inpatient unit to allow patients to continue their recovery journey safely.

The Unplanned Activity (UNPACS) budget has been used to fund 20 low secure places for NHS Lothian patients in recent years. These have been mainly at private facilities in Ayr and Glasgow, however several patients who have specialist needs due to brain injury or sensory impairment have been placed in private and NHS facilities in England.

Demand predictions for low secure beds are based on the following:

- As of March 2020, there are 17 patients with outsourced care
- An estimated 6 patients from Medium secure may be appropriate to accommodate in low secure facilities
- System changes mean there is now the ability for patients to appeal against the need for medium secure facilities, which may increase demand for low secure care.

Adult Mental Health Rehabilitation

The Mental Health Rehabilitation Service is delivered by NHS Lothian from the Royal Edinburgh Hospital site and specialises in working with people whose long-term and complex needs cannot be met by general mental health services. Services are delivered to anyone in Lothian requiring mental health rehabilitation; however, most patients are from Edinburgh City as there is only small demand from East Lothian and Midlothian and there are local mental health rehabilitation provisions in West Lothian.

Who might need a mental health rehabilitation service?

People who require inpatient mental health rehabilitation may have a diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder. Typical difficulties include:

- problems with organising and planning daily life – finding it hard to plan and carry out plans
- symptoms of mental illness, such as hearing voices that are distressing or make it difficult to communicate with other people
- being exploited or abused by others
- behaving in ways that other people find difficult or threatening - this can lead to contact with the police or courts
- harmful use of alcohol and non-prescribed ("street") drugs.

People may have these difficulties because:

- standard medications do not work well for them
- the illness affects people's concentration, motivation and ability to organise themselves
- they also suffer from depression and anxiety
- they may struggle to manage everyday activities – like self-care, budgeting, shopping, cooking, managing their money.[2]

People who are admitted into these units are over the age of 18 and there is no age cap on who may benefit from the model of care offered. Older people, with higher levels of frailty may not be accepted though, due to the limitations of the built environment. Due to the impact of the illnesses on their understanding of their difficulties almost all the patients are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and many will be subject to provisions under the Adults with Incapacity (Scotland) Act 2000.

The patient group admitted to this service will be highly symptomatic, have several or severe co-morbid conditions and most will have significant risk histories. Usually people in this group have had difficulty in engaging and maintaining contact with medical and support services in non-hospital-based care and have exhibited limited therapeutic treatment responses to pharmacological and/ or other treatments. A history of coping with trauma will impact on the care and treatment of a substantial proportion of the patients.

When are people referred to rehabilitation services?

- Usually after a few years of mental health problems - and several hospital admissions. However, it can sometimes be helpful if you are trying to get over a first episode of illness.
- If you can't be discharged from an acute ward but are unlikely to get any better there.
- If you are moving to a placement with less support and supervision. This can happen if you are leaving a forensic or secure service, or if you are moving from residential care to a more independent home in the community.
- If you might benefit from the structured environment and intensive therapeutic programmes that are available on a rehabilitation unit.[3]

Most people admitted to the rehabilitation wards will have a history of spending substantial periods of time socially and economically disadvantaged e.g. homeless and without work. For most it is predicted that they will require a protracted length of inpatient stay to build a secure base from which they can continue their recovery journey out of hospital. In-patient rehabilitation services are eight times more likely to support these people with complex needs, including psychotic illnesses, to live independently in the community long-term when compared to standard mental health services.

What are the aims of mental health rehabilitation?

[2] Royal College of Psychiatrists – 'Mental Health Rehabilitation Services' https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services
[3] Royal College of Psychiatrists – 'Mental Health Rehabilitation Services' https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services

The rehabilitation wards adopt a holistic bio-psycho-social formulation centred on what is appropriate for the individual, built on evidence-based approaches. The strength is the multidisciplinary team approach, with the individual in the centre. Shared environments and therapy spaces are key to delivering suitable interventions to enable rehabilitation. Patients may be aiming to:

- learn or re-learn life skills.
- get their confidence back.
- cope better without so much help.
- achieve the things they want to, like living in their own flat, getting a job or building family relationships.
- feel independent and comfortable with their life.

The ethos and the basis of the care model is relationships. Clinical staff build relationships with patients over time, through interaction, discussion and interventions/ activities. Trusting relationships that maintain hope are key for promoting recovery in the units. Patients also build relationships with one another, and often enjoy activities which bring them together, building a sense of community e.g. North Wing have regularly organised coffee mornings.

Many patients have had a long history of contact with Mental Health services with over 90% having had multiple episodes of inpatient care in the general Mental Health wards alongside extensive MDT efforts to support them in the community. Patients often need the structure of how the unit functions to help stabilise them; the rehabilitation wards offer a routine and rhythm that allows them to build the confidence that may have been lost over several years in care. Many also have high levels of need for personal care due to either physical or mental health. This support can be complicated by issues with patient engagement and capacity, requiring a sophisticated range of MDT skills to overcome these challenges.

What treatments and support are provided?

The service provides specialist assessment, treatment, interventions and support to help people to recover from complex mental health problems and to gain the skills and confidence to live successfully in the community. The inpatient unit works in partnership with other agencies that support patients' recovery and social inclusion including third sector and social care agencies in the provision of accommodation, education, employment, advocacy and peer support services. Central to the service's function is a recovery orientation that places collaboration with patients and carers at the centre of all activities.

Treatments may include:

- Medication.
- Talking therapies (e.g. cognitive behaviour therapy and specific work with families and carers).
- Guidance on healthy living (e.g. diet, exercise and stopping smoking).
- Help to reduce or stop alcohol and street drug use.
- Support to manage everyday activities such as personal hygiene, laundry and more complex living skills such as budgeting, shopping and cooking.
- As people get better, they will spend more time in the community. They may do some sport, go to the cinema, do a course, learn some skills for work, or start to get a job.
- Help with accommodation and social security benefits.
- Sometimes legal advice.

Rehabilitation services aim to support patients to regain skills for community living, with the same opportunities as anyone else. The Royal College of Psychiatrists state that ‘Rehabilitation units should provide a safe and homely space where you can feel comfortable, safe and are able to have safe relationships with other people’[4] – this is the ambition of the current units and for any future plans.

[4] Royal College of Psychiatrists – ‘Mental Health Rehabilitation Services’ https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-rehabilitation-services

Current Ward Establishment

The breakdown of existing funded capacity of 63 beds is as follows:

Table 3: Existing funded capacity

Location	Format	Number Beds	Layout
Crammond	Mixed	14 beds	Single rooms, shared dormitories, shared toilets
Myreside	Female	15 beds	Single rooms, shared dormitories, shared toilets
North Wing	Male	15 beds	Single rooms, shared dormitories, shared toilets
Craiglea	Male	15 beds	Single rooms, shared dormitories, shared toilets
Margaret Duguid Unit	Mixed	4 beds	Single room, en suite
Total		**63 beds**	

Currently, due to the demands of the service, there are an additional 3 beds being used across the four wards. There are currently 67 inpatients, although the service's funded capacity is 64.

Table 4: Patient activity 2018 - 2021

	2018/19	2019/20	2020/21
No. Of admissions	28	48	1
No. Of Discharges	31	49	1
Average Length of Stay (days)	512	195	266

2.2 Drivers for Change

The following section expands on the need for change as identified in the Strategic Assessment (included in Appendix 2) and describes the anticipated impact if nothing is done to address these needs and why action should be taken now through this proposal.

Low Secure

There is currently no low secure provision in the Lothian area. Patients are receiving care far from home which means that connecting with family members becomes even more challenging than it would be normally for this patient group. In addition to this, out of area low secure placements currently cost NHS Lothian approximately £3.2million per year.

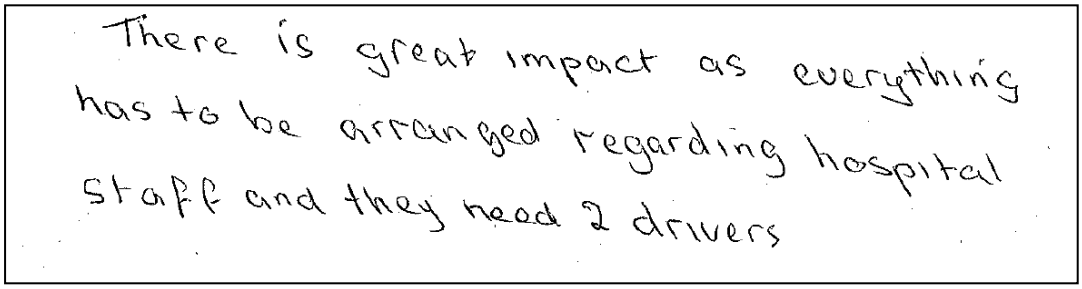
An exercise to gain feedback from patient's currently receiving low secure care out of area and their families was conducted in early 2021. Some of the quotes from this exercise are listed below, which clearly demonstrate some of the challenges currently experienced:

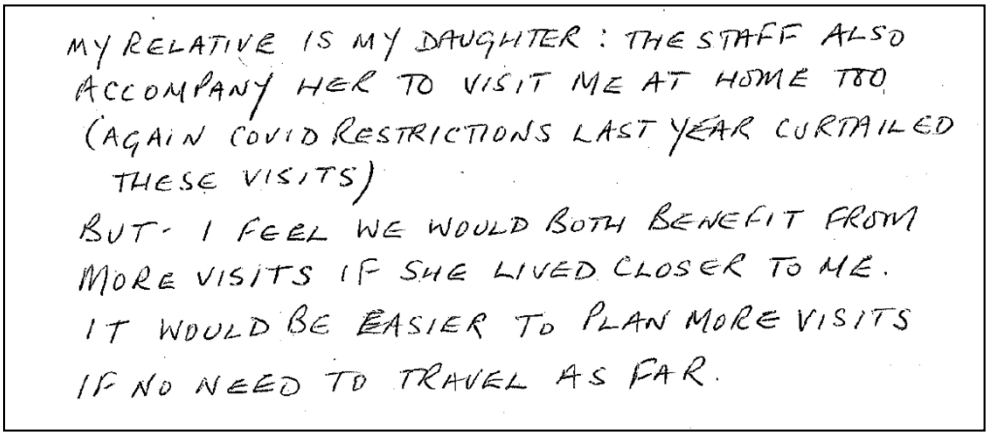
'I am from here, why do I need to be sent away? That is not going to make be better' Low Secure Patient

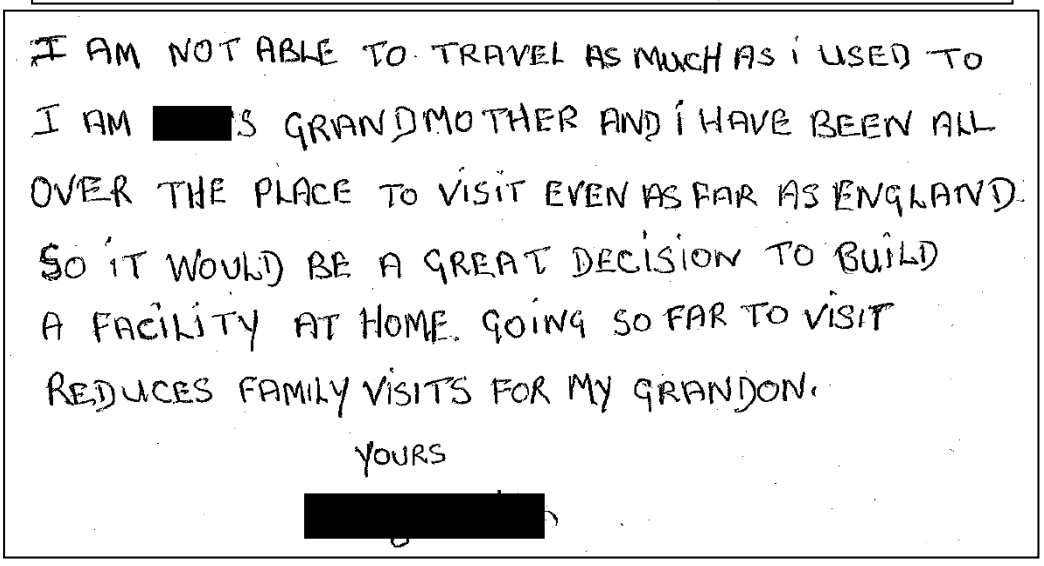
'I have not seen my third grandson since he was born, if I was in Edinburgh, I would have the chance to meet with him.' Low Secure patient

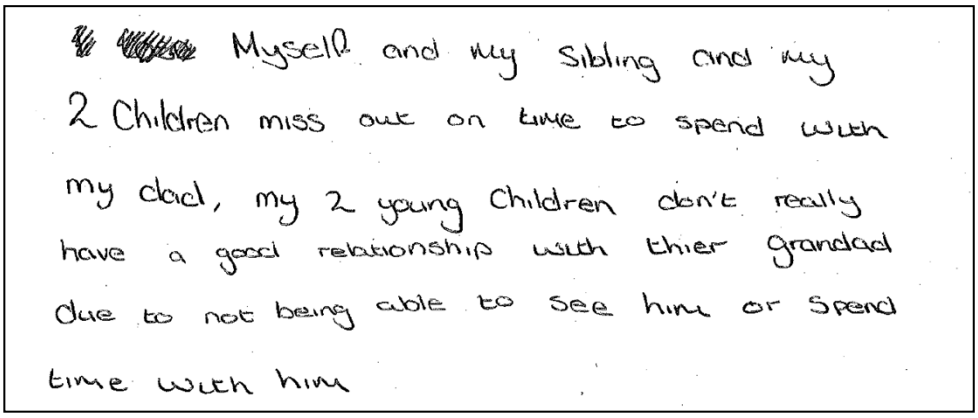
'The day it was decided that my son had to move to a different hospital was the worst day of my life. I just couldn't see how I could help him get back to living a life again from the other side of the country' Relative of low secure patient

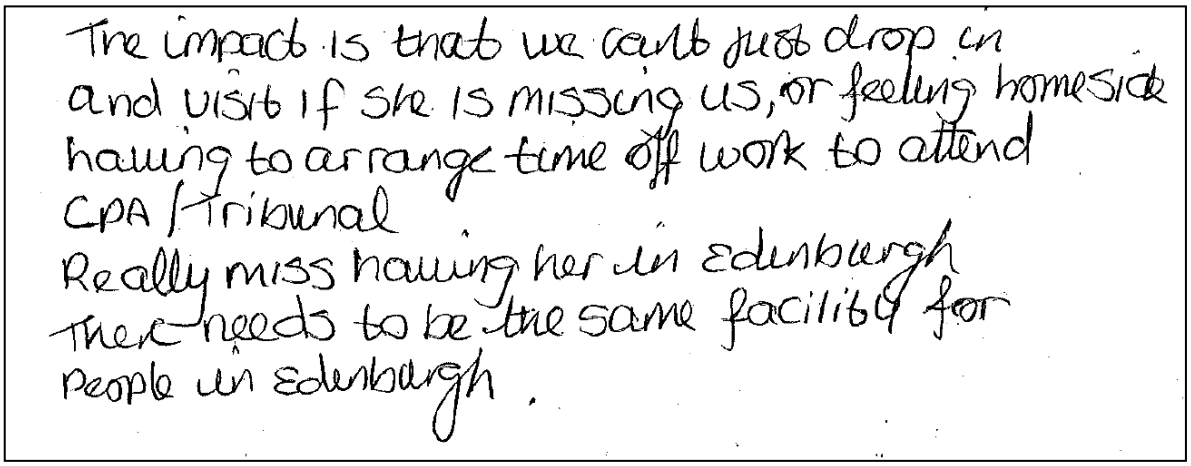
Some of the written responses are shown below:

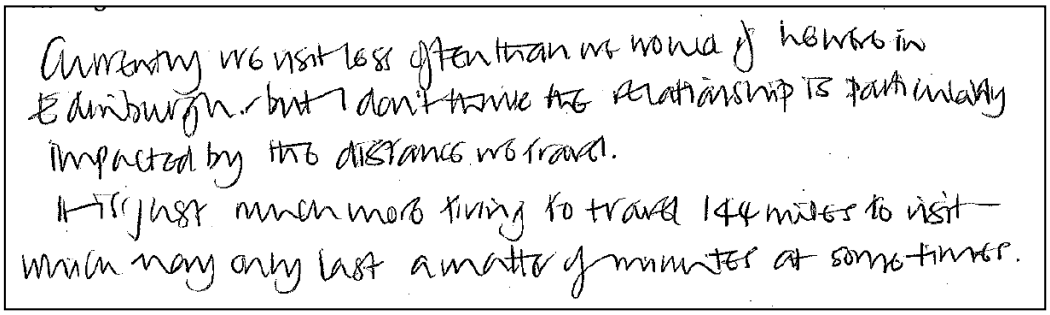

There is great impact as everything has to be arranged regarding hospital staff and they need 2 drivers


MY RELATIVE IS MY DAUGHTER : THE STAFF ALSO ACCOMPANY HER TO VISIT ME AT HOME TOO (AGAIN COVID RESTRICTIONS LAST YEAR CURTAILED THESE VISITS)
BUT I FEEL WE WOULD BOTH BENEFIT FROM MORE VISITS IF SHE LIVED CLOSER TO ME.
IT WOULD BE EASIER TO PLAN MORE VISITS IF NO NEED TO TRAVEL AS FAR.


I AM NOT ABLE TO TRAVEL AS MUCH AS I USED TO
I AM [redacted]S GRANDMOTHER AND I HAVE BEEN ALL OVER THE PLACE TO VISIT EVEN AS FAR AS ENGLAND.
SO IT WOULD BE A GREAT DECISION TO BUILD A FACILITY AT HOME. GOING SO FAR TO VISIT REDUCES FAMILY VISITS FOR MY GRANDON.
YOURS
[redacted]







The psychological impact on families on taking patients out of their community and support structures can have huge impact of their mental health wellbeing. It can have a significant detrimental impact on people's capacity to recover as they do not have their normal support structures or any access to their local community. It can also cause clinicians to feel they have let down both the patient and their family by not being able to provide care and support them within their local community.

Concerns regarding the adequacy of provision of low secure mental health rehabilitation in Scotland have been raised by several sources. This was identified in the Mental Welfare Commission's Intensive Psychiatric Care in Scotland report and from contacts with individual patients and hospitals by the Mental Welfare Commission, and it was noted that NHS Lothian currently do not have local provision for low security services. The 'Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen'[5], published in February 2021, expressed surprise that NHS Scotland spends millions of pounds a year in cross-charges for accommodating people out of area. These out of area placements place people further away from their support networks.

[5] Independent Review into the Delivery of Forensic Mental Health Services – What we think should happen https://www.gov.scot/groups/forensic-mental-health-services-independent-review/

The review also heard that clinical teams could be inflexible about the timing of these meetings, making it difficult for family members to attend, especially if the person was being cared for out of area. Recommendation 30 of the review states that individual Health Boards should put in place a system to reimburse travel expenses to those family members (or other carers) who have travelled to visit a person receiving forensic mental health services out of area. This additional cost will require to be met by NHS Lothian until further notice.

There are also significant capacity pressures on Medium Secure services, which could be improved with the development of a Low Secure Unit on the Royal Edinburgh Hospital site due to improved flow between services.

Mental Health Rehabilitation

The buildings in which rehabilitation services are currently situated are not fit for purpose. Despite two rehabilitation wards recently moving to new accommodation in the Andrew Duncan Clinic to clear buildings which require demolition in order to progress works on the site, the wards continue to fail to meet requirements such as having single, en-suite rooms. The remaining three wards are delivered from significantly out dated accommodation, the impact of which will be described in the following paragraphs and are shown in the pictures included in Appendix 1.

A 'Residential Environmental Impact Scale' (REIS) was recently conducted by a Specialist Occupational Therapist in two of the rehabilitation wards (Crammond and North Wing). These reviews indicated several issues for patients and staff posed by the current ward environment; they also made it clear that environmental changes were on hold due to the expectation that a new facility for these wards was going to be made available. The outcomes of the review have informed the following paragraphs, as well as information gathered from staff and patients on ward rounds conducted in July 2021.

Shared bathroom and shower facilities

The rehabilitation wards do not have en-suite facilities, except for the 4 bedded Margaret Duiguid Unit. The other wards have between four and six toilets for 15 patients, and two to four showers.

This does not meet modern care standards and can have a particularly detrimental impact on this patient group. Some patients may have a lack of inhibition due to their condition and may therefore leave toilet doors open. This means that they are not granted the dignity and respect of a private place to go to the toilet. It may also be difficult emotionally for some patients to use shared bathroom facilities due to a history of abuse.

Nurses also reported that the bathroom facilities were old and that the toilets clogged very easily.

The provision of single rooms with en-suites would give the rehabilitation service greater flexibility in terms of gender separation, which will support flow through the hospital as demand for these services is high.

Shared Living Spaces

In all the rehabilitation wards, except for the newly refurbished Margaret Duguid Unit, there is at least two shared dormitory bedrooms. This means that two patients are sharing one sleeping space. This presents several significant issues for patients and staff. Firstly, patient's report that sharing bedroom space makes them feel unsafe and they worry about their belongings, a patient stated, "I don't feel safe sleeping with others in my room". Patients can feel very vulnerable at night and are easily disturbed by other patients moving around the bedroom. Patients may feel frightened if the person they are sharing a room with becomes unwell and exhibits distressed behaviour. For the person exhibiting the distressed behaviour, there is no private and safe space which can feel like their own for staff to support them in or to enable them to have the privacy to spend some time alone. Additionally, patients can be intimidated

or bullied by other patients and may be coerced to hand over cigarettes, money or other valuables. They may also be influenced by the person they are sharing a room with, which could have further detrimental impact on their recovery.

For staff, the shared living spaces can present challenges for managing patients and providing meaningful rehabilitation. As would be expected, not all patients get on and sometimes patients need to be moved room because they have fallen out with the person they are sharing with. Sharing a room may make some patients frustrated and more likely to exhibit the behaviours they are trying to move away from as part of the rehabilitation process – this then delays their rehabilitation and can increase their length of stay. Additionally, when a new patient is being admitted to the ward, Charge Nurses need to consider where is best to place them in the ward. Due to the shared living spaces, admitting this new patient could require 3 or 4 other patient moves. Considering the wards are people's homes for a significant period of time, this frequent need to move can make patients feel that they are being uprooted again and further delay their rehabilitation progress as they are distracted by the trauma caused by the move. One Senior Charge Nurse said that they felt that it was 'difficult to get on with the task of rehab as people are preoccupied with trying to survive in the environment'.

Access to Outdoor Space

Patients and staff express frustration at the lack of safe, contained outdoor space for the ward. There is no direct access to outside space due to current location of 4 out of the 5 wards. Many patients will require an escort to leave the ward at various points during their admission based on clinical risk. This means that they cannot leave the wards without staff accompanying them. Since there is no safe, contained space linked to the ward, this means that patients need to wait for staff to be available in order to go outside. One patient stated, "For long periods of times I'm unable to go outside", another stated "Why should I have to ask staff and be escorted when all I want is a bit of day light and fresh air?"

Wheelchair Accessibility

The ward is not wheelchair accessible and is difficult to access independently for those with other mobility issues such as the use of walking stick. The ward is situated on the first floor and the lift often breaks down which affects wheelchair users being able to leave the ward and access outdoor space. Wheelchair users also struggle with the heavy doors, lack of turning space and small shared toilets. Staff commented that the shared toilets affect the wheelchair user's privacy and dignity and the shared bathroom/toilet space is too small for adaptive equipment. The dining room area is also not set up to meet the needs of those in a wheelchair, the height of the kitchen cupboards and the lack of door handles on cupboards make the cupboards difficult to access for all residents.

Storage of Belongings

There is very limited storage available for each patient in the ward. One patient stated, "My belongings are not safe from others in my room and I have don't have enough storage to keep my personal things". Patients in current Rehabilitation service have been in hospital for a considerable period and in some cases several years and have accumulated large amounts of personal belongings, which cannot be securely stored within the ward environment.

Lighting and Temperature

There are challenges with the lighting and the ward temperature. Staff stated that patients complain about the heat on the wards 'all of the time'. Staff commented that the ward temperature is difficult to control i.e. some bedrooms are very cold at times and when the weather is warmer the whole ward is uncomfortably hot. The windows in the current wards are a unique design which means they do not let very much air into the wards.

Some of the corridors are dark and staff reported that it was not nice for them to work in 'dark, dingy places. The current environment is having a detrimental impact on staff wellbeing which adds to the challenge of recruitment to nursing posts.

Physical Structure

In order to accommodate this patient group, the ward environment must be robust and able to withstand some stress caused by patients. In North Wing, for example, the door to one bedroom has been slammed so many times that the supporting wall is becoming cracked and therefore unsafe. Repairing this damage will come at significant cost to NHS Lothian and in a newer building; walls would be made more robust and re-enforced to ensure similar damage could not happen.

Lack of Therapeutic Space

There is very limited access to private space across all the rehabilitation wards. This has been particularly challenging during the Covid-19 pandemic as there has not been space for patients to sit on their own and it has been challenging to distance patients as their only leisure spaces are shared. One patient stated, "When feeling unwell I sometimes like to be alone but there is no escape from a noisy and busy ward".

Additionally, there is very little private space for one to one conversations and support, so often when a therapist meets with a patient, this is in shared, communal spaces which may not feel private and may lead to a less open conversation which could delay progress. Group work also takes place in communal areas, meaning patients cannot use the TV or the space while the group is taking place.

There is also no therapy kitchen in some of the wards, which limits patient's ability to practice cooking, which is a key skill to prepare for going home. There are shared kitchens in communal spaces, but this means that cooking sessions are interrupted by other patients making cups of tea etc.

Combined Treatment room and Dispensary

The room where treatment and dispensary take place is very small. If a patient is in the room receiving treatment, it is difficult and invasive for nurses to go in to dispense medications. It is also distracting for patients to receive treatment in a room which is also used for dispensing medications and contains medical supplies.

A Vision for the Future

This IA sets out the case for an integrated rehabilitation centre that encompasses psychiatric rehabilitation in both low secure and open environments. This is an innovative approach that aims to support people to spend the least possible amount of time in secure care by making the transition to open settings, and onto the community, as easy as possible. Building a unit with layers of shared, rehabilitative spaces that people can transition to as they build their recovery journey will allow that. The relationships built with all members of a person's network including both statutory staff and wider supports will be maintained as people are accommodated in the least restrictive environment. The integration proposed will embed a recovery and

rehabilitative focus throughout all areas of the unit and allow this to be maintained throughout a person's stay.

A new facility would address all the issues described above and would provide the best possible space to enable optimum rehabilitation and recovery for patients. Additionally, this proposal suggests that the inpatient bed numbers should reduce, and the funding transferred to support community alternatives for those currently in rehabilitation wards who have significant needs, but who are not benefitting from active rehabilitation.

Mental Health Rehabilitation and Low Secure care are delegated functions in Lothian, which means that the four Lothian IJBs are responsible for setting the direction for the future. Therefore, the Royal Edinburgh Project Board has worked closely with colleagues from across the four Lothian IJBs to create a joined-up plan for Adult Rehabilitation and Low Secure care.

Proposed Bed Numbers

Working through the Royal Edinburgh Hospital Campus Project Board, all 4 Lothian IJBs have agreed on a reduced bed number from a current funded capacity of 64 beds to 37 beds. The breakdown across the IJBs is as follows:

Table 5: Proposed be numbers - mental health rehabilitation

IJB Area	No. Of MH Rehabilitation Beds Commissioned
West Lothian	0
East Lothian	3.5
Midlothian	3.5
Edinburgh City	30
Total	**37**

The reduction in Mental Health Rehabilitation beds will be facilitated by a transfer of investment from current hospital-based services to alternative services in the community. The new model of care will help to facilitate a reduction in the length of stay in the rehabilitation wards, which will improve flow through the wards and enable NHS Lothian to stay within the reduced bed base. This will be further supported by community-based developments such as the recent re-tendering of the Edinburgh support contract which will enable providers' greater flexibility which should further improve flow through community support services.

The IJBs have also commissioned 23 beds for Low Secure care to facilitate the flexible model of care described above and to deliver people's care as close to home as possible. The breakdown per IJB area is as follows:

Table 6: Proposed bed numbers - low secure

IJB Area	No. Of Low Secure MH Beds Commissioned
West Lothian	6
East Lothian	1
Midlothian	1
Edinburgh City	15
Total	**23**

The Low Secure provision will be across three wards, one for people with higher levels of frailty, one for females and one for males.

This proposal is therefore for a 60 bedded facility which provides Mental Health Rehabilitation and Low Secure care within the same building, benefitting from flexibility for patients and staff.

Alignment with National and Local Strategy

National Strategy

1. *Mental Health Strategy for Scotland 2017-2027*

   The Scottish Government's 2017-2027 Mental Health Strategy has the vision of "a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma". The strategy aims to provide parity between mental and physical health services and to ensure equal access to the most effective and safest care and mental health treatment. This campus redevelopment supports this goal by replacing existing poor-quality facilities with high quality facilities.

2. *National Health and Wellbeing Outcomes Framework 2015*

   The development of new rehabilitation facilities will be supported by a model of care which is aligned with the PANEL principles[6], supporting flow through the system to ensure people are only in hospital when they require that level of care. This is aligned with a focus on human rights which is promoted throughout the existing review of mental health legislation.

3. *Forensic Mental Health Services: Independent Review 2021*

   The current configuration of forensic mental health services for inpatients developed from principles set down by the Scottish Executive in its letter HDL (2006)48 to NHS CEOs in July 2006. There are three different levels of secure hospital provision as described by the Forensic Network in its Security Matrix and each has been developed at a different national, regional or local level. In general:
   - High secure is provided at a national level.
   - Medium secure services are provided at a regional level; and,
   - Low secure services are provided at a local level.

   The review states "People recognised that flexibility to respond to local need was necessary to deliver person-centred care. However, the differences in services highlighted to the Review were experienced more as inconsistencies, inequalities and frustrations by the people for whom these services were provided and the staff delivering them. Such differences mean that people's experiences and outcomes are affected by factors that are not related to their care needs or risk management requirements. There were calls for a more integrated approach to service development and resourcing rather than what was described as a 'postcode lottery' affecting care and treatment."

   This proposal meets the review's recommendations to provide Low Secure care at a local level, and to ensure there is consistent and high-quality care for people requiring care in the forensic system.

   The Review also states that there is a pressure on Medium Secure facilities across Scotland. Having Low Secure provision on site would help NHS Lothian to manage flow through its medium secure service.

4. *National Clinical Strategy for Scotland*

   The National Clinical Strategy describes the rationale for an increased diversion of resources to primary and community care. This proposal supports this direction of travel by proposing a reduction in the inpatient bed base and a transfer of resource to community-based services. This case also advocates for improved therapeutic spaces for patients to gain skills they require to be discharged

[6] National Health and Wellbeing Outcomes Framework – Description of PANEL principles - https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/pages/9/

to the community. The new facility would build upon established relationships with third sector providers, both on and off the REH site.

5. *2020 Vision*

   The 2020 Vision is for more care to be delivered at home or in a homely setting. This case builds upon decades of work within mental health services to shift focus from hospital-based services to community services. However, it also advocates for the highest possible standard of care when someone does require admission to hospital, which should minimise the amount of time people need to receive care in a more restrictive, inpatient setting. Bringing Low Secure care to NHS Lothian also helps to meet the aim of delivering care more locally.

6. *The Healthcare Quality Strategy for NHS Scotland 2010*

   This proposal supports key priorities stated in the Healthcare Quality Strategy such as clean and safe environment, continuity of care and delivering clinical excellence. Specifically, providing low secure care on the REH site is more person centred as it improves people's ability to maintain links with their family and local community, it is also more efficient in terms of time and money both for the health service and for families visiting patient's in low secure care.

7. *Public Health Priorities for Scotland*

   Priority one is for 'A Scotland where we live in vibrant, healthy and safe places and communities' It advocates asset-based approaches and the importance of changing the places and environments where people live so that all places support people to be healthy and create wellbeing; strategic approaches to greenspace, community gardens and developing walking and cycling networks are given as examples. Greenspace is important to the recovery of patients within rehabilitation services and would be incorporated into any design going forwards.

8. *The Sustainable Development Strategy for NHS Scotland*

   The strategy includes actions in relation to facilities management (promoting greenspace and the outdoor estate as a healthcare facility), community engagement (engaging local people in the design and use of the outdoor healthcare estate and promoting access to it) and travel (ensuring health services can be accessed by good quality footpaths and cycle routes, and encouraging people to make active and sustainable travel choices). The site development, including this proposal, has these actions at the forefront of planning and will incorporate the existing strong links with third sector services on site which host some of the important green spaces such as the Community Garden and Glass Houses.

Local Strategies

1. *NHS Lothian Hospitals Plan*

   The Lothian Hospitals Plan describes the Royal Edinburgh Hospital as one of the four key strategic planning priorities for NHS Lothian alongside the 4 Lothian IJBs and Borders IJB. NHS Lothian's property and asset management strategy (2015 – 2021) states that NHS Lothian's vision is for major hospital services to be focused around four main sites, one of which is the Royal Edinburgh Hospital Campus.

2. *NHS Lothian Quality Strategy*

   REAS has been at forefront of implementing the quality management approach in NHS Lothian and staff across services have implemented over 100 tests of change. The improved environment proposed in this case would give staff more time to focus on improvement work without being

distracted by environmental concerns.

3. *Our Health Our Care Our Future: NHS Lothian Strategic Plan 2014-2024*

   The NHS Lothian strategy states a commitment to re-developing the Royal Edinburgh Hospital site and to developing community services to support inpatient services. This proposal aims to realise this ambition.

4. *Greenspace and Health Strategic Framework for Edinburgh & Lothians*

   The NHS Lothian board has made a commitment to make development of green spaces across NHS Lothian a priority. This will be included within any design proposals for this case.

5. *IJB Strategic Plans*[7][8][9][10]

   The four Lothian IJBs strategic plans state the intention to support the redesign of the REH campus alongside the development of broader care pathways for people with mental health conditions. This broader piece of work is focused on ensuring people have access to treatment out with an acute hospital environment when possible, which requires reducing numbers of acute beds and increasing investment in community service. The reduction in bed numbers described in this IA aids the realisation of these local aims.

6. *Property and Asset Management Strategy*

   A key part of NHS Lothian's service delivery is ensuring best use of estate in supporting operational and corporate delivery. To achieve this, the Board has in place a Property and Asset Management Strategy (PAMS). NHS Lothian's current strategy reflects its commitment to improving the healthcare environment whilst reducing the number of hospital and other sites it currently manages, to reduce property expenditure. The Royal Edinburgh Hospital site is a major part of this strategy and its retention has been predicated on the aim to maximise its development potential. This decision has been reviewed through various updates to the site masterplan (most recently in 2019) and it continues to be viable.

   The Scottish Government's commitment to deliver a greener, zero carbon Scotland will be pursued through a focus on sustainability in this new development. In this way NHS Lothian will continue to maximise the sustainability of its estate.

7. *AEDET*

   A multi-stakeholder AEDET review has been used to set a benchmark score for the existing facilities highlighting their limitations.

[7] Edinburgh IJB Strategic Plan 2019 - 2022 - https://www.edinburghhsc.scot/wp-content/uploads/2020/01/Strategic-Plan-2019-2022-1.pdf
[8] East Lothian IJB Strategic Plan 2019 – 2022 - https://www.eastlothian.gov.uk/downloads/file/28278/east_lothian_ijb_strategic_plan_2019-22
[9] West Lothian IJB Strategic Plan 2019 – 2022 - https://westlothianhscp.org.uk/media/33786/West-Lothian-IJB-Strategic-Plan-2019-23/pdf/West_Lothian_IJB_Strategic-Plan_2019-23.pdf?m=636917136505370000
[10] Midlothian IJB Strategic Plan 2019 – 2022 - https://www.midlothian.gov.uk/info/1347/health_and_social_care/200/health_and_social_care_integration

The table below summarises the need for change, the impact it is having on present service delivery and why this needs to be actioned now:

Table 7: Summary of the Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
There is currently no low secure provision in the Lothian area	Patients are receiving care far from home which means that connecting with family members becomes even more challenging than it would be normally for this patient group. Out of area low secure placements currently cost NHS Lothian approximately £3.2million per year	Reduction in out of area spend will support NHS Lothian to shift resource from hospital to community, aligning with its strategies as well as those of the 4 Lothian IJBs
Existing buildings are not fit for purpose and the majority cannot efficiently be converted into single bedroom ward accommodation	The organisation is failing to meet requirements such as having single, en-suite rooms. Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older.	The redevelopment is required now to provide a safe, financially sustainable and high-quality environment to those requiring inpatient care for a long-term mental health illness
Existing buildings have poor energy efficiency	Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint	Spending on energy is higher than it could be because it is not efficient or sustainable
Existing building has poor environmental patient safety measures.	Current anti-ligature strategy coherence is poor and difficult to address in current building.	Existing building has poor environmental patient safety measures.
Patients unable to access fresh air.	Due to lack of direct and safe outdoor space many patients who due their mental health condition and mental health act status are unable to access fresh air unless escorted by staff.	Lack of compliance with mental health act. Lack of compliance with human rights.
Patients with physical disabilities unable to access centralised therapeutic rooms.	Main therapeutic area for current patients has no lift, and current infrastructure of the building unsuitable to provide one, No practical other space available,	Lack of compliance with the Equality Act 2010 DDA
Current building does not support services care model.	Prolonged waiting times to access rehabilitation services from other clinical areas such as acute / admission mental health wards and low secure provision currently out of Lothian.	Difficulties in accessing local mental health acute inpatient services when required / referred,
There are significant workforce challenges, particularly within nursing	High vacancy rate across mental health services	The proposed bed reduction in MH Rehabilitation will enable the recruitment of staff for the new Low Secure wards.

2.3 Investment Objectives

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

Table 8: Investment Objectives

Effect of the need for change on the organisation	What must be achieved to deliver the necessary change? (Investment Objectives)
Care far from home - Patients are receiving care far from home which means that connecting with family members becomes even more challenging than it would be normally for this patient group. Out of area low secure placements currently cost NHS Lothian approximately £3.2million per year	End out of area secure psychiatric care for people in Lothian
Shifting resource from hospital to community - The proposal set out within this IA is to reduce the number of beds within the adult mental health rehabilitation service and transfer investment into community services.	Shift the balance of care by reducing inpatient beds and developing pathways to support people with complex needs in residential settings
Quality standards - The organisation is failing to meet requirements such as having single, en-suite rooms.	Establish a high quality, safe and robust inpatient services which meet care standards such as providing single rooms with en-suite bathrooms
Backlog maintenance - Backlog maintenance for the REH is £16 million. This is made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use are older.	Establish high quality facilities which are robust and maintainable
Facilities costs - Current facilities incur high facilities costs and have poor energy efficiency which is not aligned with the national aim to decrease carbon footprint	Have a facility which meets the current standards for energy efficiency and sustainability
Ligature risks - Current anti-ligature strategy coherence is poor and difficult to address in current building.	Provide an inpatient environment designed to meet patient and staff safety.
Poorly designed space to manage patient safety - Building requires numerous exit and entrances for the building to operational work, however, creates patient and staff safety concerns ranging from entry of unauthorised persons to staff being aware of patient whereabouts.	
Lack of outdoor space - Due to lack of direct and safe outdoor space many patients who due their mental health condition and mental health act status are unable to access fresh air unless escorted by staff.	Provide integral and secure gardens to each rehabilitation and low secure ward areas.
Lack of access to main therapeutic area - Main therapeutic area for current patients has no lift, and current infrastructure of the building unsuitable to provide one, No practical other space available,	Provide therapeutic areas that can be accessed with ease by all.

Effect of the need for change on the organisation	What must be achieved to deliver the necessary change? (Investment Objectives)
Prolonged waiting times - Prolonged waiting times to access rehabilitation services from other clinical areas such as acute / admission mental health wards and low secure provision currently out of Lothian.	A clinical environment which supports rehabilitation national evidence based clinical practice.
High vacancy rate - High vacancy rate across mental health services	Realistic and sustainable workforce model using the whole multidisciplinary team (MDT)

2.4 Benefits

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; Efficient: Value and Sustainability

The above investment objectives and the Strategic Assessment (see Appendix 2) have informed the development of a Benefits Register (available from Nickola Jones, Project Owner, on request). As per the 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.

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

1. A new integrated mental health rehabilitation /low secure centre will make the environment in which patients receive care and treatment more dignified and respectful of human rights by providing single bedroom with en-suite facilities and direct access to secure outdoor green space. This will promote patient independence and improve patient outcomes, enabling patients to leave hospital with more clearly defined needs and more able to manage their mental health and living skills independently.

2. Low secure care will be provided in NHS Lothian, preventing patients from having to receive care out of area. Provision of low secure facilities will improve continuity of care, maximising the ability of patients to engage in activities through fluctuations in their mental health. Integration of low secure and open rehabilitation will reduce secure care to the minimum time necessary further improving patients' ability to maintain links to friends, family and the local community for those now able to receive low secure care in Lothian.

3. A well-designed building which has had input from clinical staff, patients, and carers will assist in the reduction of violence and aggression, self-harm behaviours, missing persons and use of illicit substances. In addition, provision of adequate secure storage for personal belongings will result in lower incidence of items going missing.

4. The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments. This will make this centre in NHS Lothian a more attractive place to work and will help to support the staff we already have to enjoy their roles and continue to work in Lothian

5. The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff recruitment and retention

6. Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting.

7. A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site

2.5 Strategic Risks

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 9: Strategic Risks

Theme	Risk	Safeguard
Workforce	Staff will need to be recruited to deliver low secure on the REH site. Currently, there are challenges recruiting to nursing within mental health.	The general risk surrounding nursing recruitment has been escalated to the Nurse Director. The low secure posts should be attractive to current and new nursing staff. Additionally, the reduction in rehabilitation bed numbers should make some nursing capacity available. Also, the clinical team will explore how a multidisciplinary team approach could mitigate this challenge.
Funding– Capital	NHS Lothian is aware that there is a high level of demand for capital funds across Scotland, therefore there may be challenges securing capital funding	The IA presents a convincing case for investment. The project team have worked to ensure the proposal presents best value.
Funding - Revenue	IJBs will be required to issue directions to both reduce the bed base and to fund the staff required for rehabilitation	The project team has worked closely with IJB colleagues to ensure the proposal is supported by all four Lothian IJBs

Theme	Risk	Safeguard
Capacity	This proposal is for a reduced bed base for rehabilitation. The model of care and community provision to support this can be delivered out with this case, however, if not delivered, there is a risk that there will not be enough beds when the new facility is built	The four Lothian IJBs are already working to identify community alternatives for those with complex needs currently in hospital. There are plans to recruit a project manager to focus on this commissioning. Additionally, Edinburgh IJB are re-tendering their mental health support contracts and the new contracts will include more flexibility for providers which should support flow through support in the community.
Training	Low secure will be a new service so training will need to be undertaken to up skill staff	Medium secure care is already delivered on the site so there is local expertise that can be shared
Greenspace assets on site	Green space is an important element of rehabilitation for people receiving care on the site. There is a risk that this is compromised as development happens on the site.	The project team are working to ensure there is as minimal disruption as possible as works go forward. Green space is an important consideration within the design of the build and will be incorporated into any plans.

A register of strategic risks has been developed as is available from Nickola Jones, Project Owner, on request. This was developed by a group of key stakeholders at a workshop held on Thursday 15th July 2021. A full risk register will be developed for the project at the OBC stage.

2.6 Constraints and Dependencies

The key constraints to be considered are:

- Workforce availability is a key constraint for this case. The availability of enough multidisciplinary staff, particularly nursing, for the Low Secure facility is dependent on the reduction in bed numbers in Mental Health Rehabilitation
- Capital availability may also be a constraint due to a high demand on Scottish Government Capital Finance

The key dependencies to be considered are:

- The proposal to reduce the bed numbers in Mental Health Rehabilitation is dependent on community-based developments as alternative places of care for those currently in hospital; these developments will require extensive partnership working with support providers as the level of support required is higher than they currently deliver.

3. Economic Case

3.1 Do nothing/baseline

The table below defines the 'Do Nothing 'option. This is based on the existing arrangements as outlined in the Strategic Case.

Table 10: Do Nothing

Strategic Scope of Option	Do Nothing
Service provision	Low secure would continue to be delivered out with Lothian at high cost. Rehabilitation would continue to be delivered from unsuitable accommodation.
Service arrangements	Low secure would continue to be delivered by private providers. Move to a more intensive, shorter length of stay model for MH Rehabilitation.
Service provider and workforce arrangements	Private Services in Ayr and Glasgow for Low Secure. Service and workforce for MH rehabilitation would continue to be provided by NHS Lothian.
Supporting assets	Low secure would continue to be delivered out of area by private providers and rehabilitation would continue to be delivered from the outdated, non-compliant wards on the Royal Edinburgh Hospital site.
Public & service user expectations	People within low secure and their families would continue to have the challenge of being out of area. People within rehabilitation wards would continue to be cared for in poor quality environments with shared bathrooms.

3.2 Engagement with Stakeholders

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

Table 11: Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
Patients/service users	Patients and service users affected by this proposal include patients receiving care out of area in low secure, patients receiving care within rehabilitation and the families of these groups. Their involvement in its development includes being involved with the development of the clinical model through the Patients Council and Carers council. The impact that this has had on the proposal's development includes additional evidence to support a move towards en-suite bathrooms to promote privacy. They have also been asked to provide feedback about services to provide evidence for support of this case.	Patient / service user groups were consulted on the Initial Agreement and their feedback is included in the Strategic Case and has been incorporated into this proposal.
General public	The general public will not be directly affected by this proposal. There has been public consultation in relation to the masterplan to redevelop the campus and the proposal to develop low secure and rehabilitation has been included in the Strategic Plans of the four Lothian IJBs, which have undergone extensive public consultation.	Outcomes from consultation have not affected this proposal thus far. Further public consultation will be undertaken as the business case develops.
Staff/Resources	Staff affected by this proposal include all the multidisciplinary team required to deliver care within the proposed wards. Their involvement in its development includes being involved with developing the clinical brief and informing the strategic case.	Staff representatives were consulted on the Initial Agreement their feedback has been incorporated into this proposal.
Other key stakeholders and partners	Other key stakeholders identified for this proposal include health and social care partnerships, IJBs and hub. Their involvement in the development of this proposal includes being members of the Project Board.	Confirmed support for this proposal has been gained through the IA being presented to the four Lothian IJBs following support from the Project Board.

3.3 Long-listed Options

The table below summarises the long list of options identified:

1. **Do minimum**

   There are fire risks associated with the current wards and therefore works would be required to bring them up to specification. There are also backlog maintenance works required to be undertaken with an estimated cost of £5-7million.

2. **Refurbishment of existing facilities for Rehabilitation and continue to provide Low Secure out of Lothian**

   Work has already been undertaken to improve facilities for rehabilitation patients; however, these still do not meet care standards such as providing en-suite bathrooms. There is no alternative venue available on the site which could be refurbished for this patient group.

3. **Transfer services to wards on an existing NHS Lothian Acute site**

   Accommodate the Rehabilitation and Low Secure wards on another of NHS Lothian's sites – the Western General Hospital, the Royal Infirmary of Edinburgh, St John's Hospital, East Lothian Community Hospital

4. **Transfer services to alternative wards on REH site**

   There is no alternative venue available on the site which could be used for this patient group.

5. **Refurbishment of existing facilities for both Rehabilitation and Low Secure**

   Identification of accommodation on site which could be refurbished to provide 60 beds for both low secure and rehabilitation. There is no alternative venue available on the site which could be refurbished for this patient group.

6. **Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure**

   Identification of accommodation on site which could be refurbished to provide 37 rehabilitation beds and a new build for the 23bed Low Secure service. There is accommodation on REH site which could be refurbished and there is a piece of unused land available for the Low Secure service.

7. **New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site**

   The Astley Ainslie Hospital site is also located in Morningside and currently provides rehabilitation services, including the SMART centre. There may be land on this site which could be used for a new build facility.

8. **New Build for both Rehabilitation and Low Secure on REH Site**

   There is a piece of unused land in close proximity to the current Royal Edinburgh Building and Orchard Clinic (Medium Secure) facilities which can be used to build a bespoke Rehabilitation and Low Secure Centre inpatient unit with sufficient capacity to include the required additional facilities such as therapy space, family room, educational suite, administration and the potential to provide secure outdoor space

9. **Provide no inpatient beds for either low secure or general rehabilitation in NHS Lothian**

   Transfer of all resources to community-based teams and have no inpatient provision. Unlikely to meet statutory duties but being considered as part of long listed options.

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

- Option 2 as does not meet the requirement set by Scottish Government, NHS Lothian, Mental Welfare Commission, Forensic Network, and the 2021 Independent review that Low Secure services should be provided in the patient's local area
- Option 3 was discounted due to the existing capacity pressures on the acute sites in NHS Lothian
- Option 4 was discounted as there is no alternative accommodation on the REH site available that would meet the needs of this patient group

- Option 9 was discounted as the four Lothian IJBs have commissioned the beds required after extensive strategic planning to determine bed numbers required. There are also minimal bed numbers required to ensure there are safe places for people to be admitted to in an emergency.

Table 12: Long Listed options (not discounted above)

Strategic Scope of Option	Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure	Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure	Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site	Option 8- New Build for both Rehabilitation and Low Secure on REH Site
Service provision	Low secure would be delivered on the REH site alongside rehabilitation, from mostly unsuitable accommodation	Low secure would be delivered from high quality facilities which have appropriate therapeutic and private space. Rehabilitation would be delivered from mostly unsuitable accommodation	Low secure would be delivered out with the REH site alongside rehabilitation, from high quality facilities which have appropriate therapeutic and private space	Low secure would be delivered on the REH site alongside rehabilitation, from high quality facilities which have appropriate therapeutic and private space
Service arrangements	Low secure and rehabilitation would be delivered by NHS Lothian on their dedicated mental health site. Move to a more intensive, shorter length of stay model	Low secure and rehabilitation would be delivered by NHS Lothian on their dedicated mental health site. Move to a more intensive, shorter length of stay model	Low secure and rehabilitation would be delivered by NHS Lothian out with their dedicated mental health site. Move to a more intensive, shorter length of stay model	Low secure and rehabilitation would be delivered by NHS Lothian on their dedicated mental health site. Move to a more intensive, shorter length of stay model
Service provider and workforce arrangements	NHS Lothian for both Low Secure and MH rehabilitation	NHS Lothian for both Low Secure and MH rehabilitation	NHS Lothian for both Low Secure and MH rehabilitation	NHS Lothian for both Low Secure and MH rehabilitation
Supporting assets	Rehabilitation and Low Secure would be delivered from adequate accommodation	Low Secure would be delivered from high quality, top specification accommodation. Rehabilitation would be delivered from adequate	Low Secure and rehabilitation would be delivered from high quality, top specification accommodation	Low Secure and rehabilitation would be delivered from high quality, top specification accommodation

Strategic Scope of Option	Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure	Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure	Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site	Option 8- New Build for both Rehabilitation and Low Secure on REH Site
		accommodation		
Public & service user expectations	Service user and public expectations would be met to an extent, because low secure care will be delivered on the REH site from refurbished accommodation	Service user and public expectations would be met to an extent, because low secure care will be delivered on the REH site from new accommodation	Service user and public expectations will be met to an extent, but services will not be delivered from a dedicated mental health site, therefore no benefitting from this co-location	Service user expectation would be met because there would be high quality, bespoke services which are delivered as close to home as possible

Initial Assessment of Options

Each of the options taken forward 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 13: Assessment of options against investment objectives

	Do Minimum	Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure	Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure	Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site	Option 8- New Build for both Rehabilitation and Low Secure on REH Site
Advantages (Strengths & Opportunities)	Smaller costs associated with this option.	The rehabilitation patients' service is refurbished to meet current standards and statuary requirements.	The rehabilitation patient's service is refurbished to meet current standards and statuary requirements Provision of low secure within REH estate.	Newly build Integrated centre comprising of mental health rehabilitation and low secure. Ending out of area care for low secure. Meets Scottish Government health building requirement for the provision of single bedroom with en-suite facilities. Consistent with the benefits register.	Newly build Integrated centre comprising of mental health rehabilitation and low secure. Improving flexibility of the service(s) and patient flow. Ending out of area care for low secure. Meets Scottish Government health building requirement for the provision of single bedroom with en-suite facilities. Consistent with the benefits register.

	Do Minimum	Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure	Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure	Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site	Option 8- New Build for both Rehabilitation and Low Secure on REH Site
Disadvantages (Weaknesses & Threats)	The current building is over 50 years old. Non-compliance with several current standards and statutory requirements. . e.g. minimal ventilation therefore unable to control air changes, electrics and heating in excess of 50 years old - parts now obsolete. The costs of maintenance over the next 5-7 years are estimated £5m to £7m Out of area care for those patients requiring low secure continues The current masterplan for the campus assumes that the existing	To undertake refurbishment is estimated to take 12months plus. The rehabilitation service and patients would require to be decanted during this and there is no current decant facility. Low secure provision would remain out of area. The current building would not be able to be refurbished to provide individual bedrooms with en-suites. The therapeutic basement of the current building would remain non-compliant with EA regulations as the structure cannot accommodate a lift. The cost of the refurbishment is estimated to cost in excess of 10 million. Retaining the current building does not fit with the current master plan for the	As per option 5 for rehabilitation service The threat would be that there is no Suitable accommodation within the REH campus site to allow low secure provision to take place.	Lack of co-location with other mental health services which would reduce safety and increase staffing levels required. Would not align with NHS Lothian's hospitals plan to move services away from the Astley Ainslie Hospital site and focus on the Royal Edinburgh Hospital. Patients often go from acute wards to rehabilitation wards, so there would be less continuity of care if they were transferred to another site which may be detrimental to their rehabilitation. Lack of capital funding.	Lack of capital funding.

	Do Minimum	Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure	Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure	Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site	Option 8- New Build for both Rehabilitation and Low Secure on REH Site
	building is demolished.	campus.			
Investment Objective 1	No	Fully	Fully	Fully	Fully
Investment Objective 2	Fully	Fully	Fully	Fully	Fully
Investment Objective 3	Partial	Partial	Partial	Fully	Fully
Investment Objective 4	No	Partial	Partial	Fully	Fully
Investment Objective 5	No	No	Partial	Fully	Fully
Investment Objective 6	No	Partial	Partial	Fully	Fully
Investment Objective 7	No	No	Partial	Fully	Fully
Investment Objective 8	No	No	No	Fully	Fully
Investment Objective 9	No	No	No	No	Fully
Investment Objective 10	No	No	No	Partial	Partial
Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)					
Affordability	Yes	Unknown	Unknown	Unknown	Unknown

	Do Minimum	Option 5 – Refurbishment of existing facilities for both Rehabilitation and Low Secure	Option 6 – Refurbishment of existing facilities for Rehabilitation and New Build for Low Secure	Option 7 - New Build for both Rehabilitation and Low Secure on the Astley Ainslie Hospital Site	Option 8- New Build for both Rehabilitation and Low Secure on REH Site
Preferred/Possible/Rejected	Possible	Possible	Possible	Rejected	Preferred

3.4 Short-listed Options and Preferred Way Forward

3.4.1 Shortlisted options

From the initial assessment above the following short-listed options have been identified:

Table 14: Short Listed Options

Option	Description
Option 1	Do minimum
Option 2	Refurbishment to existing facilities for both rehabilitation and low secure
Option 3	Refurbishment of existing services for Rehabilitation and new build for low secure
Option 4	New Build

3.4.2 Non-financial benefits assessment

Each of the shortlisted options was assessed against the benefits included in the benefits register (available from Nickola Jones, Project Owner, on request). Each of the identified benefits was weighted by a group of stakeholder representatives and following this each of the shortlisted options was scored against its ability to deliver the required benefits. The full assessment is available from Nickola Jones, Project Owner, on request.

The results of the benefits assessment are summarised below:

Table 15: Results of Non-Financial Benefits Assessment

#	Benefit	Weight (%)	Option 1	Option 2	Option 3	Option 4
1	A new integrated mental health rehabilitation /low secure centre will make the environment in which patients receive care and treatment more dignified and respectful of human rights by providing single bedroom with en-suite facilities and direct access to secure outdoor green space	25	3	5	6	10
2	Low secure care will be provided in NHS Lothian, preventing patients from being required to travel out of area. Provision of low secure facilities will improve continuity of care, maximising the ability of patients to engage in activities through fluctuations in their mental health	25	0	8	10	10
3	A well-designed building which has had input from clinical staff, patients, and carers will assist in the reduction of violence and aggression, self-harm behaviours, missing persons and use of illicit substances	10	5	6	7	10

#	Benefit	Weight (%)	Option 1	Option 2	Option 3	Option 4
4	The creation of a mental health rehabilitation and low secure service on the Royal Edinburgh Site will provide more educational opportunities on site as well as enhancing skills through working within different care environments	5	0	6	7	10
5	The improved care environment will make it safer for staff to deliver care and treatment, improving job satisfaction, reducing sickness absence rates and improving staff retention	15	4	6	7	10
6	Patient outcomes will be improved due to increased access to spaces where therapeutic activity can be delivered and where they can spend time with family and friends and the improved ability of staff supported by improved access to health technology which provides continuity of care in one setting	15	4	6	7	10
7	A new facility would be developed using the most up to date specifications for sustainability and efficiency. This means that ongoing costs of maintenance and energy use would be reduced, as well as reducing the carbon footprint of the REH site	5	0	3	6	10
	Total Weighted Benefits Points		**245**	**610**	**745**	**1,000**

From the table above it is noted that the option that will deliver the most benefits is Option 4

3.4.3 Indicative costs

The table below details the indicative whole life costs associated with each of the shortlisted options. For further detail around the determination of the costs see the Financial Case.

The additional assumptions associated with the calculation of the NPV of costs are:

- A discount rate of 3.5% has been used in line with Government guidelines.
- A useful life of 29 years for refurbishment projects (Options 2 and 3), as this is in line with the remaining useful life of the Royal Edinburgh Buildings, a useful life for a new build has been determined as 50 years (Option 4).
- The base date for the proposal is September 2022.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.
- VAT and Inflation are excluded in the NPV calculation – whole life capital costs.

Table 16: Indicative Costs of Shortlisted Options

Cost (£k)	Option 1	Option 2	Option 3	Option 4
Capital cost	12,265	29,548	41,354	49,750
Whole life capital costs	9,941	23,948	33,514	40,291
Whole life operating costs	108,399	174,950	209,600	269,714
Estimated Net Present Value (NPV) of Costs	**118,340**	**198,898**	**243,114**	**310,005**

3.4.4 Overall assessment and preferred way forward

The table below show the weighted benefit points for each shortlisted option, the NPV of costs and the calculated cost per benefit point. This calculated cost per benefit point has been used to rank the options and identified the preferred way forward.

Table 17: Economic Assessment Summary

Option Appraisal	Option 1	Option 2	Option 3	Option 4
Weighted benefits points	245	610	745	1000
NPV of Costs (£k)	118,340	198,898	243,114	310,005
Cost per benefits point (£k)	483	326	326	310
Rank	**3**	**2**	**2**	**1**

The preferred solution was identified as Option 4: New Build for Both Services on REH Site. This was identified as the preferred option because it ranked the highest it both the Non-Financial and the Economic Assessment. Option 4 delivers a greater number of the benefits that have been set out as the criteria for achievement from this project.

It is recommended that NHS Lothian proceeds with this option to Outline Business stage where the implementation of the solution shall be further developed and tested for value for money.

3.5 Design Quality Objectives

Design quality objectives have been developed for the preferred strategic / service option by taking the following steps:

1. An AEDET review of existing property arrangements has been undertaken to set a benchmark score from which change is needed.

2. A second multi-stakeholder AEDET review has been undertaken which has identified the main features the new proposal will need to focus on and has set a target score from which design expectations can be measured

3. Design objectives that explain what the design needs to achieve to improve on the existing arrangements have been outlined in the NDAP[11]Design Statement (see Appendix 5).

The AEDET worksheets provided in Appendix 5 demonstrate how the target for improvement has been set against the existing arrangements.

[11] NDAP is the mandated NHSScotland Design Assessment Process.

3 The Commercial Case

4.1 Procurement Strategy

The indicative cost (construction only) for the preferred option at this stage is £49.8m including VAT. It is anticipated that the procurement of the project will be led by NHS Lothian supported by Turner Townsend (technical advisers), Thomson Gray (cost advisers), and Burness Paull (legal advisers).

The project will be delivered in accordance with NHS Scotland construction procurement policy and it is anticipated that it will be undertaken in conjunction with Hub South East Scotland Ltd acting as NHS Lothian's development partner.

4.2 Timetable

A detailed Project Plan will be produced for the OBC. At this stage the table below shows the proposed timetable for the progression of the business case and project delivery milestones:

Table 18: Project Timetable

Key Milestone	Date
Initial Agreement approved	December 2021
Hub appointed	January 2021
Outline Business Case approved	September 2022
Planning permission in principle obtained	In place – expires March 2022 – would require extension
Full Business Case approved	February 2022
Construction starts	April 2023
Construction complete and handover begins	August 2024
Service commences	September 2024

4 The Financial Case

5.1 Capital Affordability

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.

Table 19: Capital Costs

Capital Cost (£k)	Option 1: Do Minimum	Option 2: Refurbishment of existing facilities for Rehab & Low Secure	Option 3: Refurbishment of existing facilities for Rehab and New Build for Low Secure	Option 4: New Build for both services on the REH Site
Construction	7,000	14,226	19,909	25,892
Inflation	280	500	700	910
Professional Fees	-	1,724	2,413	3,138
Furniture, Fitting & Equipment	218	532	745	969
IT & Telephony	73	177	248	323
Contractor Contingency & Risk	-	1,293	1,810	2,354
Optimism Bias	2,650	6,459	9,039	8,396
Total Cost (excl VAT)	**10,221**	**24,911**	**34,864**	**41,982**
VAT	2,044	4,982	6,973	8,396
VAT Recovery		(345)	(483)	(628)
Total Capital Costs	**12,265**	**29,548**	**41,354**	**49,750**

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

- Construction costs for Option 4 have been provided by independent quantity surveyors, their costs have then been used to estimate the costs for Options 2 and 3, which were given as a range, the upper of which has been assumed. Costs for option 1 were provided from the NHS Lothian Estates Manager for the Royal Edinburgh site.
- An inflation allowance of 4%, provided by NHS Lothian's external cost advisors, has been included using a base date of September 2022 and the construction timeline detailed in the Commercial Case. This allowance will need to be further refined as the project progresses due to the volatility in the market currently. The table below contains a sensitivity analysis on Inflationary amount only due to this level of uncertainty.
- Professional fees are assumed to be 10% of the total Capital costs provided or estimated.
- Furniture, Fitting & Equipment has been estimated at 3% of total costs, based on another recent project. This has been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.
- IT & Telephony has been estimated at 1% of total costs, based on another recent project. This has been included in Option 1 also as it would be expected that these items would also need replaced/upgraded in a 'Do Minimum' scenario.

- Contractor Risk is included at 7.5% as advised by the independent quantity surveyors.
- Optimism bias calculated in line with SCIM guidance, it has been calculated at 25% for Option 4 and 35% for all other options due to the level of design already carried out for Option 4.
- VAT has been included at 20% on all costs. Recovery has been assumed on Professional Fees only – no further VAT recovery has been assumed. VAT recovery will be further assessed in the OBC.

Inflation

Over the last twelve to eighteen months there has been a decline in the Tender Price Index (TPI) but a sharp rise in the Building Cost Index (BCI). This reflects the difficult economic conditions. This impact was initially felt by main contractors with fixed price contracts and, the cumulative pressure due to increased material prices. The knock-on effect has been transferred to the client side as contractors look to correct or offset the reduction in margin on existing contracts. When pricing new projects, contractors are inflating their prices (or are qualifying tenders) in order to return their margin to a manageable position and to offset the increase in building costs and risk. This will ultimately result in a rise in the TPI which will need to increase to a position above the BCI which could represent a large jump in inflation. It is unknown how long this fluctuation will last and what impact this will have on inflation.

The impact of the COVID-19 pandemic on future projects is still relatively unknown; the capital costs presented do not have an allowance for a programme extension. It would therefore be prudent to consider a possible impact on costs, should the programme have to be extended.

The sensitivity analysis below aims to set out the possible impact on the total project costs should inflation rise or reduce as well as an extension to programme.

Table 20: **Inflation & Programme Extension Sensitivity Analysis**

	Total Capital Cost (£k)			
Sensitivity Scenario	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Scenario 1: no changes (4%)	12,265	29,548	41,354	49,750
Scenario 2: inflation percentage doubles (8%) and programme extended (10 weeks) *	12,479	30,696	42,804	55,549
Scenario 3: inflation percentage halves (2%)	11,137	28,856	40,382	52,518

** Programme extension and costs are estimated based on details provided by external advisors for another project.*

Resources and budget required to develop the case to FBC are currently being considered by the project team.

5.2 Revenue Affordability

The estimated recurring revenue costs associated with each of the short-listed options are detailed in the table below. These represent the total revenue costs required to support the project.

Table 21: Incremental Revenue Costs

Revenue Cost/Funding (£k)	Option 1: Do Minimum	Option 2: Refurbishment of existing facilities for Rehab & Low Secure	Option 3: Refurbishment of existing facilities for Rehab and New Build for Low Secure	Option 4: New Build for both services on the REH Site

Revenue Cost/Funding (£k)	Option 1: Do Minimum	Option 2: Refurbishment of existing facilities for Rehab & Low Secure	Option 3: Refurbishment of existing facilities for Rehab and New Build for Low Secure	Option 4: New Build for both services on the REH Site
MH Rehab Community Costs	5,694	2,064	2,064	2,064
Inpatient Costs		7,092	7,092	7,092
Supplies Costs		216	216	216
OOA Costs	-	460	460	460
Facilities Costs	-	1,179	1,179	1,179
Depreciation Costs	-	1,019	1,426	995
Total Annual Revenue Cost	**5,694**	**12,030**	**12,437**	**12,006**
Rehab Service Budget Release	4,310	4,310	4,310	4,310
Facilities Budgets	1,384	1,384	1,384	1,384
NHS Lothian Depreciation Budget	-	1,019	1,426	995
Total Annual Revenue Budget	**5,694**	**6,713**	**7,120**	**6,689**
Funding Gap	**0**	**(5,317)**	**(5,317)**	**(5,317)**

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

- Inpatient costs a detailed bottom up exercise has been conducted with the Chief Nurse/General Manager and professional leads based on workforce requirements for the commissioned level of beds.
- Community costs are currently included as a proxy estimate equivalent to the bed reductions for rehabilitation (24 places at wayfinder model grade 5) however as the project progresses to OBC these will be refined as community services move to a detailed commissioning stage.
- Non pay costs are based upon the current Braids ward non pay costs (rehabilitation ward within REB).
- Facilities costs are based on the Royal Edinburgh Phase 1 building, adjusted for footprint.
- Rehabilitation funding (existing ward budgets) Depreciation is based on a useful life of 29 years for Option 2 and 3, and 50 years for Option 5 and assumed to be funded from the existing NHS Lothian Depreciation funding allocation. Depreciation excluded in Option 1 as already forms part of Depreciation cost for the Royal Edinburgh Buildings.

Additional one-off revenue costs associated with commissioning of the project have yet to be identified and costed. One off cost is likely to relate to start-up costs for community accommodation commissioned by Integration Joint Boards. Discussion is ongoing in partnership with Integration Joint Boards around potential solutions to support the community start-up costs. One such action is the potential application of the community living change fund against these double running costs. The community living change fund totals £3.1m of non-recurring funding across the Lothian Integration Joint Boards and was allocated by Scottish Government to support the discharge from hospital of people with complex needs.

Funding has been identified for the additional revenue costs from the NHS Lothian out of area budget. Although the financial model shows a gap of £5.3m against available funding there is a £5.9m planned release from the out of area budget in total which has not been included. The release from the out of area budget is achieved from the creation of a Low Secure Mental Health facility on the Royal Edinburgh

Campus. However, this planned release underpins both planned developments on Campus - Learning Disabilities and Mental Health Low Secure and Rehabilitation. Overall, both initial agreements present a joint financial gap of £5.9m which is equivalent to the planned release from the out of area budget. In totality once the out of area budget has been released both initial agreements are affordable on a recurring basis.

If the Learning Disabilities project progresses first there will be a challenge around release of the out of area budget as patients will still require to be placed out of area for Low Secure Mental Health inpatient care. Current projections for the out of area budget forecasts a £0.6m underspend for the next few years so if Learning Disabilities progresses ahead of the Mental Health and Low Secure and Rehabilitation case the underspend on the out of area placements can be used to balance the Learning Disabilities financial model. This has been agreed with Chief Officers from each of the Lothian Integration Joint Boards.

Revenue affordability has been reviewed and agreed by the Finance Business Partner (Hamish Hamilton, Finance Business Partner (interim) REAS & West Lothian HSCP). These costs have been reviewed in detail with the Chief Finance Officers of each Lothian Integration Joint Board and Chief Officers also receive regular updates on the financial modelling associated with this initial agreement.

Revenue costs will continue to be refined through the OBC process.

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.

5.3 Overall Affordability

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

Funding has been identified for the additional revenue costs from the out of area budget and these have been reviewed and agreed by the Finance Business Partner (interim) Hamish Hamilton and agreed in partnership with Chief Finance Officers of each Lothian Integration Joint Board. The joint projected gap of £5.9m across this initial agreement and the Learning Disabilities project can be funded in full through the release of the out of area budget. In the scenario that Learning Disabilities progresses first the operational financial risk can be mitigated from the existing out of area budget.

All costs will continue to be refined through the OBC process.

5 The Management Case

The purpose of the Management Case is to demonstrate that NHS Lothian is prepared for the successful delivering of this project.

6.1 Readiness to proceed

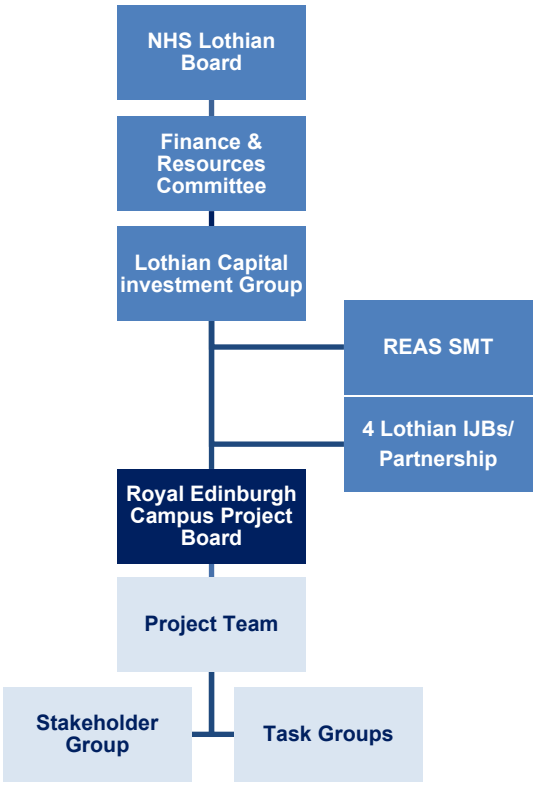
A benefit register and initial high-level risk register for the project have been developed are available from Nickola Jones, Project Owner, on request. Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

NHS Lothian is ready to proceed with this proposal and is committed to ensure the necessary resources are in place to manage it. The sections below outline the governance support and reporting structure for the proposal and the project management arrangements.

6.2 Governance support for the proposal

Stakeholder engagement is detailed in the Strategic Case and includes information on how members of the proposal's governance arrangements have been involved in its development to date and will 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

The table below identifies key members of the project team and the REH Programme Management Board that will be responsible for taking the project forward; the table includes details of individuals' capabilities and previous experience.

Table 22: Project Management Structure

Role	Individual	Capability and Experience
Senior Responsible Officer, Project Sponsor	Calum Campbell, Chief executive NHS Lothian	Calum, whose background is in nursing, first started working in the NHS in 1984 and was previously the Chief Executive at NHS Borders for five years, before he moved to take charge in NHS Lanarkshire in 2015.

Role	Individual	Capability and Experience
Senior User and Project Management Board Chair	Tracey McKigen, Services Director, Royal Edinburgh and Associated Services	As Senior User Tracey is accountable for ensuring that requirements have been clearly defined in the Clinical Brief and that the proposed development is fit for purpose and fully meets user needs. Following the principles of PRINCE2, the Senior User has primary responsibility for quality assurance and represents the interests of all those who will use and operate the new facilities. As REAS Service Director, Tracey has a deep understanding of the clinical and support needs of the services delivered from the REH. She has also held several other senior management roles in the NHS
Project owner and Strategic Planning	Nickola Jones, Strategic Programme Manager	Previous experience of NHS capital projects
Project Manager	Steve Shon, Senior Project Manager, Capital Planning	Steve has worked within NHS Capital Planning since 1998 managing and co-ordinating all aspects of the procurement of major new health facilities, from preparation of business cases through to commissioning. In terms of procurement, he has been involved in traditional, D&B, and PFI schemes and is now working on Hub developments, including the redevelopment of the Royal Edinburgh Hospital. Previous projects have ranged from small Learning Disabilities houses, through Care of the Elderly facilities, to the redevelopment of the State Hospital at Carstairs
Capital Finance Support	Laura-Jane Smith	Experience supporting capital investment projects
Finance Business Partner	Hamish Hamilton	Previous experience at Senior Manager level in similar projects
Service Lead	Andrew Watson	Associate Medical Director for the Royal Edinburgh Hospital and Associated Services
Service Lead	Karen Ozden	Chief Nurse for the Royal Edinburgh Hospital and Associated Services
Partnership Representative	To be confirmed	Dependant on appointee

The project's external advisers are:

- Turner and Townsend- Technical Adviser
- Burness Paull - Legal Adviser
- Thomson Gray - Cost Adviser

6 Conclusion

This proposal is a significant priority for NHS Lothian and the four Lothian IJBs as it realises national advice to provide Low Secure locally and will improve the quality and dignity of care for patients receiving mental health rehabilitation.

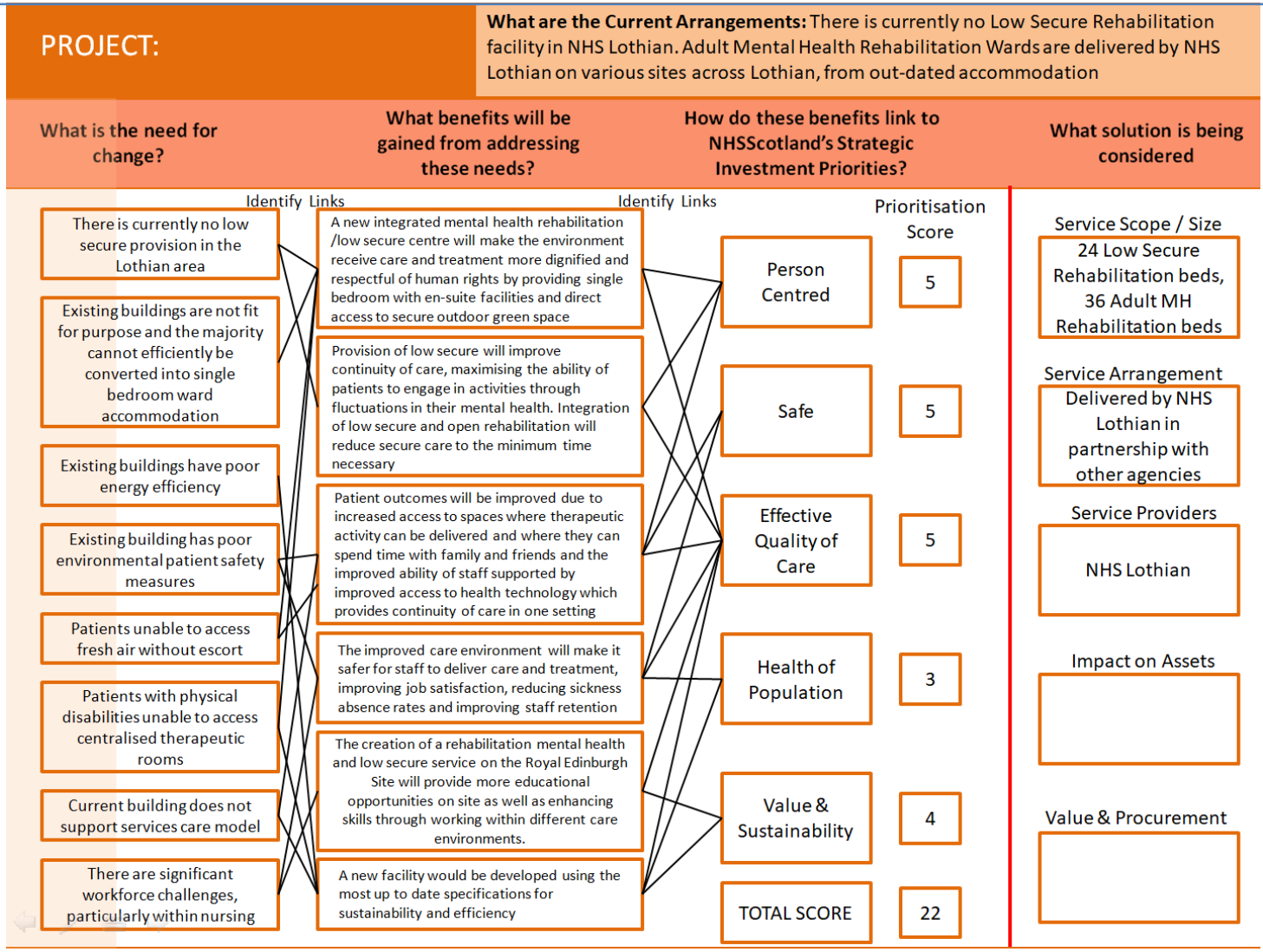
At the centre of this case is a desire to provide the best quality of care to those who require mental health care in NHS Lothian. Having to receive care out of area is detrimental to our patient's wellbeing and recovery, as is receiving care in a poor-quality environment. Additionally, staff should be delivering care from environments that they are proud to work in, not from environments that they must work around. This case provides an opportunity to create an innovative facility which can provide the flexibility required to care for patients in the least restrictive way possible.

This IA makes a compelling case for investment which would further the Scottish Government's ambitions to provide parity between physical and mental health care and to provide care as close to home as possible.

Appendix 1: Pictures of Current Mental Health Rehabilitation Wards

Provided as a separate document due to file size.

Appendix 2: Strategic Assessment



Meeting Name: Board **Meeting date: 1 December 2021**

Title: WARD 20 REPROVISION OF CRITICAL CARE AT THE WESTERN GENERAL HOSPITAL

Purpose and Key Issues of the Report:

DISCUSSION		DECISION	✓	AWARENESS	

This report has been written to present the Initial Agreement for the Reprovision of Critical Care at the Western General Hospital. Board members are asked to review the paper and accompanying Initial Agreement appendix and take assurance that the appropriate consideration has been given to this IA from various fora including Acute SMT, LCIG, CMT, PPDC and F&RC in advance of the NHS Lothian Board.

The Initial Agreement support the Corporate objectives of NHS Lothian, namely: Improve Quality, Safety and Patient Experience, and Improve the experience of our staff.

The report summarises the drivers for change and describes the significant issues associated with the current location of critical care at the Western General Hospital which combined, present a Healthcare-Associated Infections Risk.

The report details the process undertaken to identify a preferred future option and describes the very significant key risks including enabling moves between ward 58 and ward 52, remedial ventilation works and further interdependencies relation to reprovision of office space, and consequences of the Edinburgh Cancer Centre and National treatment Centre.

The resource implications are significant and on approval of the Strategic Case, it was anticipated that the costs of this project would fall within Lothian's delegated limit. However, since the Strategic Case stage, compliance requirements have evolved and ensuring compliance with all required building environment technical memoranda has significantly impacted the estimated capital cost, taking it above NHS Lothian's delegated limit.

Recommendations:

The NHS Lothian Board is recommended to review both the covering paper and attached appendix – Reprovision of Critical Care Ward 20 Initial Agreement (IA) and take assurance that this IA has been already been presented to a number of Governance Committees and Boards, all of who have endorsed the preferred option as presented.

The Board is recommended to support submission of the IA to the Scottish Capital Investment Group, early 2022.

Author: Bhav Joshi/Immy Tricker **Date: 17/11/2021**	**Director: Jacquie Campbell** **Date:**

NHS LOTHIAN

NHS Lothian Board
1 December 2021

Jacquie Campbell, Chief Officer of Acute Services

INITIAL AGREEMENT - WARD 20 REPROVISION OF CRITICAL CARE AT THE WESTERN GENERAL HOSPITAL

1 Purpose of the Report

1.1 The purpose of this report is to provide assurance to the NHS Lothian Board that appropriate consideration has been given to the Initial Agreement (IA) for the Reprovision of Critical Care Ward 20 at the Western General Hospital, ensuring alignment with Board strategy, and recognising and seeking to address the most significant challenges and opportunities.

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

2 Recommendations

NHS Lothian Board is recommended to:

2.1 **Endorse** the preferred option as Reprovision of Critical Care Ward 20 to Ward 52 at the Western General Hospital as shown in section 3.12.

2.2 **Approve** the Initial Agreement and support onward submission to the Scottish Government Capital Investment Group for consideration.

3 Discussion of Key Issues

3.1 The provision of care for patients who need continuous care is provided by a specialised medical team within critical care which is provided from Ward 20 at the Western General Hospital.

3.2 Ward 20 at the Western General Hospital provides critical care to patients receiving treatment from a range of specialities across the site. However, the current facilities within the ward are unsuitable for patients in need of critical care. There are serious issues and concerns around several aspects of the ward, and it is at severe risk of not being able to sustain safe service delivery.

3.3 The main issues facing the ward are:

- Inadequate fire safety
- Inadequate ventilation provision
- Inadequate provision of isolation rooms
- Water contamination
- Compromised functionality
- Lack of clinical adjacencies

3.4 Collectively, these issues present a Healthcare-Associated Infections (HAI) risk, result in poor patient and relative experience and present a challenge for staff.

3.5 Capital investment into the reprovision of Critical Care is urgently required as a result of the above issues, which can no longer be addressed by limited, targeted repairs.

3.6 Bed modelling in relation to Critical Care at the Western General Hospital has indicated that two additional beds may be required over the next decade. To future proof this project, the preferred option includes physical space for 2 additional beds. However, this project is driven by the issues detailed above, and not the possible bed base increase that may be required in the future.

Revenue costs associated with staffing two additional beds are therefore not included within this IA. They should be considered alongside the wider pan-Lothian Critical Care strategy going forwards and additional revenue funding would need to be sought through the financial planning process if further beds were to be staffed.

3.7 A core team has been established to support this project, led by Jane McDonald, General Manager Critical Care.

3.8 This project was prioritised by Acute SMT as part of the 2018/19 capital prioritisation process. The IA was approved by: Acute SMT in July 2021, LCIG in August 2021, CMT in August 2021, PPDC in November 2021 and FRC in November 2021. It was also heard by the Executive Leadership Team, as recommended by LCIG.

3.9 The project supports the Corporate Objectives of NHS Lothian:

- **Improve Quality, Safety and Patient Experience** - the current facilities are unsuitable for patients in need of critical care and pose a risk to patient safety. This project seeks to address the safety issues and bring the environment up to modern healthcare standards, to bridge the care deficit that patients are currently exposed to, thereby improving quality, safety, and patient experience.
- **Improve the experience of our staff -** the current facilities present a challenge for staff and do not provide an environment that is conducive to the safe delivery of care. This negatively impacts staff morale. Through addressing the current lack of clinical adjacencies this project also offers improved opportunities for multi-disciplinary skill transfer, further improving care for patients.

3.10 An Options Appraisal was undertaken in January 2021. Each option on the long list of options was assessed against a set of benefits criteria that were linked to the investment objectives and was scored by a multi-disciplinary group comprised of Medical, Nursing, Planning, Facilities and Service personnel.

3.11 Each of the identified benefits was weighted (%) before each of the options was scored against its ability to deliver the required benefits, using scores between 0 (unlikely to meet benefit) and 10 (significantly likely to meet benefit). Table 1 (below) shows the shortlisted options.

Table 1 – Short Listed Options as derived via Options Appraisal

Option	Description
Option 2	Do Minimum – Refurbishment of Ward 20 to comply with essential standards – baseline option
Option 4	Reprovision of Critical Care in Ward 57/58 and adjacent shell
Option 8	Reprovision of Critical Care into Ward 52

3.12 The preferred option was identified as Option 8: Reprovision of Critical Care into Ward 52

4 Key Risks

4.1 The preferred option entails reprovision of Critical Care Ward 20, in Ward 52 that is currently temporarily occupied by the Surgical High Dependency Unit (SHDU), pending ventilation works required to Ward 58, the ward usually occupied by SHDU. The Critical Care Ward 20 project is dependent on these ventilation works being completed and SHDU vacating Ward 52. If there is a delay to these works it could elongate the programme for this project, which could result in increased costs. It will also impact elective capacity at the site as there are limited options for augmented care. The costs for these ventilation works to Ward 58 are not included as part of this project as the move of SHDU to Ward 52 is temporary, as the ventilation findings in Ward 58 are addressed. Funding has been earmarked for required ventilation works in Ward 58, subject to separate approval.

4.2 The project team will be following the formal process for engagement with NHS Scotland Assure. As a recent addition to the assurance framework for projects this engagement could impact project programme or cost in a way that has not been fully quantified in the present IA.

4.3 There is a risk that capital funding cannot be identified to support the preferred model. This project is not presently included within the Scottish Government's Five-Year Plan. Informal engagement with Scottish Government is underway to provide awareness of the project.

4.4 There are interdependencies in relation to office space that would require reprovision should the preferred option be enacted, and potential consequences of the Edinburgh Cancer Centre and National Treatment Centre projects must be considered alongside this project.

5 Risk Register

5.1 The Corporate Risk Register contains risks associated with Access to Treatment (4191 organisational risk, and 3211 patient risk). They have both been categorised as very high.

5.2 If approved, the project will have its own risk register developed, including design, construction, contract, and post-contract risks.

6 Impact on Inequality, Including Health Inequalities

6.1 This paper does not include any policy changes which might impact unfairly on different sectors of the wider community served by NHS Lothian; however, an integrated impact assessment will be developed through the Business Case process should the IA be approved.

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

7.1 The individual proposals outlined here all bring the duty to inform, engage, and consult, so these actions are being taken forward by the core group with wider engagement with Service, Medical, Nursing, Estates, Facilities and Partnership (staff side) colleagues.

8 Resource Implications

8.1 The estimated capital costs for the preferred option (Option 8: Reprovision of Critical Care into Ward 52) have been estimated at £18.6m.

8.2 Construction costs for the preferred option were provided by independent quantity surveyors based on a feasibility study. Optimism bias has been included at 40% of all costs, to reflect the stage of this project and the unquantifiable uncertainties and risks surrounding it.

8.3 The estimated capital costs noted above address the issues related to fire safety, ventilation provision, isolation room provision and water contamination. They also allow for a larger footprint which will enable the space to better comply with modern healthcare standards for a critical care unit, for example, by improving bed space. The preferred location also improves clinical adjacencies. These developments would enable the project to bridge the care deficit that patients are currently exposed to, thereby improving quality, safety, and patient experience, whilst also improving the environment for staff, and enabling safer delivery of care.

8.4 The preferred option of Reprovision of Critical Care into Ward 52 is considered a medium to long-term solution, as it provides a degree of future-proofing for the site. The proposed space could accommodate an additional 2 beds should the bed base be required for Critical Care.

8.5 On approval of the Strategic Case, it was anticipated that the costs of this project would fall within our delegated limit. However, since the Strategic Case stage, compliance requirements have evolved and ensuring compliance with all required building environment technical memoranda has significantly impacted the estimated capital cost, taking it above NHS Lothian's delegated limit.

8.6 Annual incremental revenue costs for the preferred option have been identified as £81k, relating to facilities costs of operating a larger space. The IA assumes no increase in bed numbers or change to staffing model and therefore no increase in staffing costs are anticipated. The additional facilities costs will be reviewed at OBC stage and funding options will be investigated, but at the stage of IA submission funding is still to be agreed.

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Appendix 1 – Reprovision of Critical Care Ward 20 Initial Agreement

Reprovision of Critical Care Ward 20 at the Western General Hospital

NHS Lothian
Initial Agreement

Project Owner: Jane McDonald
Project Sponsor: Michelle Carr
Date: 29/09/2021
Version: 1.17

Version History

Version	Date	Author(s)	Comments
1	10/03/2021	Bhav Joshi	Template set up
2	12/03/2021	Bhav Joshi	Updates to Strategic and Economic Cases
3	18/03/2021	Bhav Joshi	Inclusion of Benefits and Risk Criteria
4	24/04/2021	Bhav Joshi/Jess Davis	Addition of Clinical Model Components
5	18/06/2021	Bhav Joshi	Edits to Strategic and Economic Case
6	01/07/2021	Rebecca Devine	Addition of references to strengthen Strategic Case
7	20/07/2021	Bhav Joshi	Inclusion of Executive Summary
8	21/07/2021	Bhav Joshi	Formatting Edits
9	22/07/2021	Hania Klinge	Updated Commercial and Management Cases and overall edits
10	27/07/2021	Bhav Joshi	Inclusion of prospective floorplan
11	29/07/2021	Bhav Joshi	Additions to Strategic Case Regarding Bed Profile
12	30/07/2021	Emma Amor	Addition of financial information to the Economic and Financial Cases
13	30/07/2021	Hania Klinge	Overall edits
14	02/08/2021	Emma Amor	Updates to Financial Case
15	03/08/2021	Bhav Joshi	Final formatting and visual aids
16	27/09/2021	Bhav Joshi	Removal of Appendices and integration of photographic challenges
17	29/09/2021	Hania Klinge	Edits to Executive Summary

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Executive Summary

The provision of care for patients who need augmented care in NHS Lothian is provided by a specialised medical team within critical care. Critical care is provided from Ward 20 at the Western General Hospital (WGH), which is one of the oldest Intensive Care Units in Britain. Ward 20 is a regional centre for Colorectal and Urology surgery and admits patients from the RIDU (Regional Infections Diseases Unit). Together with the Surgical High Dependency Unit (SHDU) at WGH Ward 20 provide care primarily to patients who are receiving care in the following specialties: colorectal surgery, urological surgery, gastroenterology, haematology, infectious diseases, anaesthesia, oncology, respiratory, stroke, medicine of the elderly, and acute medicine.

The unit is currently located in the Alexander Donald Building and is geographically isolated from some of the departments which work most closely with critical care e.g., Theatres, Acute Receiving Unit, Cancer Services and Radiology. It is also separated from the SHDU, which is normally sited in the Anne Ferguson Building Ward 58 adjacent to the Theatres, which limits opportunities for multi-disciplinary skill transfer and information sharing.

Ward 20 has not seen a major investment since its creation in late 1980s. The current facilities within the ward are unsuitable for patients in need of critical care with serious issues and concerns around a number of areas and are at severe risk of not being able to sustain safe service delivery going forward. The situation has been challenging for a number of years; however, the COVID-19 pandemic has highlighted further inadequacies and non-compliance issues deeming the environment not acceptable for the provision of modern healthcare. The below list includes the main issues the unit is facing at the moment:

- **Inadequate Fire Safety** – the unit does not meet current fire safety guidelines with only 1 fire exit suitable for bed transfer and no possibility of lateral evacuation putting the patients and staff at risk
- **Inadequate Ventilation provision** – overall air change rates do not meet the current standard of 10 air changes per hour (ACH) for this type of facility and fall short of the minimum 6 ACH required for a clinical setting. A number of rooms deliver as little as 2 ACH, which is unsuitable for patient care and non-compliant with current guidance.
- **Inadequate provision of Isolations Rooms** – There are only two isolation rooms in the facility, and these are not fit for purpose as they do not deliver negative and/or positive pressures required for this type of facility.
- **Water Contamination** – Water testing has highlighted issues with Pseudomonas and Aeruginosa, presenting significant risk to vulnerable patients in augmented care areas
- **Compromised Functionality** – The imperfect layout of the facility causes severe inefficiencies in patient care as well as under and over-utilisation of certain ward areas. The bed spaces are non-compliant with modern guidance, including the 5 bed-area with beds separated by curtains further affecting care being delivered to patients in these beds. In addition, there are a lack of toilet and washing facilities for both patients and families further affecting patient care as well as staff satisfaction/experience.

Collectively these issues present an HAI risk, result in poor patient and relative experience and present a challenge for staff having a negative impact on morale.

Several risks have been identified as a result of the above challenges:

- Risk of harm to patient from infection transmission due to inadequate ventilation, environment, water quality,
- Risk of harm to patient and staff due to potential delayed evacuation in event of a fire,
- Risk of increased patient delirium due to lack of natural light, claustrophobic bed spaces,
- Risk of poor relative experience due to inadequate space for private consultation, comfort facilities including toilets,

- Risk of musculoskeletal injury to staff due to performing patient transfer manoeuvres in cramped space,
- Risk of inability to recruit new staff due to poor working environment,
- Risk of inability to accommodate increased demand for critical care at the WGH, leading to delay admitting critically ill patients, increased cross site transfers and linked patient harm.
- Risk of unexpected breach in infrastructure leading to urgent need for decant or bed closures (previous issue with leaking roof) leading to a risk that there is a reduced ability to deliver elective major surgery if decant space required in ward 52 or theatre recovery.
- Risk of reputational damage to the Service, WGH and NHS Lothian.

A capital investment into Critical Care is urgently required as a result of the above issues and it has been identified as a priority for the site and for Diagnostics, Anaesthetics, Theatres and Critical Care (DATCC). The number of non-compliances and critical areas that require urgent attention, exacerbated by years of limited investment mean that the targeted repairs are no longer possible, and the unit would either have to decant for any works or an alternative location for this ward is identified to allow safe, patient centred care to continue. A number of options has been identified as a result of this constraint, which are discussed further below.

To fully understand the Critical Care position and present a robust plan for consideration, a bed modelling exercise was undertaken to quantify the future number of critical care beds required on the Western General site. This involved both a retrospective look at historical occupancy trends, as well as a prospective forecast of likely growth that may be attributed to demographic changes, and service-specific developments – with the greatest service changes projected to occur within Cancer services.

Considering projected population growth in SE Scotland up to 2030 and the projected increase in the critical care requirements for Cancer activity, it is recommended that there is an increase to the bed base for critical care on the Western General site from 10 to 12 beds. This should be considered alongside the wider pan Lothian work to increase critical care bed provision, led by Scottish Government. Therefore, the revenue costs and requirements associated with the additional beds are omitted from this initial agreement. It is recommended that critical care capacity is continually remodelled to ensure optimal distribution of beds in the future.

As part of the Option Appraisal process, a long list was developed that considered a range of options relating to refurbishment and new build options to address the critical care challenges at the Western General Hospital - the long list of options is shown as Section 2.3. Each option was assessed against a set of benefits criteria that were linked to the investment objectives and this was scored and discussed by a multi-disciplinary group to identify a preferred option.

The preferred option was identified as Option 8: Reprovision of Critical Care in Ward 52 and adjacent areas.

To enact the preferred option several supplementary moves are required. These moves come with their own impacts and risks. These are:

- Surgical High Dependency (SHDU): Ward 52 to Ward 58. This move is required in its own merits and does not form part of this project at the moment.
- Office Accommodation: Reprovide any office space that is currently situated adjacent to Ward 52. This decant work is included in this IA and has an estimate applied to it within the capital cost section.

The estimated capital costs for the preferred Option 8 have been identified as £18.6m. Construction costs for the preferred option were provided by independent quantity surveyors based on a feasibility study. Optimism bias has been included at 40% of all costs, to reflect the stage of this project and the unquantifiable uncertainties surrounding it.

Estimated annual incremental revenue costs for the preferred option have been identified as £901k. £820k of this value relates to depreciation which is assumed to be funded from the existing NHS Lothian depreciation funding allocation. The remainder of £81k relates to facilities costs of operating a larger space and has been based on Health Facilities Scotland estimates.

1 The Strategic Case

1.1 Strategic Context

The provision of care for patients who require augmented care is provided by a specialised medical team within critical care. Critical care is a medical specialty that deals with seriously or critically ill patients who are at risk of or are recovering from conditions that may be life-threatening.

Critical care is provided from ward 20 at the Western General Hospital. Ward 20 provides level 2 (High Dependency) and 3 (Intensive Care) care to all patient cohorts and has space for 16 beds, of which 10 are funded at present to be staffed as a maximum of 6 level 3 beds and 4 level 2 beds.

Current facilities within the ward are unsuitable for patients in need of critical care and it is recommended that an alternative location for this ward is identified to allow safe, patient centred care to continue. The immediate issues to address relate to Fire Safety, Isolation Rooms, Ventilation, Pseudomonas and Compromised Functionality.

There are several adjacencies that are required to be acknowledged to facilitate identification of alternative locations. Proximity to Front Door Services, Diagnostics, Theatres and Recovery space, and Surgical HDU is suggested to allow safe transition between these different services. The ongoing work to develop the Business Case for the Edinburgh Cancer Centre has also created another key clinical adjacency to consider against the clinical model and bed modelling.

The Surgical High Dependency Unit (SHDU) is currently temporarily located in Ward 52 and provides level 1 and level 2 care to surgical patient cohorts, which are primarily from the colorectal and urology services. The SHDU has previously occupied Ward 58, adjacent to Urology and on the same floor as the theatre suite. SHDU was moved to Ward 52 in 2020 due to inadequate ventilation provision in Ward 58 in connection with Covid 19 which will require investment prior to SHDU moving back.

Ward 20 and SHDU provide care primarily to patients who are receiving care in the following specialties: colorectal surgery, urological surgery, gastroenterology, haematology, infectious diseases, anaesthesia, oncology, respiratory, stroke, medicine of the elderly, and acute medicine.

Covid-19 has magnified existing concerns and challenges for health services, accelerated some trends and presented new problems. The intrinsic link to a fully operational and robust critical care facility are well documented and understood. Covid-19 has brought a wider sense of purpose and urgency to transformation and has upended our understanding of good quality care and has driven forward fundamental change as barriers to innovation have been removed and innovations that may have felt too radical have become the ‘new normal’.

1.2 Existing Arrangements

Ward 20 is a regional centre for colorectal and urology surgery and admits patients from the RIDU (Regional Infections Diseases Unit). This unit is geographically isolated from some of the departments which work most closely with critical care e.g., Theatres, Acute Receiving Unit, Cancer Services and Radiology. The unit works at an average of 85% occupancy. The unit is operational 24/7, 365 days a year.

Up until the summer of 2020, Ward 20 was a 16 bedded unit, providing care for patients within ten level 3 beds and six level 2 beds. The department has been operational for around 31 years while the bed compliment decreased to six level 3 beds and four level 2 beds upon completion of the Department of Clinical Neurosciences (DCN) move to the Royal Infirmary of Edinburgh in Summer 2020.

Current establishment is 62 WTE nursing staff and 8.5 consultants. The emergence of Covid-19 has meant there have frequently been 11 or 12 WTE registered nurses required, with greater numbers of level 3 patients, thus requiring more 1:1 care.

Critical care nurse to patient staffing levels are fixed in regulations, requiring staffing levels to flex to accommodate the number of patients on the ward at any time. Level 3 patients require a 1:1 staffing ratio whilst Level 2 patients require 2:1. These staffing levels remain the same during night, day, and weekend shifts.

Students are supernumerary. The ward typically has between one and three students.

Staff nurses flex and move between Ward 20 and SHDU dependent on the patient mix on the day. Whilst both areas provide care to level 2 patients, the patients' needs typically differ. SHDU accommodates a mix of level 1 or enhanced care and level 2 HDU patients. Level 2 patients on Ward 20 tend to be more unwell and often have multiple organ failure, requiring intensivists, whilst level 2 patients on SHDU often require more routine post-operative care as they recover, following surgery. As the SHDU post-operative patients tend to be more robust, SHDU adjusts its staffing to have fewer senior doctors during night and weekend shifts. This requires a close working relationship with Ward 20 staff, as Ward 20 staff are often asked to provide support to SHDU during these times.

Table 1: Ward 20 Current Staffing Arrangements

Medical	**As is (WTE)**
Consultants	8.5
Trainees	10-12
Nursing	
ACCP	4.0
Band 7	2.2
Band 6	7.8
Band 5	41.7
Band 2	6.2
Physio	
Band 7	0.4
Band 6	1.0
Band 5	0.5
Pharmacist	
Band 8	1.0

1.3 Drivers for Change

The following section expands on the need for change as identified in the Strategic Assessment and describes the anticipated impact if nothing is done to address these needs and why action should be taken now through this proposal.

1.3.1 Fire Safety

The grading system used in the Fire Risk Assessment is covered in SHTM (Scottish Health Technical memorandum) 86 which is a National standard and gives outcomes such as Low, Moderate, High, Extreme and Catastrophic dependant on the areas identified in the assessment.

The current critical care unit at the WGH does not meet fire safety guidelines as it has a single accessible fire exit. The secondary exit from ward 20 is by a rear enclosed fire escape stair. Although this stair is a protected route, critical care provide care for the most significantly unwell patients and as a result very few patients would be expected to be able to use the stairs to escape. It will be very difficult to evacuate patients through this area. The recommendations provided through the Fire Risk Assessment (assessed by the site Fire Safety Adviser) suggest a new second route should be created to allow Planned Horizontal Evacuation (PHE) or more commonly referenced 'Lateral Evacuation'. This is currently graded as High Risk.

The compartmentation in the ward requires upgrading as some doors are non-compliant with sliding doors at the storeroom and doors with vents as examples. In addition, a survey of voids was identified to ensure compartmentation above ceiling and other areas, this also includes upgrading any glazing identified to Fire Resistant standard. This too has been graded High Risk.

In addition, the following upgrades would be required to comply with standards:

- The Fire Detection and Fire Warning System requires upgrading to L1 Standard. This is the standard required for Hospitals and would ensure compliance with SHTM guidance (High Risk).
- Intumescent strips/seals fitted to doors are damaged and they will not give adequate protection to stop the spread of smoke or fire.

1.3.2 Isolation Rooms

Rooms 1 and 8 do not deliver the required negative and positive pressures in accordance with SHPN 04 (Scottish Health Planning Note)[i]. This impacts on the ability to deliver effective clinical care to patients with highly infectious pathogens. Currently the rooms are not suitable for use by patients with highly infectious pathogens and can only be used for other types of patients and as such are not utilised as planned.

1.3.3 Overall Ventilation Provision

The air changes per hour (ACH) are insufficient in the open areas of the unit and in the single rooms. All areas are currently less than 6 ACH and some areas are <2. Due to the inability to isolate patients with high consequence infections (HCID), these patients require to be transferred to another site with appropriate critical care isolation facilities.

The current SHTM 03-01 *Ventilation for Healthcare Premises* guidance recommends 10 air changes and 10 Pascals positive pressure to corridor mechanical ventilation provision in Critical Care Unit bedrooms.

The current provision falls significantly short of this standard.

1.3.4 Water Contamination

Water testing highlighted contamination issues with Pseudomonas Aeruginosa, with 11 out of 23 water outlets affected. This presents a significant risk to vulnerable patients in augmented care areas.

Pseudomonas Aeruginosa in environmental sources like water taps have been thought to be linked to outbreaks of hospital acquired infection before in the UK (*Walker, J. T., et al. "Investigation of healthcare-acquired infections associated with Pseudomonas aeruginosa biofilms in taps in neonatal units in Northern Ireland." Journal of Hospital Infection 86.1 (2014): 16-23,* and *Costa, D., et al. "Nosocomial outbreak of Pseudomonas aeruginosa associated with a drinking water fountain." Journal of Hospital Infection 91.3 (2015): 271-274*[1]). Moreover, within the critical care context, it is a potential cause of ventilator-associated pneumonia and can be a real concern for patients with Cystic Fibrosis (*Barbier, François, et al. "Hospital-acquired pneumonia and ventilator-associated pneumonia: recent advances in epidemiology and management." Current opinion in pulmonary medicine 19.3 (2013): 216-228.*[2]).

[1] Walker, J. T., et al. "Investigation of healthcare-acquired infections associated with Pseudomonas aeruginosa biofilms in taps in neonatal units in Northern Ireland." *Journal of Hospital Infection* 86.1 (2014): 16-23.

Costa, D., et al. "Nosocomial outbreak of Pseudomonas aeruginosa associated with a drinking water fountain." *Journal of Hospital Infection* 91.3 (2015): 271-274.

[2] Barbier, François, et al. "Hospital-acquired pneumonia and ventilator-associated pneumonia: recent advances in epidemiology and management." *Current opinion in pulmonary medicine* 19.3 (2013): 216-228.

Remedial measures have been put in place to manage this however these are only temporary and for reassurance going forward all water taps and possibly supply pipes require replacement. There have been several leaks in the ceiling of the work room in ward 20, leading to destruction of computer equipment and textbooks, and the ceiling in this room remains in a partially completed state.

1.3.5 Compromised Functionality

From previous patient and relatives experience surveys, several useful comments were generated. 19/23 (82.6%) respondents specifically highlighted toilet and washing facilities for both patients and families as an area that could be improved in the ward. Research has identified that design of healthcare facilities can play a marked role in patient care and staff satisfaction. A critical care unit is a high stress environment; improved hospital design could reduce staff stress, increase effectiveness in delivering care, reduce patient and family stress, and improve overall healthcare quality (*Joseph, Anjali. "The role of the physical and social environment in promoting health, safety, and effectiveness in the healthcare workplace." Concord, CA: The Center for Health Design (2006), and Salonen, Heidi, et al. "Physical characteristics of the indoor environment that affect health and wellbeing in healthcare facilities: A review." Intelligent Buildings International 5.1 (2013): 3-25*[3]).

Feedback has reflected a need for additional areas for relatives to stay overnight and facilities for eating and drinking including a family pantry area to allow families to make simple snacks and hot drinks, and a toilet for visitor use within critical care. Currently, patients wishing to shower must visit ward 58 which is in a separate building. Patients well enough to use a toilet cannot do so and instead must use a commode thus diminishing levels of patient dignity. Families visiting critically ill relatives have no toilet facilities within critical care and must use toilets in the X ray department again located in a separate building to critical care.

These facilities for patients and visitors are considered essential in the most recent version of Guidelines for the Provision for Intensive Care Services and the NHS England Health Building Note 04-02 for Critical Care Units.

Furthermore, Ward 20 fails to provide the following components for patients, staff, family, and carers:

- Maximise natural daylight to bed spaces
- Separate entrance for family / relative and patient access and egress
- Increasing width of HDU bedspaces – this allows greater flexibility of bed utilisation.
- Increasing area for each bed space (see Figure 1, below)
- Interview room for private discussions with relatives
- Seminar room within the critical care area to facilitate attendance of the multi-disciplinary team at governance meetings.
- Co-location of the highest users of critical care facilities

[3] Joseph, Anjali. "The role of the physical and social environment in promoting health, safety, and effectiveness in the healthcare workplace." *Concord, CA: The Center for Health Design* (2006).

Salonen, Heidi, et al. "Physical characteristics of the indoor environment that affect health and wellbeing in healthcare facilities: A review." *Intelligent Buildings International* 5.1 (2013): 3-25.

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

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
Failure to adhere to the SFRS guidance on Fire safety	Fire exit opens onto stairs so unusable as a route of escape for critical care patients immobile in beds. This is a significant safety issue and could cause the organisation significant reputational risk if the issues are not corrected with remedial works.	Fire safety is of the upmost importance to the safety of both patients, relatives, and staff. Fires in critical care units are unfortunately common due to the abundance of medical oxygen used in this setting. There have been several in the UK in the last decade which have required a full evacuation of patients, staff, and relatives. If a fire were to break out in Ward 20 and the single fire exit was blocked, the risk that not all staff, patients, and relatives would make a safe escape is very likely.
Inability to manage high consequence infectious diseases (HCID)	Rooms 1 and 8 do not deliver required negative and positive pressures in accordance with SHPN 04 (Scottish Health Planning Note)[ii]. This impacts on the ability to deliver effective clinical care to patients with highly infections pathogens or high consequence infectious diseases. A failure to deliver these facilities could be a critical point of failure given the emergence of Covid-19 and potentially other future HCID. Due to the inability to isolate patients with high-risk infections (HCID), these patients require to be transferred to another site with appropriate critical care isolation facilities	Patients with HCID who require critical care often also require isolation rooms. There is currently a lack of suitable isolation rooms at the WGH to manage a HCID case, which is a risk to the patients who have a HCID as well as the other critically unwell patients within critical care, who are put at unnecessary risk of transmission. Some patients will also require positive pressure ventilated lobby rooms and negative pressure rooms, which the WGH also does not currently provide anywhere on its campus.
The presence of Pseudomonas Aeruginosa in the water supply across multiple outlets	There have already been several surgical cancellations (some of which may have resulted in a Critical Care stay) and accompanying media coverage relating to the infection of patients who have contracted Pseudomonas Aeruginosa. Continued inaction would be viewed as negligent and cause reputational risk to the organisation.	Pseudomonas Aeruginosa is a type of bacteria that can cause lung related complications and infections. While this bacterium is regularly found in water supplies, its presence in a critical care facility is particularly concerning giving the vulnerability of patients in situ and the propensity for these patients to rapidly decline if infected.

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
Compromised functionality of the unit.	The patient experience surveys undertaken have long highlighted the inadequacy of welfare and waiting facilities for families and patients (figure 2, below). Staff surveys have also cited issues relating to an inability to effectively provide care for vulnerable patients due to current bed spacing as shown by figure 1, below.	It is vital to create a functional, fit for purpose environment which reduces unnecessary stress on patients, staff, relatives, and carers. Additionally, the department has had relatively little refurbishment in its 31-year history and seeks to create a modern critical care unit that meets standards and attracts high calibre staff from all disciplines. Crucially, improved space allows easier patient mobilisation, improved workflows, less time wasted obtaining supplies, attending off unit training and meetings.

Figure 1 - Current set up within a room in critical care, ward 20, Western General Hospital – with little room between bed and washing facilities.

Figure 2 - Current relatives waiting area – regularly used as overflow storage due to a lack of storage space within the unit.

1.4 Investment Objectives

The assessment of the existing situation and the drivers for change have been used to identify what must 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)
Improve ability to evacuate in the event of fire	Creation of a new secondary route of escape to allow PHE, the Fire Detection and Fire Warning System requires upgrading to L1 Standard. Intumescent strips/seals fitted to doors to be upgraded to stop the spread of smoke or fire. Improved glazing and compartmentation standards to be met.
Ability to manage high consequence infectious diseases	Rooms 1 and 8 to be refurbished in line with required negative and positive pressures in accordance with SHPN 04.
Reduce risk of healthcare associated infection (HAI)	Reduce reliance on bacterial filters to reduce Pseudomonas Aeruginosa by investing in modern pipework
Co-locate with highest users of critical care, develop ongoing work through shared staff and education with surgical HDU	Future location needs to recognise required clinical adjacencies to: Theatres, Critical Care and (Surgical High Dependency Unit) SHDU.

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)
Improve delivery of time-critical interventions	Future location needs to recognise required clinical adjacencies to: Theatres, Critical Care and (Surgical High Dependency Unit) SHDU. Additionally, increasing width of HDU bedspaces will allow greater flexibility of bed utilisation while increased in space for each bed space would allow improved patient care and mobilisation.
Improve the environment for patients, staff, relatives, and carers.	Space within critical care dedicated to improving access to natural daylight to bed spaces, separate entrance for family / relative and patient access and egress, interview room for private discussions with relatives and overnight stay facilities
A modern critical care unit that meets standards and attracts high calibre staff from all disciplines	Creation of seminar room within critical care to facilitate attendance of the multi-disciplinary team at governance meetings and co-location of the highest users of critical care facilities
Backlog maintenance for the WGH site is significant and made up of fire precautions and infrastructure including plant. Part of the reason this figure is so high is because the buildings in current use at the WGH are older.	Establish a high quality, safe and robust critical care unit which meet care standards such as providing optimal spacing between beds and maintains essential links with other clinical services.

1.5 Benefits

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; Efficient: Value and Sustainability

The above investment objectives and the Strategic Assessment have informed the development of a Benefits Register. 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.

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

- Compliance with required standards for fire/water safety
- Improved levels of patient care because of optimal bed space allowing easier performance of clinical duties while reducing risk of infection transmission
- Adjacencies allow safe transition between clinical care settings
- Development of capacity in terms of staff expertise now and future by improving workflows and day to day experience for staff
- Improves staff and patient facilities

1.6 Strategic Risks

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

- Unable to recruit and retain staff.
- Unable to manage all patients' needs within the space available.
- Inappropriate level of restrictions due to department layout and configuration.
- Unable to schedule enabling moves, decant and remedial works to enact preferred option.

Theme	Risk	Safeguard(s)
Funding	NHS Lothian is aware that there is a high level of demand for capital funds across Scotland, therefore there may be challenges securing capital funding	The project team have worked to ensure the proposal presents best value. The proposal assumes full compliance with current standards. Any deviation from the guidance if Value Engineering is required will have to obtain NHS Assure recommendation.
Service Continuity	Disruption to service delivery following decant	The movement and enabling moves should be conducted in a linear fashion. With ward 58 currently unused it should be prioritised for Ventilation works ahead of physical moves. This will enable SHDU to move and in doing so free space for critical care.
Capacity	Service model does not match future capacity requirements	Analysis of future service, space, and bed requirements have been conducted to deliver planned capacity and future proof through consolidation of the Pan-Lothian efforts to increase critical care capacity in totality.
WGH Building Masterplan	Project is not in line with long term masterplan for the WGH and therefore represents a short-medium term option.	Consultation with stakeholders representing site and Masterplan to understand long-term standing and vision has taken place with open dialogue between site Master Planning lead and programme leads to ensure alignment
Service Reprovision	Lack of available space on WGH site may require intrusion on existing space occupied by other specialties.	Consultation with staff and speciality groups to understand space requirements and alternative options has taken place and is ongoing

A full risk register will be developed for the project at the OBC stage. A draft risk register has been developed and is available from the Project Owner on request.

1.7 Clinical Model

1.7.1 Patient Pathway

Almost all elective planned admissions to Ward 20 are notified to critical care staff in the morning of the anticipated admission, from every admitting speciality including the Home Ventilation Service. The exception is the Cystic Fibrosis service, which typically manages its critically unwell patients within its own clinical area unless these patients require level 2 or level 3 support, in which case they are admitted to ward 20.

Using 2019 data, 14% of admissions were recorded as scheduled/elective with most admissions recorded as emergency/urgent. These can be from any of the specialties within the WGH, but predominantly from emergency colorectal surgery and acute medicine. Admissions are received directly from acute admission areas, theatre and recovery areas, other hospitals within and out with Lothian, and internal WGH wards and departments.

After being admitted to ward 20, patients are assigned either a level 3 or a level 2 bed, with the unit being able to flex to accommodate shifting percentages of necessary beds. Ward 20 is currently split to segregate Covid positive patients via 'Green' and 'Red' areas.

Delayed discharges have increased following Covid, due to the introduction of red, amber, and green pathways within the site. Before Covid there could be waits of a day or two to some specialties, but this has increased in line with Covid pressures, and affects all specialties. Delayed discharges are not always the case but can create a bottleneck in the discharge pathway that impacts several departments.

Patients are typically discharged back to the speciality they were admitted from on the WGH campus. The exception to this is where patients require further care from a speciality not represented at the WGH, such as vascular, in which case the patient would be discharged to the RIE. Patients may also be transferred internally within critical care to facilitate ongoing specialist care.

1.7.2 Clinical Requirements by Speciality

Most admissions onto Ward 20 reflect the specialities at the WGH. In 2019-2020 there were 395 admissions excluding neurosurgical and neurology patients (which have been omitted here due to DCN's move in May 2020 to the RIE campus). These are shown in Table 5, below.

Table 5: Admissions by Speciality

Admitting speciality	19-20	18-19	17-18	16-17	15-16
Cardiac surgery	2	0	0	0	0
Cardiology	6	8	5	5	6
Endocrinology	1	1	1	0	0
ENT	1	1	2	2	3
Gastroenterology	10	8	23	21	15
General medicine	52	52	64	92	93
General surgery	129	131	137	127	145
Haematology	33	31	29	27	32
Infectious diseases	21	22	17	9	15
Oncology	19	21	21	22	21
Other	8	0	0	0	0
Renal medicine	2	1	4	1	1
Respiratory medicine	45	26	35	26	23
Rheumatology	1	1	0	1	2
Stroke Medicine	2	6	13	0	0
Trauma	2	0	0	1	1
Urology	61	72	59	31	46
Psychiatry	0	1	0	0	1
Gynaecology	0	1	0	0	1
Geriatric medicine	0	2	6	11	7
Dermatology	0	2	0	1	1
Maxillo-facial surgery	0	0	0	2	0

Total	395	387	416	379	413

Without a corresponding plan to relocate services currently hosted at the WGH to other sites, the WGH needs a critical care unit which will meet the needs of all the admitting specialities.

1.7.3 Cancer

The reprovision of the Edinburgh Cancer Centre (ECC), hosted at the WGH, is dependent upon access to a fit for purpose critical care facility. The initial agreement for the ECC has been submitted with a proposed completion date of 2030, at which point it will require a fully viable intensive therapy unit.

The ECC initial agreement outlines its requirements for a critical care unit at the WGH in section 3.3.1.1

> ***3.3.1.1 Critical Care Capacity***
> ***Requirement: Level 3 ITU and Level 2 HDU capacity for Haematology/Oncology/Breast Surgery patients integrated with WGH critical care and high dependency provision (including capacity for patients being treated by licensed and investigational advanced therapeutic medicinal products).***
>
> *Over the next few years, a predicted increase in Advanced Therapeutics such as CAR-T (and potentially others) in Cancer services means the number of Level 3 and 2 beds required by Haematology and Oncology patients is likely to increase, over and above that already provided by the existing Stem Cell Transplant, High Dependency and Critical Care Facilities.*
>
> *The opportunity to re-provide a Critical Care facility of the highest standard on the Western General Hospital site would continue to support the growing needs of all services on the site and will be designed with enough capacity to accommodate the predicted increase in Cancer services patients who require care in a high dependency unit.*
>
> *Data produced during the Western General Hospital Dependency Audit (May-June 2018) will be factored into the review of future high dependency capacity requirements for Cancer Services.*
>
> *Discussions with the NHS Lothian Critical Care Team regarding how best to provide a critical care facility on site generated the list below of needs that must be met:*
> - *The need to ensure patients requiring multi-organ support and specialist care are cared for by appropriately experienced staff. It was agreed that this should remain the remit of Intensivists and critical care experienced nursing staff. Given the national shortfalls of critical care medical and nursing staff, it is important that the critical mass is retained in a single service.*
> - *High Dependency (HDU) facilities suitable to the provision of Stem Cell Transplant services and Advanced Cellular Therapeutics (including patients with single organ bone marrow failure), should be managed by specialty services, as at present, with access to Level 2/3 Critical Care remaining adjacent and on site.*
> - *Location of Intensive Treatment Unit (ITU)/High Dependency Unit (HDU) facilities will remain in a central location on the WGH campus. All relevant adjacencies will be taken into consideration at the planning stage.*

Please note that in the specification above, the HDU facilities referred to are level 1 for specialty services, excluding SHDU which provide limited level 2 support. Any level 2 or 3 patients will be admitted to critical care.

Without access of a fully functioning critical care unit, the Edinburgh Cancer Centre will lack a core requirement and patients will be put at unnecessary risk.

Current provision of cancer care at the WGH is dependent upon a fit for purpose critical care unit. The service is currently able to provide bespoke care to a wide variety of conditions, which results in an even greater number of treatment pathways. Some of these patients will be critically unwell and will require access to intensive care. To continue to function in a way that best meets the varied needs of patients, the cancer service requires a critical care unit which can flex to meet its need. This need is expected to increase over time (see section 1.8.2, below), as cancer incidence increases in an increasingly comorbid population. Lothian has the most rapidly growing population in Scotland, which will place further pressure on both the cancer services and critical care.

1.7.4 Complex Surgical Patients

The WGH hosts the pelvic exenteration surgery service for Lothian. This specialist, tertiary, and multidisciplinary surgery requires multi-speciality collaboration to remove multiple organs within the pelvis. It is a highly complex surgery on patients who generally have a prolonged and complex peri-operative journey, and it requires access to a fit for purpose critical care unit. Without appropriate provision to care for patients who will require intensive care, the risk carried by this surgery is significantly elevated.

The WGH also performs the majority of Edinburgh's colorectal and urology surgery and is the largest colorectal surgical unit in the UK. Most patients recover in the SHDU, but a small portion (less than 10%) from colorectal and urology ultimately require access to level 3 critical care beds. The SHDU can provide Level 2 care for patients and therefore a critical care unit with level 3 capabilities is required to provide a full service for surgical patients.

Within the surgical patient cohort that are admitted to critical care are patients who have undergone an emergency laparotomy. Approximately 250 patients undergo an emergency laparotomy at the WGH annually, at least 70 of which will be admitted to critical care. With increasing multi morbidities and an ageing population, this figure is projected to increase. All high-risk patients (>10% mortality risk) who receive an emergency laparotomy should be admitted to critical care post operatively, as recommended by the National Laparotomy Audit (NELA).

A further challenge is the current physical separation between SHDU and the critical care unit on ward 20. This distance formalises the separation between the two services, adding challenges where the services should complement one another. One of these challenges is that nursing staff can be required to move between the departments during times of limited staffing, flexing to assist the other department. The distinct physical separation makes it almost impossible to flex between departments quickly and easily. A more cohesive staff group near one another would also increase team resilience and wellbeing, which would create benefits to patient care.

1.7.5 High Consequence Infectious Disease (HCID)

The WGH hosts Lothian's Regional Infectious Disease Unit (RIDU) which serves primarily patients from Lothian, but which also accepts referrals from Eastern NHS Boards.

Patients with HCID who require critical care often also require isolation rooms. There is currently a lack of suitable isolation rooms at the WGH (see section 1.3.2, above) to manage a HCID case, which is a risk to the patients who have a HCID as well as the other critically unwell patients within critical care, who are put at unnecessary risk of transmission. Some patients will also require positive pressure ventilated lobby rooms and negative pressure rooms, which the WGH also does not currently provide anywhere on its campus.

1.7.6 Other Specialties

In addition to HCID patients, other patients with compromised immune systems will require isolation facilities (that ward 20 currently does not have), such as haematology and oncology patients.

Many patients will require rehabilitation therapy from the WGH physiotherapy department. Thus, the critical care space must meet physiotherapy national clinical standards to provide safe and effective

rehabilitation. Rehabilitation aids not only patient recovery, but reduces length of stay, ensuring a faster journey through the patient pathway and freeing up critical care bed spaces.

1.7.7 Enhanced Recovery After Surgery

Enhanced Recovery After Surgery (ERAS) is a national multidisciplinary programme that implements rehabilitation initiatives following surgery that allow patients to recover and be discharged more quickly. ERAS has previously demonstrated a 2-3-day average reduction in length of stay as well as fewer readmissions. Benefits of ERAS have been seen at the WGH and investment in ERAS resources have also been evidenced over longer periods at the RIE as well as in NHS Greater Glasgow and Clyde (GGC) where the programme is used more extensively.

Some of the options for reprovision of WGH critical care include varying levels of restructure to the surgical HDU pathway. Reprovision of any part of the surgical HDU pathway should consider how to embed ERAS initiatives at foundation level to take advantage of the efficiencies this programme delivers.

1.8 Future Bed Requirements

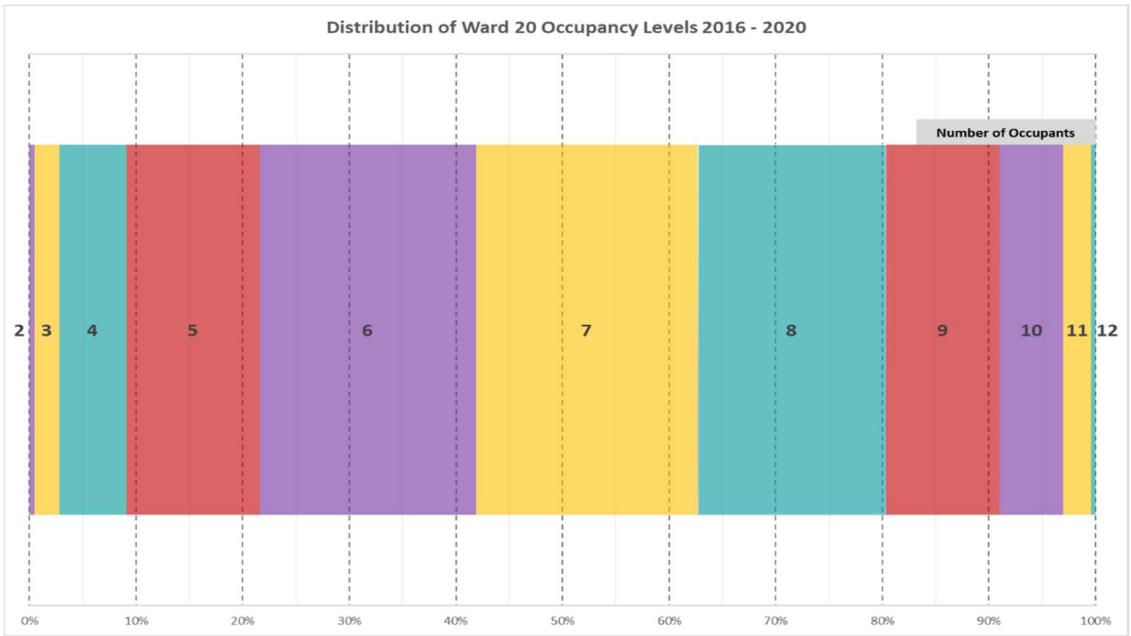
1.8.1 Methodology

A robust bed modelling exercise was undertaken to quantify the number of future critical care beds required on the Western General site. This involved both a retrospective look at historical occupancy trends, as well as a prospective forecast of likely growth that may be attributed to (a) demographic changes, and (b) service-specific developments.

For (b), the greatest change is projected to occur within Cancer services, given the anticipated establishment of the Cancer Centre on the Western General site, the associated advances in therapies, and the future rates of prevalence, all of which may have an impact upon critical care requirements.

Using historical trend data from ward watcher (March 2016 – Feb 2020), it can be concluded that the median (Non DCN) occupancy on Ward 20 was 7 patients, whilst the 95th percentile was 10 patients. In other words, 95% of the time someone was admitted to Ward 20, there were 9 or ***fewer*** other patients already in beds. The interquartile range was 6 – 8 patients, meaning that for at least half of the time during this period, occupancy was between 6 and 8. Distribution levels are shown in Figure 3, below.

Figure 3 – Distribution of Ward 20 Occupancy Levels 2016 – 2020



1.8.2 Cancer Growth

Evaluating growth in all cancers, we can see that incidence in the UK is projected to increase from 724 per 100,00 to 743 per 100,000 by 2030 – an increase of 2.6%. Applying this to the projected population of SE Scotland, it can be expected that the gross Cancer caseload will increase by 2.74% compared to today. Assuming a proportionate increase in throughput to critical care, it could be expected that a further 20 – 30 bed days per year are needed.

Incidence itself only explains the new cases diagnosed each year. Prevalence of cancer will also factor into requirements, especially as multiple therapies become viable for treatment of patients. Prevalence in Scotland is estimated to increase by nearly 40%[4] by 2030. Of course, not all of these will be viable for additional/multiple therapies, and of these a smaller number will have a subsequent critical care stay. Without reliable data on which to project an increase in activity due to increased prevalence, duplicating the estimate resulting from incidence would add an additional 20 – 30 bed days.

In terms of new therapies, in particular the offering of CAR-T Cell Therapy is expected to have the greatest impact in terms of critical care requirements. Combining population projections from NRS, and data on incidence of specific cancer types from Cancer Research UK, it is estimated that around 21 patients per year may be treated in Lothian, of whom half may need critical care stays, with a median length of stay of 8 days. Taking these estimates, it is projected that a further 160 – 170 critical care bed days may be needed per year.

Taken together with projected population growth in SE Scotland up to 2030, the projected increase in critical care requirements for Cancer activity is likely in the region of 230 bed days, or two-thirds of a bed. Rounding up to account for additional therapies not specifically considered, this indicates an increase to the bed base requirement for critical care on the Western General site from 10 to 12.

The response to the Covid-19 Pandemic has brought into focus the fact that Scotland's provision of Critical Care beds per capita is among the lowest in Europe at around 5 beds per 100,000 people[1] [2]. The Scottish Government has responded by committing to increase the ICU level 3 baseline by 30 beds across Scotland before winter 2021/2022 to safely manage anticipated demand.
Health Board allocations have been determined by National Resource Allocation Committee formula (NRAC), and revenue uplifts to increase the bed base have been received accordingly. Lothian's share of this allocation is +4 Level 3 beds. The precise application of these 4 additional beds has been left to Lothian to determine across its 3 adult acute sites.

Given known demands on each of the adult acute sites, the optimal distribution of the 4 additional beds by Winter 21/22 is proposed as:

- 2 x beds on the Royal Infirmary site, utilising existing spaces, servicing regional clinical services and a busy front door
- 2 x beds at St John's Hospital, incorporating surge capacity of 7 beds total into baseline, reflecting the regularity with which an additional 2 beds are required already,

The non-compliance issues at the Western General, alongside staffing challenges and the added complexity of the project preclude consideration of the site for additional Critical Care beds currently. Therefore, the revenue costs and requirements associated with the additional beds are omitted from this initial agreement. It is recommended that critical care capacity is continually remodelled to ensure optimal distribution of beds in the future.

1.9 Constraints and Dependencies

The key constraints to be considered are:

- Physical site constraints regarding space

[4] https://www.macmillan.org.uk/_images/cancer-statistics-factsheet_tcm9-260514.pdf

- Capital availability may also be a constraint due to a high demand on Scottish Government Capital Finance
- Interaction and co-dependencies between existing services/specialties
- Integration with other projects on the WGH site such as Edinburgh Cancer Centre (ECC) and work being undertaken as part of the Western General Hospital Masterplan

The key dependencies to be considered are:

- The proposal to reprovide critical care in Ward 52 is entirely dependent on remedial ventilation works in Ward 58 to allow the Surgical High Dependency service to move back to its original destination.
- To facilitate the move into Ward 52, there is an immediate impact to Office Space occupied by some specialties which will require reprovide as part of the programme of works.
- The enactment of the preferred option is seen as an enabler to the Edinburgh Cancer Centre (ECC); phase two of the Western General Hospital Masterplan involves infrastructure replacement and preparation of the site for the forthcoming Edinburgh Cancer Centre. Commencing in 2024, this work involves demolition of the former DCN, Theatre Buildings, D Block, and bridge link to Alexander Donald Building (adjacent to Ward 20). Significant disruption due to uncontrollable noise, dust and vibration is likely to impact on the current critical care location from this date onwards.
- Through transfer of high volume, non-complex, short stay (<48 hours) activity to the National Treatment Centre-Lothian (formally Short Stay Elective Centre), there would be a release of capacity on acute sites across Lothian to manage forecasted growth in complex elective activity in the five specialties in scope as demonstrated by the Outline Business Case for A Short Stay Elective Centre (SSEC) for the East Region at St John's Hospital, Livingston. Complex Urology and Colorectal work are predominately undertaken at the Western General Hospital and therefore access to a fit for purpose critical care unit is crucial to the safe, timely and effective delivery of this activity.

2 Economic Case

2.1 Do Minimum- Baseline Option

The table below defines the Do Minimum option. This is based on sustaining the existing arrangements as outlined in the Strategic Case.

Table 6: Do Minimum – Address Principal issues relating to Isolation Rooms, Fire Safety and Water Contamination

Strategic Scope of Option	Do Minimum
Service provision	Critical care will continue to be delivered from Ward 20 upon completion of the remedial works relating to Fire Safety, Isolation Rooms (Rooms 1 and 8) Ventilation and Water Contaminants using the current bed compliment of 10 beds – split by six level 3 and four level 2 beds – this will be unable to be expanded in the future due to space.
Service arrangements	Critical Care will be provided for appropriate patients who have compromised surgical or medicinal needs, at the Western General Hospital. The do minimum option will be unable to improve fabric and facilities to benefit staff, patients, and visitors. These facilities for patients and visitors are considered essential in the most recent version of Guidelines for the Provision for Intensive Care Services and the Health Building Note 04-02 for Critical Care Units. Furthermore, this option does not provide expansion space to accommodate predicted future need and growth in complex urology and colorectal activity.
Service provider and workforce arrangements	Current staffing arrangements will be unaffected but the ability to attract and retain staff for this high-priority service will be compromised due to the working environment and lack of facilities
Supporting assets	The current facilities will be used to deliver the service. These do not offer separate entrance for family / relative and patient access and egress, natural daylight to bed spaces, optimal area for each bed space, Interview room for private discussions with relatives, Seminar room within the critical care area to facilitate attendance of the multi-disciplinary team at governance meetings and co-location of the highest users of critical care facilities. Standard maintenance work as required to maintain existing standard (backlog maintenance on WGH site is c.£1.5m).
Public & service user expectations	Service users can expect continued care standards to be met but no benefits associated with improved discharge of clinical duties because of optimal bed spacing. There is no implication that current standards of care will be diminished as a result

2.2 Engagement with Stakeholders

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

Table 7: Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
Patients/service users	No patient engagement has taken place to date specifically for this project. Further engagement is planned at the OBC stage utilising patient experience surveys and feedback received to date to ensure that any needs for patients are considered and planned for in this redesign project.	An MDT led approach has been leading this work. The 'case for change' was based on the fundamental problems with the fabric of ward 20. Additional work was carried out by Mr Murray Blackstock (Consultant in Critical Care and Professional Medical Lead for WGH Critical Care) with the stakeholders/staff groups in critical care regarding where the opportunities for improvement lay. Furthermore, there is clear evidence of repeated feedback from relatives (in lieu of patients) stating the inadequacies of critical care with respect to the unit and its facilities for patients and relatives.
Staff	Discussions with key stakeholders from each of the impacted services have taken place from Urology, Colorectal and Cancer Services to understand their requirements and feed into any modelling to date. The wider reprovision group contains stakeholders from: Nursing, Surgery, Management, Fire Safety, Infection Protection Control Team (IPCT), Estates and Facilities and Theatres and Anaesthetics.	Support confirmed from ATCC General Manager Jane McDonald, Clinical Nurse Manager Celia McKiernan, and Murray Blackstock in addition to Clinical Specialties across Surgery and Medicine. Partnership (staff side colleagues) are also appraised of the latest developments and impacts.
General Public	The general public will not be affected by this proposal.	Any required public consultation will be undertaken as the business case develops.
Other impacted services	There will be an impact to Cancer Services (Haematology, Oncology), Urology and Colorectal Services. In addition to critical care teams, any modelling conducted to date has been shared transparently to raise awareness of the proposal and understand any considerations/ limitations that are required to be taken in to account. A clinical model has been derived from these discussions.	Support confirmed from ATCC General manager Jane McDonald, Clinical Nurse Manager Celia McKiernan, and Chris Stirling (Site Director) Further consultation will be continued through the OBC process as the preferred option and the design are developed and there is a clearer understanding of the impact on any adjacent services.

2.3 Long-listed Options

The long list of options is noted below and is an exhaustive list of options and requirements set out deliver critical care.

Option 1: Do Nothing. **Continue with the current arrangements.**

Option 2: Do Minimum - Refurbishment of Ward 20 to comply with essential standards.
Completion of remedial works in ward 20 to comply with essential requirements of recognised bodies in relation to intensive care units in the UK. These issues are described as:

- The failure to meet current Fire Safety regulations – there is currently only one fire exit for the department which poses a significant safety risk in the event of a Fire.
- Isolation Rooms – Rooms 1 and 8 do not deliver required negative and positive pressures in accordance with SHPN 04. This impacts on the ability to deliver effective clinical care to patients with highly infectious pathogens.
- Ventilation - overall air change rates do not meet the current standard of 10 air changes per hour (ACH) for this type of facility and fall short of the minimum 6 ACH required for a clinical setting.
- Pseudomonas – There is a known presence of the Pseudomonas in the water supply to critical care.

Option 3: Enhanced Refurbishment of Ward 20. Completion of remedial works in Ward 20 as per Option 2. In addition, this option will bring further improvements to the fabric and facilities to benefit staff, patients, and visitors. This work includes:

- Maximise natural daylight to bed spaces
- Separate entrance for visitor and patient access and egress
- Increasing width of HDU bed spaces
- Increasing area for each bed space
- Interview room for private discussions with relatives
- Seminar room within the critical care area to facilitate attendance of the multi-disciplinary team at governance meetings.
- Improved welfare facilities for relatives including overnight stay, toileting, and snack facilities.
- Improved toilet and washing facilities for patients

Option 4: Reprovision of Critical Care in Ward 57/58 and adjacent shell space, Western General Hospital. The relocation of critical care from its current location in ward 20 to ward 57/58 at the Anne Ferguson Building at the Western General Hospital. The adjacent 'shell space' between ward 57/58 would also be redeveloped to meet IPCT, fire and safety standards and in doing so co-locate surgical high dependency, theatres, and recovery space. Surgical bed capacity for Urology (currently located in Ward 58) would be reprovisioned as part of this option into ward 52 which has temporarily been adapted to managed SHDU.

This option creates optimal patient flow between theatres, recovery, surgical high dependency, and critical care areas. This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas.

Option 5: Construct new building at ground and first floor level within site of RIDU/ old boiler house. This option proposes the relocation of critical care from its current location at ward 20 to a new purpose-built space constructed as a preliminary phase of a future essential services hub/ front door block. This option would provide direct connection to Alexander Donald Building (ADB)/ Anne Ferguson Building (AFB) and provide future connection to ECC when completed but would not represent an optimal position for patient flow between theatres, recovery, surgical high dependency, and critical care areas.

This option would ensure that all bed spaces and ancillary accommodation meet appropriate current standards.

Option 6: Construct at first floor level above service yard. This option proposes the relocation of critical care from its current location at Ward 20 to a new purpose-built extension of the AFB, constructed at second floor level. This would also form a covered external area for the current service yard below. This option will provide direct connection to second floor surgical theatres when completed.

This option creates optimal patient flow between theatres, recovery, surgical high dependency, and critical care areas. It may however be considered too detached from future ECC.

This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas.

Option 7: Enhanced construct within current Ward 20 extending into space above ADB OT Gymnasium. This option proposes to retain critical care in its current location at ward 20, however in order to meet the necessary design and technical standards it proposes to reorganise and extend the existing critical care space and accommodate new space constructed on the existing roof space over the OT gymnasium.

This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas and provide new compliant bed space.

Option 8: Critical care to be reprovided in Ward 52 with enabling moves undertaken to create space. This option proposes the relocation of critical care from its current location at ward 20 to ward 52 at the AFB at the Western General Hospital.

As an enabler to this option, ward 58 would also require to be redeveloped to meet ventilation standards to allow SHDU to move back to its original position (currently in ward 52). Ward 52 would be redeveloped to meet IPCT, Fire and Safety standards and in doing so create flow between SHDU, Surgical Specialties (Urology/Colorectal) and Theatres with critical care located one floor down from these services. This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas.

The upgrade of ventilation in Ward 58 lies out with the scope of this project and is a known issue whose remedial works are crucial to the enactment of this option.

2.3.1 Initial Assessment of Options

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) can be seen in Table 8, below.

Table 8: Assessment of options against investment objectives

Option Number #	Advantages	Disadvantages
Option 1: Do Nothing - Continue with the current arrangements.	Cost neutral option	The Do-Nothing option is sub optimal in the delivery of safe, patient centred care. Most crucially there is a lack of adherence to fire safety regulations with a single accessible fire exit. The secondary exit from Ward 20 is by a rear enclosed fire escape stair. Although this stair is a protected route, critical care provide care for the most significantly unwell patients and as a result very few patients would be expected to be able to use the stairs to escape. Rooms 1 and 8 do not deliver the required negative and positive pressures in accordance with regulations which impacts on the ability to deliver effective clinical care to patients with highly infectious pathogens Water testing highlighted contamination issues with Pseudomonas Aeruginosa, with 11 out of 23 water outlets affected. This presents significant risk to vulnerable patients in augmented care areas. Additionally, bed spacing is sub optimal making it significantly more challenging to provide care to patients (see Figure 1, above) and the current ward space is geographically isolated from key clinical specialties. The facilities for patients and staff are poor with a lack of: • natural light at 6 bedspaces, relative waiting area (see figure 2, above) and office accommodation. • patient bathrooms. • Teaching and shared learning areas
Option 2: Do Minimum – Refurbishment of Ward 20 to comply with essential standards – baseline option. Completion of remedial works in Ward 20 to comply with essential requirements in relation to intensive care units in the UK. These issues are described as: • The failure to meet current Fire Safety regulations – there is currently only one fire exit for the department which poses a significant safety risk in the event of a Fire. • Isolation Rooms – Rooms 1 and 8 do not deliver required negative and positive pressures in accordance with SHPN 04 (Scottish Health Planning Note)[iii]. This impacts on the ability to deliver effective clinical care to patients with highly infections pathogens. • Inadequate Ventilation provision – overall air change rates do not meet the current standard of 10 air changes per hour (ACH) for this type of facility and fall short of the minimum 6 ACH required for a clinical setting. • Pseudomonas – There is a known presence of the Pseudomonas in the water supply to critical care. Pseudomonas is a type of bacteria that can cause lung related complications and infections (in correct conditions). While this bacterium is regularly found in water supplies, its presence in a critical care facility is particularly concerning giving the vulnerability of patients in situ.	Compliance with 'Guidelines for the provision of intensive care services. Less financially intense than other options. Work required would be localised and so could commence promptly and be concluded relatively quickly. No *permanent* impact to other space/services in adjacent areas.	Accommodation is unable to meet expected growth on WGH site and due to infection control standards 10 beds is the maximum this space will allow which is fixed. None of those spaces are compliant with the current standard of 25m^2 per bed. None of the issues surrounding staff resources, capacity, access, or patient rights will be addressed. There is a lack of clinical proximity to theatres and radiology and thus this option does not align with main users of Critical Care. Difficult unit to staff – layout is not conducive to need. There is also a reliance on a single link lift for haematology and oncology patients. Patient safety is compromised by the journey from theatres to ward 20 due to protracted route to ward 20 comprising several long corridors and lift. Planned maintenance work will require a full decant which will disrupt surrounding and adjacent services creating an ongoing impact to the wider site. Recent developments to healthcare guidance and creation of NHS Assure add scrutiny to the assurance around provision of compliant critical care units and other NHS facilities. Limited investment in a significantly compromised and non-compliant area that does not address all areas of concern is unlikely to obtain approval from IPCT, Microbiology and NHS Assure.

Option 3: Enhanced Refurbishment of Ward 20. Completion of remedial works in Ward 20 as per Option 2. In addition, this option will bring further improvements to the fabric and facilities to benefit staff, patients, and visitors. This work includes: • Maximise natural daylight to bed spaces • Separate entrance for visitor and patient access and egress • Increasing width of HDU bed spaces • Increasing area for each bed space • Interview room for private discussions with relatives • Seminar room within the critical care area to facilitate attendance of the multi-disciplinary team at governance meetings. • Improved welfare facilities for relatives including overnight stay, toileting, and snack facilities. • Improved toilet and washing facilities for patients • Provision of a simulation room	As per option 2 and improvements across current in-patient accommodation including toilet/shower facilities for patients, space, and welfare facilities for relatives. Additional improvements include provision of a seminar room within existing footprint for easier access to shared learning/training facilities. Delivery of this option is not reliant on demolitions or the reprovision of other services and specialties and is likely to be more affordable than new build options	Accommodation unable to meet expected growth on WGH site and due to infection control standards 10 beds is the maximum this space will allow which will limit bed spacing improvements. The inclusion of enhanced patient and staff facilities will erode the total space and give the feeling of making the existing space smaller – limiting the number of enhancements that can be made, with staff showering facilities, maximisation of daylight and storage facilities likely to be challenging to accommodate. There is a lack of clinical proximity to theatres and radiology and thus this option does not align with main users of Critical Care. Difficult unit to staff – layout not conducive to need. There is also a reliance on a single link lift for haematology and oncology patients. Planned maintenance work will require a full decant which will disrupt surrounding and adjacent services creating an ongoing impact to the wider site. Patient safety is compromised by the journey from theatres to ward 20 due to protracted route to ward 20 comprising several long corridors and lift. Similarly, to Option 2, sub-standard solutions not addressing all areas of concern and delivering compromised compliance are unlikely to obtain support from IPCN and NHS Assure.
Option 4: Reprovision of Critical Care in Ward 57/58 and adjacent shell space, Western General Hospital. The relocation of critical care from its current location at ward 20 to ward 57/58 at the Anne Ferguson Building at the Western General Hospital. The adjacent 'shell space' between ward 57/58 would also need be redeveloped to meet IPCT, fire and safety standards and in doing so co-locate surgical high dependency, theatres, and recovery space. This option creates optimal patient flow between theatres, recovery, surgical high dependency, and critical care areas. This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas.	Increased routes of escape for critical care patients immobile in beds in event of fire/evacuation Significant improvements across current in-patient accommodation including facilities, privacy, patient, and staff experience. An increased bed footprint will also address admission delays and ensure capacity flex. Proximity to other key clinical specialties such as Theatres, SHDU and Urology and would be closer than current critical care. Shared staff and education facilities with surgical HDU improving skill mix and support Proximity to staff with advanced airway skills in out of hours period (theatre suite) Optimal patient flow between theatres, recovery, surgical high dependency, and critical care areas.	Significant capital investment will be required Shell space likely to be restrictive in terms of bed spaces for combined critical care/SHDU. Urology reprovision will require further investment to bring Ward 52 area up to current standards. Failure to reprovide Urology beds will result in an 80% loss of surgical beds to Urology. Space is fixed and may limit bed placement and volume (thus compromising bed modelling).

Option 5: Construct new building at ground and first floor level within site of RIDU/ old boiler house: This option proposes the relocation of critical care from its current location at ward 20 to a new purpose-built space constructed as a preliminary phase of a future essential services hub/ front door block. This option would provide direct connection to ADB/ AFB and provide future connection to ECC when completed. This option would ensure that all bed spaces and ancillary accommodation meet appropriate current standards.	This option will be comprised of a modern purpose-built space addressing both safety issues and non-compliant standards currently unmet in addition to providing equitable care. Improvements across current in-patient accommodation including toilet/shower facilities for patients, access to natural daylight, space, and welfare facilities for relatives. Additional improvements include provision of a seminar room within existing footprint for easier access to shared learning/training and simulation facilities. An increased bed footprint will also address admission delays and ensure capacity flex. Decant of current service wouldn't be required for works and so reduced disruption to wider site and sets the model for future development of site (i.e., North to South). This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas and provides new compliant bed space.	The delivery of this option would be dependent upon the relocation of RIDU which is currently undergoing Strategic Appraisal, and demolition of old boiler house. Both buildings are identified for removal in the masterplan (2024 at latest). Timelines associated with the RIDU Reprovision are unknown and are likely to be significant. There is a lack of clinical proximity to theatres and radiology and thus this option does not align with main users of Critical Care. It is isolated from medical specialties thus increasing travel time for critically unwell and long transfer times for main users. Less ability for sharing resources with other key specialties and services and is geographically distant from front door (certainly in the short-medium term) making access difficult for relatives/visitors
Option 6: Construct at first floor level above service yard: This option proposes the relocation of critical care from its current location at ward 20 to a new purpose-built extension of the Anne Ferguson Building, constructed at second floor level. This would also form a covered external area for the current service yard below. This option will provide direct connection to second floor surgical theatres when completed. This option creates optimal patient flow between theatres, recovery, surgical high dependency, and critical care areas. It may however be considered too detached from future ECC. This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas.	This option will be comprised of a modern purpose-built space addressing both safety issues and non-compliant standards currently unmet in addition to providing equitable care. Improvements across current in-patient accommodation including toilet/shower facilities for patients, access to natural daylight, space, and welfare facilities for relatives. Additional improvements include provision of a seminar room within existing footprint for easier access to shared learning/training and simulation facilities. No decant of current service required with well serviced connections to surgery.	This option comes with the caveat of significant disruption to service areas during build. The delivery of this component will be dependent upon the demolition of the former laundry building and delivery of new energy centre. The proposal will involve the relocation of oxygen tanks and associated services, and possible longer-term disruption to site services There is a lack of clinical proximity to theatres and radiology and other key specialties such as Haematology and Oncology. The physical site is on top of geologically 'hard rock' which will elongate development and building phase and is likely to impact ability to cost effectively implement modern pipe work.
Option 7: Enhanced construct within current Ward 20 extending into space above ADB OT Gymnasium: This option proposes to retain critical care in its current location at Ward 20, however in order to meet the necessary design and technical standards it proposes to reorganise and extend the existing critical care space and accommodate new space constructed on the existing roof space over the OT gymnasium. This option also corrects the issues associated with fire safety regulations, isolation rooms, ventilation, and pseudomonas.	This option will benefit from good connections with future ECC, and work will be localised so there will be little disruption to wider site. Improvements across current in-patient accommodation including toilet/shower facilities for patients, access to natural daylight, space, and welfare facilities for relatives. Additional improvements include provision of a seminar room within existing footprint for easier access to shared learning/training and simulation facilities. This proposal does not have any masterplan interdependencies.	This option would isolate theatres from critical care and as this represents a key adjacency there would be a potential safety issue given that the link corridor is narrow. The issues with Fire would not wholly be resolved as this option retains the space on the current set up on the first floor. This option would also require a temporary service decant during refurb This option relies heavily on the current infrastructure and preliminary feasibility would suggest that this would be a complex build option possibly requiring structural refurbishment of the Alexander Donald Building (gymnasium below). The delivery of this component would be dependent upon the future use of the OT gymnasium, currently used as office overspill.

Option 8: Reprovision of Critical Care into Ward 52: The relocation of critical care from its current location at ward 20 to ward 52 at the Anne Ferguson Building at the Western General Hospital. Ward 58 would need to be redeveloped to meet ventilation standards to allow SHDU to move back to its original position. Ward 52 would be redeveloped to meet IPCT, Fire and Safety standards and in doing so create good flow between SHDU, Surgical Specialties (Urology/Colorectal) and Theatres with Critical care located one floor down from these services. This option corrects the issues associated with Fire Safety regulations, Isolation Rooms and Pseudomonas.	This option locates critical care in centre of Anne Ferguson Building creating good links to other critical services (Theatres, Radiology) including SHDU which will allow staff to flex between the departments to facilitate daily staffing needs while also returning SHDU to its optimal position in Ward 58. Staff will move/manoeuvre more quickly without such a critical space constraint (as seen in ward 20) which is likely to improve staff retention and recruitment. There is also the potential to specify number of cubicles required given plentiful supply of cubicle space in ward 52. This option also addresses a key safety concern with the current position of critical care in ward 20 with less risk of infection via transport than with ward 20, which was geographically very far from other specialties. Development of ward 52 will allow consistent standards of care to Lothian residents, ensuring a similar level of care is provided to patients who receive care at WGH, RIE, or SJH. A key benefit can also be considered as the zero-net loss of surgical beds which is crucial given the specialist services in urology, cancer, and colorectal surgery. This can be considered one project and therefore minimises disruption to wider site with a clear decant plan (52-58- once AHU refurb, 20-52) while also acting as an enabler to the delivery of the Edinburgh Cancer Centre.	Delivery of this option is dependent on timescales associated with upgrade of ward 58 ventilation standards which may delay implementation milestones. Ward 58 has also recently been repurposed for Covid vaccinations so an alternative position and long-term plan would need drafted for this function. Failure to upgrade and reprovide the Covid vaccination clinic will prohibit critical care movement. Some office accommodation would be lost to GI specialties which would require reprovision. Given the cost/scope of the project, fabric improvements to the space may become a lower priority than other improvements and then not be funded The lack of primary co-location with SHDU and theatres is not entirely ideal and will require a lift from theatres to HDU.

Does it meet the Investment Objectives (Fully, Partially, No, n/a)?								
Option Number #	**Option 1: Do Nothing -** Continue with the current arrangements.	**Option 2: Do Minimum – Refurbishment of Ward 20 to comply with essential standards – Baseline option**	**Option 3: Enhanced Refurbishment of Ward 20.**	**Option 4: Reprovision of Critical Care in Ward 57/58 and adjacent shell space, Western General Hospital.**	**Option 5: Construct new building at ground and first floor level within site of RIDU/ old boiler house:**	**Option 6: Construct at first floor level above service yard:**	**Option 7: Enhanced construct within current Ward 20 extending into space above ADB OT Gymnasium:**	**Option 8: Reprovision of Critical Care into Ward 52**
Obj 1: Fire Safety	No	Yes	Yes	Fully	Yes	Yes	Partially	Fully
Obj 2: Management of HCI	No	Yes	Yes	Fully	Yes	Yes	Yes	Fully
Obj 3: Management of HAI	No	Yes	Yes	Fully	Yes	Yes	Yes	Fully
Obj 4: Colocation of Users	No	No	No	Fully	Partially	Partially	No	Partially
Obj 5: Time Critical Interventions	No	Yes	Yes	Yes	Partially	Yes	Partially	Yes
Obj 6: Improvement of Environment	No	No	Partially	Yes	Yes	Yes	Partially	Yes
Obj 6: Delivery of Modern Critical Care Unit		No	No	Yes	Partially	Yes	Yes	Yes
Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)								
Affordability	Yes	Yes	Yes	Yes	Unknown	Unknown	Unknown	Yes
Preferred/ Possible/ Rejected	Rejected	**Baseline**	Rejected	**Possible**	Rejected	Rejected	Rejected	**Preferred**

As summarised in the tables above, the following options were not taken forward for further assessment as detailed below:

- **Option 1: Do Nothing**. This option does not deliver any of the legal and professional standards required; a situation which will worsen with increased patient activity.

- **Option 3: Enhanced Refurbishment of Ward 20**. This option has been discounted as the location of ward 20 does not bring with it the benefits associated with proximity to other key clinical specialties while patient safety will be compromised through an unnecessarily protracted route to ward 20 from theatres post-surgery. In addition, the existing footprint of the ward is too small to deliver solutions compliant with current standards and therefore deems them unlikely to obtain approval from IPCN and NHS Assure.

- **Option 5: Construct new building at ground and first floor level within site of RIDU/ old boiler house**: This option has been discounted as the timelines associated with the RIDU Reprovision are unknown and are likely to be significant. The issues concerning Fire Safety, Isolation Rooms, Ventilation and Water Contamination are pressing and require immediate-shorter term resolution. There remains some financial cost to the organisation which will exceed the option to re-provide all the derived benefits.

- **Option 6: Construct at first floor level above service yard:** This option has been discounted due to significant infrastructural challenges in enacting this option and the lack of clinical proximity to key services such as theatres and radiology.

- **Option 7: Enhanced construct within current Ward 20 extending into space above ADB OT Gymnasium:** This option has been discounted as there are significant infrastructural challenges in enacting this option in addition to decant and disruption to multiple services including physiotherapy and occupational therapy.

- The do minimum option is included for further assessment as the baseline case.

2.4 Short-listed Options and Preferred Way Forward

2.4.1 Shortlisted options

From the initial assessment above the following short-listed options have been identified:

Table 9: Short Listed Options

Option	Description
Option 2	Do Minimum – Refurbishment of Ward 20 to comply with essential standards – baseline option
Option 4	Reprovision of Critical Care in Ward 57/58 and adjacent shell
Option 8	Reprovision of Critical Care into Ward 52

2.4.2 Non-financial benefits assessment

Given the interdependencies and indicative benefits associated with each of the options on the Long List of Options, each option was assessed against a set of benefits criteria. Each of the identified benefits was weighted (%) and following this each of the options was scored against its ability to deliver the required benefits, using scores between 0 and 10.

The assessment and scoring of options were completed by a team of project stakeholders including representatives from a variety of services: Surgery, Fire Safety, Estates, Critical Care, Nursing, Theatres and Anaesthetics, Cancer Services, Planning and Finance.

The results of the benefits assessment are summarised in Table 10 below.

Table 10: Results of Non-Financial Benefits Assessment

#	Benefit	Weighting (%)	Option 1: Do Nothing	Option 2: Do minimum - Refurbishment to comply with essential standards	Option 4: Move to ward 57/58	Option 8 – ICU Movement to Ward 52
1	There is a benefit of improved levels of patient care as a result of optimal bed space allowing easier performance of clinical duties while reducing risk of infection transmission	10%	*Inviable*	1.9	7.2	9.2
2	There is a benefit of improved standards of dignity and respect for patients and visitors as a result of access	10%		2.4	7.7	8.4
3	There is a benefit that adjacencies allow safe transition between clinical care settings	10%		3.0	7.0	7.3
4	There is a benefit that this option improves staff and patient facilities	14%		1.6	7.4	7.3
5	There is a benefit that there is a more efficient use of resources to provide Critical Care to patients by increased space allowing easier patient mobilisation, improved work flows, less time wasted obtaining supplies, attending off unit training and meetings	10%		2.6	7.5	7.9
6	There is a benefit that this model builds capacity in terms of staff expertise now and future by improving work flows and day to day experience for staff	2%		2.5	7.3	7.8
7	There is a benefit that there will be compliance with required standards for fire/water safety and ICU bed space and facilities	14%		4.4	8.7	9.1
8	There is a benefit that equitable critical care service provision is provided across Lothian	5%		3.1	7.0	8.4
9	There is a benefit that critical care is provided in a timely manner as required	10%		3.9	6.7	8.1
10	There is a benefit that this option will cause minimal decant disruption	5%		1.7	6.5	8.3
11	There is a benefit that this option prepares critical care for the future, clinically and politically (Cancer Centre and Short Stay Elective Centre)	10%		2.4	6.5	7.8
	Total Weighted Benefits Points	100	-	**275**	**733**	**814**
	Maximum possible benefits points	1,100				

From the table above it is noted that the option that will deliver the most benefits from those short listed is *Option 8* - Reprovision of Critical Care into Ward 52.

2.4.3 Indicative costs

The table below details the indicative whole life costs associated with each of the shortlisted options.

For further details/assumptions made in the calculation of the capital and operating costs associated with each option please refer the Financial Case in section 4.

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 24 years has been determined for the project.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.
- VAT is excluded from the NPV calculation.

Table 11: Indicative Costs of Shortlisted Options

Cost (£k)	Option 2: Do Minimum	Option 4: Reprovision of Critical Care in Ward 57/58 and adjacent shell space	Option 8: Reprovision of Critical Care into Ward 52
Whole life capital costs	5,355	12,690	15,646
Whole life operating costs	-	377	1,233
Estimated Net Present Value (NPV) of Costs	**5,355**	**13,067**	**16,879**

2.4.4 Overall assessment and preferred way forward

The table below shows the weighted benefit points, the NPV of costs and the calculated cost per benefit point for each shortlisted option. This calculated cost per benefit point has been used to rank the options and identified the preferred way forward.

Table 12: Economic Assessment Summary

Option Appraisal	Option 2: Do Minimum	Option 4: Reprovision of Critical Care in Ward 57/58 and adjacent shell space	Option 8: Reprovision of Critical Care into Ward 52
Weighted benefits points	275	733	814
NPV of Costs (£k)	5,355	13,066	16,880
Cost per benefits point (£k)	19.47	17.83	20.74
Rank	**2**	**1**	**3**

Although the above identifies Option 4 as the highest-ranking option, the preferred solution was identified as Option 8: Reprovision of Critical Care into Ward 52, as detailed below.
Initial work has been completed to confirm the location, feasibility, and possible design for this option with engagement underway with Surgical/Critical care teams to confirm requirements in ward 52 as part of their reprovision. A key constraint maybe the enabling work to correct ventilation standards in ward 58 and future planning for Covid vaccinations however a significant benefit is the net zero loss of surgical beds. A draft drawing showing the draft floorplan is shown as appendix 1.

The feasibility study has concluded that Option 8 would provide full compliance with current standards in terms of space and services provision and provide a modern, fit for purpose, conveniently located and flexible (isolation rooms, future capacity) facility.

This was identified as the preferred option because it will deliver all the benefits listed on the Benefits Register and has the lowest cost per benefit point. By comparison, Option 2 can only attempt at delivering one of the required benefits despite its relatively high cost per benefit point. Option 4 comes with a significant impact of a loss of 24 urology beds with no clear plan for reprovision thus costing more while delivering less. The potential reprovision of the Urology Ward in ward 52, which is a smaller ward, would provide zero benefits to Urology at a high cost.

It is recommended that NHS Lothian proceeds with Option 8: Reprovision of Critical Care into Ward 52 to Outline Business Case.

Of note, a key part of NHS Lothian's service delivery is ensuring best use of estate in supporting operational and corporate delivery. To achieve this, the Board has in place a Property and Asset Management Strategy (PAMS). NHS Lothian's current strategy reflects its commitment to improving the healthcare environment whilst reducing the number of hospital and other sites it currently manages, to reduce property expenditure. As part of the Lothian Strategic Development Framework (LSDF), NHS Lothian has committed to making best use of its existing estate and reducing the number of new builds it commissions. Option 8 remains consistent with the principles set out by both the Lothian Hospitals Plan and Lothian Strategic Development Framework (LSDF).

3 The Commercial Case

3.1 Procurement Strategy

NHS Scotland has established national procurement routes for major asset investment which have been fully developed within the EU public sector procurement regulation framework. It is a requirement for all NHS projects above £1m threshold to be procured under the NHS Scotland Frameworks Scotland 3 (FS3) arrangements. As the estimated capital cost at this stage is £18.6m including VAT, this route has been selected for the procurement of the project. This means the contract will be run in a design and build approach, this being the only available option under Frameworks Scotland 3. This procurement route appoints a single contractor to act as sole point of responsibility for the management and delivery of an integrated design and construction project.

Frameworks Scotland has been used successfully by NHS Lothian for several years and there is a clear organisational understanding of the process for appointment of Principal Supply Chain Partner (PSCP, Main Contractor) and any relevant consultants that may be required.

The procurement of the project will be led by the Estates Department Project Team and members of the DATCC Service with support from Capital Finance on behalf of NHS Lothian and with assistance from Health Facilities Scotland in terms of PSCP and Professional Services Consultants (PSC).

3.2 Timetable

The table below shows the proposed timetable for the progression of the business case and project delivery milestones:

Table 13: Project Timetable

Key Milestone	Date
Initial Agreement approved	December 2021
Appointment of the PSCP	February 2022
Outline Business Case approved	November 2022
Full Business Case approved	January 2024
Decant works start	March 2024
Construction starts	July 2024
Construction completes and commissioning begins	July 2025
Service commences	August 2025

4 The Financial Case

4.1 Capital Affordability

The estimated capital cost associated with each of the short-listed options is detailed in the table below.

Construction costs for the preferred option were provided by independent quantity surveyors based on the Feasibility Study and by the Estates Department Project Team for the other options based on the cost/m^2.

Table 14: Capital Costs

Capital Cost (£k)	Option 2: Do Minimum	Option 4: Reprovision of Critical Care in Ward 57/58 and adjacent shell space	Option 8: Reprovision of Critical Care into Ward 52
PSCP Construction and Design Costs	1,750	6,048	9,104
Professional Fees	173	533	747
Equipment and Furniture	93	317	470
Estates and Facilities Support	60	90	90
IT and Telecoms	50	90	90
Decant	1,725	2,070	800
Optimism Bias	1,540	3,660	4,521
Total Cost (excl VAT)	**5,391**	**12,808**	**15,822**
VAT	1,044	2,455	3,015
VAT Recovery	-140	-181	-273
Total Capital Cost	**6,295**	**15,082**	**18,564**

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

- Optimism bias has been included at 40% of all costs
- Preliminaries have been included at 25%
- An inflation allowance of 9.88% has been included using a base date of Q3 2021 and the construction timeline detailed in the Commercial Case
- VAT has been included at 20% on all costs. VAT recovery has been assumed as 40% of VAT on Construction Costs for Option 2 and 15% of VAT on Construction Costs for Options 4 and 8. VAT recovery will be further assessed in the OBC.

4.2 Revenue Affordability

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 15: Incremental Revenue Costs

Incremental Revenue Cost/year (£k)	Option 2: Do Minimum	Option 4: Reprovision of Critical Care in Ward 57/58 and adjacent shell space	Option 8: Reprovision of Critical Care into Ward 52
Facilities	-	25	81
Depreciation	271	660	820
Total Annual Revenue Cost	**271**	**685**	**901**

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

- Depreciation is based on a useful life of 24 years for buildings and 10 years for equipment and is assumed to be funded from the existing NHS Lothian Depreciation funding allocation.
- Facilities costs relate to the incremental costs of operating a larger area and are based on Health Facilities Scotland estimates.

Revenue costs will continue to be refined through the OBC/ FBC process.

4.3 Overall Affordability

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

The facilities revenue costs will be reviewed by the Finance Business Partner (Shona Binning) at the OBC stage and funding options will be assessed.

All costs will continue to be refined through the OBC/FBC process.

5 The Management Case

5.1 Readiness to proceed

An initial high level risk register for the project has been drafted and is available from the Project Owner on request. 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.

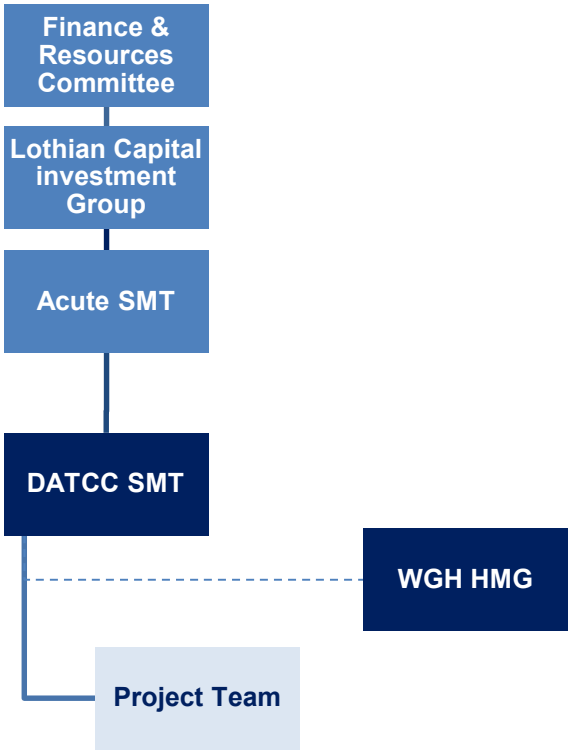
NHS Lothian are ready to proceed with this proposal and are committed to ensure the necessary resources are in place to manage it. Section 5.2 outlines the governance support and reporting structure for the proposal while section 5.3 below, details the project management arrangements.

5.2 Governance support for the proposal

Engagement with Stakeholders is detailed in the Strategic Case and includes information on how members of the proposal's governance arrangements have been involved in its development to date and will continue to support it.

Figure 4 below, shows the organisational governance and reporting structure that will be in place to take forward the proposed solution from Initial Agreement to Business Case.

Figure 4: Proposed Governance Structure



5.3 Project Management

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

Table 16: Project Management Structure

Role	Individual	Capability and Experience
Senior Responsible Officer	Jacquie Campbell	Chief Officer of Acute Services. Previous experience at Senior Responsible Officer level in similar and larger projects
Project Sponsor	Michelle Carr	Service Director of DATCC. Previous experience at Senior Manager level in similar projects
Project Owner	Jane McDonald	General Manager for ATCC. Currently supporting National expansion of critical care and previous experience in capital projects.
Project Director	Hania Klinge	Estates Portfolio Manager with engineering and APM qualifications and 10+ years of experience in managing NHS Lothian capital programmes and projects of similar size.
Estates Project Manager	David Guild	Property, Development and Construction (or Estates) Project Manager experienced in delivering capital projects and programmes.
Strategic Programme Manager	Bhav Joshi	Previous experience of NHS capital projects
Finance Business Partner	Jacqui Hamilton	Business Partner for DATCC. Previous experience of NHS capital projects
Capital Finance Support	Emma Amor	Financial professional with experience of supporting multiple capital investment projects
Clinical Lead - Consultant ICM/Anaesthetics	Murray Blackstock	Consultant in Critical Care and Professional Medical Lead for WGH Critical Care
Nursing Lead - Clinical Nurse Manager	Celia McKiernan	Clinical Nurse Manager in Critical Care and Professional Nursing Lead for WGH Critical Care
Surgical Lead	James Mander	Surgical Associate Medical Director for Western General Hospital
Infection Control Support	Sarah Sutherland, Lead HAI SCRIBE Advisor, Donald Inverarity & Simon Dewar, Consultant Microbiologists	Infection Control Specialists with years of experience in providing advice to capital projects
Estates Liaison Manager	David Williamson, Estates Sector Manager	Over 30 years' experience in Estates with extensive knowledge of M&E services on WGH site.

Role	Individual	Capability and Experience
Partnership Representative	Sharlene Philp	Partnership lead for ATCC. Previous experience in similar projects

The use of specialist external advisors will be essential, and the early release of funds will allow their appointment via Frameworks Scotland 3.

Appendix 1: Proposed Ward 52 Floorplan

[i] Health Facilities Scotland (September 2008) Scottish Health Planning Note 04
In-patient Accommodation: Options for Choice Supplement 1: Isolation Facilities in Acute Settings. pp 1-33.

[ii] Health Facilities Scotland (September 2008) Scottish Health Planning Note 04
In-patient Accommodation: Options for Choice Supplement 1: Isolation Facilities in Acute Settings. pp 1-33.

Meeting Name: NHS Board

Meeting Date: 1 December 2021

Title: PERFORMANCE SUPPORT OVERSIGHT BOARD: PROGRESS UPDATE

Purpose and Key Issues of the Report					
DISCUSSION		DECISION		AWARENESS	X

The purpose of this report is to update the Board on progress made by the Performance Support Oversight Board (PSOB) and to set out how a focus on performance management is being maintained despite ongoing system pressures.

The key points to note are:

- NHS Lothian continues to focus on key performance targets and remains under Scottish Government performance escalation processes for Mental Health.
- In order to address current performance issues and help mitigate the risk of future escalation, a Performance Support Oversight Board (PSOB) was established in Spring 2021. The aim of the PSOB is to identify services with performance challenges as early as possible and provide an internal escalation route to address the issues identified
- At present nine services have been 'escalated' and requested to attend the PSOB. To date the Board has focused on specialties with long waiting times (Dermatology, Oral Health Services, Orthopaedics), those in the Scottish Government Performance Escalation Process (CAMHS and PT), as well as other pressures including Theatres (nurse shortage), Emergency Department (front door processes) Urology (subspecialty queues) and Edinburgh Delayed Discharges (rapid increase);
- Progress has been mixed across the portfolio of services, in part reflecting ongoing system pressures, as well as the challenging nature of the services included in the programme. For example, good progress has been made in Oral Health Services whilst difficulties remain in areas such as Dermatology and the Emergency Department.
- The programme will continue into 2022, monitoring performance against agreed plans on a monthly or quarterly basis, as well as using benchmarking data and other intelligence to decided whether other services (clinical or non-clinical) should be brought into its remit.

Recommendations

- To note that NHS Lothian continues to focus on key performance targets and areas of under- performance.
- To take assurance that there is a process for escalating performance and supporting services to put in place plans to address performance challenges.

Director: Peter Lock
Date 24 November 2021

NHS LOTHIAN
NHS Lothian Board

1 December 2021

Director of Improvement

PERFORMANCE SUPPORT OVERSIGHT BOARD
PROGRESS UPDATE

1. Purpose of the report

1.1 The purpose of this report is to update the Board on progress made by the Performance Support Oversight Board (PSOB) and to set out how a focus on performance management is being maintained despite ongoing system pressures.

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

2. Recommendations

2.1 To note that NHS Lothian continues to focus on key performance targets and areas of under- performance.

2.2 To take assurance that there is a process for escalating performance and supporting services to put in place plans to address performance challenges.

3. Discussion of Key Issues

Introduction

3.1 In April 2021, the Scottish Government wrote to NHS Lothian and the four Integration Joint Boards to inform them that they would be de-escalated on the performance framework with the exception of Mental Health (CAMHS and Psychological Therapies) which remains on escalation Level 3.

3.2 In order to ensure further progress, and help mitigate the risk of future escalation, a Performance Support Oversight Board (PSOB) was established in Spring 2021. The aim of the PSOB is to identify services with performance challenges as early as possible and provide an internal escalation route to address the issues identified. It has provided a forum for Senior Board Directors to help unblock performance issues, support the development of recovery plans and monitor progress. The initial aim was to commence planning for recovery early, however, given continuing system pressures and Covid restrictions, performance expectations have had to be reconsidered within this context.

3.3 This paper sets provides an overview of the process adopted by the PSOB, the scope of services included within the programme, and a forward look into 2022. Annex 1 provides an overview of progress across the programme portfolio as of October 2021.

Annex 2 provides a more detailed progress update for Dermatology and Oral Health Services.

PSOB Support Process

3.4 The PSOB meets weekly and was created to provide time and space for Senior Board Directors to consider how best to tackle issues in the most problematic services or those which have had long standing, complex and multi-faceted issues, i.e. the 'wicked' problem areas.

3.5 The process has broadly followed a 'three conversation model' with a gateway step to enter the programme, as set out below:

- **Conversation #1 Understand the Problem**: articulate and quantify the problem, provide comparative benchmark data and agree what the performance ask is;
- **Conversation #2 Initial Solutions**: set out initial ideas to address the issues highlighted, as well as any required support;
- **Conversation #3 Agree the Deal**: finalise the plan for addressing the performance ask and agree the proposed targets and outcomes to be achieved.

3.6 Once agreed, each plan is monitored on a monthly, or quarterly basis with exception reporting. The final plan and financial consequences are be subsequently approved at the Executive or Corporate Management Team. Once a service has demonstrated they are delivering against plan they will be de-escalated from the process.

Scope and Progress of the Programme

3.7 The focus of the programme was initially on the most challenged services, or those which benchmark adversely within NHS Lothian or external peers.

3.8 It has predominately focused on specialties with long waiting times (Dermatology, Oral Health Services, Orthopaedics), those in the Scottish Government Performance Escalation Process (CAMHS and PT), as well as other pressures including Theatres (nurse shortage), Emergency Department (front door processes) Urology (subspecialty queues) and Edinburgh Delayed Discharges (rapid increase).

3.9 Oral Health Services and Dermatology were provided with additional management support from the Director of Improvement in recognition of the challenges they faced. As of April 2021, these two specialties accounted for 30% of the over 12 week outpatient waiting list and 50% of over 52 week waits.

3.10 Progress has been mixed across the portfolio of services, in part reflecting ongoing system pressures, as well as the challenging nature of the services included in the programme. Good progress is being made by Oral Health Services with the outpatient waiting list 50% lower than in April 2021. Reasonable progress has been made in relation Psychological Therapies with a continued decline in those waiting. Performance within Dermatology continued to deteriorate until September, with waiting times only now starting to reduce. Challenges remain in a number of areas,

particularly within the Emergency Department. Annex 1 provides an update of overall progress as of October 2021.

3.11 Annex 2 provides additional detail of the plans in place within Oral Health Services and Dermatology, as well as an overview of progress to date.

Future Plans

3.12 The programme will continue into 2022 with a focus on addressing the most challenged performance areas and monitoring existing plans in place. Performance benchmarking data (Discovery dataset) continues to be used to determine if other services should be escalated into the process.

3.13 It has been agreed that the programme will also consider performance issues in non-clinical services or processes. However, the aim is to keep the number of services in the programme small and focused.

3.14 Most services are now reporting either monthly or quarterly through the PSOB and services will be de-escalated if they demonstrate performance in line with trajectories/plans.

4. Key Risks

4.1 The main risk to the programme relates to the ongoing impact of Covid and other system pressures, particularly in relation to staffing shortages.

4.2 There is a risk that demand increases as Covid measures are eased. To some extent this has occurred already. For example, Urgent Suspected Cancer referrals into dermatology, Emergency Department attendance levels as well as referrals into mental health services are back to (or higher than) pre Covid levels.

4.3 Some areas have improved outpatient performance through the pivot of activity away from surgery, or other inpatient procedures, whilst bed and theatre pressures remain high. In the short term this will increase inpatient treatment lists which will need to be cleared in the future in line with clinical priorities.

5. Risk Register

5.1 This supports a number of the key Board level risks including Access to Treatment, 4 Hour Emergency Access Standard and Access to Mental Health Services.

6. Equality Impact

6.1 No equality impact assessment has been undertaken of the programme per se.

7. Resource implications

7.1 The resource implications of each approved trajectory / plan have been articulated as part of the ‘three conversation model’. These are subject to approval by the

Executive Leadership and Corporate Management Team in line with available resources allocated for recovery by the Scottish Government.

Peter Lock
Director of Improvement
23 November 2021

Annex 1.

Performance Support Oversight Board (PSOB)

Status Report 31 October 2021

Service Area	Lead	Key Issue(s)	Stage	Deal Description	Impact	RAG
Orthopaedics	Sam Patton	• Restriction on operative capacity due to Covid and TTG waits • Pivot to OP activity	Quarterly Reporting	• Service Ask: Trajectory for zero 12 week OP waits by end March 2022 PSOB Ask: procure theatre capacity from private sector to address treatment backlog	• OP reduction reversed over summer • Plan B in place to hit target	
Oral Health Services (OHS)	Peter Lock	• Restriction on AGP treatments with long OP waits • 10% OP waiting list	Quarterly Reporting	• Service Ask: Trajectory for <700 12 week OP waits across PDS and EDI by end March 2022 • PSOB Ask: investment in 12 months fixed term posts and WLI	• On plan waiting times reducing in line with trajectory • Rapid decline >52 week waits	
Dermatology	Peter Lock	• Long OP waits (20% OP waiting list) • Underlying capacity gap • Service modernisation	Monthly Reporting	• Service Ask: Trajectory to be finalised to March 2023 based on finance availability via Scheduled Care. 10 point 'Deal'. Medium term sustainability plan. • PSOB: investment in capacity (consultant, WLI and nursing)	• Performance continues to deteriorate • Actions to impact this Autumn	
Psychological Therapies	Belinda Hacking	• Long treatment and assessment waits	Quarterly Reporting	• Service Ask: Trajectory for zero 18 week waits by end March 2023 • PSOB: agree finance deal across HSCPs, SG and Board. SG funded but some local risk	• Waiting times continue gradual decrease from Summer 2020	
CAMHS	Tracey McKigen	• Long treatment and assessment waits	Quarterly Reporting	• Service Ask: Trajectory for zero 18 week waits by end March 2023 • PSOB: to monitor trajectory and SG financial ask	• Waiting times have reached a plateau but underlying challenges remain	
Urology	Lyndsay Cameron	• Subspecialty queues • Cancer waits	Quarterly Reporting	• Trajectory to March 2023 to be finalised		
Theatre Staffing	Michelle Carr	• Shortage staff to deliver theatre sessions	Monthly Reporting	• Support for external recruitment and internal process enhancements. Considering broadening into theatre / session utilisation more broadly	• Theatre recruitment two months behind plan	
Emergency Department	Dave McKean	• Deteriorating 4 hour performance and 8/12 hour breaches	Monthly by exception	• Exec Directors now attending huddles. Focus on refreshing front door investment and staff benchmarking		
Edinburgh City Delayed Discharges	Judith Proctor	• Delays increase back to pre Covid levels • Pressure on social care	Monthly Reporting	• Progressing conversations, focused on demand and capacity modelling and actions to address delays		

Annex 2. Case Studies

Oral Health Services

Introduction

7.2 Oral Health Services have struggled for a number of years with long waiting lists. This underlying position deteriorated further during the Covid pandemic due to closure of outpatient services during the early lockdown in 2020, limitations in capacity associated with social distancing as well as restrictions on the use of Aerosol Generating Procedures (AGPs) and as capacity was switched to support the unscheduled care dental service. As a result NHS Lothian placed OHS into performance escalation and provided additional management oversight to develop a plan for short and long term for service sustainability

7.3 Table 1 illustrates the baseline waiting time position across OHS as of April 2021. At this point in time the service had started to remobilise as improved ventilation solutions were deployed.

Table 1. OHS Outpatient Performance (April 2021)

Reportable EDI Outpatients	Total Waiting	>12 Weeks	>52 Weeks
Oral Medicine	254	58	13
Oral Surgery	3,382	2,654	1,588
Orthodontics	169	72	40
Paediatric Dentistry	1,030	737	273
Paediatric Dentistry - RHSC	30	14	3
Restorative Dentistry	755	555	310
Sub Total	*5,620*	*4,090*	*2,227*
Non reportable Public Dental Service (PDS) Outpatients			
PDS Paediatric Dentistry	1,010	705	381
PDS Paediatric Dentistry - RHSC	2	2	2
Special Care Dentistry	715	518	279
Sub Total	*1,727*	*1,225*	*662*
OHS Total	**7,347**	**5,315**	**2,889**

* source Management Information

7.4 These data illustrate that there were 5,315 patients waiting over 12 weeks for an initial appointment with 2,889 waiting over 52 weeks. The biggest numerical backlogs were in Oral Surgery, Paediatrics and Restorative Dentistry.

The Performance Ask

7.5 The Performance Oversight Board requested that OHS worked towards eliminating 52 and 12 week waits by the end of March 2022. The underlying premise was to make significant inroads into the waiting list backlog whilst the General Dental Service was not fully mobilised.

7.6 A key component of the plan is to pivot activity away from (AGP) treatments towards new patient assessment, whilst recognising this would in due course increase waiting lists for treatment.

7.7 Whilst waiting times for the Public Dental Service (PDS) are not reportable it was considered appropriate to treat both reportable and non-reportable patient waiting times equally and therefore PDS waits were incorporated into the performance ask.

7.8 The initial focus was to be on short term waiting list reduction whilst recognising that alternative models of care would be needed to rebalance care provision away from a secondary care setting into the community.

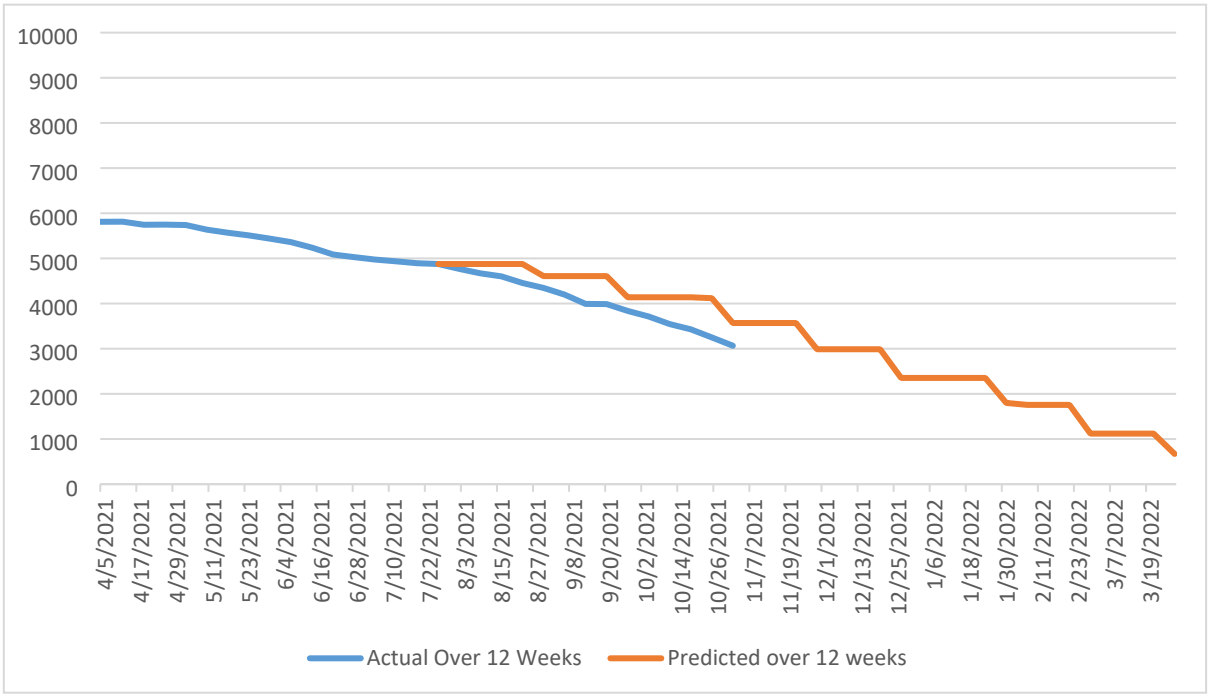
Waiting Time Improvement Programme

7.9 A Waiting Time Improvement Programme was put in place to address these points. The Programme was badged as the 'Big Ask' and there has been broad support from clinical teams in the PDS and Edinburgh Dental Institute (EDI).

7.10 A number of immediate actions were put in place including pivoting the booking of assessment slots rather than treatment slots, recruitment plans were accelerated to cover vacancies and fill additional fixed term posts, and a schedule of Waiting List Initiatives (WLIs) has been agreed with the clinical teams.

7.11 Figure 1 illustrates the progress made since April 2021 against the trajectory agreed with the PSOB.

Figure 1. OHS Outpatient Trajectory (waiting over 12 weeks)



7.12 The trajectory illustrates that the programme is ahead of schedule. Based on the latest management information as of 22 November, over 12 week waits were 2,414 and 52 week waits at 219 (representing a 55% and 90% reduction since April). Risks remain in some of the smaller subspecialties, however, overall the programme is progressing well.

7.13 Management attention remains on achieving the targets set by the PSOB, but also looking forward into next year will focus on plans to tackle the dental treatment backlog and alternative models of delivery within the community.

Dermatology

Introduction

7.14 The Dermatology Service has struggled for a number of years with long waiting lists. Over the past six years an underlying capacity gap has been bridged by external providers, and over this period, the service has become increasingly reliant on this capacity to meet demand.

7.15 The waiting list position deteriorated dramatically during the Covid pandemic when clinics were reduced due to social distancing measures and external provider contracts were placed on pause. With referral numbers, particularly cancer referrals now back or exceeding pre Covid levels, the service is facing increasing pressure. As a result NHS Lothian placed the Dermatology Service into performance escalation in April 2021 and provided additional management oversight to develop a plan for short and long term for service sustainability.

7.16 Table 1 illustrates how waiting times have changed pre and post Covid.

Table 1. Dermatology Waiting Time Position

Waiting Position	April 2020	April 2021	September 2021
Additions	574	1,914	1,864
Removals	410	893	1,675
Total Waiting List	5,061	11,065	12,792
Over 12	2,626	7,228	9,292
Over 52	102	3,320	4,062

*source Management Information

7.17 These data illustrate the rapid deterioration in waiting times over the Covid period which has continued, albeit at a slower pace, up until September this year. Over this period of time the service has managed the clinical risk associated with long waiting times by prioritising Urgent Suspicion of Cancer referrals.

The Performance Ask

7.18 To agree timescales, targets, and trajectories on a sustainable basis for moving to recurrent balance, reducing the backlog as well as detailing the services vision for the future. This will include a plan for balancing demand and capacity in the medium term and would be delivered through the development of a multi professional workforce.

7.19 To meet Urgent Suspicion of Cancer targets and urgent patient demand in line with clinical prioritisation.

7.20 Set out a plan for delivering teledermatology at scale across Lothian.

Waiting Time Improvement Programme

7.21 A Waiting Time Improvement Programme is being put in place by the new management team, covering a number of facets as outlined below.

7.22 Job Planning with the consultant body was undertaken in September and is currently being finalised. The aim was to align Job Plans as closely as possible to guidelines from the British Association of Dermatology which set out expectations around the numbers of patients seen and clinic timetables. Clinic templates for these revised job plans will be in place before Christmas allowing more accurate monitoring of care provider productivity.

7.23 As part of the Job Planning process, additional time was earmarked for Active Clinical Referral Triage (ACRT) to ensure that only those patients who really needed to be seen were accepted onto the waiting list, with a greater proportion of advice given to primary care.

7.24 The Department recruited two additional consultant Dermatologist in September, with one commencing work in October and one in December.

7.25 A keeping in touch process with cohorts of patients on the waiting list commenced in August. This is still underway and is being used to check whether those who have waited the longest still wish to remain on the waiting list, and to provide reassurance that they will be seen in due course. This has resulted in a large number of patients being removed from the waiting list.

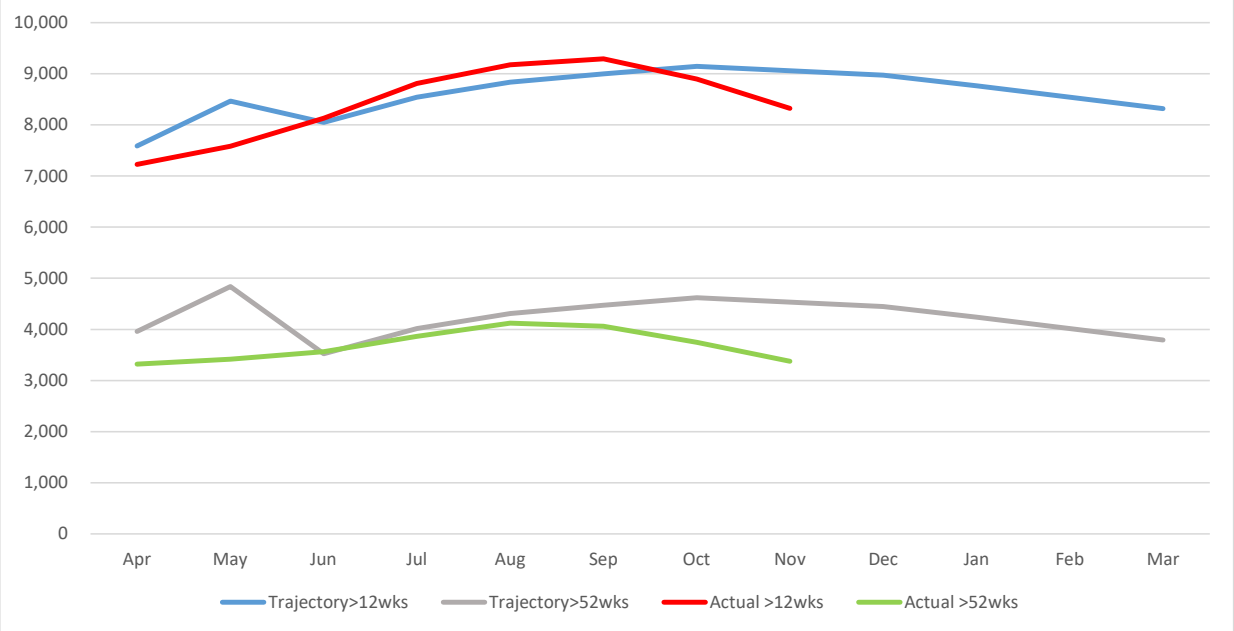
7.26 The department is putting in place a multi- professional workforce as part of the longer term plan to reach a sustainable demand and capacity position. Nursing and pharmacy teams will support greater throughput in consultant led clinics, and incrementally increase responsibility for seeing return patients over the course of the next 12 to 18 months. This will in turn allow the consultant workforce to pivot job plans from return to new patients. Training plans for the nursing team are being developed, whilst two dermatology pharmacists are now in post and will be qualified to take on return patients in the next month.

7.27 Additional capacity from the private sector and from Waiting List Initiatives has recommenced during the weekends and mid-week evenings.

7.28 The department is progressing a number of teledermatology initiatives. Digital appointments using the national ‘Lenus’ platform app commenced in mid-November and if successful will be scaled further. In parallel, the team have tested an approach for embedding high quality dermatoscopic images in GP referral letters where there is a suspected skin cancer lesion. The images will allow a consultant at point of triage to assess and ultimately diagnose skin cancer. The aim is to roll this out from six GP practices to 25 GP practices in the next three months, before scaling across Lothian. The outpatient modernisation team will also support the Department in January put in place functionality for online booking and improved ‘instant’ messaging back to primary care.

7.29 Figure 1 illustrates the progress made since April 2021 against the trajectory agreed with the PSOB.

Figure 1. Dermatology Outpatient Trajectory (waiting over 12 and 52 weeks)



7.30 The trajectory illustrates that waiting times continued to increase from April to September 2021. However, during October and November have started to fall as additional measures that have been put in place. Regardless, there remains a long way to go, and further change is required in working practices within the department.

Meeting Name: Board
Meeting Date: 1 December 2021

Title: Flu and Vaccine Programme

Purpose and Key Issues of the Report					
DISCUSSION	X	DECISION		AWARENESS	X

Delivery of tranche 2 Covid vaccination (boosters and 3rd doses), along with the expanded annual flu cohort and an evergreen Covid programme offering first and second vaccine to people who have not previously opted in is underway across Lothian.

The key points to note are

- NHS Lothian's performance against the national uptake assumptions is on track to deliver the tranche 2 cohorts and is ahead of the assumed uptake for the clinically extremely vulnerable cohort.
- NHS Lothian is working with the national delivery team to optimise the efficiency and accuracy of the National Vaccination Scheduling System (NVSS) in defining appropriate appointments for the cohorts of people due to have a vaccination and in parallel the HSCPs are identifying suitable local venues.
- The national imperative to increase delivery acknowledges the public health advice to need to vaccinate people as quickly as possible but the Board must ensure that all options for acceleration are risk assessed, both for the impact on people receiving their vaccine and the staff, and that pace is balanced with safety.
- A robust assurance framework is being used to provide a pan Lothian approach to quality and safety .

Recommendations

- Note the performance against the national delivery plan
- Recognise the current challenges and the actions put in place to mitigate system issues and the difficulties in providing a future view and assurance of programme delivery given continued Scottish Government review of delivery expectations and timelines with changes in national policy or direction in light of emerging evidence on covid/flu vaccination priorities
- Note that this is a national programme and not all aspects are within the direct control of the partnerships or wider organisation and require close working relationships with the National Vaccination team.

Author: Alyson Cumming Date 24 November 2021	Director: Fiona Ireland Date 24 November 2021

NHS LOTHIAN

Board Meeting
1 December 2021

Interim Executive Director of NMAHPs

FLU AND COVID VACCINE PROGRAMME

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress to date on the delivery of the national vaccine programme (Covid and Flu). The paper highlights the risks and mitigating actions and controls that have been put in place.

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

2 Recommendations

2.1 Note the performance against the national delivery plan

2.2 Recognise the current challenges and the actions put in place to mitigate system issues and the difficulties in providing a future view and assurance of programme delivery given continued Scottish Government review of delivery expectations and timelines with changes in national policy or direction in light of emerging evidence on covid/flu vaccination priorities

2.3 Note that this is a national programme and not all aspects are within the direct control of the partnerships or wider organisation and require close working relationships with the National Vaccination team.

3 Discussion of Key Issues

3.1 Context

3.1.1 In line with the General Medical Services (GMS) contract and the associated Memorandum of Understanding (2018) there has been an ongoing programme of work to migrate responsibility for vaccination administration from General Practice (GP) to the Health and Social Care Partnerships(HSCPs) in line with the national Vaccination Transformation agenda. Following the transfer of children's and travel immunisation flu vaccine was the next programme to transfer out of GP delivery. By April 2022 all vaccination work will be the responsibility of the HSCPs as a delegated function of the Integrated Joint Board (IJB).

3.1.2 Tranche 1 of the Covid Vaccination programme – (first and second doses to the eligible population) was delivered by NHS Lothian corporately under the NHS Emergency Measures to respond to the pandemic.

3.1.3 The delivery arrangements for tranche 2 were aligned to the wider programme of vaccination transformation with the HSCPs in Scotland taking over operational delivery. Overall governance for all immunisation programmes sits with the newly established NHS Lothian Immunisation Oversight Board chaired by the Deputy Director for Public Health (the governance structure is set out in appendix 1).

3.1.4 The clinical governance around the administration of any vaccination is determined by "the Green Book" this is a national publication setting out the prescribing and

administration criteria for every type of immunisation. The green book is updated following any change in advice from the Joint Committee for Vaccination and Immunisation (JCVI).

All vaccinators, medical and non medical registrants and non registered vaccinators are required to follow the protocols of the Green Book, as described in Patient Group Directives (PGD) or the National Protocol (NP). All non medical personnel are required to physically sign each iteration of the PGD or national protocol and the Board is responsible for the retention of these signed documents. There have been over 30 iterations of the PGD and NP throughout the Covid campaign as these require to be updated when advice changes or further cohorts identified.

3.2 Tranche 2 Vaccination Cohorts

3.2.1 The delivery of the routine winter flu vaccination and covid booster / 3rd dose is known as Tranche 2. In parallel the "evergreen" element of the programme – the continued access to a first or second Covid vaccination for those who become eligible by age and those who have previously opted out but choose now to opt in is being delivered.

3.2.2 The cohort eligible for flu vaccination has been expanded and the inclusion of a Covid booster (or 3rd dose for individuals with specific conditions rendering them immunocompromised) added to the complexity of the programme that was to be delivered. Table 1 illustrates the increasing cohorts and appendix 2 sets out the summary of the programme as cohorts are eligible in different timelines, to different vaccines and / or different doses and can access their vaccination through different routes.

Table 1 Flu Vaccine Cohorts (F) Covid (C) Covid Booster (B) / 3rd Dose (T)

	2019	2020	2021
Adults over 40 - 49			C B
Adults over 50 - 65			F C B
Adults over 65 (includes care home residents and housebound in this age group)	F	F	F C B
People 6/12 – 18 years with an eligible health condition		F	F
People 18 – 64 years with an eligible health condition	F	F	F C B or T
People living with persons previously shielding		F	
Pregnant Women		F	F C B
Healthcare workers	F	F	F C B
NHS Independent Contractors & Support Staff			F C B
Social Care Workers delivering direct care		F	F C B
Social Care Support staff			F C B
Unpaid Carers		F	F C B
Young Carers			F C
School teachers & pupil facing support staff			F C
Prison Population			F C
Prison Officers & Support Staff			F C
Children aged 2 – 5			F
Primary School Pupils			F
People aged 12 - 15			F C#1
People aged 16 – 17 (12 week gap between #1#2)			F C#1 #2

3.2.3 The JCVI have recently recommended the inclusion of 40 – 49s to the booster programme and a second dose for 16 -17 year olds adding a further level of complexity to the tranche 2 programme with further cohorts potentially being added to the covid arm and not the flu vaccination arm.

3.3 Vaccination Workforce

3.3.1 The vaccination workforce for tranche 1 was made up largely of staff being redeployed from other duties (furloughed), retirees and returners engaged on fixed term / supplementary staffing contracts. 358 wte were engaged through fixed term contracts to the end of August 2021 were offered, as at the time of recruitment in December 2019 / January 2020 there was no indication of a booster programme leading on from the primary vaccination. There have been further extensions until end October then until the end of March 2022 as the extent of the programmes unfolded. The remainder of the staffing required is sourced from Supplementary Staffing (bank vaccinators).

Moving into tranche 2 the workforce comprised 129 wte registered vaccinators and 42 wte non registered in fixed term contracts with c 100 wte from supplementary sources.

The successful MACA request for tranche 2 has provided an additional resource to the Lothian wide delivery plan. MACA was used on two occasions during the tranche 1 programme. MACA support is available until early December 2021, the national delivery team have submitted a request to the MOD to request an extension to this support to NHS Boards.

3.3.2 NHS Lothian was a pilot site for the non registered vaccinator workforce (drawn from applicants without a health care background) and successfully trained 34 non registered vaccinators using nationally developed materials and on the job training at the Lowland Hall.

3.3.3 Recruitment to employ the sustainable workforce is underway for the vaccinators and some of the support staff (Comms, pharmacy, facilities etc). A proportion of the funding has been released by the Scottish Government to support this recruitment.

Scottish Government are working with Boards to understand the quantum of the workforce required to deliver Vaccination Transformation with the assumption that Covid boosters will be an annual event in the short / medium and potentially long term.

Work is on-going to complete a further sustainable workforce return which is due for submission to the Scottish Government on 25th November.

From 24th November, NHS Boards are required to submit to the Scottish Government daily workforce returns coving the period 22nd November to 26th December (to be updated daily) to include details:

- Vaccinators Confirmed Rostered (WTE)
- Vaccinator Vacant Shifts (WTE)
- Daily Vaccination Capacity (total number of vaccinations able to provide each day)

3.4 Tranche 2 Timeline

3.4.1 In March 2021 the Scottish Government issued SGHD/CMO(2021)7 which described the flu programme as a strategic and Ministerial priority and stated that "all those eligible should be offered the flu vaccination as soon as possible so that individuals are protected when flu begins to circulate". Guidance from Scottish Government requires flu vaccination be completed by 20th December.

3.4.2 In response to the national priority to see flu vaccination delivered as early as possible NHS Lothian began administering tranche 2 vaccinations with a winter flu campaign for the over 70 age cohort including care home residents and housebound on 20 September 2021. At the time these vaccinations were being scheduled the NHS was still awaiting JCVI advice on the programme for covid booster/ 3rd dose.

The decision to proceed with the flu campaign was taken at the Flu and Covid Vaccine Programme Board with the support of Public Health. This decision was founded in the delivery of an effective flu campaign before what was widely reported to be a potentially very virulent flu season, a risk that remains. It was further agreed that the HSCPs would move to coadministration for all eligible patients on the receipt of updated advice

3.4.3 The Scottish Government provided a policy statement regarding Covid Booster/3rd dose on 17th September 2021 via the issue of a CMO letter SGHD(2021)25, followed by revised PGD / National Protocol being issued on 18th September 2021. The first covid boosters / 3rd doses were scheduled to begin around 2 weeks later.

3.4.4 Further communications from Scottish Government Director of Delivery (FVCV) on 3rd November required all Boards across Scotland to increase capacity for tranche 2 from week beginning 22nd November through to the 20th December to ensure that the tranche 2 vaccinations could be completed before Christmas. A plan was submitted in line with the Scottish Government request and was followed up by discussion at the Scot Gov / NHS Lothian Performance Monitoring meeting.

The ask of NHS Lothian was to run our capacity at 144%. This level of increase is not possible and NHS Lothian have intimated to the Scottish Government that the tranche 2 current cohorts will complete by the end of January 2022.

Table 2 below provides a summary of capacity, booked and available appointments over the coming weeks to support citizens who come forward to self-register for vaccination.

Table 3 provides a summary of eligible cohorts who have not come forward to self-register for a vaccine appointment. As yet, there is no confirmation from the national programme team if citizens who do not come forward to self-register will be issued with a vaccination appointment letter.

Table 2 Capacity and Utilisation of Appointments

weeks commencing 29 November 2021 - 20 December 2021				
HSCP capacity	**w/c 29 Nov**	**w/c 6 Dec**	**w/c 13 Dec**	**w/c 20 Dec**
East Lothian	4,922	4,922	4,462	3,281
Edinburgh	25,172	25,172	15,344	7,596
Midlothian & Other/Unknown	6,552	6,144	6,552	4,360
West Lothian	10,855	10,855	10,855	6,063
	47,501	**47,093**	**37,213**	**21,300**
Appts booked (as at 22 Nov)	46621	22931	16949	3163
Available appts	**880**	**24,162**	**20,264**	**18,137**

Table 3 Numbers by Cohort Not yet booked via portal

COHORT	**Number remaining to self-reg**	**Note**
People Aged 50_to_59	61,722	Portal opened on 15th Nov 21
NHS Staff	9,766	
Social Care Staff	9,786	
Unpaid_Carers	3,660	

The Scottish Government have instigated weekly acceleration meetings to discuss plans and review performance. HSCPs continue to review plans to identify potential to increase vaccination capacity, however workforce continues to be a significant risk and rate limiting factor to expansion plans. To date, the following actions have been taken or are being explored:

- Edinburgh – extension of Ocean Terminal shopping centre venue for 6 vaccination stations to mid-January 2022.
- East Lothian – increase in vaccination capacity for the next two weekends and clinic at North Berwick each Tuesday workforce permitting
- West Lothian – weekend clinics at Strathbrock Health Centre
- Midlothian – extension of working day to 8pm every day at Eastfield. Exploring potential to increase from 7 vaccination stations to 9 vaccination stations at Midlothian community hospital.

3.4.5 A further CMO letter outlining extension of Covid booster vaccination to those aged 40-49 years and 2nd Covid dose for 16-17 years and programme acceleration was issued on 22nd November 2021 (http://www.sehd.scot.nhs.uk/cmo/CMO(2021)33.pdf_)

Data review has been undertaken which indicates of those aged 40-49 years 18,329 will be due a booster vaccination and 6,714 aged 16-17 years will be due a 2nd dose vaccine by 26th December. The Scottish Government will confirm when self-registration for these ages will go live.

3.5 Safe Care

3.5.1 In Tranche 1 in excess of 1.2 million covid vaccine doses were administered and to date (as at 18 Nov 2021) 215,540 Flu and 177,899 covid third dose/boosters have been delivered.

3.5.2 Issues which have been flagged up in the media as problems in the programme of delivery are related to mechanisms put in place to ensure delivery of a safe programme of vaccination.

3.6 Incidents and Adverse Events

3.6.1 There are systems and processes in place support a culture of continuous improvement. The learning from each incident and the adverse event have shaped the practice across all the vaccination centres.

3.6.2 A Quality and Assurance group has been set up, reporting directly to the Flu and Covid Vaccination Programme Board.

The purpose of this group is to support the delegated delivery to the HSCPs by providing a corporate approach to the quality and safety assurance processes. A review by a Senior Nurse of all existing arrangements has been undertaken and a number of recommendations to implement improvement actions are being taken forward to ensure standardised safe practice. The assurance tool is now being used.

Through these processes improvements will be taken forward and a regular weekly Quality Group, comprising the Clinical Leads, will ensure that each site operates according to consistent protocols and that concerns are identified, managed, resolved and learned from timeously.

A dashboard has also been created by analytics for the group to monitor performance data, specifically the dashboard will play a key part in measuring the effectiveness of outputs/actions contained with plans that have been developed from site quality assurance framework.

3.6.3 There are daily safety huddles on every site at which a standardised template is used to ensure that every huddle covers the key messaging. Additional huddles take place before every shift start to ensure that all vaccinators are up to date with any changes that have been adopted since their last vaccinator shift – particularly around the Green Book / PGD or National Protocol. The huddle tool was amended following the Significant Adverse Event to ensure that vaccinators are made aware of the date of any update to the Green Book / PGD / national protocol.

3.6.4 There is a daily huddle across all 4 partnerships to review the operational details, to deploy staff for that day and to plan for staffing shortfalls in the coming days and to share / exchange any learning from issues arising.

3.6.5 There is a weekly operational meeting and a fortnightly Programme Board through which any escalations are reported, risks considered and mitigations agreed.

3.6.6 There have been 419 incidents recorded on the Datix system (c1.5m Covid vaccines administered). One incident affected 144 people receiving the wrong dose for their 3rd dose (they received a booster dose). It was confirmed by national experts that there was no harm or clinical impact on the efficacy of this for this group. The next four most frequently occurring are described in table 4 below. All other incidents have occurred in less than 25 occasions (out of the 1.5m doses recorded).

Table 4 Incidents & Adverse Events

Incident Description	Number of Datix Records	Number of People Affected
Received booster dose rather than 3rd dose of vaccine	1	144
Reaction to Vaccine	84	84
Received different vaccine for 2nd dose to that given in 1st dose	51	51
Vial Contamination	34	0
Needlestick injury (Staff)	28	28

3.7 Effective Care

The effectiveness of the tranche 2 vaccination programme is demonstrated by the uptake of vaccination and the impact of the vaccination on the spread of disease. The scheduling and appointment system, the access to support through the national and local helpline and the efficiency of the centres when people attend for the vaccination all underpin the objective of delivering a health benefit from the vaccination programme.

3.7.1 The National Vaccination Scheduling System (NVSS) is used to build all clinic appointments and to issue invitation letters to the public.

3.7.2 The situations which have arisen around appointment scheduling have been largely down to the increasing complexity in the programme combined with there not being a single data source that accurately defines the cohorts.

NHS Boards are required to use the National Vaccination Scheduling System (NVSS). This system has fixed timelines for clinic build and cohort appointments.

NHS Lothian is working at least 3 weeks ahead for lettered appointments; Lothian is the only board area that work 3 weeks in advance and this is to mitigate against people being sent appointments outwith their partnership area.

A national self-registration portal is only currently available for self-declared staff groups and people who self-register within defined permitted cohorts; this facility offers booking into available appointments from 24 hours ahead.

Together these scheduling processes result in a capacity management conundrum; providing sufficient capacity for self-registration and / or locally directed appointments via the call centre to occur there must be unused capacity whilst utilising all the available appointments to deliver vaccinations to the eligible groups within target dates. Table 2 (above) illustrates that NHS Lothian is maintaining a positive balance of available appointments for people booking.

Cohorts for scheduling are constructed by NHS Lothian analytical team based on eligibility criteria for flu and Covid boosters.

There is limited time in this national process for checking the output of a schedule. The team checks overall clinic capacities match with the level of appointments requested and ensures patients have been appointed within their own HSCP area. No other checks are routinely completed as the outputs needs to be signed off for letters to be sent within the same day.

Any issues identified during these checking processes need to be manually moved by NVSS or the entire cohort file(s) removed and rescheduled which would delay the issue of letters and would negatively impact the timing of subsequent scheduling runs for NHS Lothian and other NHS Boards, due to the NVSS resource required to rework the cohort.

The complexity of the scheduling system has resulted in 3 issues that have required intervention.

Table 5

Issue	Situation	Mitigation	Impact
Booster Invites Sent Too Early	5000 invitations for booster doses were issued to a cohort of adults in the clinically extremely vulnerable who had already had their 3rd dose vaccine and would not be eligible for any booster until 24 weeks after the date of their 3rd dose. This was due to the invite logic being based on second dose dates initially.	The error was identified very quickly, text messages were sent advising of the error BEFORE the appointment letters arrived with the individuals	People were able to utilise the appointment for a flu vaccination if they had not yet received it
Inability to Issue Vaccine Passport	c 7000 people in Lothian being unable to obtain a vaccine passport. c 600 records require a clinical review to resolve the issue with their record	A dedicated admin team have been reviewing records and correcting records where possible, the remaining records are pending a national solution.	Inconvenience for individuals
Failure to invite Cohort	At risk 2-5 year age group who were not issued with a flu vaccination appointment invitation via the national appointing system.	Additional clinic capacity was created	Children were appointed with dates which exceeded the programme completion timeline by one week

3.7.3 In tranche 1 there were in excess of 20 000 appointment letters returned to NHS Lothian as "not known at this address". The lists that are used for all tranche 1 and tranche 2 appointments are lifted from CHI, which is sourced from GP practice lists. The inaccuracies of these data sources will continue to impact on subsequent cohorting until individuals contact the helpline / their own GP to amend their personal details. There is now a daily feed of GP data into the national cohort files so changes are picked up straight away.

3.7.4 The national self-registration portal opened on 15th November for all over 50 year olds and the over 16 years unpaid carer cohorts in addition to the currently available self-declared staff groups and people who self-register. 143,000 appointments have been made available for self booking in Lothian with current nearly 20,000 appointments self-booked during the first week.

3.7.5 The effectiveness of the programme however from a public health and patient perspective is around the efficacy of the vaccine and the impact on immunity and spread of the disease. Tables 6 and 7 show progress towards the uptake target.

Table 6 Flu Vaccination Update by Age Group / Cohort

Cohort	% Uptake (based on population estimates)	National Uptake Working Assumption
Age 70 and over	84.2%	90%
Clinically Extremely Vulnerable or Severely Immunosuppressed	73.9%	65%
Age 50 – 69	33.9%	65%
Age 16 – 64 who are in flu at risk group	30%	65%
Pregnant Women	64.3%	70%
Pre school Children (2 – 5 years)	64.6%	70%

Table 7 Covid Vaccine Boosters Administered by Board

Board	Covid Boosters Administered (% fully vaccinated)
NHS GG&C	21.1%
NHS Lanarkshire	27.9%
NHS Lothian	21.2%
NHS Tayside	31.7%

3.8 Person Centred

3.8.1 The provision of local centres in tranche 2 has been central to the HSCPs delivery campaign. Edinburgh H&SCP relied on 80% of the capacity focussed at the Lowland Hall and have taken steps to open a further centre in the Ocean Terminal Shopping Centre on 8th November and are pursuing further options to provide more accessible locations. The other sites for Covid booster in Edinburgh are operating on a Monday to Friday basis at local centres such as Leith CTC, Pennywell, Tollcross and Craigmillar. In addition, Edinburgh have used the Bus regularly at Fort Kinnaird, Waverly Bridge and on other sites for the evergreen programme.

3.8.2 A local helpline was established early in tranche 1 to resolve individual problems. A range of solutions have been incrementally put in place to allow the local helpline to resolve individual difficulties with appointments.

3.8.3 The stewarding staff on sites are available to assist people attending and the volunteers guiding can identify people needing additional support. In order to deliver a person centred service and recognising that some people have differing needs the larger centres where queues can develop have instigated a “frailty fast track” and booths outwith the main hall for those with an anxiety.

3.9 Performance

3.9.1 NHS Lothian performance against national comparators. This is illustrated at figure 1 and figure 2.

Figure 1

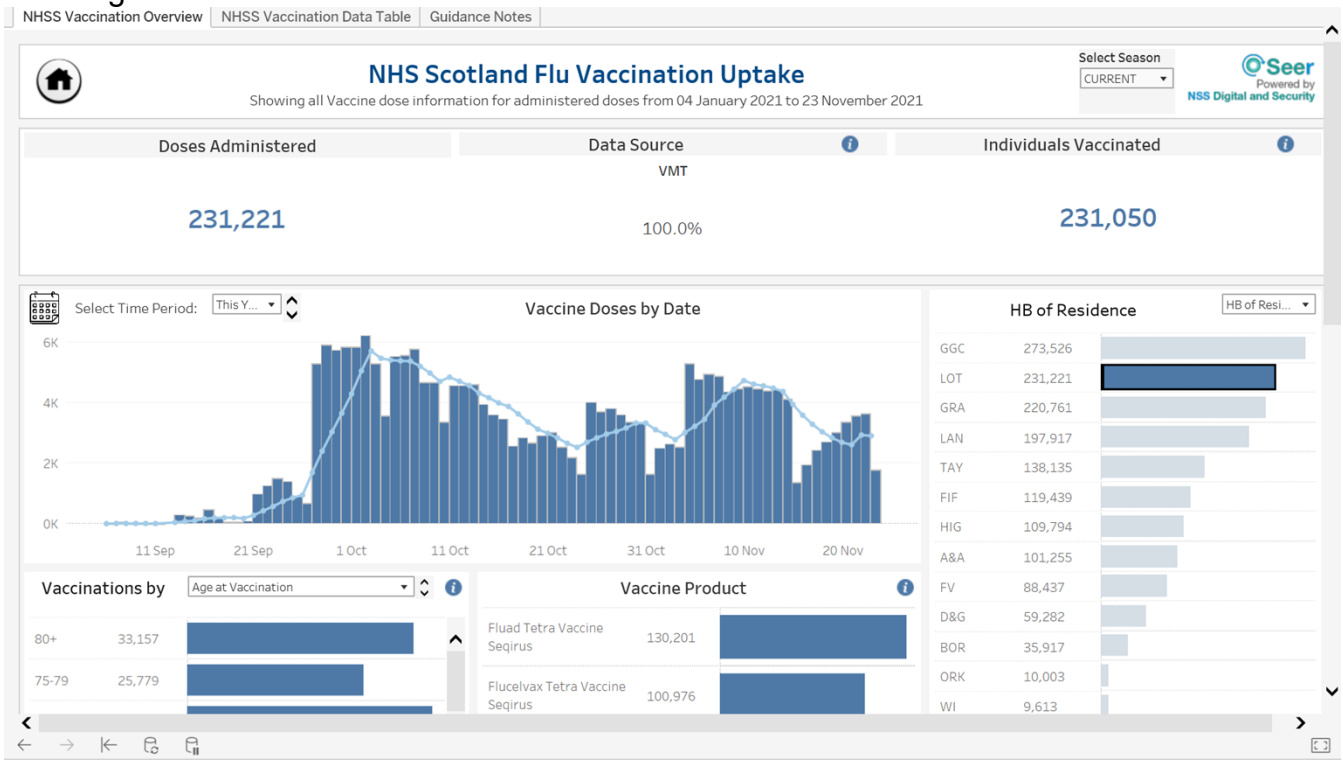
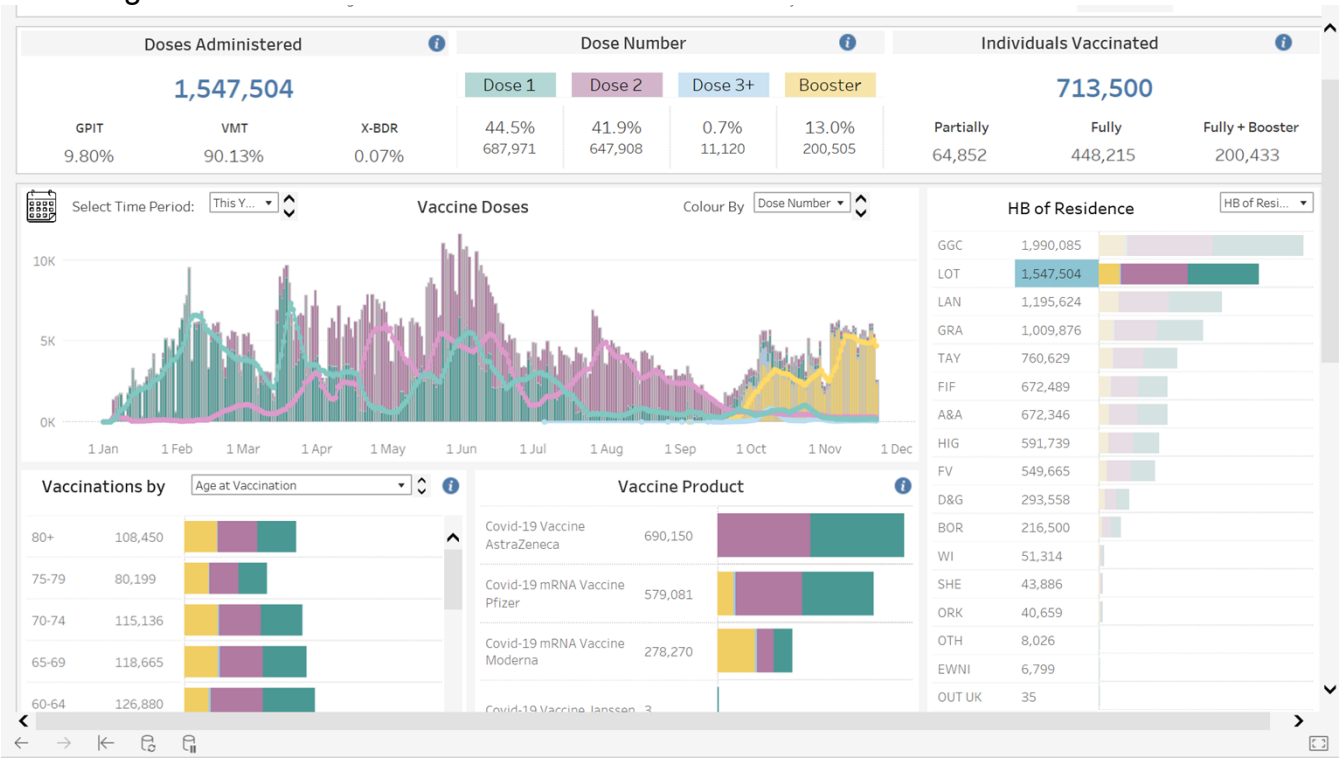


Figure 2



3.9.2 There are national and local dashboards illustrating NHS Lothian's performance against the national uptake assumption by cohort and analysis of the cohort that remain unvaccinated to allow targeted efforts. Examples of the dashboard data is included at figures 3 to 5

Figure 3 Flu Vaccination Uptake for Age 70 and over by HSCP (as at 21 November 2021)

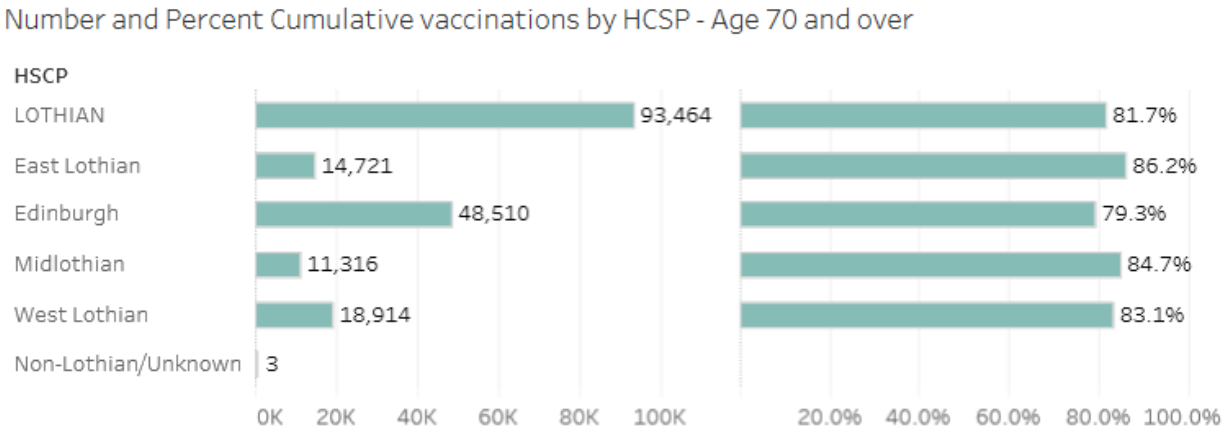


Figure 4 Covid Booster Uptake for Age 70 and over by HSCP (as at 21 November 2021)

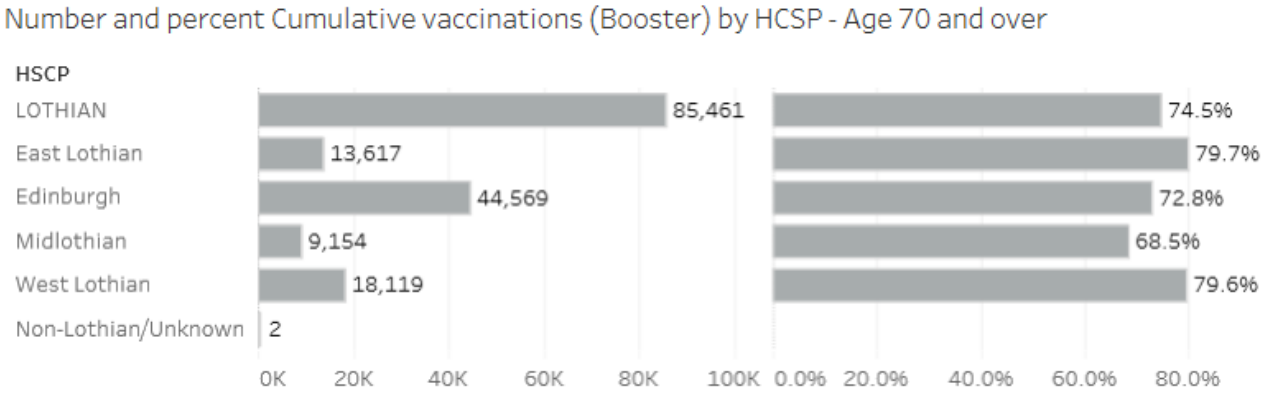


Figure 5 Covid Booster – number vaccinated and percentage by group (Lothian, as at 21 November 2021)

Group	Number Vaccinated	Population Estimate	% coverage
All adults	193,171	NA	NA
Age 70 and over	85,461	114,698	74.5%
Clinically extremely vulnerable	10,736	24,982	43.0%
Age 50-69	77,241	232,075	33.3%
Adults age 16-64 who are in a covid at-risk group*	38,600	137,197	28.1%

* Please note these figures only include those identified in national cohort files
Please note that some dose 3 vaccinations are being incorrectly recorded as boosters. Work is ongoing to address this issue.

4 Key Risks

4.1 The Flu and Covid Vaccine Programme Board Risk Register is reviewed each week through both the Operational Group and Programme Board with risks mitigated at an operational level.

4.2 There is a national imperative to increase delivery and whilst the public health advice is that we need to vaccinate people as quickly as possible, it must be done safely, both for the people receiving their vaccine and staff. Option for acceleration are subject to a risk assessment to ensure that pace is not at the expense of safety.

5 Risk Register

5.1 There are no risks escalated to the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 An initial Covid vaccination Integrated Impact Assessment was undertaken on 8 December 2020 with continued review undertaken through the Covid Vaccination Public Health Sub Group.

6.2 An NHS Lothian Inclusive COVID-19 Vaccination Plan was developed and finalised at the end of March 2021 which provided an outline of specific barriers to vaccination that may be encountered by each group, recommendations of how these barriers could be overcome and an update of what actions have been undertaken or are planned by NHS Lothian to put these recommendations into action. Plans continue to be reviewed on a regular basis and adapted as more information on vaccine uptake becomes available.

6.3 NHS Lothian's Head of Equalities and Human Rights prepared an update paper, distributed in early October 2021, which includes details of Covid enhanced response and support provided to communities to access vaccination.

6.4 A national flu and Covid vaccine integrated impact assessment was undertaken on 11 August 2021, the output of the assessment was recently shared with NHS Boards and discussed at the Lothian Programme Board on 12th October. It is anticipated NHS Boards will receive a request to submit an update inclusive plan to the Scottish Government in the coming weeks.

6.5 Whilst impact assessments are under continual review, the national scheduling system appoints on the basis of an assumption that all citizens have access to a vehicle to drive to vaccination appointments. The national system algorithm appoints to closest venue based on peak driving time. NHS Lothian vaccination call centre continues to support citizens to reschedule appointments as required. The findings of the IIA and subsequent reviews have been instrumental in determining the delivery routes for the programme, including using local faith communities and outreach to ensure that the vaccination programme is as inclusive as possible.

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

7.1 The programme team continues to inform and engage with people accessing the vaccination programme through regular review and update of NHS Lothian, HSCPs and Council internet sites, NHS Lothian's intranet site and via daily social media posts.

Weekly meetings take place to discuss enquiries and to review and update Frequently Asked Questions available on NHS Lothian's intranet pages and website

8 Resource Implications

8.1 The resource implications associated with delivery of Covid and flu vaccination to date are detailed in Table 8 below.

8.2 Scottish Government have issued a preliminary letter intimating the level of ongoing budget that will be made available to Boards to create a sustainable workforce to deliver the vaccination programme. Work is ongoing to reconcile the indicative budget to the workforce profile.

Table 8 Programme Delivery Costs to Date

Programme Delivery	**Estimated Cost**
Tranche 1 - 1st and 2nd dose Covid Vaccination	£24.5m
2021-22 Expansion of Flu Programme (Secondary Pupils, School Staff, Prison Staff and Prisoners c75,000 vaccinations)	£2.4m
Tranche 2 Covid Vaccine Booster Programme and Full Cost of Extended Flu Programme (Covid Vaccination c450,000 and Annual Flu Vaccination c320,000)	£12.8m

Alyson Cumming
Programme Manager
23 November 2021
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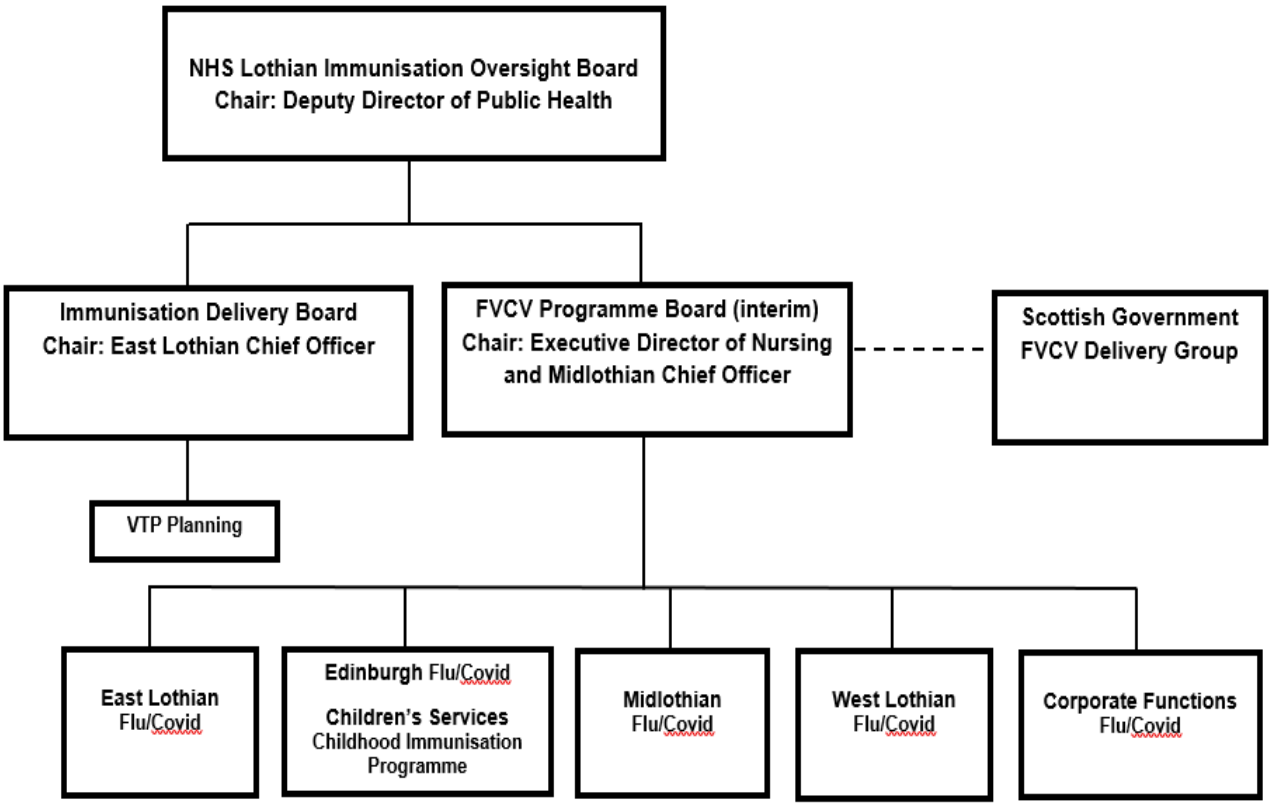
List of Appendices

Appendix 1: Immunisation Programmes Governance

Appendix 1: IMMUNISATION PROGRAMME GOVERNANCE



Meeting Name: Board Meeting date: 1 December 2021

Title: BOARD EXECUTIVE TEAM REPORT - DECEMBER 2021

Purpose of the Report:

DISCUSSION		DECISION		AWARENESS	X

The aim of this report is to update Non–Executive Board members on areas of activity within the Board Executive Team Director's portfolios.

This report also includes contributions from Integration Joint Board Chief Officers. Directors have been invited to focus on key strategic / operational issues to bring to the attention of Non–Executive Board members, not otherwise covered in the Board papers.

Recommendations:

The Board is asked to receive the report.

Authors: Executive Team **Date: 19.11.21**	**Director: Calum Campbell** **Date: 19.11.21**

LOTHIAN NHS BOARD

Board
1 December 2021

BOARD EXECUTIVE TEAM REPORT

Aim

The aim of this report is to update non – executive Board members on areas of activity within the Board Executive Team Director's portfolios. This report also includes contributions from Integration Joint Board Chief Officers. Directors have been invited to focus on key strategic / operational issues to bring to the attention of non – executive Board members, not otherwise covered in the Board papers.

1. Chief Executive

1.1 **System Pressures -** The NHS Lothian system continues to remain under considerable and sustained pressure. The Pan Lothian 4 Hour Compliance rate for October 2021 was 67.6%. The comparable September 2021 position was 69.6%. The 12 week and 52-week Outpatient breach position has shown a very small improvement. The 12-week October position was 41215 against 41984 for September and for 52 weeks the October position was 6713 against 7059 for September. Since July 2021 P3 and P4 patients have had their surgery cancelled with the same being the case for Paediatric patients over the last 12 weeks. LUCS continues to perform well although staffing remains tight.

1.2 The demand for staffing for vaccination clinics and Test and Protect as well as winter pressures is placing considerable demand on the service and system. In addition, Mental Health Old Age Psychiatry services are operating consistently at 100% bed capacity as is the Melville Unit.

1.3 **Delayed Discharge Flow -** NHS Lothian is experiencing a period of significant hospital flow pressures due to a combination of sustained front door attendances, increased delayed discharges and staffing issues previously described. This is resulting in high occupancy levels across our Acute Adult Hospital sites, increasing congestion within our EDs and front door and increasing wait time for patients awaiting admission. These high occupancy levels have resulted in a number of services being reduced, postponed and some bed closures to support safer staffing levels. There is significant stress across the system at the moment and very difficult clinical decisions are having to be made every day. Actions currently being considered are being balanced against our system responsibilities over the longer term to ensure people's needs are preserved.

1.4 GOLD Command has requested that the HSCPs develop a proposal to facilitate the transfer of patients who are delayed from a planned discharge being transferred to a temporary Care Home placement until more appropriate care can be sought in the community. Communications and consultation with

patients and their families will be central to this initiative and our Chief Officer cohort will collaborate on the process and procedures to be adopted and formal approval to proceed will be through our GOLD command group. It should be noted that the majority of our Care Homes are independent providers who are able to choose whether or not to admit patients and this will be a key limiting factor to this proposal. The NHS Lothian GOLD command structure is currently in play and will continue to scrutinise and review the position as it evolves and responds to the actions being implemented.

1.5 **Annual Review -** The Lothian NHS Board Annual Review with the Cabinet Secretary was held on 8 November 2021. This was attended by myself, the Chair, the Chief Executive and Director General of the NHS in Scotland and the Chief Operating Officer Health and Social Care NHS Scotland. The Review went well and once the formal follow up letter has been received this will be shared with Board Members and published.

1.6 Scottish Government colleagues had been complimentary about the hard work and commitment of staff during the Pandemic. The 2021 achievements around the Pandemic Response had also been recognised. In addition, the opening of the 24/7 Paediatric Unit at St John's in October 2020 and the full opening of the RHYCP and DCN in March 2021 had also been welcomed.

1.7 Scottish Government colleagues recognised challenges anticipated around winter in the coming year.

1.8 **COP26 -** COP26 was held at the SEC in Glasgow from the 31 October until the 13 November 2021 under the presidency of the United Kingdom. It was attended by around 140 Heads of State and approximately 30,000 delegates, including Ministers, businesses, Non-Governmental Organisations (NGOs) and media. A large number of activists travelled to Glasgow and held protests across Scottish cities including Edinburgh.

1.9 As part of the planning arrangements, NHS Lothian held several training events and exercises. In addition, NHS Lothian was a member of member of the COP26 Edinburgh Working Group and COP26 Healthcare Planning Group.

1.10 Lothian had around 60 world leaders staying for the first 3 days of the conference, none of whom required medical treatment. There were no disruptions to any NHS Lothian services and all protest events within Lothian passed peacefully.

1.11 **Scottish Health Awards 2021 –** The Scottish Health Awards are the most prestigious and recognised awards for those working across NHS Scotland and its Partners to deliver high quality health and social care services to the people of Scotland. These awards are now well established and recognise those that go the extra mile to improve the health and wellbeing of others. The announcement of this year's winners was made on 4 November 2021.

1.12 I would like to recognise the efforts of all the staff and teams across Scotland who were nominated under each of the sixteen categories. I am particularly delighted to report that the Doctor Award was won by Dr Gourab Choudhury a Respiratory Consultant Physician in Lothian. The other winner linked to us under the Top Team Award was Harlawhill Day Care Centre which is third sector but supported by East Lothian HSCP. Judy Newton, Nurse Consultant in MND for Scotland and manager at the Anne Rowling Clinic was nominated for Leader of the Year.

1.13 **NRAC (National Resource Allocation Committee)** - For 21/22, NHS Lothian remains behind NRAC parity by 0.8%, equating to a value of circa £14m. Since 2015/16, Lothian has received over £80m less funding than NRAC parity would provide (cumulative). For 21/22, this cumulative shortfall increases to £100m. On the basis the SG maintains a 0.8% limit on parity funding as it has done in prior years, the NRAC funding stream we have received annually over a number of years will cease, at least temporarily for 22/23.

1.14 The additional NRAC funding received in recent years has been driven by a rising NRAC share in Lothian, rather than closing the parity gap. Stabilisation of Lothian's NRAC share at a 0.8% gap will result in no future additional NRAC funding for NHS Lothian. Based on the latest update to NRAC eight territorial boards (including Lothian) are behind NRAC parity with six Board's ahead.

1.15 With the number of Boards behind NRAC parity now in excess of those ahead, the challenge of returning all Boards to a parity position is more difficult. Getting boards that are currently behind their NRAC share to parity can only be delivered by returning those boards ahead of parity to equilibrium.

1.16 The impact of the shortfall in funding has resulted in a care deficit within Lothian and is evidenced by the challenge of delivering scheduled and unscheduled care targets that impacted even before Covid. Recently the Scottish Government has allocated resources disproportionately to reflect need (Substance Misuse funding based on numbers of drug related deaths, Covid funding based on costs incurred) and there remains an opportunity for the SG to redress the NRAC imbalance created by continuing to apply the principle of resource allocation based on need, particularly to Access resources where these are additionally available in 21/22.

1.17 Negotiations are continuing with SG colleagues to ensure that appropriate funding streams recognise the unique imbalance in funding impacting on NHS Lothian over a number of years. However, it is clear that our ability to recover from the impact of Covid and the legacy of our NRAC driven care deficit will place a greater burden on our services to achieve national performance targets in the future.

2. Deputy Chief Executive

- **Reprovision of Eye Services:** After a significant programme of work and detailed collaboration with Scottish Government (SG) colleagues NHS Lothian has received written approval from SG to proceed to Full Business Case following submission of a revised Outline Business Case earlier this year. An Options Appraisal / Feasibility Study has identified a suitable site in the Edinburgh Bioquarter. The appropriate plot has been allocated to us and negotiations to acquire it from the vendor- Scottish Enterprise- have begun. We are currently assembling a project team, lead adviser and both operational and clinical staff who will review the Board Requirements (technical and clinical) with comprehensive governance before our Principal Supply Chain Partner (PSCP) commences the process to full business case (FBC). Given the passing of time since the procurement of the previous PSCP and change of site there may be a requirement to re-tender for PSCP services rather than re-engage. The Board, with advice from CLO and HFS, are currently considering the balance of risk in relation to a legal challenge from an aggrieved PSCP against a programme prolongation of up to four months with associated inflationary cost increase. Later in the programme timeline, we will see a submission to Scottish Government of a FBC in the summer of 2024 with full operational status being achieved in late 2026.

- **National Treatment Centre (Lothian):** Approval to progress to Full Business Case in respect of the Short Stay Elective Centre - now named the National Treatment Centre (Lothian) – has also been received. This follows the conclusion of a study into the potential merging of the Eye Pavilion and the National Treatment Centre. This study concluded that a separate Eye Hospital in Edinburgh remains the optimum solution. As with the Eye Pavilion reprovision project, we are assembling a project team, lead adviser and both operational and clinical staff who will review our technical and clinical requirements with comprehensive governance before re-engaging with the current Principal Supply Chain Partner in the second quarter of 2022. Finalisation of the clinical model and brief remains the first priority to deliver an optimal operating model in relation to maximised theatre throughput, the use of technology such as robotic assisted surgery, enhanced recovery after surgery, reduced length of stay and patient initiated review. The facility will deliver flexibility to accommodate future changes to the clinical model, whether via an expansion of in scope procedures or specialties. The Full Business Case is expected to be submitted in the summer of 2024 with full operational status being achieved in late 2026.

- **Cancer Centre:** We have recently completed a further round of queries and clarifications with the Scottish Government Cancer Policy Team about our Internal Audit. These have all been addressed or will be by the review of the data and proposed service model by an external Healthcare Planner. The scope of works to be completed in a twelve week review includes:
    - Undertake a review of the outputs from 2018 service redesign workshops through re-engaging with stakeholder groups.
    - Define the service requirements for each component of the cancer service model

- Undertake a review of existing data and modelling work completed previously. Using existing local and regional data, assist in the modelling of the demand and capacity requirements to support item 2 above to further define the capacity required at each level / service area.
- Assess and remap future health and care services demand across the services across the region.
- Identify and appraise configuration options to deliver the required services.
- Define the infrastructure required to deliver the above, including inpatient beds, day case numbers and outpatient attendances.
- Scope the workforce requirements to deliver the above.

The above will all then feed into the first output of planning needed to inform the Outline Business Case. The first meeting with the appointed Healthcare Planner is being arranged for the end of November, with the 12 week review to commence shortly after.

- **New Director of Operations (Estates and Facilities) Appointed:** Morag Campbell has been appointed as Director of Operations (Estates and Facilities). She will commence in post from 5 January 2022. Morag brings a wealth of experience having worked both within and alongside the NHS for 24 years. Over the last 13 years she has held a variety of senior roles covering multiple sites and services, including appointments as Director of Estates and Facilities in two different NHS Trusts. Latterly, Morag has been working for Lewisham and Greenwich NHS Trust where she had operational responsibility for all Hard and Soft FM services. We are delighted to welcome Morag to NHS Lothian. Morag's skills, experience and proven track record will be a huge asset to the organisation, particularly as we navigate the ongoing demands of the COVID pandemic. Our Estates and Facilities teams do a huge amount of vital work which can often go unseen, but the role they play is instrumental in ensuring our services can deliver first-class patient care.

3. Interim Executive Director of Nursing, Midwifery, & AHPs

3.1 The interim rotational arrangement to cover the role of the Executive Director of NMAHPs has been in place since 4th October 2021.

3.2 The extant meeting structure / remit for the senior nursing, midwifery and AHP teams have been revised to strengthen and improve the communications and governance across the professions. A NMAHP Senior Management Team and NMAHP Senior Leadership Group have been established. The Senior Management Team comprises the Exec Director of NMAHPs direct managerial and professional reports. The NMAHP Senior Leadership Group includes a wider group including the direct reports and their immediate subordinates coming together in a professional forum.

3.3 **<u>Vaccination Programme</u>** - Participating in the national Future Workforce Group influencing the Scottish Government proposals for the workforce policy to support the Sustainable Workforce for Vaccination Transformation.

3.4 The NHS corporate vaccination programme team are collating the partnership responses to the request on all Boards from the Scottish Government to accelerate the pace at which the flu / covid booster programme is delivered.

3.5 Additional resource has been identified and work continues to address the data anomalies in the national Vaccination Management Tool.

3.6 **Recruitment -** Nursing recruitment continues at pace, with refreshed generic adverts running consistently. There has been an agreement to reinstate the principles of generic recruitment (One application One Interview One Decision) for band 2 / band 5 nursing posts.

3.7 The total number of newly qualified registrants taken on from the 2021 outturn is 592. The underlying establishment gap is, at October 5.15% (the target is to hold the establishment gap at 5% or less).

3.8 Negotiations with the HEIs are working towards increasing the routes giving direct access to year 2 of nurse training, subject to NHS Lothian offering practice placement equivalent hours and support with competency assessment for students undertaking the HNC programme.

3.9 The Director of Midwifery has been offered and has accepted the position of Chief Midwifery Officer at the Scottish Government. Recruitment is underway to seek a replacement for this senior professional advisory role within the Board.

3.10 **Staffing Pressures** - In response to the continuing staffing pressures the NMAHP senior team have developed a Workforce Escalation Framework, bringing together the range of tools to measure staffing /acuity / risk together with a range of potential workforce responses to support wards and departments.

3.11 **Advanced Practice Academies Workshop -** Presented to the National Advanced Practice Academies Workshop showcasing the work being carried out in the East of Scotland, and in particular the development of an Advanced Practice policy in NHS Lothian.

3.12 **Care Homes** - Introduced the first Care Home Collaborative Workshop with c40 participants from across all the services providing a supportive infrastructure to the care homes across Lothian.

3.13 **MEG** - A new electronic system has been launched across all nursing teams for the collection of routine audit data. The Health and Safety audits have been uploaded and this tool will be incrementally populated with all the nursing / midwifery audits. This will enable upload of data to national systems, supporting the Excellence in Care and Patient Safety programme data capture and provides a locally accessible dashboard.

4. Executive Medical Director

- Most of my time has been providing support to teams under pressure with visits or meetings with primary care and secondary care teams, focusing within acute services on discharge processes
- I am very pleased that the HEPMA roll out at St John's is complete and this is a fantastic achievement by everyone involved, considering the pressures on the site
- The Career grade welcome day was a useful opportunity to meet and speak to consultants and specialty doctors just beginning their career in NHS Lothian.
- The Innovation team are continuing to work on developments in care to support improved exchange of information and monitoring of patients' conditions by means other than face to face review, with exciting developments in paediatric asthma and chemotherapy toxicity
- The R and D team have been working with University of Edinburgh colleagues preparing for final presentations to the CSO in the bids for funding for Precision medicine projects. We have three proposals that have reached the final round.

5. Director of Finance

5.1 As a senior finance team we have been focussing on how we develop the medium term financial framework in support of the Strategic framework over the last few months. This now has a much clearer shape and will be considered at Finance and Resources Committee in January, although there is still a significant amount of work required to fully populate and answer the questions set out in the framework. Much of this requires engagement with Service colleagues who have been very focussed on operational pressures. We will continue working with each of the Programme Boards and Scottish Govt on planning assumptions for the next five years, at present no confirmation is available on future year uplift or pay awards. We await the Scottish budget on the 9 December. In parallel we have been finalising the management of the year end position and working with SG colleagues to manage the resource flow over this year and next.

5.2 Following the (almost) conclusion of the organisational change process within Capital I am now working with the Deputy CE and the Senior Programme Director to secure the appropriate level of resource to support the delivery of the NTC and PAEP. In addition we are working with NHS Assure to understand their systems and processes in their scrutiny of capital projects. Inevitably this is adding time to delivery of projects and it is hoped to agree a session with them and the F&R committee to consider respective roles and responsibilities, particularly in the light of the internal assurance processes we are putting in place. Delivery of capital projects is also challenged by supply chain constraints and evidence of cost pressure as a result. This will require to be factored into the future capital programme.

5.3 An appointment has now been made to the Head of PPP contract management although the announcement needs to await the conclusion of the formal paperwork. This individual will bring valuable skills to the contract management

of all our PPP assets and support the work we are doing to improve the performance of the contract for the RIE. A report on this will be brought to the Board following discussion on the strategy at F&R in November.

5.4 Finally we are nearing the end of responding to the requests for information by the Public Inquiry with the exception of those relating to requests for email/all correspondence in relation to some specific topics. Despite the utilisation of a document management system there are still a vast number of documents/emails identified as relevant to the search terms. This will require further dialogue with the Inquiry team. The CLO team have a scheduled meeting with the Inquiry team to discuss witnesses for the May hearings and how statements are to be taken.

6. Director of Human Resources and Organisational Development

6.1 **Staff Wellbeing Support -** Over the last 18 months we have mobilised emotional, pastoral, psychological support for our staff (e.g. peer support network, here 4 u helpline, staff listening service, occupational psychology expertise & services, promotion of online self-help resources), and developed wellbeing spaces in addition to our core occupational health services . In preparation for winter we are focusing on the needs of our staff to rest, refresh and refuel. The recently announced additional funding from Scottish Government will be targeted to this need.

6.2 **Advancing Equalities -** We celebrated Black History Month in October through our social media and staff intranet.

6.3 One of our priorities this year as a corporate management team is to spend more time talking to members of our staff networks. During October we started a small test of change. A simple yet powerful idea to connect people at random and give them time to meet over a cup of coffee /tea, and talk about whatever they wish. This idea is called '***coffee roulette'***. What makes it useful to advancing equalities work is that this approach enables people to talk with others who they might not otherwise meet and allows people to learn from each other, build relationships, breakdown silos and build community.

6.4 Covid-19 has meant that the more casual informal social connections have been reduced, so this will enable people to connect more and promotes a more inclusive and diverse workforce, whilst building networks. Early feedback has been extremely positive and the concept has been well received. The 'test of change' is currently being evaluated before full roll out.

6.5 **Recruitment to Healthcare Support Workers Band 2-3 -** Significant focus for both the HR and Corporate Nursing teams on recruiting additional healthcare support workers to help with system pressures now and over the winter period across the system. It is clear that we are experiencing a slowing of the market for our non-registered support staff and there is stiff competition with other industry sectors, most notable hospitality and retail particularly in Edinburgh. We are working with DWP who have acknowledged that it is

currently a job seekers market, to promote the health and care sectors. We have undertaken significant programmes of work over the last 12 months to widen access routes into health, in particular: modern apprenticeships, Kickstart scheme and skills boost programmes with local colleges and this work continues. We are working closely with the communications team to maximise our social media profile and other promotion.

6.6 We have also targeted retirees and returners but many of these individuals are already supporting our vaccination teams.

6.7 **East Region Recruitment Transformation -** Given the system pressures and significantly increased recruitment activity across the 5 Boards (NHS Borders, NHS Fife, NHS Lothian, SAS and NES) involved in this programme of work, we have decided to pause the change programme to concentrate our resources on the delivery of core recruitment services. It is anticipated that the change programme will re-commence in April next year.

6.8 **Celebrating Success – Staff Awards -** The virtual celebrating success event for 2020 took place on the evening of 28th October to recognise and celebrate the extraordinary efforts of our staff every day. We will shortly be opening the nominations for 2021.

7. Director of Public Health and Health Policy

7.1 **COVID-19:** Lothian reached a peak rate of 750 cases per 100,000 population on 5th September. The rate fell steadily throughout September to reach a low of around 250 cases per 100,000 population on 5th October. Since then, the rate has risen slowly and plateaued, with the current rate 275.3 per 100,000 population (as of 5th November 2021). EDR has fluctuated around 1 and is currently 0.9. The number of PCR tests taken peaked at the end of October and has gradually decreased, with test positivity plateauing. The current positivity is 6.6% (as of 5th November).

7.2 The rate in West Lothian remains higher than the other local authority areas, with a current rate of 382 per 100,000 population. In relation to age specific trends across Lothian, the highest rates during the peak were initially in the 10-19 years, however we are now also seeing higher rates in the 30-39 years and 40-49 years age groups.

7.3 COVID-19 related hospital admissions have continued to fall from the peak in mid-September. There are currently 79 COVID-19 patients across our acute sites and 6 of these are in ICU (as of 5th November). Our local COVID-19 trends have generally mirrored the national picture.

7.4 **Health Protection response**: We have seen a decrease in the number of COVID-19 related situations and outbreaks since the September peak. We continue to prioritise care homes and social care settings, in order to protect the most vulnerable. We managed a relatively large outbreak in a local prison, working with the prison to promote vaccination and ensure good vaccine uptake.

7.5 We have seen an increase in the number of non-COVID situations, which is forming an increasing proportion of the Health Protection Team workload. We expect non-COVID situations/outbreaks to increase further as we head into the winter period.

7.6 **Asymptomatic Community Testing Programme**: Community testing programmes continue to employ an agile response to target testing towards high prevalence COVID-19 areas with our most vulnerable populations. This has involved establishing a network of asymptomatic testing sites which have been supplemented by deployment of Scottish Ambulance Service Mobile Testing Units (MTUs).

7.7 In each local authority area, teams from the council, NHS Lothian, the Health and Social Care Partnership, voluntary and community organisations worked to develop ways of taking testing and vaccination to places and people beyond the mass vaccination facilities and healthcare premises. The NHS Lothian Analytical Services team developed real-time vaccination and testing dashboards which allowed teams in each local authority to target places and population groups where uptake seemed lower. These dashboards incorporated information about age, gender, ethnicity and deprivation. The vaccination buses and vaccination taxis were subsequently deployed to locations across Lothian: places of worship, community centres, schools, universities, football grounds, community gardens, shopping centres and tourist destinations.

7.8 Information seminars about testing, vaccination including advice and support for self-isolation have also been run with vital assistance from third sector partners. Some voluntary sector organisations participate in an LFD Collect network in community locations.

7.9 Lothian Multi-agency Community Testing Silver continues to meet weekly and provides partners with intelligence from local and national dashboards highlighting key Covid data (test uptake, positivity rate, Covid-infection rates by Intermediate Zones, age breakdown, and hospital admissions), as well as up to date data from the Test and Protect, and Health Protection teams.

7.10 **Immunisation Governance -** The governance arrangements for the Immunisation programmes have been reviewed over recent months to take into account learning from the pandemic and the COVID vaccination programme. The new governance structure aims to streamline previous governance arrangements and strengthen the system wide overview of the programmes. The new structure will be live from April 2022 and over the coming months existing groups will transition into the new model.

8. Chief Officer Acute Services

8.1 Acute services remain under significant operational pressure from unscheduled care demand and staffing pressures, similar to pressures across the whole Health & Social care system. Clinical prioritisation of patients continues to be the key focus for all services, to ensure the most urgent patients receive their treatment. Outpatient activity is exceeding pre-Covid levels and the waiting list backlog of routine, non-urgent patients that built during the Covid lockdowns is now reducing across a number of specialty areas. However, due to the staffing pressures impacting on bed and theatre capacity, inpatient and daycase activity remains below pre-Covid levels, resulting in increasing waiting times and numbers of patients waiting.

8.2 Within our laboratory service, work and run-rates for combined laboratory Covid testing at the Royal Infirmary Edinburgh (RIE) and Hub sites continue to be high at an average of 4,000 tests per day, and this remains steady as we move into winter. Planning for winter 2021/22 is entering its implementation phase, aimed at readiness status for mid-November 2021. Laboratory systems are prepared for any Flu or associated respiratory virus testing in combination with SARS-COV2 (Covid) testing. Work continues to expand Point Of Care Testing (POCT) at the 'front-end' of Acute sites, allowing quicker decisions to be made on patient flow, infection control and patient placement, using rapid PCR and Antigen technology. Staff are being recruited to a POCT co-ordinating team to support frontline colleagues.

8.3 NHS Lothian continues to work with the Scottish Government and National Services Scotland to deliver the next phase of pandemic testing, which will focus not only on securing screening capacity, but also now on how to expand ability to detect variants through 'whole genome sequencing'. Whole genome sequences will allow mutations to be identified and tracked, and aid with evidence to verify that vaccines are working. Whole genome sequencing although live at present is now also on track to deliver over 1000 virus sequences by mid-November, with the recruitment of further science colleagues, and delivery of the final pieces of robotic equipment.

8.4 Within the Royal Hospital for Children & Young People (RHCYP), the Youth Navigator service is now live. This is a youth-work based service for 12-16 year-olds who present to hospital with a wide range of complex social issues. The model is designed to support these young adolescents to live healthier lives through appropriate and timely support. The service launched in June 2021 and has been well received with a >90% uptake from those referred into the programme, as well as positive professional feedback and initial anecdotal feedback of a reduction in frequent presentations to the hospital.

8.5 Western General Hospital (WGH) were delighted to reopen the recently refurbished Staff Wellbeing Wing in late October 2021, following a generous £75k donation by NHS Charities Together. This bright and welcoming space (pictured below) has been well received and utilised by staff and we would like to thank Edinburgh & Lothians Health Foundation for their ongoing support. To improve the offering to staff on site, WGH is also in the process of upgrading and repurposing Pentland Lodge, for use as a Junior Doctor break and wellbeing area, with planned reopening in mid-November 2021.

9. Director of Improvement

9.1 The team continues to focus on performance recovery in a number of NHS Lothian's most challenged services. The Performance Support Oversight Board provides the reporting forum for these services helping them address and unblock performance issues and monitor recovery plans. A number of services now report through the Board, including Orthopaedics, Dermatology, Oral Health Services, CAMHS, Psychological Therapies, RIE ED and Urology. Edinburgh City HSCP have now been brought into the programme in recognition of the recent challenges around delayed discharges. A specific piece of work has been commissioned looking at how to assess, measure and monitor demand and capacity across the Edinburgh City system and how this links to delays.

9.2 My operational leadership role in Dermatology and Oral Health Services continues. Oral Health Services are making good progress with implementing their Waiting Time Improvement Plan, and work has started on plans to shift care into a community setting where appropriate. I continue to spend considerable time with the Dermatology department focused on modernising working practices. This period, the focus has been on revising consultant job plans to increase core activity levels, as well as putting in place revised triage processes. A cohort of six GP practices have tested an approach to sending high quality images of skin lesions with referral letters and we are looking to expand the roll out of teledermatology further.

9.3 I also undertook an assessment of NHSGGC's emergency surgical services following the unplanned removal of my appendix in mid-October.

10. Director of Strategic Planning

10.1 The Directorate has been focussed on continuing to develop the Lothian Strategic Development Framework, and the Board have received regular updates from the team at PPDC and in other sessions since the last Board meeting.

10.2 As Board members are aware, we continue to work closely with the RSA and a highlight has been the work with our citizen's group, and indeed our Public Entrepreneurs Programme, which Rebecca Miller updated you on at PPDC. Both have been interesting and challenging for us but, gratifyingly, have underlined that we do seem to be on the right track with the LSDF.

10.3 Nickola Jones has been successful in piloting our Initial Agreements for the Royal Edinburgh Hospital through all four IJBs, with additional work required f or Midlothian IJB. This has not been an easy task but the work Nickola has done over the previous months has paid positive dividends.

10.4 Oli Campbell and the Women's and Children's Team continue to push forward the agenda on The Promise and the work with our Children's Partnerships. In particular, Oli was a driving force behind a proposal to provide employment opportunities for care-experienced young people, which offers real promise for the future and illustrates our commitment to children and young people and to the Anchor Institutions concept.

10.5 Peter McLoughlin has undertaken a huge amount of unseen work to provide materials for RMP4 and to support the Annual Review process.

10.6 Colin Briggs remains heavily involved in national work on forward planning within the service and is inputting to the work to support the National Care and Wellbeing Portfolios. He has also been supporting discussions on the National Care Service and as a member of the national Systems Response Group.

11. Director of Primary Care Transformation

11.1 As of 1 November 2021, a number of changes to the Lothian Covid community pathway were made with General Practice (both in-hours practices and GP Out-of-Hours Service) providing triage of all patients with symptoms of acute respiratory infection including possible covid and providing face-to-face assessments of children under 16 with possible covid symptoms. This has allowed the covid triage hub at the flow centre (which was proving very difficult to staff following 18 months of delivery of the service) to stand down, and also the paediatric covid assessment centres at RHCYP ED and SJH paediatric ward have stood down, providing a better patient journey and supporting to alleviate pressures at the RHCYP ED and SJH paediatrics. The adult covid

assessment centre, which is co-located at SDEC, WGH, is continuing to accept GP referrals of adults with deteriorating covid symptoms.

11.2 A proactive communications plan for the public and wider health and care staff to explain access to general practice, why it is working differently to some models used pre-pandemic, and how this benefits patients by managing demand and keeping people safe, has been progressed and is being scheduled on NHS Lothian social media channels.

11.3 Work continues to progress applications to the pharmaceutical list with two Pharmacy Practices Committee hearings taking place over October and November. Decisions are published on the website . Lothian Pharmacy Practices Committee Decisions (nhslothian.scot). Two joint public consultations for proposed new pharmacies are due to go live in November and will also be available to view on the website.

11.4 I have been progressing recruitment to the new senior management team posts for the GP Out-Of-Hours Service (LUCS). I am delighted to confirm Hayley Harris has been successful in securing the permanent Clinical Director role. Hayley is the current interim CD and will provide continuity for the service. Ed Witkowski will join the team in January as the new Clinical Service Manager. Ed comes from NHS Borders and brings a wealth of experience of urgent and unscheduled care services. Finally, the new Clinical Nurse Manager recruitment is now underway.

12. Director of Communications, Engagement and Public Affairs

12.1 **Vaccination Programme & COCVI -** Comms has supported HSCPs in their response to a number of issues that have arisen in the vaccination programme – some of them arising from limitations with the national booking system software, others home grown errors. These have generated a requirement for extra cohort letters and signposting as well as proactive and reactive media work.

12.2 We continue to promote COVID guidance including information on the importance of vaccination for pregnant women. Using Public Health intelligence, we have been targeting some of our content to areas where we know COVID case numbers are high.

12.3 **Winter plan -** Dir. of Comms has been contributing to the national comms group, steering national campaigns for winter. Our own winter comms plan is in four main strands
Right Care, Right place (111)
Scheduling of Minor Injury Appointments
Primary Care – GPs are open, Pharmacy First
Redirection at ED

12.4 **Celebrating Success & Commemorative film -** We held a virtual awards ceremony to recognise outstanding staff nominated for 2020's Celebrating Success which did not take place last year because of the pressures of the pandemic. It featured a film and song written and produced especially for NHS Lothian staff to honour them for their exceptional service.
https://vimeo.com/639909371/627abb77a1

12.5 **Media – Proactive -** In October we supported a visit by the Minister for Mental health to the new inpatient CAMHS unit a RHCYP.

12.6 Director of Comms had a meeting with Editor, Edinburgh Live (EL) following a series of serious factual errors and unfair reporting in their coverage. EL has agreed to work more constructively and fairly with us in future.

12.7 **Highlights -** Two pieces about system 'flow'. The first of these, for BBC and achieving lead story prominence across TV, Radio and Online, explained the relationship between the front door and the back door and was filmed at RIE. The second, filmed with STV, looked more closely at the Delayed Discharge challenge, exploring what is being done in community to try to help ease pressure. This featured the work of east Lothian's Discharge to Assess Team.

12.8 During COP26 we invited the BBC to St John's to see two separate initiatives to reduce harmful emissions from used medical gases which was featured across radio, TV and online
https://www.bbc.co.uk/news/uk-scotland-59238413

12.9 There has been a number of positive pieces linked to innovation such as a new treatment for diabetes and for prostate cancer.
https://news.nhslothian.scot/Pages/20211026_prostatecancer.aspx

12.10 Generated coverage for the new Renal Dialysis Unit
https://news.nhslothian.scot/Pages/20211021_dialysis.aspx

12.11 The living donor organ transplant service at RIE is the subject of a two part feature by Dani Graviella for the Scotsman which will follow the journey from donor's organ retrieval operation , the flight to Cardiff and transplant into the recipient, the donor's sister. Part 1 was published on 14/11/21
https://www.scotsman.com/news/people/insight-the-gift-of-life-for-a-beloved-sister-dani-garavelli-3457190

12.12 **Black History Month –** In October we worked with the staff network on content to promote Black History month including a piece about NHS Lothian's Minority Ethnic Health Inclusion Service.
https://news.nhslothian.scot/Pages/20211029_BHM_MEHIS.aspx

12.13 **Web Development -** We are upgrading NHS Lothian's web estate as the platform on which it sits – SharePoint 2013 – will soon no longer be supported. A rebuild is also necessary to ensure it will continue to meet accessibility standards. We have initiated a cross Board working group as many Boards are considering the same challenges.

13 Services Director – REAS

13.1 Inpatient services under pressure in acute, old age and young people. Young person's unit has seen a 58% increase in young people with an eating disorder, 16 additional beds remain open in adult acute but occupancy near 100%. Old age have a significant number of people who are delayed discharges (around 20% of the overall acute old age bed base)

13.2 IAs for Intellectual Disabilities and Rehab/ Low secure have been agreed by Corporate Management Team, 4 IJBs, PPDC and Finance & Resources committees and are on agenda for discussion at Board meeting. Scottish Government have written to ask up to swiftly develop plans for a low secure unit given the pressure on medium secure nationally

13.3 CAMHs and Psychological Therapy performance – Both remain on escalation but recovery plans in place. Both on trajectory at the moment. There is a risk around being able to recruit enough staff but this is being monitored

13.4 The Mental Health/Learning Disability Programme Board is re-organising to bring a clearer focus on strategic and recovery / operational elements. Will align to the Unscheduled Care Programme Board re-organisation

13.5 Mental Health is contribution to the Strategic Development Framework

Business case preparation underway for future move to paper-lite operation as in acute.

14. Director/Chief Officer, Edinburgh Integration Joint Board

14.1 **Annual Performance Report 2020/21 -** The EIJB Annual Performance Report 2020/21 was approved by the EIJB on 26 October and published on the Edinburgh Health and Social Care Partnership website on 29 October 2021. This year, due to the impacts of the COVID-19 pandemic on City of Edinburgh Council and NHS Lothian, we shared in the summer that our report was unable to be published to the usual statutory timescale. In accordance with Part 3 of the Coronavirus (Scotland) Act 2020, we took the decision to postpone the publication of our Annual Performance Report to the end of October 2021. The Annual Performance Report outlines how the partnership has navigated the COVID-19 pandemic, whilst remaining able to implement and deliver longer term strategic services that will further our mission to deliver even more meaningful care across the city. The report can be accessed at: https://www.edinburghhsc.scot/the-ijb/annualperformancereport/

14.2 **Older People Improvement Programme -** The Care Inspectorate and Healthcare Improvement Scotland jointly carried out an inspection of services for older people in the city of Edinburgh in 2016 and published the report in May 2017. A subsequent progress review was published in December 2018. The reports are available on both scrutiny bodies' websites. The purpose of the

original joint inspection was to find out how well the partnership achieved good personal outcomes for older people and their unpaid carers. As important weaknesses were found and 17 recommendations for improvement made, a further review was undertaken in 2018 to check progress.

14.3 A series of online meetings were held between January and April 2021, involving the Joint Inspection Team and officers responsible for improvement activity. The Joint Inspection Team has noted that overall, positive progress has been made. The report acknowledges that, since the progress review of 2018, senior leaders in the partnership have driven forward the change agenda and invested resources to progress strategic planning, which had previously lacked vision, direction, and pace. A positive shift has been noted, from a reactionary to a more planned and structured approach. A copy of the full report can be found in the Admincontrol meeting folder.

14.4 **Flu Vaccination Programme -** The Edinburgh Flu programme commenced at the end of September 2021. Initially, the national priority was to maximise flu vaccination, with Covid boosters administered if flu patients attending were eligible (strict 24 week / 168 day parameter). This changed in late October with enhance priority for COVID boosters, particularly for 70+ and CEV. Subsequently, eligibility was lowered to 22 weeks from second dose.

14.5 To date 94,813 Adult Flu Vaccines have been given (as at Tuesday 10th November) and 71,238 Adult Covid boosters or 3rd dose (Clinically Vulnerable).

14.6 We have achieved our projected 75%+ flu uptake in the 70+ age group and will gradually add to this up to Christmas. It should be noted that some adult flu vaccination uptake is lost as people who attend community pharmacists for **private** appointments, do not have their vaccination recorded on the national system. Anecdotally, this may be relatively significant for Edinburgh as the Lowland Hall mass clinic will not be accessible for all.

14.7 Our Covid booster/3rd dose performance in the 70+ population (at Tues 10th November) is at 66%, based on those who came forward for their 2nd doses. This is in line with expectations at this point with c15,000 additional appointments for these patients scheduled to the end of November and c4000 housebound people still to be visited. We expect to reach 75%+ uptake in this cohort. In addition, the planned delivery of adult flu/covid was delayed with the additional cohort of 12-15 year olds which had to be accommodated as a priority in October, followed by the suspension of the mass site at Ingliston due to COP 26.

14.8 **Care homes** - The Care Home Programme was able to be considerably accelerated due to the release of staff form the Lowland Hall during the 4 days enforced closure due to COP 26. Whilst this lost us c8000 appointments, the staff were able to ensure that all City Care Home residents and staff were vaccinated by 4th November. (figures suggest that 96% of residents have been vaccinated, this is because some residents were not clinically suitable for vaccination or declined).

15. Director/Chief Officer, East Lothian Integration Joint Board

15.1 The partnership continues to maintain above trajectory performance on reducing delays to discharge. We have further integrated our Home care and Hospital to Home teams to increase flexibility and capacity as well as integrating our Care allocation Team to ensure flexible approach to both hospital discharge and community pressures.

15.2 **Care Homes:** we continue to work closely with our care home and care at home providers to ensure sustainability within the market. We have engaged with providers to support patient discharge with interim placements.

15.3 **Social Care Capacity:** Situation remains fragile for all East Lothian CAH providers. Continuing, deteriorating trend in reduced capacity since beginning of summer. Recruitment for frontline staff remains mainly static. All providers have a significant front line staffing shortfall, inadequately supplemented by an insufficient supply of agency workers, increasing amounts of paid overtime, and office and managerial staff delivering care. Reduced capacity in office teams means providers cannot run service effectively or respond to stakeholders or report in timely manner.

15.4 We anticipate further erosion of capacity across East Lothian in the coming weeks. ELHSCP does not have sufficient resources to cover staffing shortfall. The incidence and impact of Covid-19 on staff absence is currently low. Already depleted staffing levels are vulnerable to impact from flu or another virus.

15.5 **Performance Management:** The East Lothian IJB Annual Report for 2020-21 describes performance over the year from 1st April 2020 to the 31st March 2021. It includes elements of the Scottish Government's Core Suite of 23 National Integration Indicators, first published in 2015. It also reflects on the Ministerial Strategic Group for Health and Social Care additional indicators. Between them, these indicators provide a means for Health and Social Care Partnerships to measure progress in delivering the National Health and Wellbeing Outcomes. The APR reflects on the management of responses to the complex and rapidly evolving challenges presented by COVID during the year. This required a high degree of coordination and agility by the HSCP and flexibility and dedication across all staff groups.

15.6 **Primary Care:** We continue to see pressure in particular in the west of the county and are working closely with practices to increase services available to them.

16 Director/Chief Officer, Midlothian Integration Joint Board

16.1 **System pressures -** Midlothian continues to experience workforce challenges, in relation to the well-rehearsed NHS Lothian and National health and social care system challenges. Midlothian have been able to maintain flow from acute service, and delayed discharges remain within agreed trajectory. Additional care capacity has been successfully secured for the beginning of December, with an additional 15 wte Healthcare Support Workers joining our Discharge to Assess team. This injection of care capacity should significantly improve performance. Additional funding to review and case manage all moderate and severe frail patients who attend Emergency department in now underway as part of our Winter planning. Additional capacity has also been added to our Community Respiratory team, Flow team and Care at Home to further augment capacity.

16.2 **Covid and Flu vaccination programme -** The flu vaccine rollout continues to progress well in Midlothian with an 80% uptake in the current over 70s cohort. Patient cohort 2 will now receive letters inviting them for their vaccination.

16.3 Scottish Government has recently changed the priority weighting of the vaccines and are now considering both the flu and COVID booster to be of equal importance. Planning assumptions were based on the initial assertion that flu was to be given priority. Our COVID booster rollout is therefore a little behind where we would like it to be, currently at 31% for eligible cohorts. This is set to increase rapidly over the next few weeks, with clinic capacity and appointments in place.

16.4 All Care Homes have received the covid booster. The team are currently remodelling on Scottish Government guidance to pull covid booster forward in relation to 24 weeks. This will present additional workforce challenges, and a plan will be submitted to Scottish Government with other HSCPs.

16.5 **Improving the Cancer Journey (ICJ) launch -** A new service to ensure cancer patients are offered emotional, practical, and financial support has launched across Lothian.

16.6 The new Lothians Macmillan Improving the Cancer Journey (ICJ) Service will see every newly diagnosed cancer patient offered a meeting with a dedicated one-to-one support worker. The worker will help the patient access a wide range of support, from benefits advice and emotional support to help at home or with other practical needs.

16.7 This will mean cancer care teams in hospitals no longer need to help with non-medical issues, freeing them up to provide personalised care and support to those with complex medical problems.

16.8 Morag Barrow, Calum Campbell, and Janice Preston (MacMillan) were joined at the launch by Midlothian ICJ Practitioner Dawn Craig as well as Phyllis Bennett who has used the service and shared her story.

16.9 **Midlothian IJB Annual report 200/21 -** Following approval at the October IJB Board meeting the Midlothian annual report can now be viewed at: www.midlothian.gov.uk/mid-hscp/info/3/what-we-do

16.10 **Funding for Digital Inclusion Skills Development -** Funding has been secured from the Scottish Council of Voluntary Organisations and the Edinburgh and Lothians Health Foundation to deliver a six-month programme of training to practitioners in the HSCP and Third Sector to support the digital inclusion of older people.

16.11 The training will build knowledge and confidence to pass on digital skills when practitioners meet older Midlothian citizens in their work roles. It is delivered by the HSCP Learning and Development team and goes live on 11 November.

17. Director/Chief Officer, West Lothian Integration Joint Board–

17.1 **Workforce Planning Engagement** - The Scottish Government is likely to ask NHS boards and health and social care partnerships to submit medium term workforce plans next year. In preparation for this, engagement has commenced within the West Lothian Health and Social Care Partnership to better understand the current workforce challenges and to explore potential for more innovative solutions to addressing some of the existing gaps. We have put some additional resources in place to help develop the future workforce plan through meaningful engagement: we want to ensure that our staff have a voice and are central to shaping the future.

17.2 Engagement sessions have now taken place with service leads in all areas, led by senior managers, focussing on robust challenge of the status quo, and exploring creative and innovative solutions. In the coming weeks there will be several operational manager meetings to explore innovation within individual service areas including digital opportunities, new roles, etc. On top of the focused management engagement, a workforce planning webpage was launched with a message from the Chief Officer, directing staff towards a 4-question e-survey which asked what staff thought our services should look like in the next 3 to 5 years. Finally, there will be several other opportunities for others to engage with the development of the plan include sessions with local high school pupils, an engagement session with West Lothian College, coffee and chat sessions with planning teams, a session with the local third sector interface to name a few.

17.3 **Single Point of Contact Development** - West Lothian Health and Social Care Partnership is progressing its Home First Programme at pace to ensure people in West Lothian are cared for at home wherever possible, are only admitted to hospital if there is an absolute clinical need and if they are admitted to hospital, are discharged home or into a community setting as quickly as possible with the right supports in place. This programme is being taken forward under a whole system approach with a strong emphasis on stakeholder engagement.

17.4 The three workstreams are as follows:

- Workstream 1 – Community prevention, early intervention, and pre-hospital attendance (to include access to Community Single point of Contact and Flow Centre pathways)
- Workstream 2 – Primary/Community proactive and longer-term intervention, Intermediate Care pathways and intervention, delivery models in acute front doors, admission pathways and hospital discharge
- Workstream 3 – Bed Based review and bed utilisation in medicine and rehabilitation across acute and community sites

17.5 The partnership held a virtual launch event on 3 November 2021, in which plans were outlined for a Single Point of Contact (SPoC). The SPoC will provide a single route of access to a senior decision maker to screen, triage, assess and develop a plan, to respond to urgent care needs rapidly (within 2-4 hours). The longer-term vision is to extend this single access point to both urgent and non-urgent community care and support.

17.6 The event was very well attended and received by colleagues from across the partnership, staff from the wider council and NHS Lothian, GPs, carer representatives, service users, commissioned providers and the third sector. Stakeholders expressed their support for a SPoC and views were captured from breakout groups on what needed to change in the current system and the differences this could make.

17.7 The outcome of these discussions is currently being collated and a Project Initiation Document will be drafted. The next steps will be to establish a Project Design and Implementation Group and to ensure that we continue to engage and communicate with stakeholders as the project progresses.

18. The Board is asked to receive the report.

Policy/Strategy Implications	Policy/strategy implications will be addressed in the management of any actions resulting from these events, activities and issues.
Consultation	Board Executive Team
Consultation with Professional Committees	None
Risk Assessment	Risk assessment will be addressed in the management of any actions resulting from these events, activities and issues.
Compliance with Board Policy requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	Resource/staffing implications will be addressed in the management of any actions resulting from these events, activities and issues.

Approved by

Name	Designation
Calum Campbell	Chief Executive

Author(s)

Name	Designation	Name	Designation
Calum Campbell	Chief Executive	Dona Milne	Director of Public Health and Health Policy
Jim Crombie	Deputy Chief Executive	Jacquie Campbell	Chief Officer Acute Services
Fiona Ireland	Interim Executive Director Nursing, Midwifery and Allied Healthcare Professionals	Pete Lock	Director of Improvement.
Tracey Gillies	Medical Director	Colin Briggs	Director of Strategic Planning
Susan Goldsmith	Director of Finance	Jenny Long	Director of Primary Care Transformation
Janis Butler	Director of Human Resources and Organisational Development.	Judith Mackay	Director of Communications, Engagement and Public Affairs.
Morag Barrow	Director/Chief Officer Midlothian IJB/HSCP	Judith Proctor	Director/Chief Officer Edinburgh IJB/HSCP
Alison Macdonald	Director/Chief Officer East Lothian IJB/HSCP	Alison White	Director/Chief Officer West Lothian IJB/HSCP
Tracey McKigen	Services Director - REAS		

Meeting Name:	**Board**
Meeting date:	**01 December 2021**

Title:	**NHS LOTHIAN BOARD PERFORMANCE PAPER**

Purpose of the Report:					
DISCUSSION	**X**	DECISION		**AWARENESS**	**X**

The Board is being asked to consider the performance report so they are aware of the operational and strategic performance challenges which NHS Lothian are experiencing, reacting to and developing plans to mitigate against.

The risks during this remobilisation phase have largely remained the same and are detailed in this paper. There are a number of related corporate risks with corresponding action plans for the issues noted in this paper, with assurance and reporting structures in place for these across the Boards existing Sub-Committees.

The key issues are related to the following factors and are discussed throughout this report:

- Workforce availability and capacity restrictions
- COVID-19 and the pandemic response
- Flow between community, acute and social care services
- Clinical prioritisation & increasing backlog of scheduled care

Recommendations:

This report is being provided for awareness, an executive summary has been included.

Members should note the launch of a project group following the active governance sessions which will further enhance coordinated and aligned performance reporting across the system.

If further deeper dives are requested by the Board, it is requested that these are addressed in separate reports to maintain the structure of the core performance report.

Author: Wendy MacMillan **Date: 18/11/2021**	**Director: Jim Crombie** **Date: 22/11/2021**

NHS LOTHIAN

Board Meeting
01 December 2021

Jim Crombie, Deputy Chief Executive

NHS LOTHIAN BOARD PERFORMANCE PAPER

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board discuss and review the current performance position of key metrics relevant to the Lothian Performance Recovery Programme and Remobilisation Plans.

The overall approach adopted is that performance management is integral to the delivery of quality and effective management, governance and accountability. The indicators included in this report are a high-level set of performance standards which are supported by a comprehensive framework of measures reviewed across existing committees. These are reported to and monitored by the relevant responsible officers and their clinical and senior professional staff. A key vehicle for monitoring the wider performance metrics in our health and care system will be managed through the Planning, Performance and Development Committee (PPDC) which will report into the NHS Lothian Board. These metrics will be aligned with the NHS Lothian Board priorities:

- improving the health of the population,
- improving the quality of healthcare,
- achieving value and sustainability and,
- improving staff experience.

This categorisation of key metrics aligned to our board priorities will facilitate a greater visible connection to their performance. Local intelligence is gathered through quarterly performance reviews, existing committee structures and additional context sought from service areas, offering a robust and expansive set of indicators for review at PPDC. PPDC will also receive more detailed reports on issues or areas of strategic priority which have been escalated from subcommittees or via the performance review cycle. This reporting link to the Board will offer the opportunity for separate papers to be introduced to the board on specific escalated issues discussed by the PPDC.

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

2 Recommendations

2.1 The Board acknowledges the supporting performance infrastructure in place which provides formal assurance on a wider set of metrics aligned to Board priorities through existing committees.

2.2 The Board recognises the performance challenges detailed in this paper including exacerbated pre-existing performance issues and dips in performance following the impact of COVID-19 and current measures.

2.3 The Board considers the clinical reprioritisation exercise undertaken on all inpatient and day case waiting list patients and the focus on maintaining and improving performance in order of clinical priority and longest routine waits.

2.4 To note the ongoing work following the active governance sessions which will further enhance coordinated and aligned performance reporting across the system.

2.5 If further deeper dives are requested by the Board, these are addressed in separate reports to maintain the structure of the core performance report.

3 Discussion of Key Issues

3.1 Strategic – Tactical – Operational Oversight Structure

3.1.1 Since the last report, there has been a reduction in positive COVID admissions to hospital, however a significant issue for the Acute Sites is the unscheduled admissions and continued management of separate red, amber and green beds. Services across NHS Lothian face ongoing challenges to meet demand. As this is a time of severe pressure NHS Lothian continues to use the Gold Command structure which provides:

- clear leadership;
- accountable decision making; and
- accurate up to date and far-reaching communication.

3.1.1.1 This forum continues to flag vulnerabilities in care provider's resilience, including; significant workforce issues, increased attendance at Emergency Departments and our front doors, in addition to poor flow linked directly to care at home and care home availability.

3.1.2 In addition to GOLD, National System Sustainability Sessions with the Chief Executives chaired by the Chief Officer of NHS Scotland are ongoing. Furthermore, Scotland's Health, Council and Social Care leaders regularly meet with the Cabinet Secretary to discuss system pressures and mitigations.

3.2 Executive Summary

3.2.1 **COVID:** Positive COVID-19 cases for Lothian residents has remained relatively stable since the end of September. However, a significant issue for the Acute Sites is the unscheduled admissions and continued management of separate red, amber and green beds. This is impacting workforce, Infection Control measures taken across the system and patient attendances.

3.2.2 **Workforce:** Staffing availability remains a significant challenge across acute, community and social care settings due to a combination of COVID isolation, sickness and vacancies. Members will be aware from October PPDC and previous board papers the actions being taken to help the wider system over winter, although it is recognised this winter will likely remain challenging for the duration.

3.2.3 **Flow:** In October, there has been a slight reduction in emergency department (ED) attendances, however our 4 hour attainment remains significantly below the standard which has been observed in various boards across Scotland. Pan-Lothian delayed discharges are on an upward trend, with October 2021 figures exceeding the average monthly rate seen in 2019/20. East Lothian HSCP continues to be well within the Remobilisation (4) forecast set, whilst Edinburgh HSCP were higher than their planned position in October 2021 and have continued to deteriorate over recent months. Both the Royal Infirmary of Edinburgh (RIE) and Western General Hospital (WGH) sites are experiencing the highest number of delays out of the adult acute sites, similar to the yearly rate observed in 2019/20.

3.2.4 **Scheduled Care:** The combination of increased Emergency Department attendances, closure of beds due to staffing pressures and increased delayed discharges and increased occupied bed day will continue to impact on elective activity for Inpatients/Day case patients, and some Outpatients. This is due to the impact of responding to the pandemic which has resulted in a significant reduction in scheduled care services to release workforce to support and expand critical care and other inpatient activity. The number of people awaiting treatment, and length of wait for treatment will continue to rise unless there is a sustainable increase capacity to meet demand, non-recurrent actions available to reduce backlog and a sustainable workforce. The overall trend for outpatients is relatively stable, with a slight reduction

observed from September 2021 to October 2021. The Inpatients/ Day case waiting list size and the number of patients waiting over 12 weeks and over 52 weeks have further increased due to the limited capacity available.

3.3 Performance Support Oversight Board

3.3.1 Where there are significant performance issues of key services, an escalation process to the weekly Executive-led Performance Oversight Group is in place. This process ensures there is ongoing detailed review of the services and enables the deployment of rapid improvement support to increase performance. The services currently involved in this escalation include; Delayed Discharges within Edinburgh HSCP, Oral Health Services, Dermatology, CAMHS, Urology, Orthopaedics and 4-Hour Access Standard at the Royal Infirmary of Edinburgh (RIE).

3.4 Remobilisation Plans (4)

3.4.1 Committee members will be aware that the revised and updated 2021-22 Remobilisation Plan 4 was submitted to the Scottish Government at the end of September 2021. This contains the details of all the initiatives and actions that will underpin the remobilisation and development of services into 2021-22 and beyond with corresponding activity trajectories.

3.5 Clinical Prioritisation

3.5.1 Members are reminded that we continue to prioritise the treatment of urgent, urgent suspicion of cancer, and our longest waiting patients. An initial re-categorisation exercise was undertaken by clinicians in January to reclassify all inpatient and day case waiting list patients according to the national agreed clinical categories (Priority 2 – 4), and record prioritisation category on Trak. All new additions to our waiting lists have their priority recorded at time of being added to the waiting list.

3.5.2 This categorisation framework remains for all new patients and they receive an 'Add to Inpatient Waiting List Letter' informing them of their assigned priority.

3.5.3 Patients' clinical priority are reviewed on an ongoing basis.

3.5.4 A clinical review of a patient's condition may determine that their priority is upgraded and their treatment expedited, therefore, some urgent and cancer patients are being reported as waiting longer than their upgraded priority as waiting list rules do not allow date added to waiting list to be adjusted due to clinical upgrade. We have developed tools internally that allow us to report date of upgrade and wait from this date.

3.5.5 Currently, each service is responsible for managing the keeping in touch process for patients. Due to the volume of patients waiting this has been hard to achieve in a systematic way within service resources. A Board-wide framework is currently being evaluated within our out-patient services with dedicated health records team and initial findings are this is working well. A Board wide process for in-patients is being developed to provide consistency in approach and resources.

3.6 Winter Planning

3.6.1 The winter period is recognised as a time when significant additional demand is placed upon NHS Lothian. This relates primarily to higher prevalence of winter illness and an increase in the ageing population with co-morbidities resulting in complex care needs, however this will likely be exacerbated by COVID prevalence in 2021/22. Winter planning is one way in which NHS Lothian can ensure organisational resilience to provide safe, effective patient care. High level briefings were included in the September 2021 Board Paper and additional considerations have been included throughout this paper.

3.6.2 A number of plans are in place to enhance capacity and improve flow across the acute sites.

3.6.3 A key commitment throughout winter planning is to ensure clinical prioritisation of urgent patients will remain at the forefront of scheduled care planning throughout the winter.

3.6.4 The four Health & Social Care Partnerships continue to focus on prevention of emergency department attendance and hospital admissions and are taking a proactive management approach of patient flow from acute services to reduce delayed discharges. Although the significant workforce pressures felt across all these services will mean this remains challenging.

3.7 Active Governance

3.7.1 A working group has been set up to develop and deploy a common approach to corporate reporting based and learning from the Scottish Ambulance Service. An approach has been drafted and shared with Dr Mike Bell (SAS) who led the data section of the Board Active Governance session (28th October 21) prior to submission to the PPDC in January 2022. The metrics are being assessed and tested against the approach in preparation for the February Board including mechanisms to automate the processes. Sessions with managers who produce the narrative for the Board metrics are also being planned to ensure a consistent, informed narrative with regard to the measures, rules and language.

3.8 The table below outlines the key performance metrics for the attention of the board:

Metric		**Trajectory/ Standard**	**October 2021 position**	**September 2021 position**	**August 2021 position**	**2020/21 monthly average**	**2019/20 monthly average**	**2018/19 monthly average**
4 Hour ED Standard[1]		95%	67.6%	69.6%	72.4%	89.5%	88%	88%
Outpatients (End of month breaches)[2]	➢ 12 weeks	-	41,215	41,984	41,731	37,123	22,414	20,777
	➢ 52 weeks		6,713	7,059	7,272	5,142	923	567
Delayed Discharges[3]	Health and social care / patient and family reasons	212	253	242	211	111	217.7	303.4
	All census delays (above plus complex code 9s)	254	274	270	238	131	247.2	331.4
TTG (End of month breaches)[4]	➢ 12 weeks	-	12,083	11,375	10,558	9,098	2,795	2,328
	➢ 52 weeks		3,571	3,322	3,066	1,290	49	73
Cancer Waiting Times[5]	31 Day Standard	95%	-	98.4%	97.3%	97.6%	94.5%	94.3%
	62 Day Standard		-	86.1%	88.2%	85.8%	79.2%	81.0%
CAMHS < 18 weeks standard (Seen within 18 weeks)[6]		90%	75.1%	75.6%	65.4%	61.3%	54.0%	63.0%
Psychological Therapies < 18 weeks standard (Seen within 18 weeks)[7]		90%	78.6%	83.0%	81.6%	79.7%	79.2%	72.3%
Acute Adult Mental Health Bed Occupancy[8]		85-90%	96.9%	95.8%	96.9%	92.5%	92.6%	-
HAIs per 100,000 bed days[9]	CDI	<11.4	-	13.8	18.7	13.1	12.0	12.6
	ECB	<26.6	-	16.3	18.7	31.2	35.2	35.5
	SAB	<12.2	-	30.1	33.6	14.0	12.6	13.5

[1] Data sourced from Lothian internal management system
[2] Data sourced from Lothian WT Monthly dashboard data
[3] Data sourced from PHS official statistics. *Standards are reportable census delays as projected for the 21/22 Remobilisation Plan.
[4] Data sourced from Lothian WT Monthly dashboard data
[5] Data sourced from Discovery. October position not available until later in November 2021.
[6] Data sourced from Lothian internal management system
[7] Data sourced from PHS official statistics
[8] Data sourced from Lothian internal management system – average % Occupancy (inc. Pass) based on weekly data time points
[9] These rates represent overall rates for the year rather than monthly average: (sum of healthcare associated infections for the year / sum of total occupied bed days for the year) *100,000. Data sourced from Lothian internal management system. October position not available until later in November 2021.

Metric		Trajectory/ Standard	October 2021 position	September 2021 position	August 2021 position	2020/21 monthly average	2019/20 monthly average	2018/19 monthly average
Paediatrics and St Johns		7 days a week 24x7	**7 days a week 24x7**	7 days a week 24x7	7 days a week 24x7	-	-	N/A
8 key diagnostic procedures > 6 weeks standard (end of month breaches)[10]	Upper GI endoscopy	-	1,849	1,805	1,845	1,805	759	1,308
	Lower Endoscopy (other than colonoscopy)		739	725	695	558	351	680
	Colonoscopy		1,262	1,179	1,108	1,279	828	1,508
	Cystoscopy		951	950	921	946	375	418
	Magnetic Resonance Imaging (MRI)		258	274	396	930	342	304
	Computer Tomography (CT)		292	266	215	521	124	29
	Non-obstetric ultrasound		1,996	1,993	2,037	1,031	7	10
	Barium Studies		10	9	23	14	0	0

[10] Data sourced from Lothian DMMI

Please note that due to the process of receiving updates directly from services and submission deadlines for papers, the latest data available at that point in time dictates the latest month of data available.

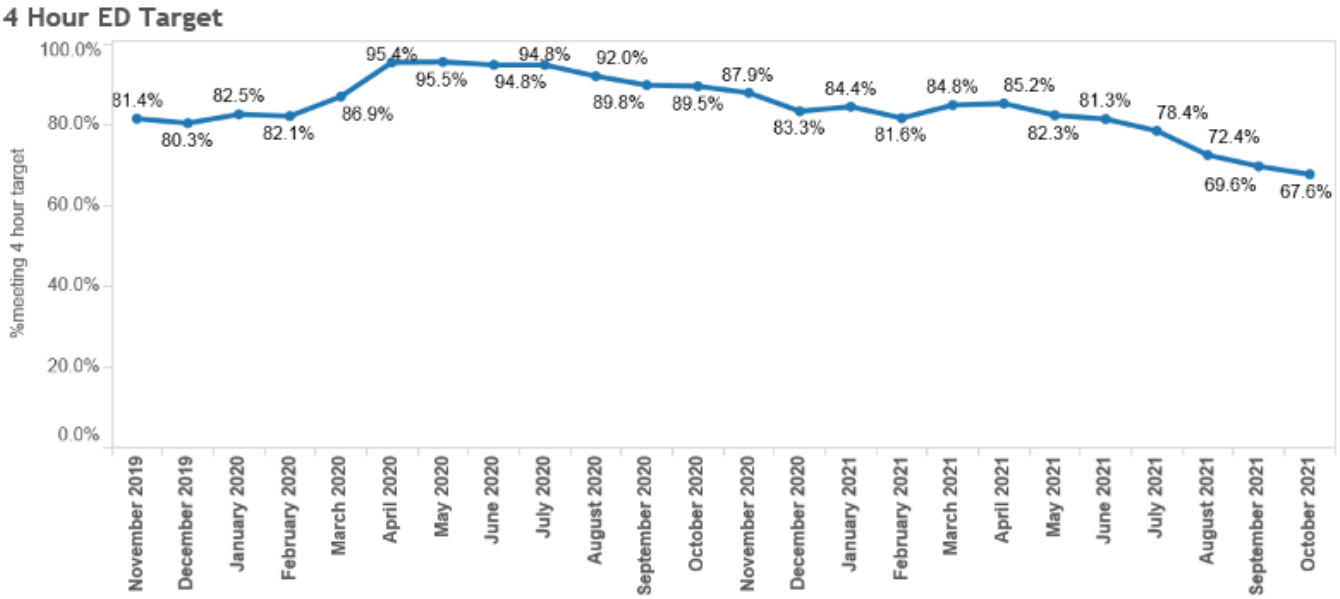
3.9 The following section provides summary narrative on the performance demonstrated in the metrics in the table above.

- **Unscheduled Care**

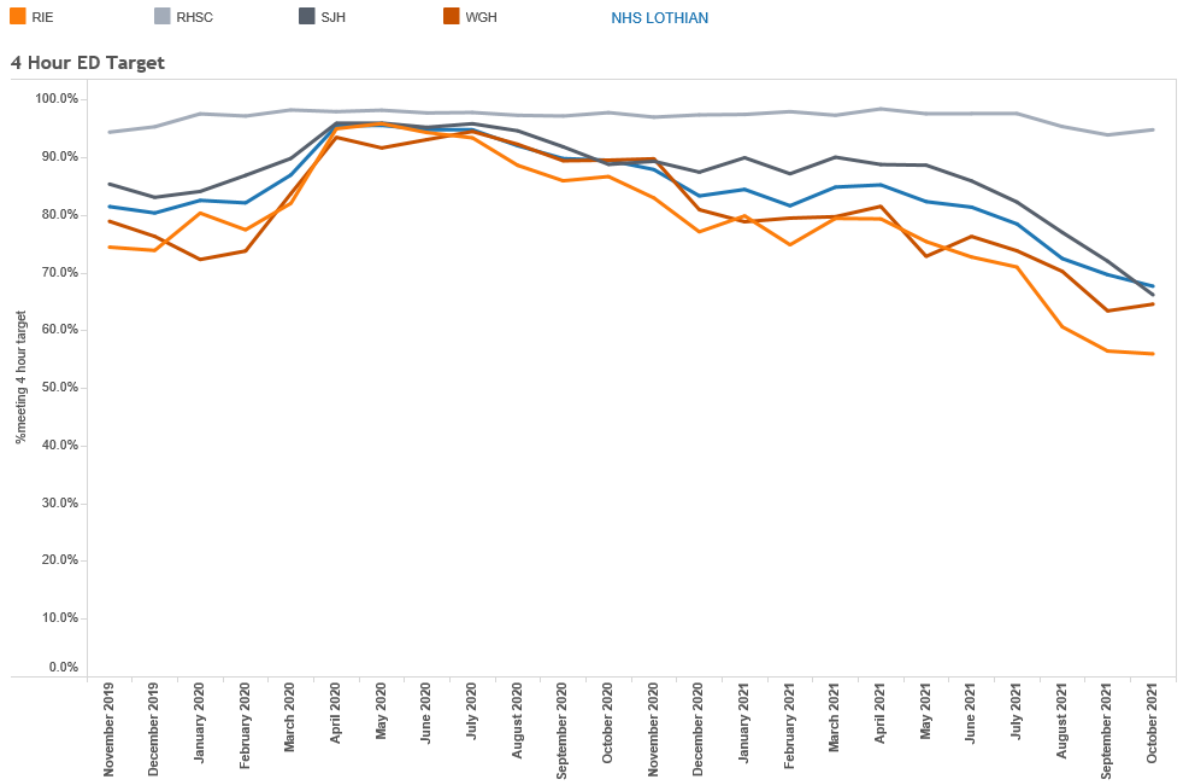
Measures definition: The summary table above shows the monthly average percentage of patients seen within 4 hours as a percentage of all attendances at Emergency Departments across NHS Lothian.

What the data tells us: Attendances for October 2021 are almost 4,000 higher than October 2020 and almost 8,500 higher than at the quietest point this calendar year to date (February 2021, 14,736). Four Hour performance for NHS Lothian has deteriorated since April 2021, when it was 85.2%, to 67.6% for October 2021.

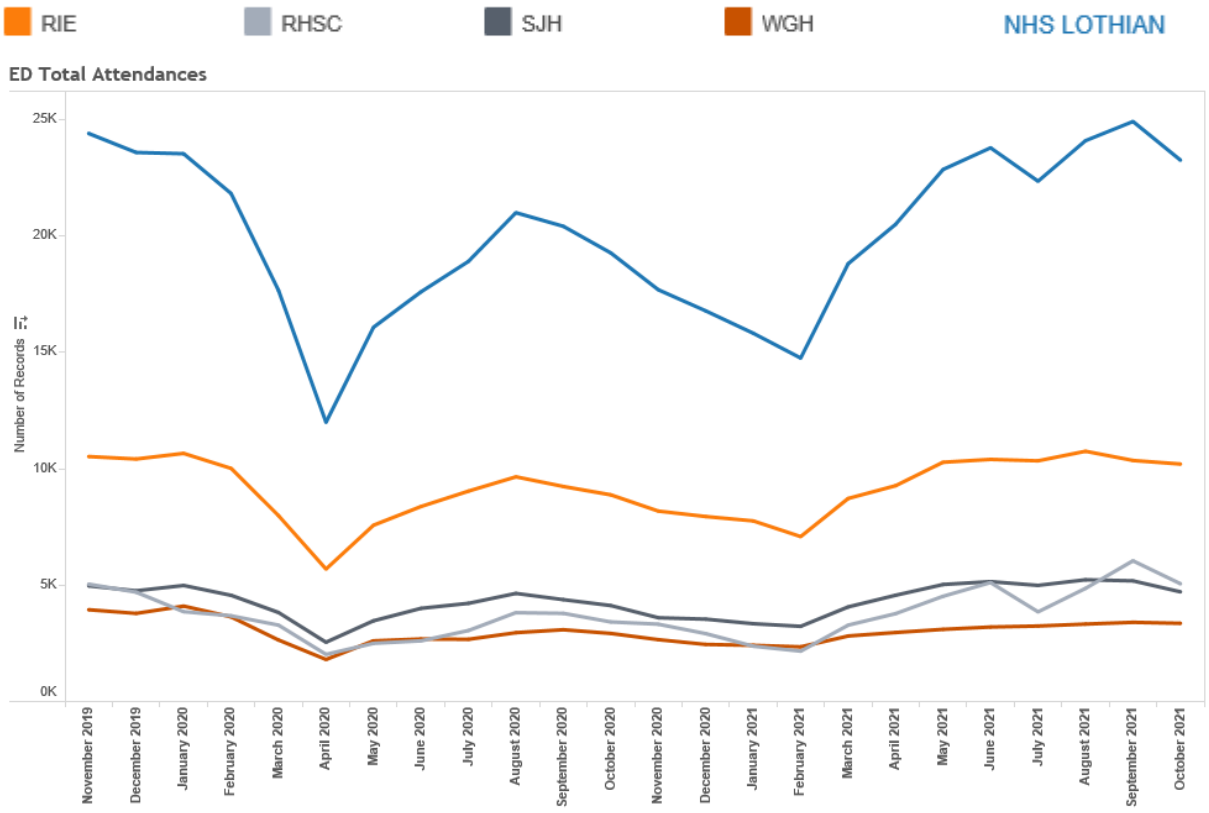
Narrative: NHS Lothian is experiencing significant challenges in delivering the 4-hour standard with performance dropping to 67.6% in October 2021, significantly below the national standard of 95%. Overall performance has deteriorated over the past 6 months. RIE 4-hour access performance has dipped further in October 2021 to 55.9%. This follows a deteriorating trend over the past 6 months, a trend also seen at SJH. WGH and RHCYP (Royal Hospital for Children and Young People) 4-hour access performances have seen slight improvement in October 2021, compared with September 2021, rising to 64.5% and 94.7% respectively. The overall reduction in performance is due to several factors, including attendance levels at all sites being back to pre-pandemic levels; increase in acuity; high bed occupancy and work force challenges.



4 Hour ED Target by Site



Total Attendances



Emergency departments (EDs) are seeing high presentations at the beginning of a week, with attendances spiking across midday for both self-presenters and major attendances. Although first assessments account for the majority of breaches, bed waits, and treatment end waits

have been responsible for an increasing number than previously. General staffing availability remains a significant challenge on all acute sites, due to a combination of COVID isolation, sickness, and vacancies. In addition, due to pressures across the whole health and care system the ability to admit patients from EDs has reduced, with hospital occupancy remaining high. The number of patients delayed in their discharge has increased in recent months due to workforce pressures within care services. This along with the number of COVID admissions is having a negative impact on performance in the EDs and has resulted in frequent significant overcrowding within front door areas, high volumes, and long waits for admission.

An update on the broader aspects of the cross-system unscheduled care programme is provided below:

- Redesign of Urgent Care (RUC) – public referrals via 111 to the Flow Centre, to allow scheduling, continue, since go-live in December 2020. This pathway was widened to include patients under 12 on 1 June 2021. Despite a recent launch of a national communications campaign across June 2021, referrals remain low with an average of 65 daily to the Flow Centre, of which approximately 38 are provided with a scheduled Minor Injury Assessment (virtual, or face-to-face via Call MIA).

- RUC - professional referrals. GP (General Practitioner) referrals for same day secondary care have been made via the Flow Centre for some time. This pathway has been widened to include access for ambulance service clinicians. Each HSCP has also developed local single points of access for professionals to access same day community services, and work is underway to ensure an interface between the Flow Centre and HSCP community services, to allow referrals from ambulance clinicians via one Lothian access point. A short life working group (SLWG) to determine the pan-Lothian approach to delivering Same Day Emergency Care (SDEC) has concluded and the recommendation from this SLWG is to develop an SDEC service within all acute receiving sites, and for the patient referral pathway to follow the current GP flow. This pan-Lothian model has been agreed through a governance process and acute site teams are in the process of determining site-specific SDEC models and implementation plans. The Scottish Government has also developed national work streams for Community Pharmacy, SAS, Musculoskeletal, Mental Health and Distress, and Digital Solutions, to optimise patient flow within urgent care. A representative from NHS Lothian attends each of these work streams and the team are aligning our local Re-design of Urgent Care Programme plan to meet the aims and deliverables of these national work streams.

- Interface Care - NHS Lothian are also participating in the recently launched Scottish Government's National Interface Care Programme. Interface Care will focus on safely reducing admission rates or shortening lengths of stay to improve patient experience and to minimise hospital related complications. The programme will be delivered in a phased approach over 2-3 years. The specific target population for Interface Care are those patients currently presenting with Acute Care Sensitive Conditions (ACSC codes), with a length of stay of between 0-14 days. The overall aim for the programme is to achieve a 20% reduction in length of stay for our target population and we will need to agree what % reduction we are aiming to achieve, and by when, within NHS Lothian.

- Signposting and Re-direction – NHS Lothian are in the process of developing a Signposting and Redirection policy. This will aim to ensure that ED attendees are appropriately reviewed in line with their presentation. These processes also reduce the potential for crowding within EDs, by maximising use of safe alternatives for attendees to access care. The purpose of Signposting and Redirection is not to turn attendees

away from EDs but to direct them, where appropriate, to an area/service where their healthcare need may be best met, minimising the risk to them and others. This policy promotes the delivery of safe, effective, person-centred care on a 24/7 basis, by ensuring that the public have access to the best clinical advice and care, from the right professionals at the right time, reducing unnecessary waits and delays: Right Care, Right Place, Right Time.

- Members may be aware the Scottish Government has committed to evaluating the recently launched RUC Programme to ensure that objectives to date have been achieved, and to inform next steps for redesign and implementation. To support this process, NHS Lothian have undertaken a review of the initial phase of the RUC and provided an update of our progress against the recommendations at the end of August to the Scottish Government. We will continue to input into the ongoing national evaluation. The RUC project delivery group continues to meet monthly to review progress of phase 1 following Go Live, and to continue with phase 2 implementation. Scottish Ambulance Service (SAS) are an active member of this group and NHS Lothian continues to meet on a regular basis with NHS24.

- Discharge planning and transfers of care – The draft Discharge and Transfer Policy is currently available for comment on the NHS Lothian Consultation Zone and has also been widely shared with Partnership colleagues via the HSCP Chief Officers. This is building on good practice from elsewhere in Scotland and the UK and is being informed by a test of change currently underway between WGH and Edinburgh HSCP to support parallel working and ensuring the safe facilitation and effective discharge for patients who experience inpatient care in an acute or community hospital setting within NHS Lothian. A further test of change will commence in the coming weeks within the RIE incorporating the learning from other test areas and a detailed implementation plan for the spread and adoption of a pan Lothian PDD (Planned Date of Discharge) model is currently being prepared.

- A new national work stream called ‘Discharge without Delay’ (DwD) has been introduced. This is a joint programme of work between the Scottish Government’s Unscheduled Care Programme and Home First Team and spans the whole patient pathway with work required in the acute environment and the community to ensure that delay is prevented for all patients, and that hospitals’ ability to provide timely access to care is improved. Edinburgh HSCP has been identified as one of four Partnership Pathfinders to commence this work, where initial steps involve undertaking a Self-assessment widely used across public services and the private sector. It allows organisations to identify strengths and weaknesses, highlighting areas where improvements could be made, and resulting in actions being developed to make these improvements, which are then monitored against a set of agreed indicators to measure progress.

- System capacity – a review of the four Hospital at Home (H@H) services across NHS Lothian has produced initial findings, working with colleagues from Healthcare Improvement Scotland (HIS), to identify where services are working well and where there are opportunities to improve. The aim of this is to determine how best to size H@H provision to manage population growth that supports care at home, and prevention of hospital admission. This work will be developed to expand into the sizing of other community services. There is a focus on increasing flow and capacity within our Intermediate Care Services by reviewing all potential options to create community-based capacity; specifically focusing on early intervention, urgent care, and prevention of admission. There is recognition that challenges exist including a lack of care provision, available care home capacity and recruitment and retention issues which are

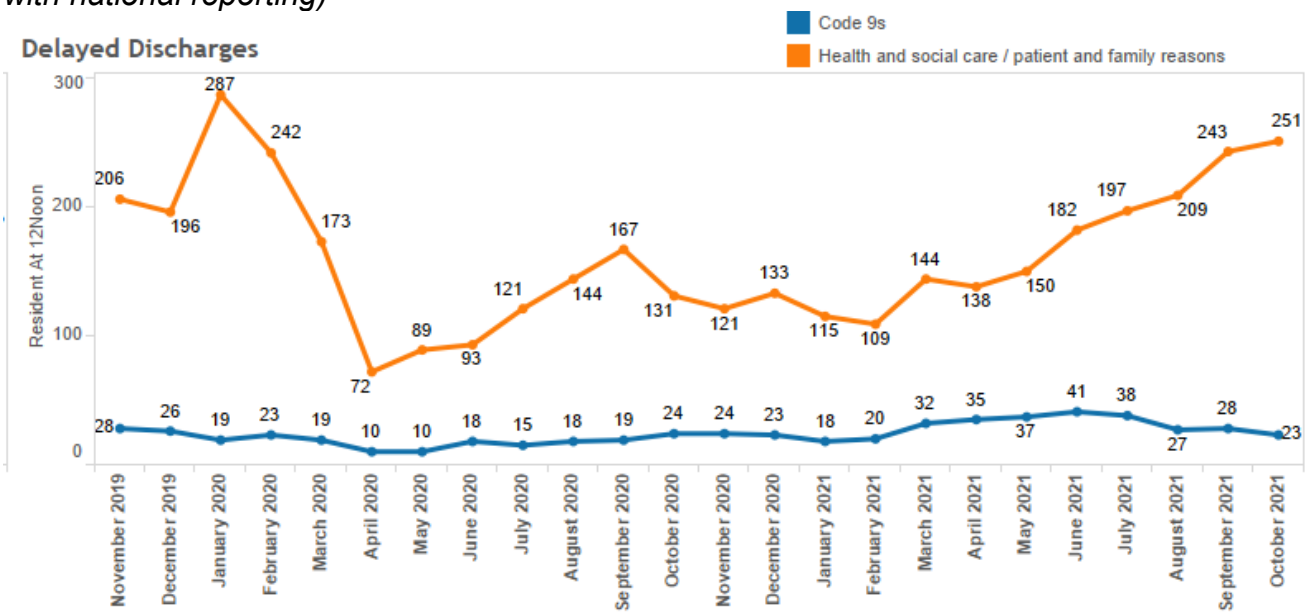
ongoing national concerns. The requirement for care at home capacity within Local Authorities is essential to underpin all approaches to ensure flow.

- Delayed Discharges

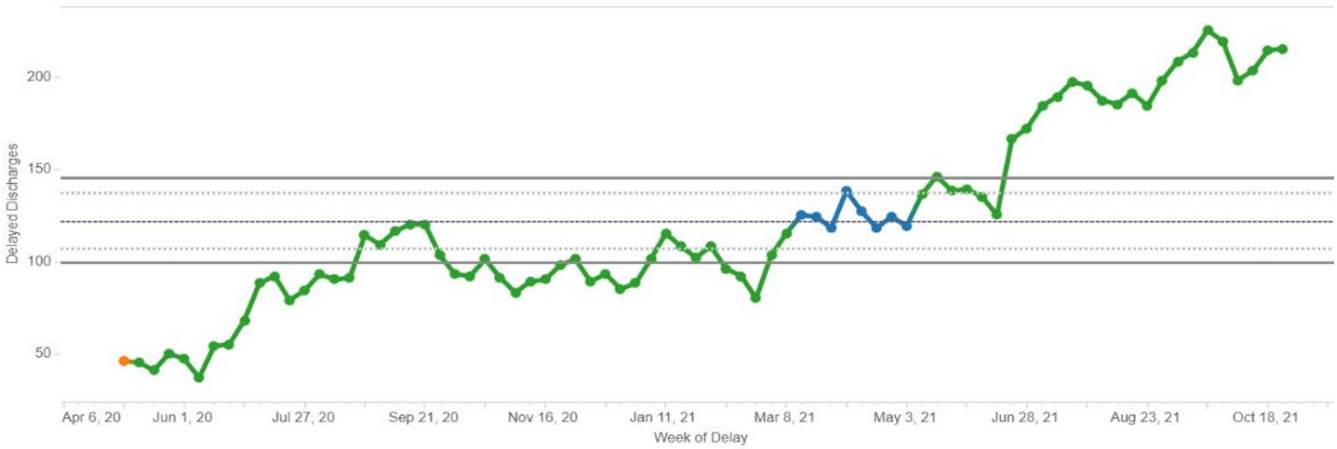
Measures definition: The summary table shows Delayed Discharges for Health and social care / patient and family reasons, and all census delays (plus complex code 9s).

What the data tells us: Pan-Lothian delayed discharges are on an upward trend, with October 2021 figure of 274 exceeding the average monthly rate of 249 in 2019/20. East Lothian HSCP continues to be well within the Remobilisation (4) forecast set, whilst Edinburgh HSCP were higher than their planned position in October 2021 and have continued to deteriorate over recent months. Both the RIE and WGH sites are experiencing the highest number of delays out of the adult acute sites, similar to the yearly rate observed in 2019/20.

Lothian Acute Sites Delayed Discharges (please see appendix 1 for inclusion/exclusion in line with national reporting)



Edinburgh HSCP Delayed Discharges (6 April 20 to 31 Oct 21; Average patients delayed, including Health and Social Care reasons and code 9s)



Narrative: With the continued growth in delayed discharges, tackling this drop in performance has been a key priority for the Board as we approach winter. It should be noted this remains a critical focus of the Board's Gold Command remit, with Executive Directors requiring Edinburgh Health & Social Care Partnership (HSCP) to deliver resilient improvement plans to relieve pressure both in the short, and longer term. As the data above shows, Edinburgh HSCP continue to miss their forecasted trajectory and their delays continue to increase. Edinburgh

HSCP delays have grown significantly over the previous months almost exclusively due to challenges with Package of Care (POC) capacity. Providers in general are maintaining status quo and replacing closed packages only, with no overall net increase in capacity created by this approach. Within the HSCPs a number of Care Homes are closed due to COVID outbreaks, and the Care at Home market is fragile with providers reporting difficulty with recruitment and in sustaining their businesses, which is likely to continue for some time. This is acknowledged to be a national issue for the social care sector, as indicated in the recent Adult Social Care Review. There is also increased demand due to higher patient acuity and the focus of care is to use Care Homes as interim placements for patients awaiting other care packages, to support flow, reduce bed occupancy levels and support admissions from E.Ds.

The additional impact of EU (European Union) Exit is now also starting to show, and providers are reporting a significant drop in applications for care worker posts, as European workers return home or are now unable to come to Edinburgh to fill these vacancies, as they have in recent years. Edinburgh HSCP are working in partnership with external providers to identify areas where we may be able to offer support to overcome some of the recruitment challenges being experienced locally. It is hoped that with Scottish Government announcements of changes to COVID isolation requirements, some resource pressures experienced by providers will be eased. This would enable the release of small amounts of capacity to pick up new packages – as a less cautious approach to maintaining higher than average staff reserves to support isolation requirements.

Through Remobilisation 4 Planning, refreshed delayed discharge trajectories have now been set across the four HSCPs.

A recent short life working group involving key stakeholders from within NHS Lothian and HSCPs has enabled collaborative and parallel working, to implement a Planned Date of Discharge model approach, supporting effective discharge planning. A test of change within both an acute ward and Intermediate Care Facility is currently underway which is providing valuable guidance to the wider spread and adoption of this new way of working. In addition, Healthcare Improvement Scotland have offered to provide a focused piece of support to discharge planning over the next 6 weeks and work has progressed to map out the scope of this within the RIE. The work will support the operational/user perspective on discharge planning, including, current state process/value stream mapping, development of a measurement framework and implementation support.

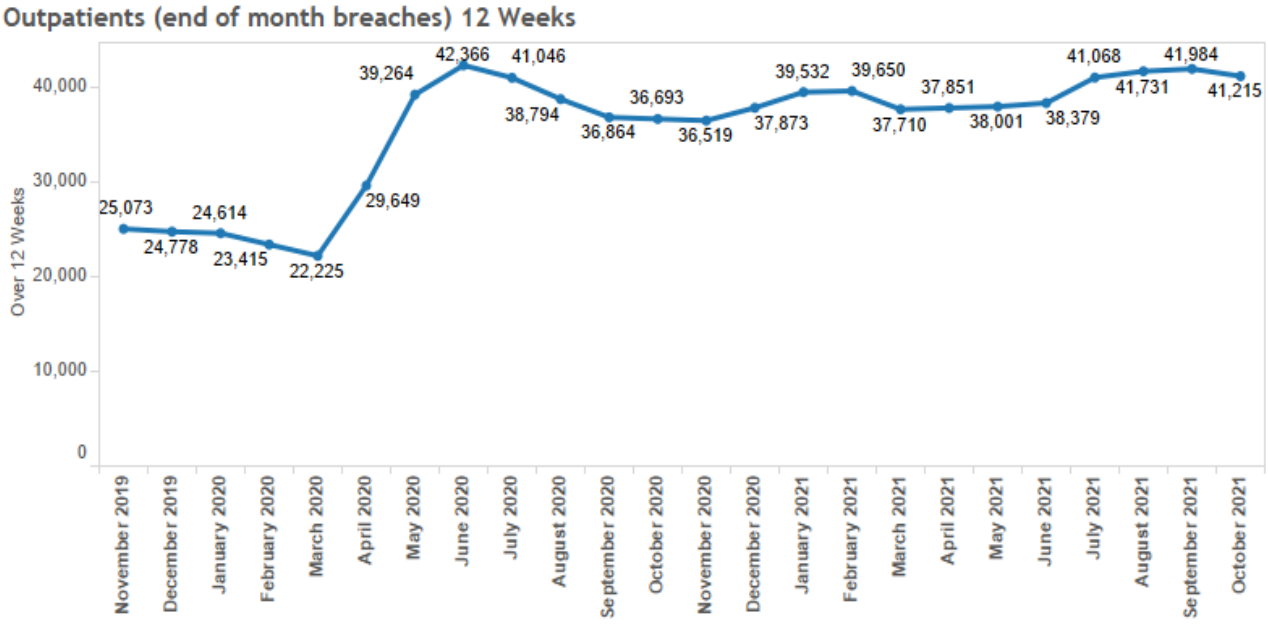
Remobilisation Plans 4: Work has already commenced with a review of the Lothian Hospital at Home (H@H) service against H@H Healthcare Improvement Standards and principles. Funding has been received from Healthcare Improvement Scotland to support a focussed approach, and an initial steering group with key stakeholders commenced in September 2021.

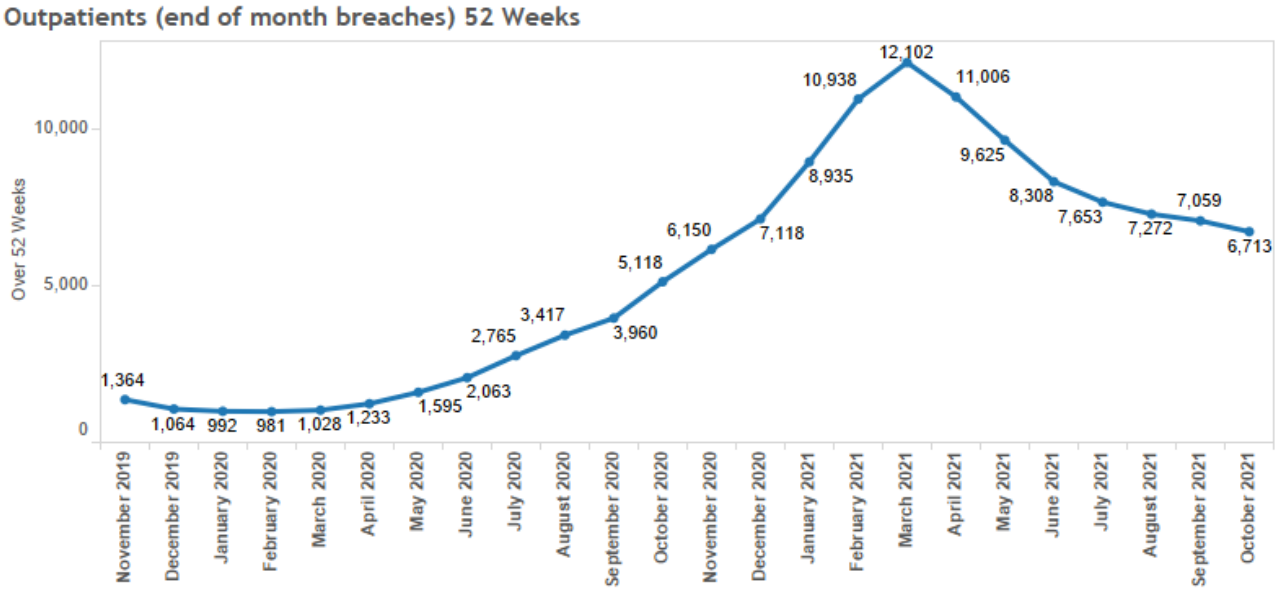
Winter Planning: The four HSCPs continue to focus on the prevention of ED attendance, hospital admissions and proactive management of patient flow from acute services to reduce delayed discharges. Winter plans are in place to enhance Hospital to Home, Discharge to Assess, Hospital at Home and Community Respiratory Teams to support flow. However significant workforce pressures felt across all these services, remain challenging.

- **Outpatients**

Measures definition: The summary table shows two indicators covering outpatient end of month breaches waiting over 12 and over 52 weeks at the end of October 2021.

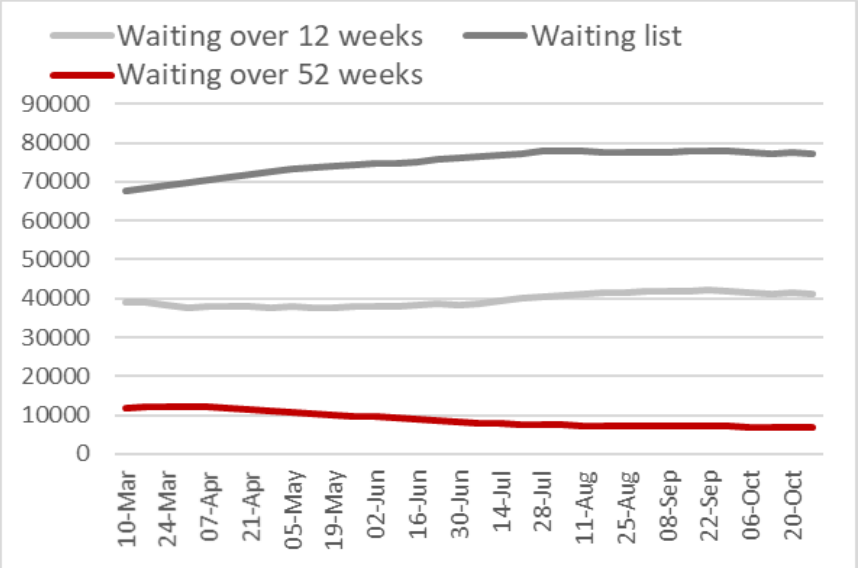
What the data tells us: A number of specialty areas are seeing a reduction in their waiting list size and the number of patients waiting over 12 weeks and over 52 weeks is decreasing. The overall trend for outpatients is relatively stable, with a slight reduction of 769 from September 2021 to October 2021 as shown in the total outpatients' chart(s) below.





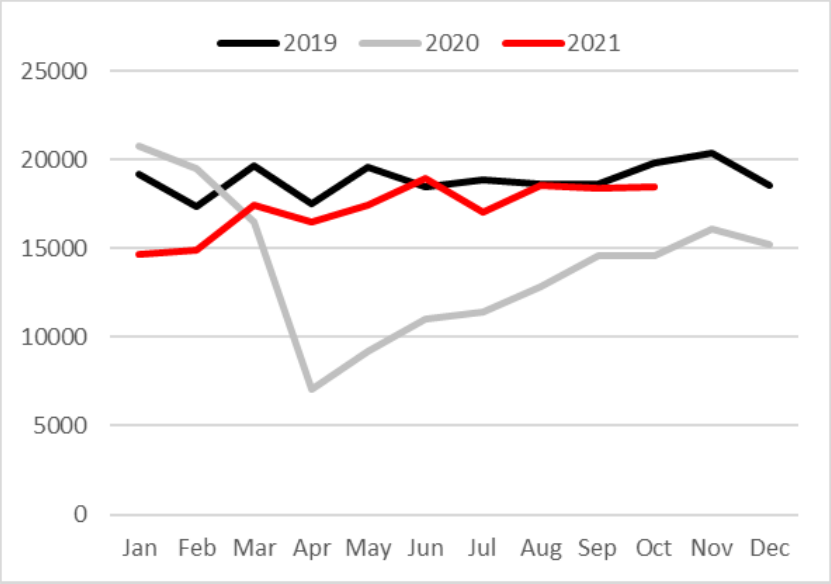
Narrative: Across a number of specialty areas, the waiting list size and the number of patients waiting over 12 weeks and over 52 weeks is decreasing. Dermatology remains a pressure for Outpatient's performance, with the backlog of urgent and routine patients being compounded by significantly increasing USoC demand. The majority of longer waiting routine and urgent patients within NHS Lothian are Dermatology patients. Dermatology's waiting list size and number of patients waiting over 12, and over 52 weeks has, nevertheless, decreased in recent weeks, as further additional activity has come on stream.

Waiting list for a New Outpatient appointment- all specialities



Remobilisation Plans 4: Outpatients have achieved comparable levels of activity (not including additional External Provision activity) to 2019; activity was 100% of 2019 activity levels in August 2021; 99%, in September 2021 and 93%, in October 2021.

New Outpatient activity trend- all specialities

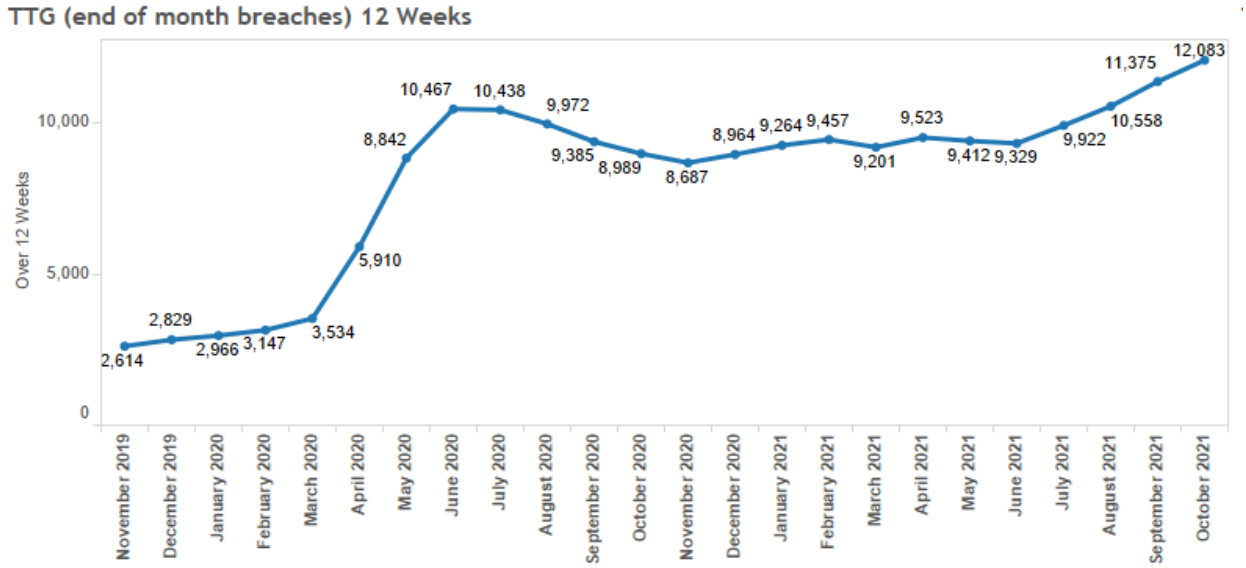


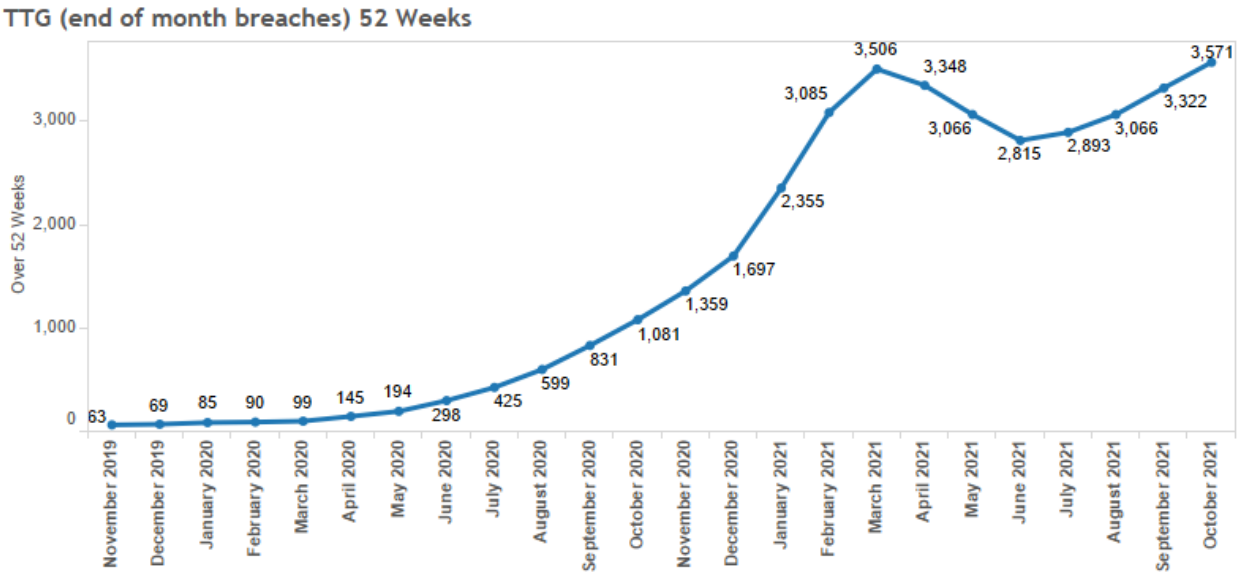
Winter Planning: The combination of increased Emergency Department attendances and closure of beds due to staffing pressures have resulted in some staff being allocated from out-patient services to support in-patient activity.

- **Inpatients & Day Case (IPDC)**

Measures definition: The summary table shows two indicators covering inpatients and day cases end of month breaches waiting over 12 and over 52 weeks at the end of October 2021.

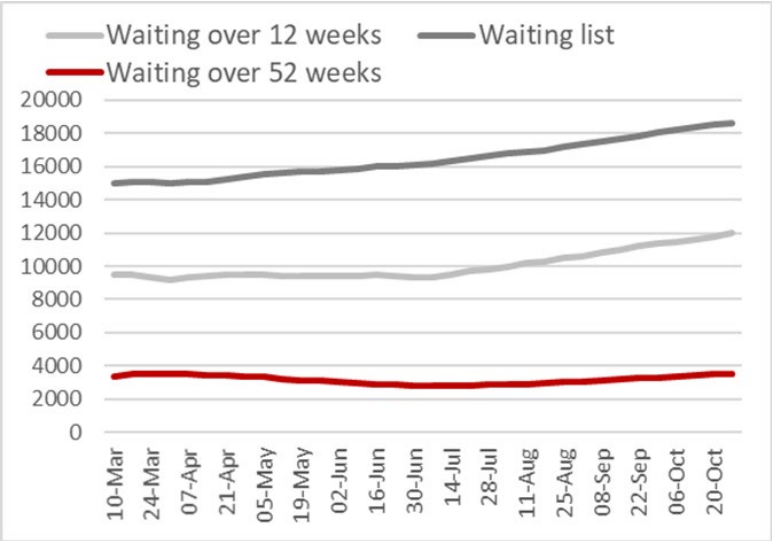
What the data tells us: The waiting list size and the number of patients waiting over 12 weeks and over 52 weeks have further increased due to the limited Inpatient/Day case capacity available, as shown in the chart(s) below.





Narrative: The waiting list size and the number of patients waiting over 12 weeks and over 52 weeks have increased due to the limited Inpatient/Day case capacity available.

Waiting List for TTG Inpatients/Day Case Patients- all specialties



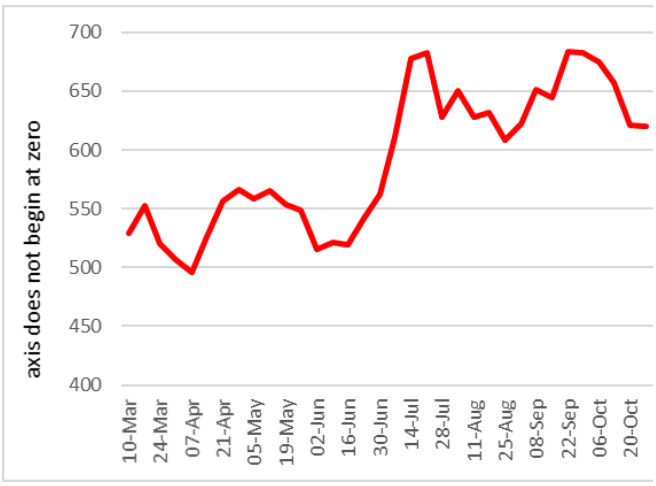
The new clinical prioritisation framework for TTG Inpatients/Day case patients was implemented in February 2021 onwards to support prioritisation of treatment of the most urgent patients. The previous priorities of Urgent and Routine were enhanced to:

- P2 Urgent Suspicion of Cancer (USoC; scheduled within 4 weeks)
- P2 Urgent (scheduled within 4 weeks).
- P3 (scheduled within 12 weeks)
- P4 (may be safely scheduled after 12 weeks).

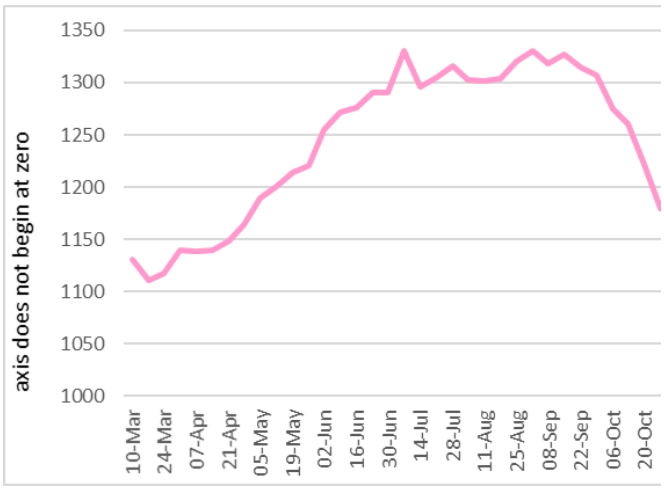
Whilst the overall TTG Inpatient/Day case waiting list continues to increase; the limited capacity available is being allocated to treat P2 patients.

TTG Inpatient/Day case waiting list trend- all specialties

P2 USoC

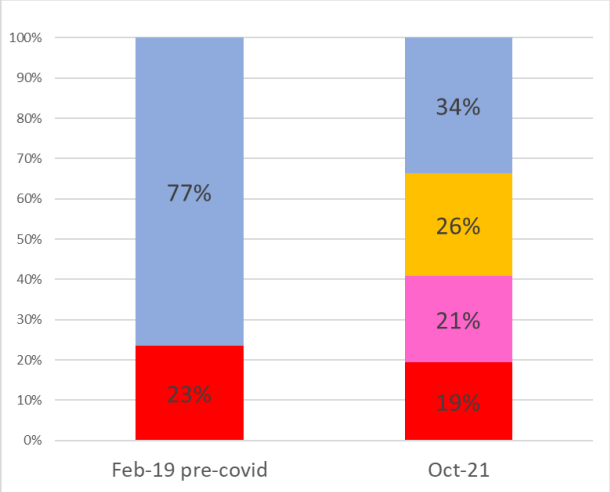


P2 Urgent



An increased proportion of patients who are now added to the TTG Inpatients/Day case waiting list are in the most urgent category, compared to the proportion pre-COVID. Around two-thirds of October's waiting list additions were P2-P3 rather than P4 category patients.

Proportion of the priorities of the TTG Inpatients/Days case added to the waiting list – pre-COVID and current

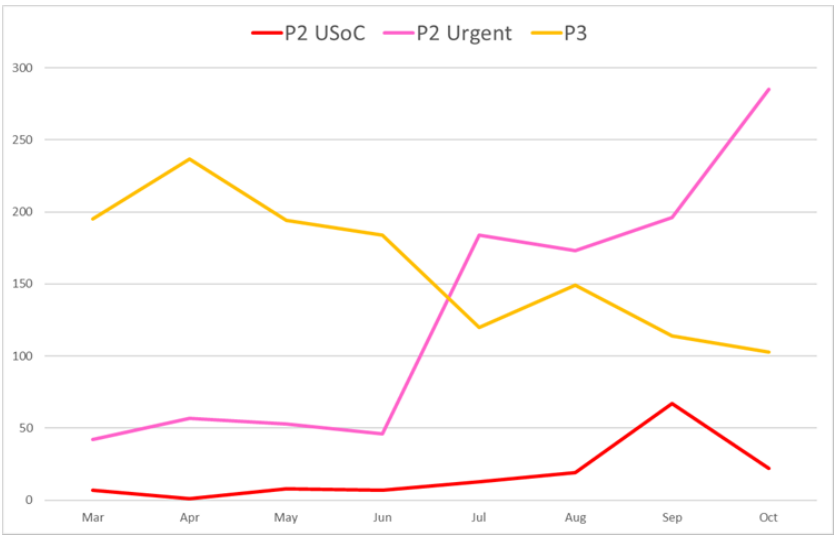


Legend:

Previous priorities (Pre-Mar 21)		**Mar-21 onwards clinical prioritisation framework**			
Urgent	Routine	P2 USoC	P2 Urgent	P3	P4

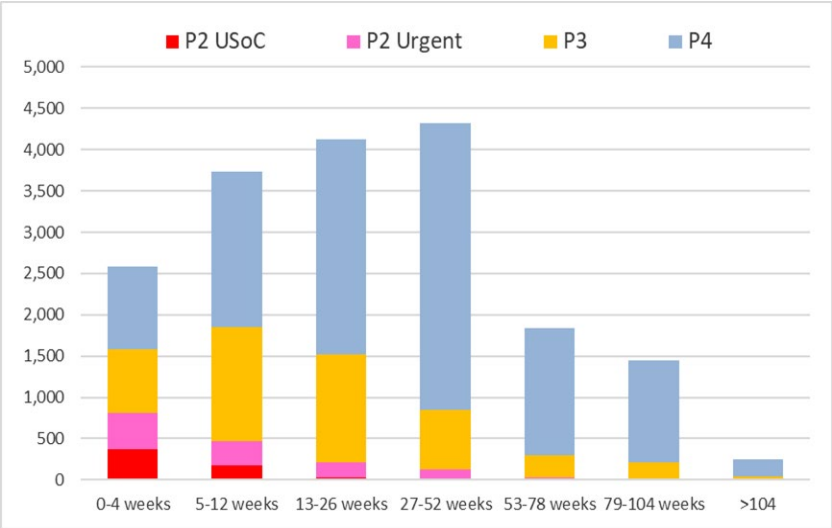
There is an ongoing clinical review of long waiting patients. Once a patient has been reviewed, their priority may be upgraded if their condition has deteriorated. An increasing number of TTG Inpatients/Day case patients are now being upgraded to P2 Urgent. The highest number of upgrades to P2 Urgent status are for patients within General Surgery and Urology waiting lists.

Trend in TTG Inpatients/Day cases upgraded to P2 or to P3



A patient previously added to the waiting list as less urgent but who then subsequently had their priority upgraded following clinical review, will appear on the waiting list as having a lengthy overall waiting time (where waiting time is counted from date added to the list, rather than since priority upgrade).

Waiting list and times for TTG Inpatients/Day cases by patient priority



Remobilisation Plans 4: Since the onset of the pandemic theatres have been operating below pre-COVID levels, and activity continues to be reduced due to significant staffing constraints within theatres, critical care and elective beds. Treatment Time Guarantee Inpatient/Day case (TTG) activity (not including additional External Provision activity) was 71% of 2019 activity levels in August 2021: 63% in September 2021 and 51% in October 2021.

Although we have had to cancel a number of non-urgent (P3-4) adult patients throughout the earlier phases of the pandemic aligned to our clinical prioritisation framework, the surgical programme for non-urgent patients including paediatrics had to be fully suspended due to staffing constraints and service pressures during September and October. This position is reviewed on a weekly basis. The Board will be aware that there have also been P2 patients cancelled during times of significant challenge. Local governance and oversight frameworks are in place to ensure the patients are re-booked as a priority and this topic will be subject to a more detailed discussion at a future PPDC meeting.

From trajectories and activity forecasts it is anticipated that we will continue to see a deterioration in TTG performance.

Winter Planning: The combination of increased Emergency Department attendances, closure of beds due to staffing pressures, increased delayed discharges and an increase in occupied bed days, will continue to impact on elective activity for both Inpatients/Day case patients.

➢ Cancer

Measures definition: Measures the % of patients diagnosed with cancer to begin treatment within 31 days of decision to treat and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62-days from urgent receipt of referral for newly diagnosed primary cancers.

What the data tells us: 62-day cancer performance remained below target in September 2021, however Lothian's performance was higher than the Scottish average; with NHS Lothian performance at 86.1% and NHS Scotland 83.1%. 31-day cancer performance was within target (>95%) and similarly above the Scottish average; NHS Lothian performance was 98.4% and for NHS Scotland was 96.9%.

31 Day performance, by Tumour Group, where under 95% for most recent month

	Mar 20	Jun 20	Sep 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
Melanoma	85.7 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	88.2%	100.0 %	92.9 %
Lymphoma	100. 0%	100.0 %	92.3%	0.0%	0.0%	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	91.7 %
All Cancer Types	**96.8 %**	**92.2%**	**97.9%**	**99.7%**	**97.8%**	**98.3%**	**98.0%**	**98.6%**	**98.6%**	**98.3%**	**96.6%**	**97.3%**	**98.4 %**

62 Day performance, by Tumour Group, where under 95% for most recent month

	Mar 20	Jun 20	Sep 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
Urological	57.8 %	46.9 %	63.6%	72.2%	62.5%	56.8%	54.8%	48.8%	64.1%	47.8%	48.8%	54.5%	46.2 %
Colorectal (screened excluded)	79.2 %	88.9 %	83.3%	63.6%	83.3%	91.3%	85.2%	92.3%	90.0%	88.9%	70.8%	79.2%	75.0 %
Colorectal (screened only)	50.0 %	0.0%	100.0%	100.0%	100.0%	100.0%	80.0%	81.8%	84.6%	87.5%	84.6%	75.0%	92.3 %
Melanoma	100. 0%	100.0 %	85.7%	60.0%	85.7%	71.4%	80.0%	93.8%	100.0%	88.9%	84.6%	100.0%	77.8 %
Cervical (screened only)	n/a	0.0%	n/a	n/a	n/a	0.0%	66.7%	n/a	100.0%	100.0%	100.0%	0.0%	0.0%

	Mar 20	Jun 20	Sep 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21
Lung	82.8 %	92.9 %	87.5%	83.3%	91.7%	100.0%	68.8%	100.0%	100.0%	100.0%	100.0%	100.0%	89.5 %
Upper Gastro-Intestinal	100. 0%	100.0 %	100.0%	95.7%	93.1%	94.1%	88.5%	93.1%	94.7%	100.0%	96.7%	96.7%	92.9 %
All Cancer Types	**83.8 %**	**83.9 %**	**86.5%**	**87.3%**	**87.6%**	**84.0%**	**83.0%**	**86.2%**	**89.6%**	**88.8%**	**82.9%**	**88.2%**	**86.1 %**

Narrative: Cervical (screened excluded) performance demonstrated an improvement in September 2021 achieving 100%; an increase from the previous month (66.7%). The following tumour group types also achieved 100% performance:

- Breast screened only & screened excluded;
- Head & Neck;
- Lymphoma
- Ovarian.

Cervical (screened only) 62-day performance shown in the table above was 0.0% in September 2021; linked to the small numbers of patients involved. Cervical pathway improvement and development work is underway within Gynaecological services.

Most 62-day and 31-day breaches occurred within the Urology pathway and several recovery actions are underway as part of a Prostate Action Plan. Urology 31-day performance in September did improve on the previous month from 90.2% in August to 95.5% in September, meeting target for the first time this financial year.

Remobilisation Plans 4: Challenges associated with managing demand due to staff vacancies, sick leave and COVID isolation continue to impact across pathways. Cancer patients are prioritised but some surgical deferrals have been made in line with clinical prioritisation where this is considered essential; any deferred patient is clinically risk assessed for priority rebooking.

Referral numbers remain above pre-COVID levels, creating pressures across many pathways.

The contract for Robotic Assisted Radical Laparoscopic Prostatectomy procedures at Spire Murrayfield has been extended to the end of March 2022 as part of the Prostate Action Plan. Scottish Government commissioned theatre capacity for priority 2 (urgent/cancer) patients at Spire Murrayfield Hospital for a number of specialties from December 2021 to March 2022 (6 sessions per week in December 2021: 4 sessions per week January - March 2022 inclusive). The logistics of this arrangement are currently being worked through, including careful identification of suitable patients.

Winter Planning: Clinical prioritisation will continue over winter but it is anticipated that surgical services and critical care will remain under pressure this winter.

- **CAMHS**

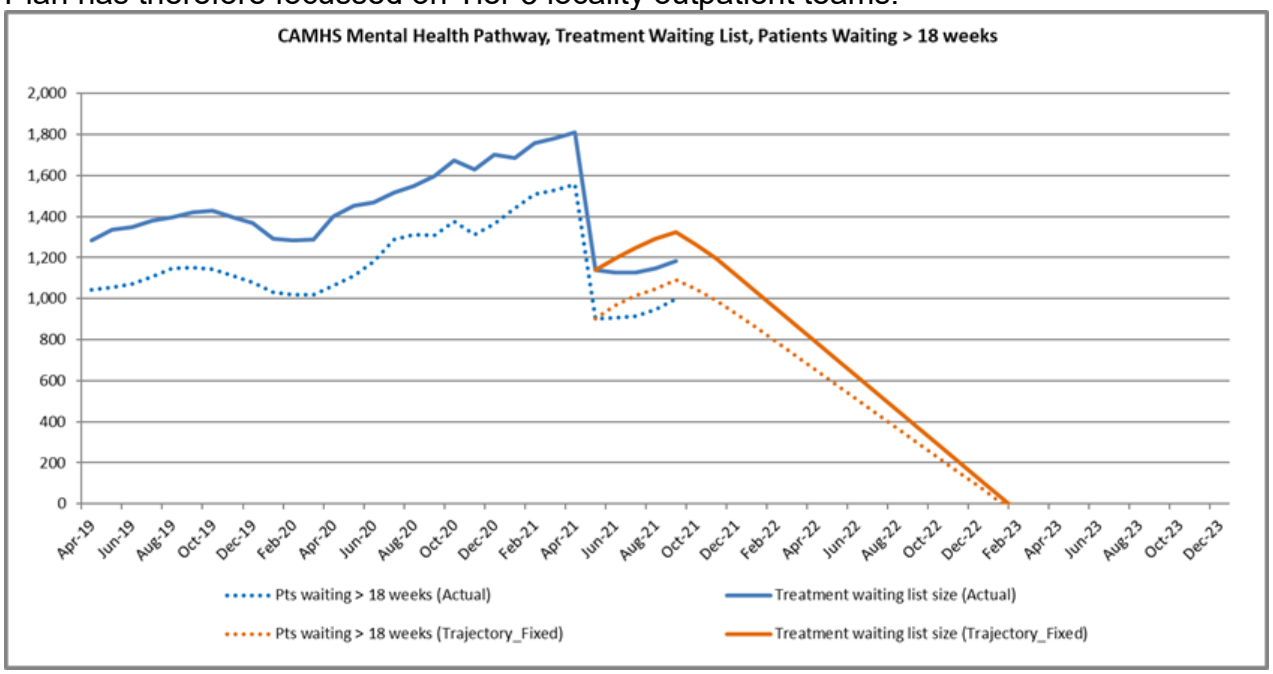
Measures definition: The main function of CAMHS is to develop and deliver specialist services as part of tiered model of care for those children and young people between the ages of 0-18 who are experiencing mental health problems. Lothian CAMHS provides treatment at Tier 3 and 4.

Since December 2014, the LDP Standard has been that 90% of young people are to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.

The CAMHS LDP Standard Definitions and Scenarios document was updated in May 2019 to reinforce clarity for Boards on the scope of the standard. The standard applies where two conditions are met: (i) a child/young person has or is suspected to have a mental disorder or other condition that results in persistent symptoms of psychological distress, and (ii) there is also the existence of at least either serious or persistent impairment to social functioning, or an associated risk that they child or young person may cause serious harm to self or others, or an associated significantly unfavourable social context (e.g. child in care, abuse, parental mental health problem).

From September 2021 Lothian CAMHS is now in full compliance with the LDP Standard Definition and future LDP Standard reporting (previously Lothian CAMHS had reported patient waits for neurodevelopmental services and some specialist services).

What the data tells us: The LDP Standard for 90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral has not been met. The majority of all patients are waiting in the Tier 3 locality outpatient teams, including those patients waiting more than 18 weeks. The NHS Lothian CAMHS Recovery and Renewal Plan has therefore focussed on Tier 3 locality outpatient teams.



Narrative: To sufficiently recover the waiting times position by March 2023, CAMHS implemented a sequential and resource intensive approach to delivering the Choice & Partnership Approach (CAPA). A significant amount of progress has already been made in CAPA planning and the Edinburgh North and South teams have moved towards full implementation and delivery. Additional senior management time and resources from the project team are being made available to support staff in the locality teams to deliver CAPA. The team

leads have completed their first job planning exercise with staff and provided the project team with draft team capacity plans.

The longest waits remain in the Tier 3 Outpatient Teams and an analysis of activity identified additional pressures including the increase in demand and urgent referrals. There has been an increase in more severe illness such as eating disorders and a need to focus on urgent cases and patients at clinical risk. The proportion of patients seen <18 weeks in the mental health pathway is reflective of the current acuity of new referrals to the service for this pathway. To mitigate risk, staff in the Outpatient Team workforce have been redeployed to the Melville Inpatient Unit to support the high dependency/acuity of the current patient group.

The CAMHS Improvement Plan continues to be implemented, though the pace of improvement is impacted by the challenges around recruitment and staff retention. From October 2021, the agreed mental health trajectory included the additional capacity secured through growing the workforce by 23 WTE (Whole Time Equivalent). The proactive strategy of over-recruitment in the Outpatient Teams has not provided the increase in staffing levels and a strategy to secure additional capacity has been developed. Future referral demand is planned to be delivered in the new primary care and unscheduled care pathways. Recruitment to the Primary Mental Health Workforce care team is progressing with appointments to the Team Lead posts expected by year end. The unscheduled care service is now operational 7 days per week and will commence 24/7 upon the recruitment of additional nursing staff. The Clinical implementation of the partnership with Healios was successfully accelerated allowing the first patients to be streamed across in October 2021. Ongoing work is underway to further develop our response to the National Multiagency Neurodevelopmental Specification which is supported by additional funding from the Scottish Government Mental Health and Recovery and Renewal Fund.

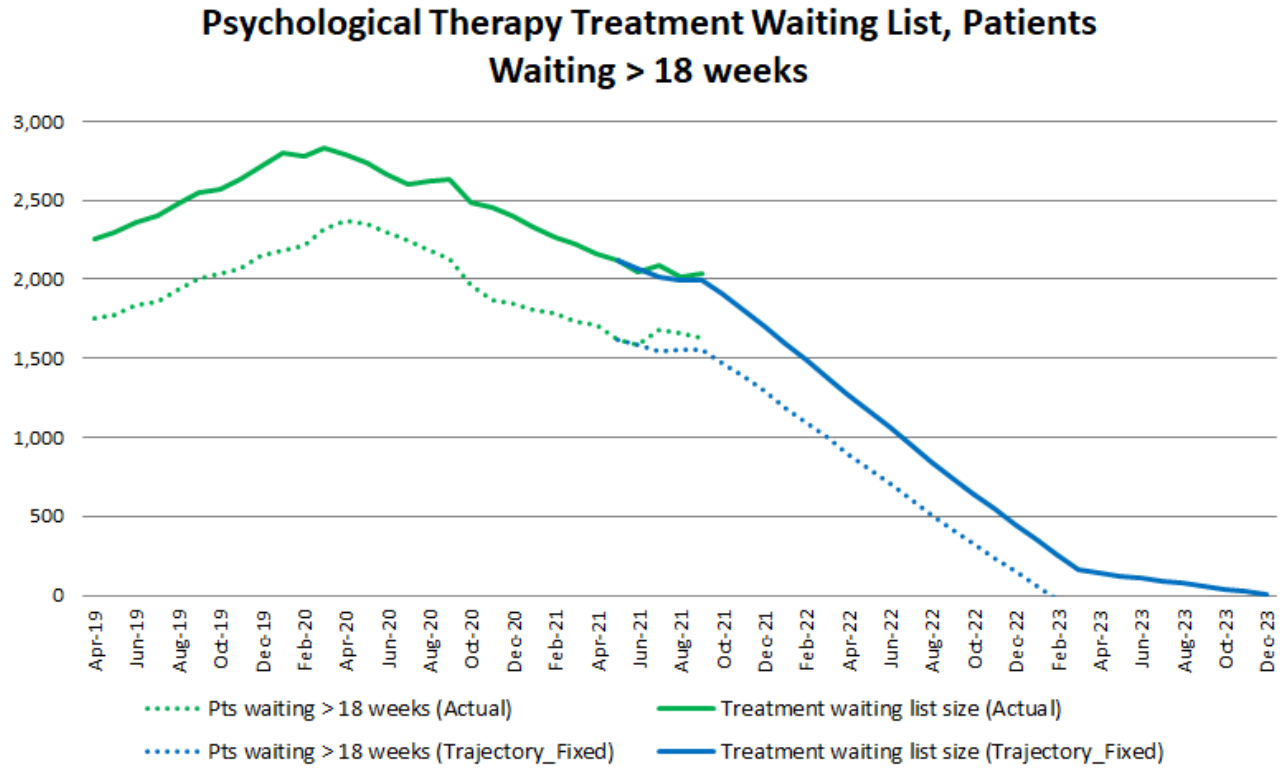
Despite challenges with recruitment, five additional Psychology Assistants have been successfully recruited, two are already in post and three due to start by December. The new intake of psychology trainees in November 2021 and new stream of newly qualified clinical psychology practitioners in February 2022 are also opportunities to secure the additional required capacity early in the New Year. Five Band 5 occupational therapists have been successfully recruited to support the CAMHS OT career framework and many of these new OT posts will support the development and expansion of the CAMHS Group Service. Three Clinical Pharmacists have been recruited and the remaining posts are being advertised with the ambition that every outpatient team will have access to a Clinical Pharmacist. Growing and developing our workforce remains a priority and rolling adverts for Nursing, Psychology, Occupational Therapy and Psychiatry are being progressed through recruitment or are currently live.

Remobilisation Plans 4: With respect to re-mobilisation CAMHS is following the detailed Recovery and Renewal Plan which has been approved by the Scottish Government.

- **Psychological Therapies**

Measures definition: Psychological therapies refers to a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress. The indicators included show performance against the Scottish Government's key target that 90% of patients with mental health conditions that meet the service's clinical threshold should start treatment within 18 weeks of referral. 78.6% of patients with mental health conditions that meet this clinical threshold received treatment within 18 weeks of referral.

What the data tells us: The LDP Standard for 90% of patients to be seen within 18 weeks of referral to treatment has not been met. There has been an improvement since March 2020 relating to the total number of patients waiting over 18 weeks for psychological treatment, although further improvement is needed for those patients waiting the longest period, over 52 weeks. The waiting times in general Adult Mental Health Services remain the longest, some specialty services namely the Community Mental Health Teams, Group Management Service, Clinical Health and Veterans 1st Point also have long waiting times. The trajectory agreed by the Scottish Government demonstrates how the waiting times can be reduced to meet the LDP Standard by March 2023 with additional investment for recruitment.



Narrative: Teams delivering psychological therapies continue to experience challenges in the context of the increase in demand associated with COVID-19 as well as the recruitment and retention of staff.

The improvement plan submitted to the Scottish Government set out a request for £2.7m funding (£1.5m non-recurring and £1.2m recurring) to recruit 12.6WTE to support specialist services, administration, and supervisory capacity as well as 18.00WTE fixed term posts to general AMH services. The demand was projected in the trajectory as being consistent with the average over the prior 6 months. Recruitment to these posts is ongoing; the supervisory posts are pending job evaluation. To date, recruitment to the permanent posts has been successful, for the fixed term positions, 14.6WTE of the 18.00WTE have been offered posts. The trajectory identified recruitment to be completed by October 2021 with a commensurate increase in productivity, the updated position is that the posts will be filled by January 2022, pending

success with accepted offers of employment. The trajectory to eliminate >18 waits by March 2023 is highly reliant on both successful recruitment as well as staff retention; there is a risk associated with this given the competitive recruitment environment and long-standing limitations relating to workforce supply for psychological therapies.

A range of measures are being implemented across all services delivering psychological treatment. The job planned individual and team capacity models with monthly new patient allocations are being met across general adult mental health teams. The efficiency of the new patient booking process will be improved with the anticipated TRAK upgrade to include Patient Focused Booking; it is anticipated that this will be fully implemented for adult mental health general teams by January 2022. All general adult mental health teams have agreed that the new patient allocation rate is increased by 20% to take account of non-attendance rates, job plans are predicated on average duration of treatment periods which are reviewed with the activity reports at monthly performance management meetings with the senior management teams for psychological therapies. The additional supervisory capacity when recruited will facilitate this process of case management across all AMH and specialist teams.

Remobilisation Plans 4: With respect to remobilisation Scottish Government are aware and content that Psychological Therapies is following the more detailed Plan that was submitted to them and recently approved.

- **Acute Adult Mental Health Bed Occupancy**

Measures definition: This measure shows the average % Occupancy (inc. Pass) based on weekly data time points. *(Pass occupancy = beds that have been used for admitting additional patients when a patient originally allocated that bed is out of the ward on overnight 'pass' as part of the assessment of their preparedness for safe discharge).*

What the data tells us: The position on pressure for admission capacity for Acute Adult Mental Health continues unchanged since the last reporting period other than that of normal variation.

Narrative: There continues to be the requirement for additional inpatient capacity across Adult Acute Mental Health, largely from the Edinburgh HSCP population. This has varied between an additional 15 to 19 beds on a day-to-day basis. 15 of these beds (Braids ward) are reflected in the occupancy data however the ad hoc use of up to an additional 4 beds at any given time is not reported in the data. Six of the additional beds have been funded through funding allocations linked to the COVID-19 Pandemic, with the remaining beds still being unfunded. During the last reporting period there have been wards closed to admissions each for 14-day periods because of patients testing positive for COVID-19. Any empty beds in these wards are reflected in the data, however they have not been 'available' for admissions during the 14-day periods of closure, which will account for some of the reported vacant capacity.

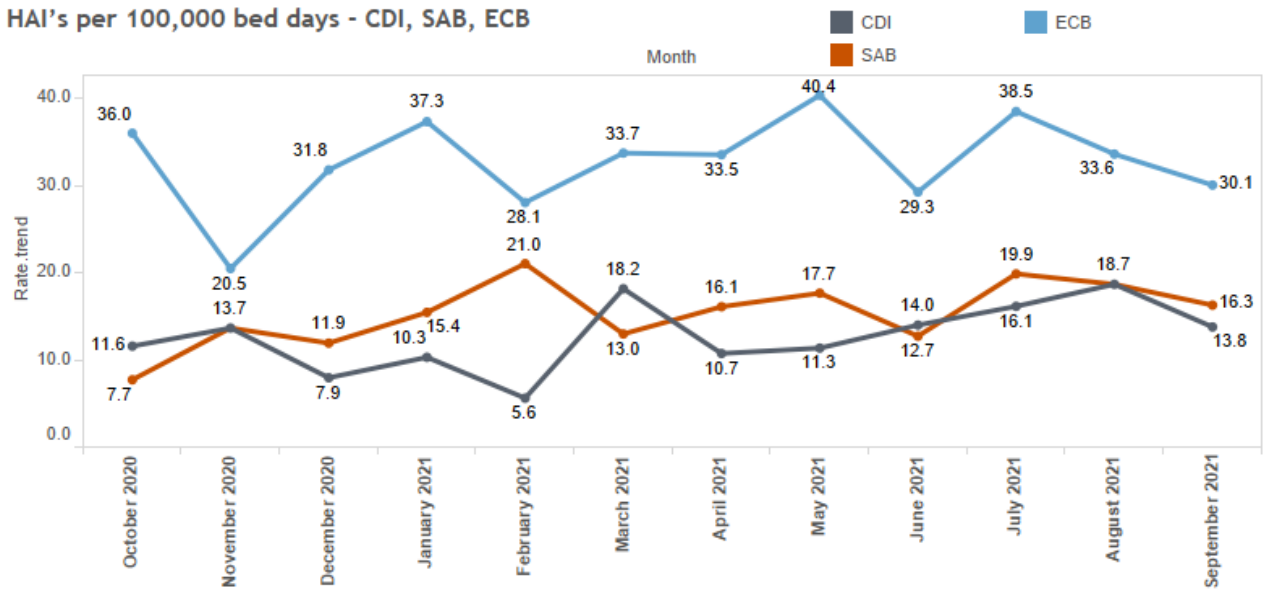
The workforce resource required to safely and effectively care for this number of additional acutely mentally unwell patients continues to place a significant pressure on the existing nursing and medical workforce. There is continued use of Bank and Agency nursing although vacancies have been reduced. The first cohort of three Band 4 Assistant Practitioners have started in post and a further 6 have been recruited to start imminently.

Remobilisation Plans 4: Consideration still needs to be given to whether the current unfunded bed usage is to be substantiated through the strategic and financial plans of Edinburgh HSCP.

- **Healthcare Acquired Infections (HAIs)**

Measures definition: The table illustrates the sum of healthcare associated infections for the year / sum of total occupied bed days for the year.

What the data tells us: The data suggests that at this point in the year NHS Lothian is currently exceeding the planned incidence rate of local delivery plans for Clostridioides difficile infection (CDI), Staphylococcus aureus bacteraemia (SAB) and Escherichia coli bacteraemia (ECB).



Narrative: Reporting of HAIs is made to the Healthcare Governance Committee with the most recent update of November 2021 summarised below.

Staphylococcus aureus Bacteraemia (SAB): NHS Lothian's Local Delivery Plan (LDP) target for 2021/2022 has been set to achieve an incidence of 12.2 healthcare associated episodes (or less) per 100,000 bed days (as per HPS Scotland reporting criteria). For the financial year to date (Apr 2021 - Sep 2021), incidence is 16.9 (n=80 episodes). This is above the LDP target rate of 12.2 (n=58 approx.). Key messages include:

- Device-related SABs continue to account for a proportion of healthcare associated SABs in NHS Lothian.
- In addition to targeted feedback to local clinical teams, opportunities for wider quality improvement action in relation to invasive device insertion and maintenance are being explored in collaboration with the Acute Services Clinical Management Group.

Clostridioides difficile Infection (CDI): NHS Lothian's Local Delivery Plan (LDP) target for 2021/2022 has been set to achieve an incidence of 11.4 healthcare associated episodes (or less) per 100,000 bed days (as per HPS Scotland reporting criteria). For the financial year to date (Apr 2021 - Sep 2021), incidence is 14.2 (n=67 episodes). This is above the LDP target rate of 11.4 (n=54 approx.). Key messages include:

- Exposure to antibiotics with recognised association with CDI continues to contribute to cases of CDI. Some cases noted to have had exposure to 4C antibiotics and a few patients had exposure in the community prior to hospital admission. It should be noted that all C. difficile toxin positive inpatients are reviewed by the ward pharmacists.
- Community associated CDI incidence (as per HPS surveillance programme reporting criteria) in NHS Lothian for September 2021 has seen a decrease from the peaks observed in the previous two months and is now below the current mean.

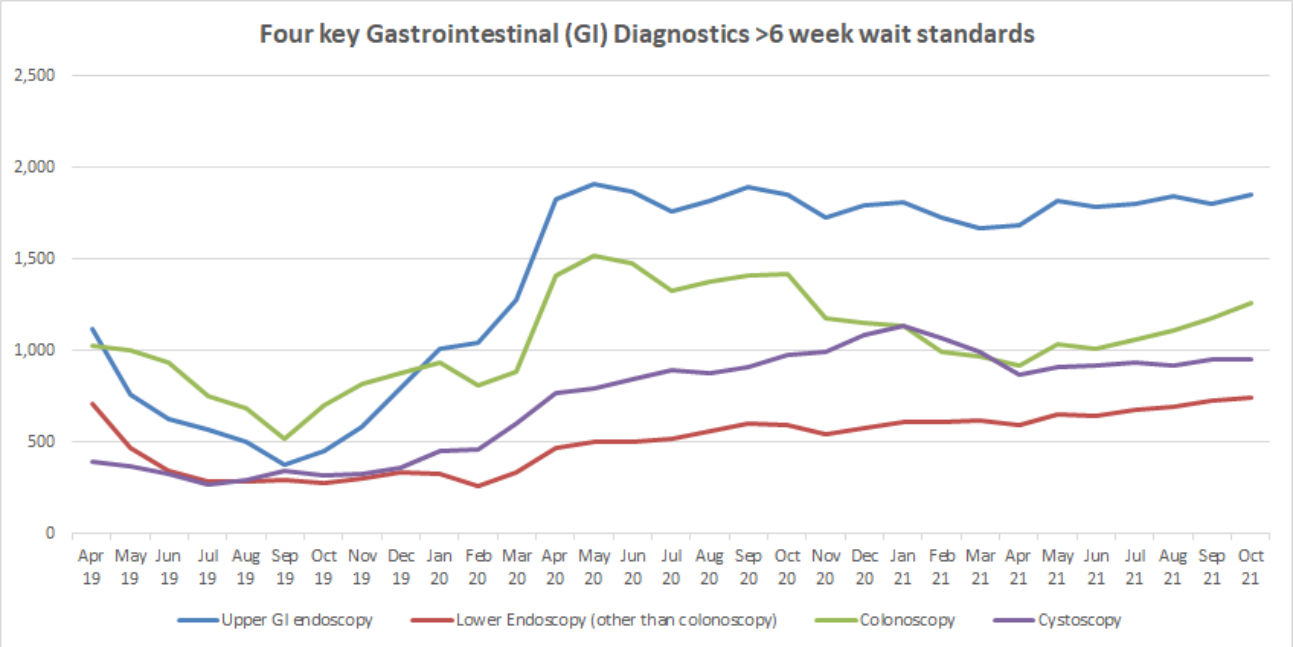
Escherichia coli Bacteraemia (ECB): NHS Lothian's interim Local Delivery Plan (LDP) target for 2021/2022 has been set to achieve an incidence of 26.6 healthcare associated episodes (or less) per 100,000 bed days (as per HPS Scotland reporting criteria). For the financial year to date (Apr 2021 - Sep 2021), incidence is 34.2 (n=162 episodes). This is above the LDP target rate of 26.6 (n=126 approx.). Key messages include:

- Appendix 1, Figure 3.2 shows the healthcare associated Escherichia coli Bacteraemia (ECB) incidence across NHS Lothian for September 2021 (n=24) has seen a decrease from the previous month and remains below the current mean.
- 29% of the healthcare associated ECB were deemed on review to be associated with a source that was potentially preventable (including urinary catheter and Hickman line related sources). NHS Lothian continues to encourage the reduction in use of urinary catheter and optimise care and management of all invasive devices.
- 78% of the community associated ECB cases were related to renal tract infection, none of which were deemed on review to be associated with a source that was potentially preventable.
- From October 2021, NHS Lothian will only report case numbers and origin of infection data as detailed in the CNO letter dated 25 March 2020 (Temporary changes to routine surveillance) in response to staffing pressures & workload within the Infection Prevention & Control Team. This will still allow Lothian to report on case numbers and to establish whether cases are healthcare or community associated.

- **Diagnostics – Gastrointestinal Diagnostics**

Measures definition: The summary table above shows data for the four key Gastrointestinal (GI) Diagnostics >6 week wait standards, as of the end of October 2021.

What the data tells us: The data shows a slight deterioration in performance for patients waiting over 6 weeks for October 2021 for all four GI Diagnostic standards. The chart below shows the numbers waiting over 6 weeks up to October 2021.



Narrative: The continued lower than planned level of new patient lower and upper endoscopy activity has been partially due to existing vacancies in terms of endoscopy practitioners, and unsuccessful attempts at recruiting locums to cover activity; the service confirmed the appointment of one locum from September, to improve in-session utilisation on an ongoing basis but activity over the last two months has decreased due to staff requiring periods of COVID-19 isolation, resulting in the cancellation of sessions. The closure of the Regional Endoscopy unit at Queen Margaret Hospital in Dunfermline for 5 weeks has also significantly impacted capacity and a reduced level of waiting list initiatives has been undertaken because of seasonal leave. Appointment slot prioritisation remains for Urgent Suspicion of Cancer (USoC), Bowel Screening and urgent surveillance patients, irrespective of diagnostic test.

The 14-day USoC target was achieved for 70% of USoC oesophago-gastro-duodenoscopy (OGD) patients. Bowel screening demand has reduced to pre-pandemic levels, with approximately 200 patients per month being referred to the Bowel Screening team following a positive Bowel screening test. USoC demand remains higher than pre-pandemic levels, so new OGD and lower urgent and routine endoscopy waits remain extended. Case-mix is dependent on incoming referral priority, and the urgency at which appointments require to be booked. This also impacts activity per diagnostic test, in any given month.

Remobilisation Plans 4: OGD, lower urgent and routine endoscopy capacity remains at 82% of pre-COVID, levels due to ongoing reductions in appointment slots, resulting from 2-metre distancing in waiting rooms and recovery areas. Infection control guidance has confirmed that any service involving recovery, should remain at 2-metre distancing.

Cytosponge activity continues to be delivered, reducing the number of patients waiting beyond their target date for Barrett's surveillance. A webinar on the use of Cytosponge was delivered at the end of October 2021 by a lead Gastroenterology Consultant and it is anticipated that

this will increase the number of patients referred for Gastro-oesophageal reflux disease (GORD), to be considered for cytosponge, rather than an OGD.

The introduction of Carvedilol in Lothian continues to see GI banding patients being scoped within target intervals, as the number of referrals for this group of patients has reduced by 75%. The NHS Lothian SOP (Standard Operating Procedure) for Carvedilol has been approved by the Chief Medical Officer (CMO) and distributed to other health boards for their use. To date, all but one health board has taken this up.

Due to an increased length of wait for urgent colonoscopy the endoscopy pre-assessment team are contacting patients by telephone, and depending on the outcome of the telephone call, and patient clinical condition, patients are being sent Qfit tests to determine whether their referral requires upgrading, and to be booked more urgently. Approximately 800 patients will be contacted during this exercise.

Scottish Government funding to recover the long waiting position will be allocated to further insourced activity, locum appointment, and private sector activity, although it should be noted this has been limited to date.

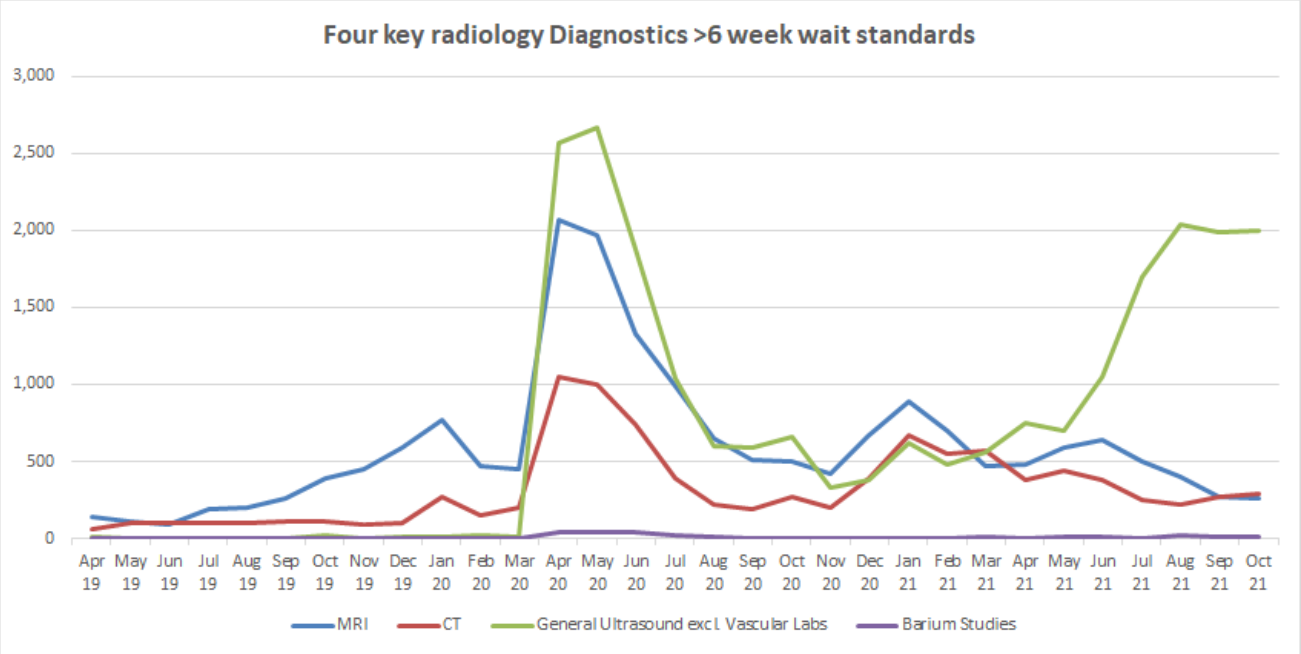
Winter Planning: The increased prevalence of COVID-19 in the community has the potential to further impact ability to deliver expected levels of activity, and recovery of new and surveillance waiting positions, due to patients and staff requiring periods of COVID-19 isolation.

- **Diagnostics - Radiology**

Measures definition: The summary table above shows data for the four key Radiology 6 week wait standards, as of the end of August 2021.

What the data tells us: Over 6-week waits have improved for MRI but have slightly deteriorated for CT, Barium and for Ultrasound diagnostics.

Diagnostics – Radiology Waiting Over 6 Weeks



Narrative: A level of stability continues to be sustained within Computer Tomography (CT) and Magnetic Resonance Imaging (MRI) modalities.

A period of 7-8 weeks of relative stability within Non-obstetric Ultrasound (US) has ended and demand has seen a recent increase. This results from continued high demand for general US referrals and recent lost capacity owing to planned and unplanned staff absences.

Current operational plans are delivering additional US lists via registrars, and this is impacting positively, but not sufficiently to address the underlying demand. The department is targeting further increased numbers of US sessions from mid-November 2021 onwards. Two new sonographers will commence in post in late November/early December 2021, providing net additional US slots to extend capacity. Ongoing recruitment for further sonographers is continuing.

An increase in sonographic training has supported an additional 1 WTE trainee position, taking the current cohort to 3 WTEs, but this will not yield net benefits to sonographic capacity until the completion of the training cycle (18 months' duration).

A change within the planning of medical leave will see reduced rates of cancellation of US slots due to radiologist absence, with c. 1,000 US appointments (annually) safeguarded as a result. Radiologists will now look to cover one another's leave to maintain US appointments - previously these might have been cancelled, or absorbed by sonographers, which is not possible currently due to a lack of sonographic capacity.

Remobilisation Plans 4: The department continues to address workload pressures by running additional sessions internally (covering MRI, CT and US), and through the procurement of external services for outpatients from commercial partners.

One key issue external to NHS Lothian is that our commercial provider is undertaking a replacement exercise of its CT scanner, and the new service is not likely to be available before January 2022. This has resulted in NHS Lothian adjusting booking arrangements, to ensure that CT scanning performance can appropriately be sustained throughout the coming winter period. This activity would have included CT colonoscopies, but NHS Lothian are absorbing these cases into internal slots across our sites. There are unfortunately no current alternative external providers beyond those we are already using, although we are linking in with the Scottish Government and regional services, should mobile CT vans become available (as had been the case in July/August 2021.)

Winter Planning: The Radiology department will undertake seasonal enhancements to its rotas across all sites, in line with well-established winter practices. The winter initiatives target unscheduled and inpatient work flows to promote safe and effective care of inpatients within the hospital pathways. Further developments to enhance dedicated portering staffing levels are also being supported, including allocation of staff to RIE Main Imaging, but also flexibly deploying staff to areas of greatest need at a given time within RIE, DCN and RHCYP, particularly to support patient flows amongst these sites, and to optimise use of the scanning capacity available.

4 Key Risks

The risks during this remobilisation phase have largely remained the same, as shown below.

4.1 The risks associated with delivering the performance metrics relate to the need for recurring, longer term investment plans and availability of workforce to support delivery of access standard trajectories relating to outpatients, treatment time guarantee, diagnostic, cancer, child and adolescent mental health services and psychological therapies.

4.2 Pre-COVID staffing challenges, driven by vacancies, have been exacerbated in 2021 due to an increase in COVID related absence including Positive test, Test and Protect Isolation, Long COVID, Quarantine, Self-Isolating Household, Self-Isolating Symptoms, Other/Unknown, Underlying Health Condition. This includes acute, community and social care staffing groups.

4.3 Implementation of some of the longer-term ambitions to improve performance require an ambitious cultural change for patients, the public and staff. The key risk to this is the potential for services to revert to pre-COVID-19 working practices.

4.4 There are limitations, due to infection control measures and national lockdowns on both internal and external capacity.

4.5 Some specialties have particular challenges with recruitment into key roles, ultimately impacting their capacity to support clinical services.

5 Risk Register

5.1 NHS Lothian's Risk Register already includes the risks associated with delivery of performance standards outlined in the Annual Operational Plan, Recovery Plans and Remobilisation Plans. The corporate risk register is subject to on-going review and update. Some of the key linked corporate risks to this paper have been highlighted below:

5.1.1 1076- The Healthcare Associated Infection Corporate Risk - has been reviewed via Healthcare Governance Committee (HCG) and is graded as medium reflecting the impact on individuals acquiring a Healthcare Associated Infection.

5.1.2 4984- COVID-19 Corporate Risk- has been reviewed via HCG and accepted limited assurance with a grading over very high (20) in June 2021.

5.1.3 5186 – 4-Hour Emergency Access Target Corporate Risk – has been reviewed via HCG with a grading of high (16) in June 2021.

5.1.4 3726 – Timely Discharge of Inpatients Corporate Risk – has been reviewed at HCG with a grading of high (15) in June 2021. The grading is currently under review by the Chair of the Unscheduled Care Board, Director of Primary Care and Director of Acute Services (COO).

5.1.5 5185 – Access to Treatment Corporate Risk – has been reviewed at HCG with a grading of very high (20) in June 2021. Each of the 4 Recovery Boards have plans in place, which include at specialty level. Monitored by the Performance Oversight Board, currently too early to see any measurable impact as yet and there is acknowledgement of longstanding capacity issues.

5.1.6 5187 – Access to Psychological Therapies Corporate Risk – has been reviewed at HCGG in June 2021 with a scoring of very high (20).

5.1.7 5188 – Access to CAMHS Corporate Risk – has been reviewed at HCG in June 2021 with a grading of very high (20).

5.1.8 3828 – Nursing Workforce Corporate Risk – has been reviewed at September 2021 Board and graded very high (20).

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment associated with this grouping of performance metrics has not been undertaken. The directors for each service area are responsible for ensuring an integrated impact assessment is carried out where new services, redesign of services and new strategies/plans are referenced to allow NHS Lothian's Lead on Equalities and Humans Rights to follow up and review whether the necessary assessments have been completed as appropriate.

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

7.1 NHS Lothian Directors, IJB Chief Officers and their teams have supported the development of the Remobilisation Plan which NHS Lothian is currently working to enact. Any public engagement and consultation relating to the contents of the plan remains with this programme of work.

7.2 Patients are kept informed by their clinical care teams.

8 Resource Implications

8.1 The resource implications are being clarified through our finance department. Any financial reporting will remain within the remit of the Director of Finance.

Wendy MacMillan
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15/11/2021
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List of Appendices

Appendix 1: Delayed Discharge Code Inclusion

Appendix 1: Delayed Discharge Code Inclusion

Health and social care reasons: Public Health Scotland		
	Assessment:	
		awaiting commencement of post-hospital social care assessment
		awaiting completion of post-hospital social care assessment
	Funding:	
		non-availability of statutory funding to purchase Care Home Place
		non-availability of statutory funding to purchase any Other Care Package
	Awaiting place availability:	
		in Local Authority Residential Home
		in Independent Residential Home
		in Nursing Home
		in Specialist Residential Facility for younger age groups (<65)
		in Specialist Residential Facility for older age groups (65+)
		in care home (Dementia bed required)
		Awaiting place availability in an Intermediate Care facility
	Awaiting completion of care arrangements:	
		for care home placement
		in order to live in their own home – awaiting social care support (non-availability of services)
		in order to live in their own home – awaiting procurement/delivery of equipment/adaptations fitted
		Re-housing provision (including sheltered housing and homeless patients)
	Transport:	
		awaiting availability of transport
Patient and family related reasons -		
	Legal/Financial:	
		legal issues (including intervention by patient's lawyer) e.g., informed consent and/or adult protection issues
		financial and personal assets problem - e.g., confirming financial assessment
	Disagreements:	
		internal family dispute issues (including dispute between patient and carer)

		disagreement between patient/carer/family and health and social care
	Other:	
		patient exercising statutory right of choice
		patient does not qualify for care
		family/relatives arranging care
		other patient/carer/family related reason
Code 9 reasons -		
	Patients delayed due to the Adults with Incapacity Act	
	Code 9 patients (excluding those delayed due to Adults with Incapacity Act):	
		awaiting completion of complex care arrangement - to live in own home
		awaiting place availability in specialist residential facility (under 65)
		awaiting place availability in specialist residential facility (65+)
		patient exercising statutory right of choice – where an interim placement is not possible or reasonable

Meeting Name: Board **Meeting date: 1 December 2021**

Title: *Lothian Strategic Development Framework*

Purpose and Key Issues of the Report:

DISCUSSION	x	DECISION	x	AWARENESS	

The paper outlines progress on developing the Framework. Appended to the paper is the 18-page draft summary of the LSDF. Board members are asked for comment and to note the arrangements for the sharing of supporting draft sections.

The point of decision in the paper is to ask the Board to agree to take the final version to the February 2022 Board and decide at that point whether or not to proceed to public consultation. Reasoning is explained in the paper.

Recommendations:

- **Note** the work undertaken since the update to the October Board;
- **Agree** the content of the summary document;
- **Agree** that the formal consultation period should commence after the February 2022 Board meeting

Author: Colin Briggs **Date: 24th November 2021**	**Director: Colin Briggs** **Date: 24th November 2021**

NHS LOTHIAN

Board Meeting
1st December 2021

Director of Strategic Planning

LOTHIAN STRATEGIC DEVELOPMENT FRAMEWORK – PROGRESS UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress in developing the Lothian Strategic Development Framework (LSDF).

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

2 Recommendations

2.1 The Board is recommended to;

- **Note** the work undertaken since the update to the October Board;
- **Agree** the content of the summary document;
- **Agree** that the formal consultation period should commence after the February 2022 Board meeting

3 Discussion of Key Issues

3.1 Board members have been well-sighted on the full process for developing the LSDF. The intent of this process is to identify the approach the Lothian Health and Care System (LHCS) will take over the next five years to deliver improved outcomes in;

- **Population Health** – tackling inequalities, maximising prevention of ill-health and increasing the number of years of healthy lives;
- **How we work with people** – increasing citizen engagement and understanding of the system, and working to ensure that the way we deliver care is of a standard we would all wish;
- **Performance** – working to improve our performance against key national measures.

3.2 Taken together, these measures should summarise how LHCS will contribute to the delivery of the Scottish Government's National Outcomes and progress against the National Performance Framework (https://nationalperformance.gov.scot/national-outcomes).

3.3 At the last Board meeting, members noted that the final document suite will include;

- A short, accessible and readable, summary of the case for change and the actions we will take;
- A series of aligned documents which cover, in detail, the case for change in each section and the actions we will take. This will therefore be a mix of narrative and bullet points;
- Cross-cutting sections on our parameters and outlining our commitments around workforce, finance, capital, and environmental measures.

3.4 The short summary, which will form the centrepiece of our consultation, is appended to this document. It includes the proposals outlined to the Board in the paper on the LSDF which came to the October Board meeting. A draft of this summary was taken to the informal buddy group in place and that group broadly endorsed the structure, tone, and content. Approval is therefore sought from the Board for this document to be adopted, noting that this does need to be given "corporate livery" before progressing. The content, however, is considered final draft.

3.5 The series of aligned documents, and cross-cutting sessions, constitute approximately 175 pages. These were being finalised at the time of circulation of papers and therefore will be circulated to Board members separately for comment.

3.6 The original intention of the process for putting together the LSDF was to align consultation and final agreement with the pan-Scotland planning cycle, which was previously anticipated to include a request for a three-year forward view from 1st April 2022. This is now anticipate to be aligned to July 2022. It is also understood that there will be greater detail on the national Care and Wellbeing Portfolio next steps around this time and there is therefore an opportunity to both influence this work and ensure that the LSDF appropriately aligns.

3.7 Key to the future of the system is where proposals for a National Care Service settle. We understand that there will be an independent evaluation of responses provided to the Scottish Government and published in January 2022, ahead of legislation being prepared.

3.8 The Board had also been conscious of local authority elections on 5th May 2022. There would be a risk that following the original plan to consult during December, January, and February would create an impression of seeking to make decisions ahead of the public debate associated with elections.

3.9 Taking the information in paras 3.6 and 3.7 together, it is therefore recommended that final approval to go to consultation would be sought at the February Board, with consultation commencing immediately thereafter.

3.10 Agreeing the recommendation in 3.8 would allow further time for further refinement and taking the entire package of proposals and detail out to staff and partners ahead of the formal public consultation, which is likely to be helpful. Although there has been a huge amount of consultation and support from across the system, it would seem prudent to always go the extra mile when staff and partners have been so busy and may not have linked all the different elements of the LSDF together. This particularly applies to our IJB partners.

4 Key Risks

4.1 The LSDF should be a tool to manage risks for the organisation over the next five years.

4.2 As noted in the October paper, one particular risk to the LSDF lies in the final shape of a national care service, and the disruption that will inevitable ensue in its establishment. It is understood that there will be a summary and evaluation of responses published in January 2022.

5 Risk Register

5.1 No entries are made to the risk register with regards to the LSDF, but it would seem likely that some will be as the programme of implementation progresses.

6 Impact on Inequality, Including Health Inequalities

6.1 No specific impact assessment has been undertaken. The consultation and engagement processes will clearly inform a final impact assessment more clearly and meaningfully.

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

7.1 As noted, the LSDF will be subject to public consultation. It is important to note that there has been a huge amount of engagement in the construction of all proposals.

8 Resource Implications

8.1 Detail on resource implications will come back to the Board in February and April 2022.

8.2 There will be a resource implication associated with the consultation process, and this will be resolved ahead of the February Board.

Colin Briggs
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19th November 2021
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Appendix
The Lothian Strategic Development Framework – draft to Board

The Lothian Strategic Development Framework

Draft 5 – for consideration by the Board, 1st December 21 meeting

About this document

This document is the Lothian Strategic Development Framework and lays out what will happen across Lothian's Health and Care system over the next 5 years, up to and including the financial year 2027-28. It is a collaboration between the bodies with responsibility for the planning, commissioning, and delivery of health and care services in the Lothians;

- East Lothian Integration Joint Board;
- Edinburgh Integration Joint Board;
- Midlothian Integration Joint Board;
- NHS Lothian;
- West Lothian Integration Joint Board.

Collectively, we refer to these five organisations as the Lothian Health and Care System (LHCS).

We call this document a Framework because it knits together the five interdependent approaches of the collaborating bodies and lays out a basis for us to collectively move forward. It represents our high-level thinking of what will happen and what we will do over the next five years, but it is important to note that it is impossible to guarantee that our aims and objectives will be met over that time period. Indeed, it may be that as we go forward, it will make more sense for us to change our plans than to stick with what is outlined herein.

We do need to be candid that as we are publishing this, public services are under enormous strain. The NHS and services which are crucial to promoting health, preventing disease, and providing treatment are no different. The ongoing challenges of the pandemic, combining the disease, the impact on our workforce, and "catching up" with other diseases, means that we are in a position where performance and outcomes are not what we would want them to be. However, we believe that the principles and assumptions we make support a general direction of travel in a post-COVID world, and that we will adhere to these.

As you read through this Framework, you will see some words and phrases are underlined. These are links to associated documents with much more detail on that particular word or phrase. These may be detailed plans, or they may be the glossary of terms we use to aid understanding.

The Framework describes;

- What we are trying to achieve;
- Where we are now and the impact of the COVID-19 pandemic on the services we provide;
- Our principles, assumptions, and fixed points;
- The needs of our population, and the longer-term demographic challenges we face;
- The parameters of our system in terms of our people, our financial resources, and our infrastructure;
- The actions we will take to deliver over the next five years across a range of settings;
    - Population health and anchor institution status;
    - Children and Young People;
    - Mental Health, Illness, and Wellbeing;
    - Primary Care;

- Unscheduled Care;
- Scheduled Care

We also present supporting assessment and evidence which outlines the parameters we work within;

- Our **workforce** context, where we have a population growing rapidly and aging simultaneously. We note that across the country we have a reducing number of people of working-age, which means there are fewer people to work in health and care services and settings;
- Our **financial** context, where we have an accumulated financial gap as a result of the national funding formulas as they have applied to the public sector in the Lothians, and growing financial challenges from new drugs and treatments;
- Our **capital** context, where, while we have significant Scottish Government investment pledged for large new clinical facilities such as a new Cancer Centre, a new Eye Pavilion, and a new short-stay scheduled treatment centre at St John's Hospital, we do not as yet have investment for improvements to the Royal Edinburgh Hospital and have a significant challenge to fund other community facilities;
- Our **digital** context, with technology more and more capable and supportive of clinical practice and practitioners;
- Our **environmental** context, where we have an obligation to ensure that we reduce our carbon footprint. 5% of all travel in the UK is healthcare-related.

What are we trying to achieve?

The health and care system is a key underpinning of the success and prosperity of Scottish society. To this end, it contributes directly to the National Outcomes which drive the national Programme for Government. At a more local level, our organisations seek to work together to improve the health and wellbeing of a population of nearly 1 million. Our population has grown by 12% since 2011 and we expect it to grow by 8% over the next ten years.

Our aims and objectives for the next five years are;

- An improvement to population health;
- Outcomes we aim for in how we will work with citizens and with patients;
- To deliver nationally-prevailing performance measures;

There are some broad themes about how we will work that are central to our approach;

- We want to move care closer to home where we can. The citizen's home will be the key fixed point for how services are designed and delivered. We believe that we should have very good clinical reasons to ask someone to come to one of our facilities;
- We see an ever-increasing role for self-care by citizens, and of their deeper engagement in the prevention of disease. We see this as particularly valuable in the provision of services for children and young people;
- We will seek to embed things we have learned from the covid-19 pandemic in everything we do;
- We will work ever-closer with all of our partners in the public square – local authorities, the third sector, the Scottish Government, educational institutions, and the private sector – to maximise and augment the positive impact each sector can have on citizen's lives. We see this as crucial to meet our aspirations to work as an anchor institution;
- We will work to improve our health and care facilities whenever and wherever we can, and remain committed to our campuses at the Royal Edinburgh Hospital, Royal Infirmary of Edinburgh, St John's Hospital, and the Western General. This will mean some new buildings, but also the closure of buildings which are no longer suitable for treatment and care;
- When we do need to build new facilities, we will work with our partners from across the public square to ensure that these are multi-use and bring together the services citizens access on a regular basis. It doesn't matter to the citizen what the nameplate on the building says – it matters that we make it easier for the citizen to get the right help;
- We will increasingly use technology and innovation to support our delivery of treatment and care. Citizens will see this in the increased use of digital communications technology to provide appointments where previously they had to travel to outpatient or general practice settings;
- Recovery from the impacts of the COVID-19 pandemic will take years, not months, and this will mean longer waits for scheduled care. We will work to prioritise treatment for cancer and life-threatening illness in this context.

Where are we now? The impact of Covid-19

We are all aware of the direct impact of COVID-19. It will be rare to not know someone who has been infected, and unusual to not know of someone who has been seriously ill, or died, as a result of the disease. Our people worked, and continue to work, to manage the spread of the disease and the impact of the illness where it appears. We continue to run the largest vaccination programme in history, and our hospitals continue to see high numbers of people admitted to wards and to critical care units.

What is less clear to many is the set of associated impacts, which include but are not limited to;

- A health debt built up in people who did not access our services during the most acute lockdowns, and who now have conditions which are more advanced than they would have been previously;
- A rapidly-increased series of waits for scheduled care – hip replacements, cancer treatments, outpatient appointments;
- Severe difficulties for many independent-sector care providers, who support people in their homes. Many of these organisations are struggling to sustain themselves;
- Impacts on the people who work in our services, ranging from exhaustion, through stress-related mental illness, to a desire to retire early or reduce their hours to protect their own wellbeing;

Changes in how society operates that previously may have taken years have happened in days and weeks and we have delivered some services in very different ways, with a much greater reliance on digital services, on self-management, on being remote from buildings, and on explicitly prioritising some forms of care above others. LHCS has also shown an ability to re-engineer and re-provide at a pace that hasn't existed previously. This work has also shown the importance of working effectively and at speed with our partners in the rest of the public sector, the third sector, and the private sector.

Before the pandemic we did find it increasingly difficult to meet national targets due to the nature of our funding settlement. This funding settlement sees us receive less revenue than we should according to the national resource allocation framework set by the Scottish Government. This has, over time, widened the gap between the money we should have, and the money we do have. Similar challenges apply for our local public sector partners and this, in particular, has contributed to widening inequalities.

We also have the same problems as before the pandemic in terms of finance and the fabric of our buildings, and the pressure put upon us by the changing demographics within the Lothians. We also need to step up our efforts to improve quality and play our part in tackling climate change.

Perhaps our biggest concern in sustaining and improving our services is ensuring we can recruit and retain an appropriately-skilled workforce. The demographic challenges we face in caring for and treating an expanding and aging population also apply to our workforce. Some key services are facing particularly acute challenges, where the workforce is unbalanced and where not enough young people are joining the workforce. These pressures mean that we need to radically redesign some of our services in order to sustain them.

How we built the LSDF

The extant NHSL strategy – *Our Health, Our Care, Our Future* – was intended to cover the years 2014-2024, which would have coincided with the end-point for the next iteration of IJB Strategic Plans. However, the impact of first wave of the pandemic was such that during the late summer of 2020, we began working with the Royal Society of the Arts, using their Future Change Framework, to see what we had learned. We were also open to the idea that, as well as the vast range of problems and difficulties that the pandemic had wrought, we had also learned a lot about ways we could positively change how our system works and the services we provide.

Based on this work the NHSL Board adopted a series of principles and assumptions, and agreed fixed points to give us a skeleton to work within.

We have also worked with our finance, workforce, and other teams to identify the parameters of what can be done over the next five years. We have worked on the basis of the best currently-available information on these areas and have drawn our conclusions in good faith, and are keen to be as transparent with citizens as we can be.

We are keen to be seen as an anchor institution in the community. Across the LHCS we have a combined purchasing power of close on £2 billion. We are the largest employer in the South-East of Scotland, and have extensive land holdings. We therefore aim to leverage these more effectively and document 4 shows more detail on this.

Over the last 3 years, we have established a series of programme boards which bring together the leadership teams from our IJBs and from NHSL to map out our actions to improve services. These programme boards – for scheduled care, unscheduled care, and mental health, illness, and wellbeing – have worked over the last year to build plans for the next five years to deliver on our aims and objectives. These are summarised in documents six, eight, and nine.

In addition, we have worked with partners to develop plans for primary care and children's services and these are shown in documents five and seven.

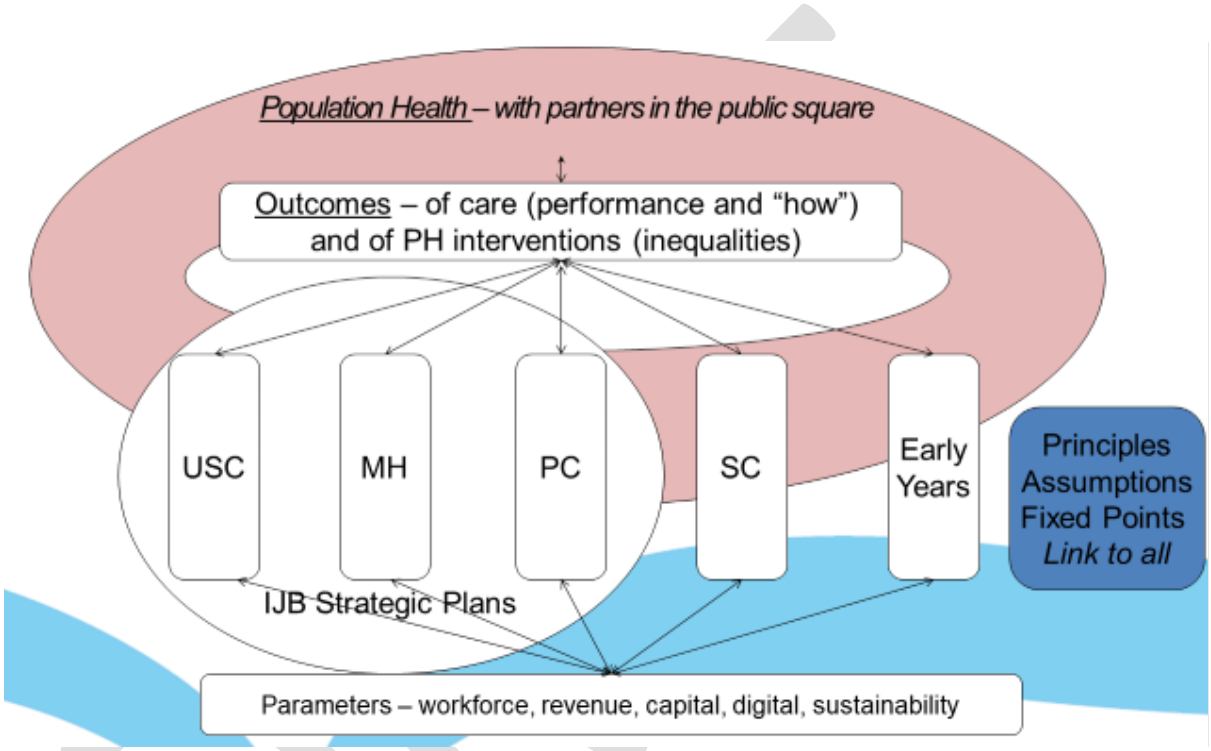
We have worked to ensure that we take account of citizens views. The consultation exercise we will undertake is crucial in seeking the broader view of a larger number of people but our engagement work, which seeks to inform our thinking, is outlined below:

Figure x: Engagement

Purpose	It is important that we don't do what we think is right without seeking the views of the people we work for. Engaging our communities in this work will help us to understand what is important to people who live in Lothian, and help to inform the choices we make.
Expectations	By sharing with residents what we and our partners have learned during the pandemic, we hope to build understanding about how we might tackle the challenges we face to deliver efficient and effective services to support good health and wellbeing in future. By seeking views on what is important to our residents, we hope to shape our ideas to ensure they meet the needs and wants of our communities. By engaging in dialogue with our communities, we hope to envisage new models of wellbeing and care, and to begin to discuss what we might let go of in order to make way for new innovations and models. By working with partners across the public and third sector, we hope to improve understanding of our shared challenges, and tease out synergies and opportunities for collaboration to address these challenges. Some elements of our future direction are fixed by policy directives, and will be out of scope of this work. We will be open about what these elements are.
Anticipated Outcomes	**For Lothian residents:** Able to influence choices within a harsh reality, informed by relevant data and information. **For NHS Lothian:** Confidence that our future direction is cognisant of the priorities of our communities, and focussed on delivering the outcomes they value.
Actions	**Inform:** We will share information about the LSDF via our website, social media and by engaging with the media, and invite local networks to participate in engagement opportunities. **Engage:** We will may existing local and national engagement activity, and distribute an online survey to seek a broad understanding of what is important to people in Lothian, in terms of health and care. Working with the RSA, we will bring together partners from across the public and third sector to understand our shared challenges and tease out synergies and opportunities for collaboration. Working with the RSA, we will convene a reference group to engage in a dialogue with residents, to envisage new models of care and consider what we might let go of to make way for new innovations.

Taken altogether, the work we have done builds into a strategic framework where the outcomes we aim to achieve are delivered by our 5-year plans for scheduled care and children's services - where NHSL is the planner and commissioner – and for unscheduled care, primary care, and mental health, illness, and wellbeing – where our IJBs are the planners and commissioners. These plans are sensitive to and supported by our parameters – workforce, revenue, capital, technology, and sustainability. Figure xxx below shows how this all fits together.

Figure xxx – how the Lothian Strategic Development Framework fits together



Our principles, our assumptions, and our fixed points

We have agreed a series of principles and assumptions to guide our work in developing this strategy and delivering it over the next 5 years. These will help us deliver on the outcomes of care we are committed to delivering. These are shown in Figure 1, below.

We also have a series of fixed points that we will work with over the next five years. The most important of these fixed points is the citizen's home. We believe that we will continue to work to enhance our four major hospital campuses as the backbone of our acute hospital system.

1. We will retain the four campus sites – The Royal Edinburgh Hospital, the Royal Infirmary of Edinburgh, St John's Hospital at Howden, and the Western General Hospital.
2. Per *the Lothian Hospitals Plan*, we will use the sites as;
    a. The Royal Edinburgh Hospital will be the specialist acute mental health facility with specialist learning disabilities and rehabilitation services;
    b. The Royal Infirmary of Edinburgh will be South-East Scotland's major unscheduled care centre, incorporating the Major Trauma Centre, and specialist neurosciences and children's services;
    c. St John's Hospital will be West Lothian's district general hospital, with specialist regional surgical services and a short-stay elective centre;
    d. The Western General will be South-East Scotland's Cancer Centre, with breast, urology, colorectal surgical services on-site
3. We will have community inpatient facilities in East Lothian (ELCH) and Midlothian (MCH);
4. We will only provide general anaesthetics at RIE, SJH, and WGH, with provision at REH to support treatments such as electro-convulsive therapies;
5. We are clear that the Western General will be the home for the new Edinburgh Cancer Centre, which will be the Cancer Centre for the South-East of Scotland
6. Sexual Health Services within Edinburgh are provided at the Chalmers Centre
7. We will not provide high-secure forensic mental health accommodation
8. The strategic planning and commissioning of unscheduled care, primary care, general practice, rehabilitation, and mental health services are delegated to the four IJBs – East Lothian, Edinburgh, Midlothian, and West Lothian
9. All other services are the strategic planning and commissioning responsibility of NHS Lothian.

Figure 1: Challenges & Principles

Assumptions	Principles
We will honour legally committed investment to date. We will test fully approved investment (not yet legally committed) against the principles to the right before legally committing. We accept that there will be significant financial constraints We will start with large waiting lists and work through these according to clinical prioritisation Workforce availability will be a key consideration, and all models will need to reflect this. The pandemic has and will continue to change our models of care (how significantly is uncertain) There will be a requirement for redesign capacity to support change There will be an evolving context and narrative.	All cases and actions need to be clear on the question they seek to answer All cases and actions need to be able to demonstrate that they advance the organisational strategy All facilities will be flexible and multi-use We will work to reduce "on-site" attendances wherever we can We will separate emergency and elective activity where possible and maximise the use of "single-day" pathways We will align actions and facilities with our public and third-sector partners Non-clinical space will be minimised Our actions and facilities will align with the Climate Change (Scotland) Act which outlines a requirement for the public sector to achieve net-zero by 2045 at the latest.

Specific proposals for change

We have a system serving a million people, employing over 35,000, and with budgets totalling over £2billion, would have a broad range of actions it intends to take forward. There is a lot of detail provided in the supporting documents, but key highlights are;

- We expect to increasingly emphasise prevention and self-management of disease, supporting this with community services and new technologies like closed-loop insulin pumps;
- We will work to develop our ways of accessing our services and this will mean an increasing use of digital communication technologies for outpatient and primary care services, in particular;
- Where we need to replace buildings that we deliver community services in, we will look to bring as many services together from across public services together in community centres and use these as flexibly as we can;
- We will continue to change the model of care in primary care generally and general practice in particular, emphasising the role of the GP as the "expert medical generalist" and developing alternatives delivered through pharmacy, nursing, mental health, physiotherapy, and other services;
- We will work to strengthen communications and links between the different parts of our system to deliver streamlined pathways for citizens;
- We will continue with our work to provide more services for people with mental health needs or learning disabilities in the community. This includes increasing the number of community placements and reducing the size of the Royal Edinburgh Hospital;
- We will look to move from buildings that are no longer fit for purpose and utilise land to create modern, flexible, multi-use, accommodation to replace them. This immediately affects the Royal Edinburgh Hospital, St Michael's Hospital in Linlithgow, as well as a number of facilities inside the City of Edinburgh. It will also see us develop business cases for REH, for a new West Lothian Community Hospital, and for the development of East Lothian Community Hospital, as well as community treatment centres;
- We will continue to implement systems to schedule urgent care, with citizens given same or next-day appointments to attend, and will work with NHS24 and the Scottish Ambulance Service to deliver this;
- We will develop a new Cancer Centre on the Western General Hospital campus;
- We will deliver surgical treatments where the patient will stay less than 48 hours in hospital in the new National Treatment Centre at St John's Hospital in Livingston. This will include procedures in gynaecology, general surgery, colorectal surgery, urology, and orthopaedics;
- We will develop a new specialist eye hospital in Edinburgh to replace the Princess Alexandra Eye Pavilion;
- We will work to improve the efficiency and productivity of our elective services, but our recovery from the impact of COVID-19 will take years, and not months or weeks, to reach the levels we would want;
- We will explicitly consider the sustainability impacts of our services and commit to deliver the commitments made by the Scottish Government on carbon zero service provision.

Working to become an Anchor Institution

LHCS has a combined spending power of £2 billion, employs roughly 35,000 people, and serves a population of nearly a million people. The actions we take are fundamentally focussed on improving the health and wellbeing of our population, as we have described in the rest of this document. We will continue to undertake our work in preventing ill-health through our services, but we also recognise that prevention needs to work beyond service provision. Engaging with and influencing the wider social determinants of health such as housing, employment, income, sustainable placemaking and sustainable transport systems is crucial to population health improvement.

A key element of this is recognising the LCHS can have a direct impact through our spending power, our providing jobs, and how we work with partners to maximise our economic "weight" for social good. The LCHS should seek to be a good neighbour, a good consumer, and a good employer by deploying its influence in purchasing and procurement, its assets and facilities, its significance as a regional employment hub to impact positively the health and wellbeing of the local population. The Sustainable Development Framework is a key component of this approach.

This work comes under the banner of seeing LHCS as anchor institutions for our communities, where we impact on lives not just through the way we provide care and treatment but through our engagement with health in all policies at local partnership, regional and national level to shape and influence a health promoting environment across Lothian.

Our analysis is that several key actions are fundamental to how we can deliver on this aspiration;

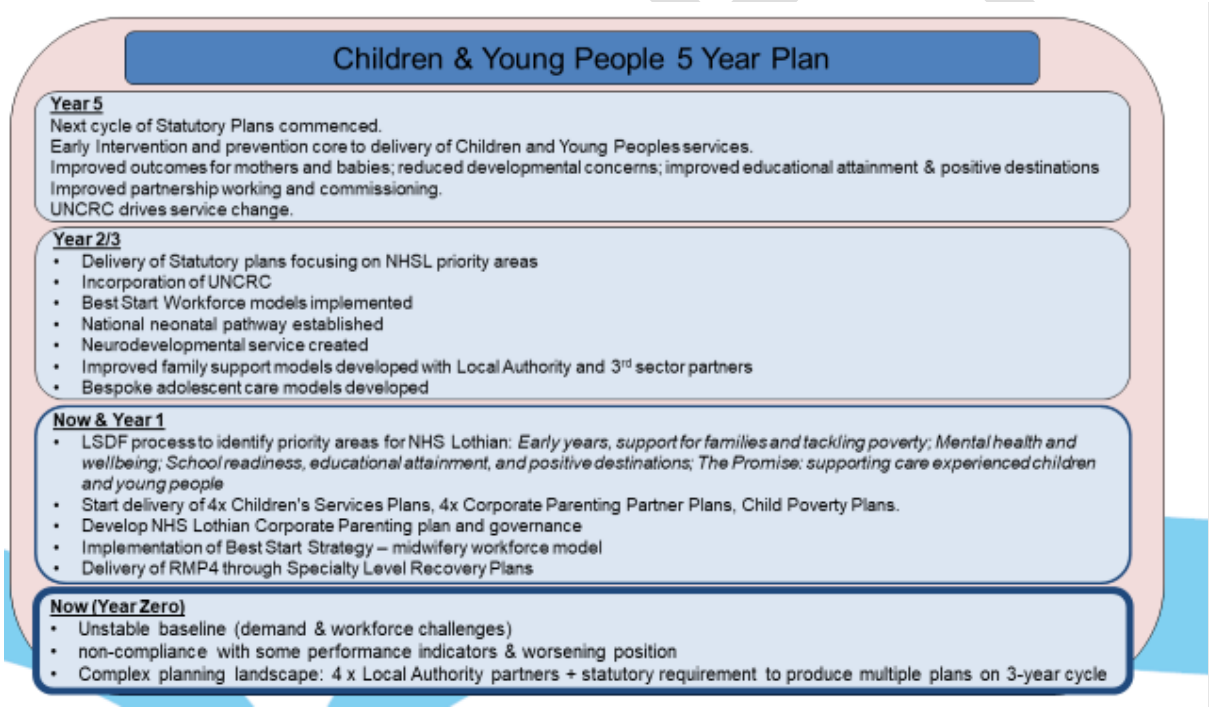
- Focussing on providing the best possible start to life, as outlined in the Children and Young People's section of this LSDF;
- Focussing on supporting people in their own homes and neighbourhoods, as described in our Mental Health, Illness, and Wellbeing, Primary Care, Unscheduled Care, and Scheduled Care sections;
- Maximising income for the low-paid, some of whom are within our own workforce;
- Becoming accredited Living Wage employers, and working to ensure that our suppliers and contractors are also Living Wage employers;
- Ensuring that our community benefits clauses really provide benefit for our population;
- Ensuring that NHS Lothian contributes actively to emerging community planning partnership discussions about community wealth building by utilising its influence as an anchor institution
- Considering whether and how our buildings can bring together a broader range of public services to deliver on shared aims;
- Considering whether and how our land disposal and redevelopment can support a larger series of broader public goals including population health improvement and reduction of health inequalities.

Children's Services

We see the provision of appropriate support, care, and treatment when required for children as the major investment we can make in the health of the Lothians. To this end, we will continue to work closely with our partners in education, the third sector, social care, and with parents and families, to ensure that we provide the best possible support for our young people.

Foremost in this area is the radical redesign of mental health services for children and young people. It is well-known that our performance in providing treatment for children waiting for psychological support has not been at the level we would have wanted for some time. Our analysis shows that this is at least in part because the other layers of care have weakened, and in turn that our highly specialised services are unable to cope. We have therefore set out to strengthen the less specialised levels, and will work to provide support closer to where young people are – in communities, in schools, in youth clubs, and by remote means where appropriate.

We will design and implement a new pathway for children and young people with neurodevelopmental challenges.



Mental Health, Illness, and Wellbeing

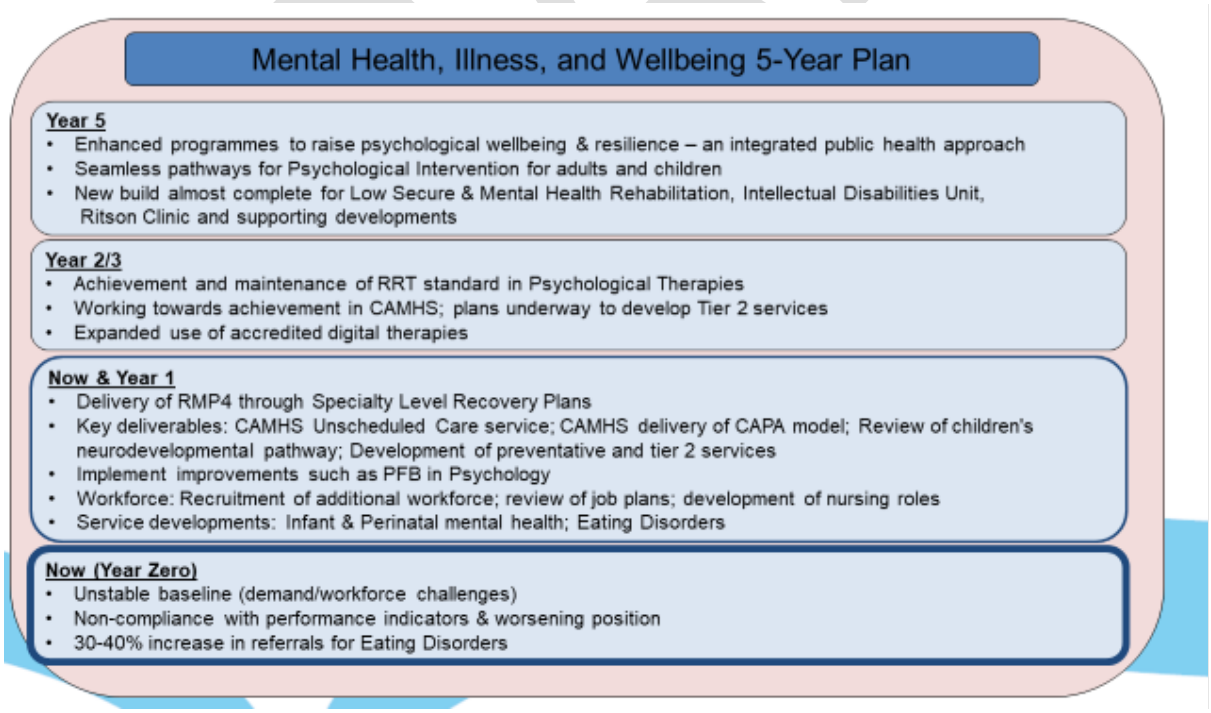
All four of our IJB areas are committed to developing programmes focussed on sustaining people's wellbeing. These programmes are tailored to the particular circumstances of each community, but bring together NHS services, volunteering, lived experience, the third sector, local authorities, and the private sector to expand access for support at a less acute level.

We will invest to expand our capacity in respect of psychological therapies, with a focus on meeting the Scottish Government's target that no one should wait longer than 18 weeks for this key form of treatment.

All five partners in the Lothian system are committed to improving the standard of facilities provided for inpatient treatment at the Royal Edinburgh Hospital, which looks after patients diagnosed with serious mental illness. We aim to commence construction of new facilities for mental illness rehabilitation, and of a new national unit for young people with learning disabilities and mental illness, by 2024.

The changes to the Royal Edinburgh Hospital will see us implement a radical redesign of care. For people with learning disabilities, care will increasingly be provided away from hospital, in homes with support provided by care workers, as opposed to doctors and nurses.

Similarly, our 4 IJBs will invest heavily in providing non-medicalised care and support outside of hospital for those recovering from long-term mental illness, with people settled into new homes and supportive environments designed around them.



Primary care and community services

We will implement the next stage of the GP contract. We are conscious that GP contracting arrangements are negotiated nationally and not locally, and that as we complete this document, the Scottish Government's proposals for general practice would see these contracts managed in new Community Health and Social Care Boards. What we propose as a direction of travel, however, is one that we believe stands as the right direction to ensure a sustainable and high-quality service.

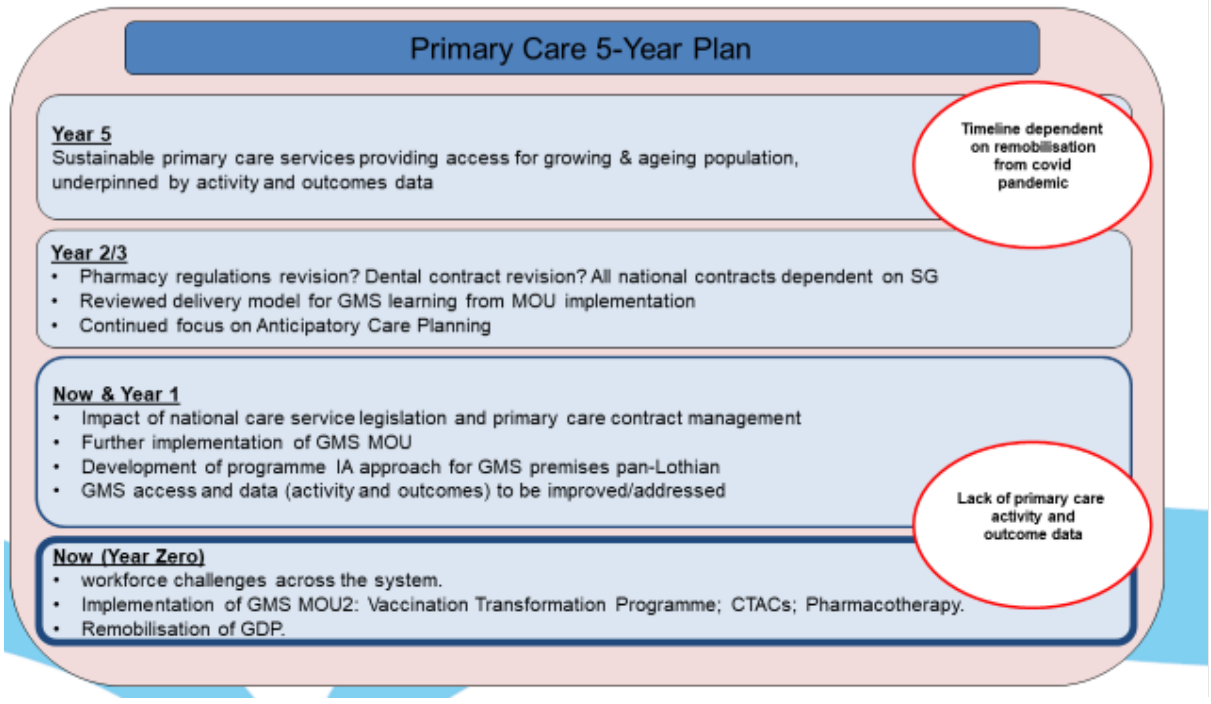
The way in which we deliver general practice services will continue to evolve. As with the model for hospital outpatients, we will seek to ensure that people only travel to their general practice if they absolutely have to, with alternatives via digital technologies – and the telephone – increasingly offered. This will also mean that we continue to use telephone triage to stream citizens to the most appropriate professional, which will not always be the general practitioner.

We also recognise that general practice is one of the key elements of any community, and we also recognise that many of our primary care buildings are in need of replacement. When we require to replace a facility of this type, we will seek to do so in conjunction with our partners and create new buildings which bring together education, social care, other primary care services, the third sector and other services. Experience of the pandemic has been that citizens seek one place for support.

We have collectively sought to move from buildings which are not suitable for the delivery of modern care and treatment, and this affects general practices and hospitals both large and small.

We will look to further develop the services that are provided through pharmacies across the Lothians, recognising that these are a vital part of communities.

We will also work to help the recovery of our dental services. Currently our estimate is our services are running at 20% of pre-pandemic levels.



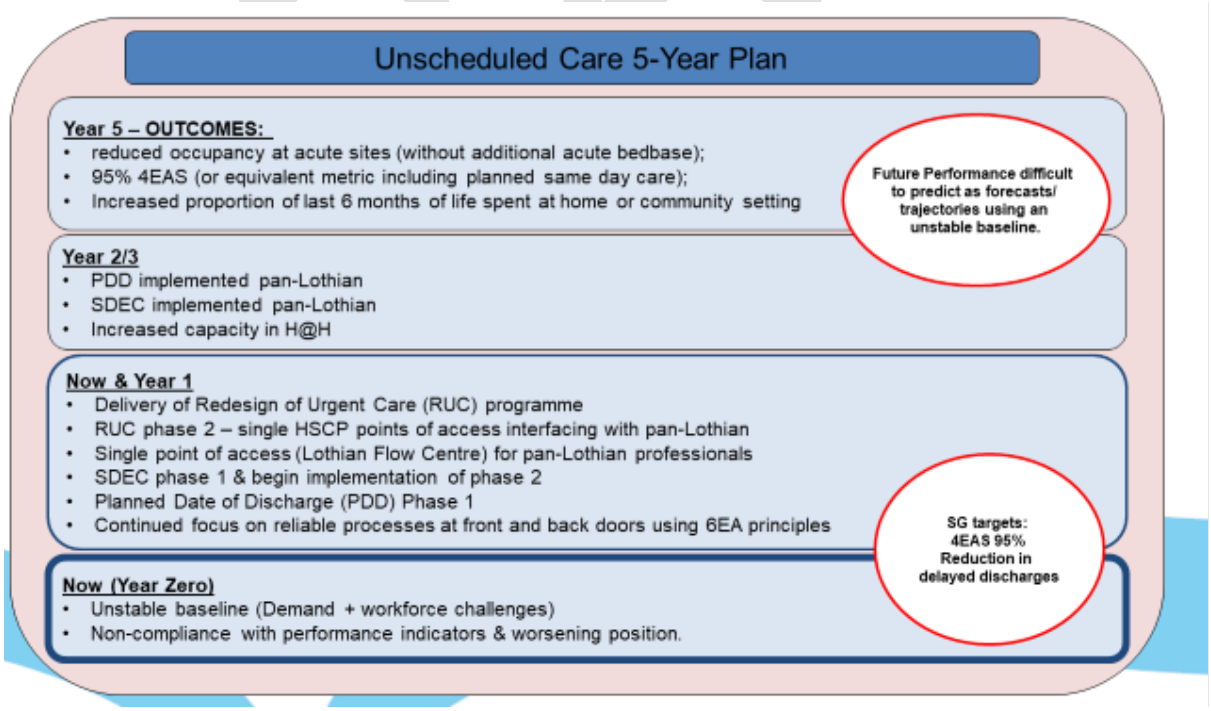
Supporting access to unscheduled care

We will continue to aim to deliver improved patient experience and safety as measured against the 4-hour emergency access standard.

Our system is consistent in its belief that people should only come to a hospital if they absolutely have to, and should not stay in hospital any longer than absolutely necessary. We will therefore continue to develop the approach to redesign urgent care we introduced during the pandemic, with citizens asked to use the 111 phone number to be assessed and directed appropriately, with as many attendances as possible scheduled according to clinical priority and patient convenience.

To support this change, we will also roll out the Same-Day Emergency Care programme that has been very effective at the Western General Hospital. We will introduce the service at the Royal Infirmary of Edinburgh and St John's Hospital, and look to deliver as much as possible of this work at East Lothian Community Hospital and Midlothian Community Hospital. We will develop a business case for a new West Lothian Community Hospital and seek to develop further the services delivered at the East Lothian Community Hospital. We believe that this will improve the quality of care we can offer in these areas and allow us to replace buildings which are no longer fit for purpose.

We will continue to develop the approaches introduced successfully in each of the four IJB areas to get people home quickly after they have been in hospital. This means we will expand our Hospital to Home, HomeFirst, and Discharge to Assess approaches, allowing elements of acute hospital care and social care assessment to take home in the patient's own home.



Scheduled Care

We will

Begin the construction of a new regional Cancer Centre on the Western General campus, which will include specialist diagnostics, breast care, and chemotherapy and radiotherapy services;

Build and commence operating a new National Treatment Centre at St John's Hospital, which will see the vast majority of elective treatment for patients we expect to stay less than two days. We expect this centre to see the bulk of people receiving treatment in general surgery, orthopaedics, urology, colorectal surgery, and gynaecology;

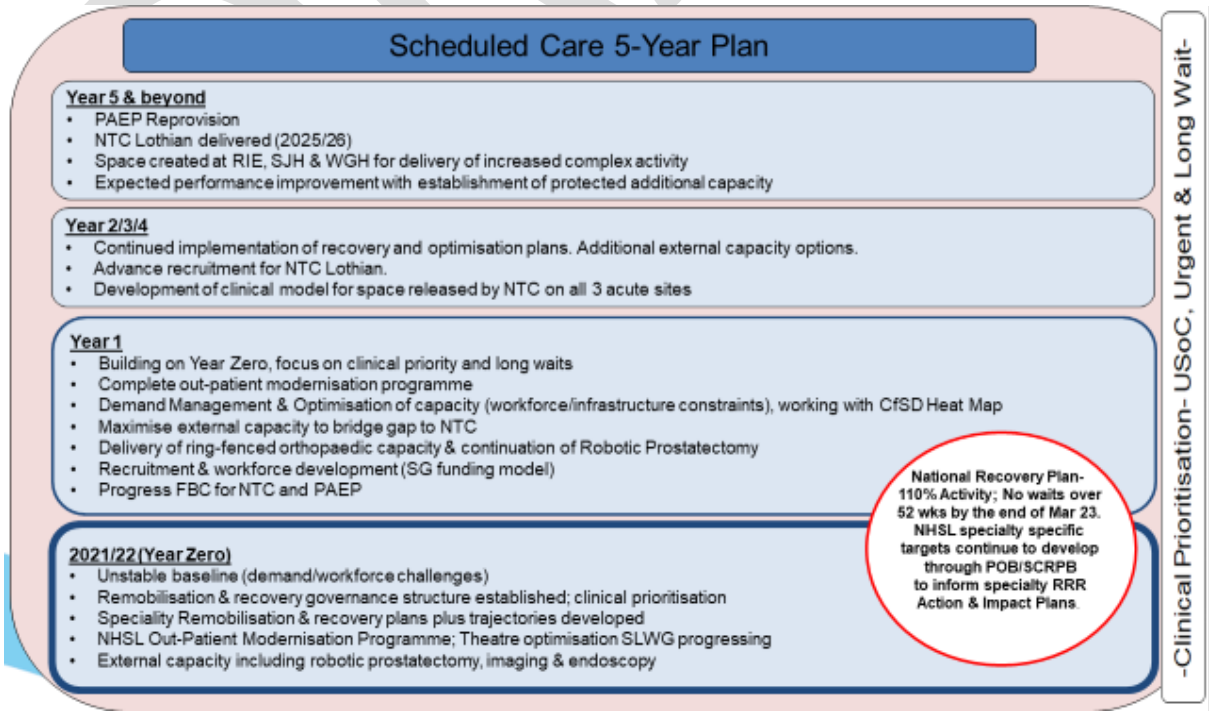
Work to recruit an additional xxx staff to operate this NTC;

Build and commence operating a new Princess Alexandra Eye Pavilion on the Royal Infirmary of Edinburgh campus, to bring together all aspects of specialist eye treatment for the people of Lothian;

Work to achieve prevailing national targets for diagnostics and treatment, prioritising those with life- and limb-threatening conditions, and supporting those who wait longer than we would want;

Use the physical space freed up in the Royal Infirmary, St John's Hospital, and the Western General to increase our capacity for the most complex conditions, thereby accelerating treatment for those with cancer or complex orthopaedic needs;

As part of our move to improve the waiting time for outpatient assessment, we will look to build on learning from the pandemic and use digital communications technologies such as NearMe to replace appointments in person, when this is appropriate to do so.



What next?

This summary lays out the framework as we see it. We are keen to work with our citizenry, our partners, and our staff, to refine this and make sure we have captured all the elements required for a credible strategy that we would all endorse.

To this end, we are undertaking a formal consultation exercise in Spring 2022. We have therefore prepared a suite of documents which provide further detail on the concepts and initiatives explained here. The entire suite is linked to in the following list;

- Summary
- Assessment of where we are and what people have told us
- Where we want to be - Outcomes/population health/performance
- Anchor Institutions
- Children and Young People
- Mental Health, Illness, Wellbeing
- Primary Care
- Unscheduled Care
- Scheduled Care
- Overall 5-year plan
- Finance - revenue
- Capital - capital plan
- Workforce planning
- Workforce wellbeing
- Digital
- Environmental and sustainability
- Engagement process
- Questions

We would particularly direct readers to the section titled “Questions”, as we have specific questions we want to discuss with you and need your views so we can progress our system. You do not have to read all of the documents we have identified, but you are very welcome to do so.

Meeting Name: Board **Meeting date: 1 December 2021**

Title: *Remobilisation Plan*

Purpose and Key Issues of the Report:

DISCUSSION	x	DECISION	x	AWARENESS	

The paper outlines the update on the latest iteration of the Remobilisation Plan, RMP4. Board members will recall that this was circulated in draft form before submission to the Scottish Government at the end of September.

Board members are asked to approve RMP4, noting that this was written in September 2021 and was therefore a snapshot in time.

Feedback from SG has now been received and this is appended to the paper at appendix 2.

Board members are also asked to note the forthcoming planning diet.

Recommendations:

- **Note** the purpose and process of RMP4;
- **Approve** RMP4;
- **Note** expected forthcoming work required

Author: Colin Briggs **Date: 24th November 2021**	**Director: Colin Briggs** **Date: 24th November 2021**

NHS LOTHIAN

Board Meeting
1st December 2021

Director of Strategic Planning

REMOBILISATION PLAN 4

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board formally approve Remobilisation Plan 4 (RMP4).

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

2 Recommendations

2.1 The Board is recommended to;

- **Note** the purpose and process of RMP4;
- **Approve** RMP4;
- **Note** expected forthcoming work required

3 Discussion of Key Issues

3.1 Board members will recall the paper on RMP4 which came to the October 2021 Board, which outlined the purpose, process, and arrangements for sign-off of RMP4. Board members will also recall that in light of the invocation of emergency powers for Ministers, the Cabinet Secretary retains direct control of NHS Scotland activities.

3.2 Board members will also recall that RMP4 had been commissioned by the Scottish Government Health and Social Care Directorates to cover the work of Boards between 1st October 2021 and 31st March 2022. The planning process had therefore been during late August and September 2021 and so was based on the best available information at that time. As Board members will understand, the general position has been even more challenging than was expected at that point.

3.3 Board members were invited to an informal session ahead of the last Board meeting to discuss in detail the winter planning actions undertaken and the RMP4.

3.4 Board members will also recall that the focus for the winter is clearly in managing the risks presented by the unstable baselines for staffing, COVID-19 infection, flu and respiratory disease, and managing the “health debt” from the first series of lockdowns.

3.5 The Chair and Chief Executive met the Cabinet Secretary for the Board’s Annual Review in early November and consequently a letter has been received from SGHSCD outlining issues for resolution and review in NHS Lothian’s RMP4, but that there was a high level of comfort from SGHSCD in the planning approach taken by NHSL.

3.6 Board members will also recall from previous discussion that while the Executive Team felt that the actions and plans outlined in RMP4 were the right ones, there was less confidence that they were all deliverable.

3.7 RMP4 now requires formal approval by the Board and hence is attached to this paper, as is the letter received from SGHSCD.

3.8 The future schedule for planning submissions includes updates at the end of January and end of April, with a new planning approach expected from the end of quarter 1 2022. This is discussed in detail in the paper brought to this Board meeting on the LSDF.

4 Key Risks

4.1 RMP4 is intended to bring together the key risks faced by the system into a single document. Board members will recall that the risks were discussed in detail at previous sessions.

5 Risk Register

5.1 RMP4 is intended as a tool for risk identification and mitigation, and therefore all major risks to the service are the subject of some element of this work.

6 Impact on Inequality, Including Health Inequalities

6.1 No specific impact assessment has been undertaken. The function of RMP4 is minimise the impacts of inequality. More detail is provided in the winter planning actions paper.

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

7.1 No formal consultation undertaken. Where specific changes are proposed consultation lies at individual clinical service level.

8 Resource Implications

8.1 The resource implications of producing RMP4 have been contained within the Directorate of Strategic Planning and the organisation's management structures.

Colin Briggs
Director of Strategic Planning
18th November 2021
Colin.briggs@nhslothian.scot.nhs.uk

List of Appendices

1 – Remobilisation Plan 4 (with appendices)
2 – Confirmatory letter from SGHSCD

NHS Lothian

Remobilisation Plan 2021/22: Mid-Year Update (Remobilisation Plan 4)
April 2021 – March 2022

September 2021

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Appendix 6 Data Template T3 - Elective Waiting Times Trajectories for patients waiting over 12 weeks (over 6 weeks for Diagnostics) and over 52 weeks. 87

How this document is structured

RMP4 is presented in 2 parts, with associated supporting appendices.

Part 1 gives a brief overview of the updated plan and describes the assessment and action planning work undertaken as key components of RMP4. It provides the winter assessment checklist (*appendix 1*) and references our winter planning actions; and provides our key strategic actions supporting recovery and remobilisation between now and the end of March 2022 (via the Delivery Plan - *appendix 2*, and via an outline of our new work with the Centre for Sustainable Delivery – CfSD, including the HEAT map and workplan - *appendix 3*). This section also gives a summary of our projected activity and performance in key areas (via key data outlined in *appendix 4, 5, and 6*); and describes our financial processes, funding commitments and plans. **This section and its appendices meet the ask in planning guidance for RMP4.**

Part 2 gives an update report on progress, actions and developments in key areas initially outlined in our Remobilisation Plan 3. This update is effectively a 'stand-alone' sub-report providing detail on the vaccination programme, Public Health, workforce, the Care and Wellbeing programmes, Primary Care and Lothian Unscheduled Care Services, Health and Social Care Partnership actions, Mental Health services, Acute services, and Digital service developments and support.

PART 1: OVERVIEW; WINTER; KEY DELIVERABLES; ACTIVITY AND PERFORMANCE

1.1 Overview of RMP4

Introduction and purpose

NHS Lothian's Remobilisation Plan 4 (RMP4) is an update to our previous plan (RMP3) approved by the NHSL Board in June 2021. This update exercise, half-way through the year, has been planned to allow recognition of the uncertainty faced by the NHS during the COVID-19 Pandemic. Developing the plan now allows the inclusion of new developments and priority actions across the Health and Social Care system in Lothian. As well as providing an update on key actions specified in RMP3, this plan focuses on risks and mitigating actions from October 2021 to the end of March 2022.

As we head into winter our assessment shows a high degree of planning and preparedness across our services and our systems, alongside considerable delivery and capacity risks particularly in unscheduled and elective Care. Our key risks are associated with the difficulty and complexity in forecasting and planning emergency and elective demand and trends in infection rates; managing the ongoing balance of provision across the system for scheduled elective, unscheduled and COVID-19 activity; and capacity associated with managing patient discharge and flow. It is important to note that all services are working from inherently unstable baselines deeply affected by the ongoing COVID-19 pandemic and that despite our confidence that we have sensible, well-thought-through plans, we cannot be equally confident that we will be able to source sufficient staff in various parts of the system to ensure consistent delivery. We are particularly conscious that we have already had bed closures due to lack of staff, and are technically still in late summer, not the depths of winter.

Our acute services activity and performance baseline is unstable and therefore we are currently planning from a deteriorating position, making the forecast of waiting times positions and any assumed impact of recovery actions uncertain. Our Primary Care teams and Health and Social Care Partnerships report significant risks and increased demand for Care at Home services in particular with the sector experiencing significant strain, alongside intensive ongoing work to oversee and provide the support required to care homes. As reported in the acute remobilisation update given in this plan, and reflected in Delivery Plan actions, there are limitations currently with independent sector capacity and support and also with partner support from the GJNH and Regional Endoscopy Unit due to their own workforce pressures.

In acute care, our remobilisation of Scheduled Care will continue to be overseen by the Scheduled Care Programme Board and supported by 4 constituent recovery boards: Cancer, Diagnostics, Outpatient, and Inpatient Daycase. These recovery plans have directly informed the RMP4 Delivery Plan. In addition to this, the Scheduled Care Recovery Programme will move to focus on supporting a programme of deep dives in further priority specialties from October 2021 onwards.

As illustrated in appendix 3 to RMP4, via completion of the Heat Map tool, NHS Lothian has identified key areas for potential support from the Centre for Sustainable Delivery. These areas include:

- Ophthalmology NESGAT, cataract additional procedures, imaging hub
- EQUiP in General Surgery, Colorectal, Vascular Surgery
- ERAS in General Surgery and to all specialties at the RIE (apart from orthopaedics which is already in place)
- Neurosciences ADEPt
- Cardiology Heart Failure RHP

Support in other pathways will come through our Outpatient Redesign programme which is underway across Lothian, and via actions on specialty Recovery Action & Impact plans.

To support Primary Care, our Health and Social Care Partnerships have set out the implementation process for their areas in HSCP Primary Care Improvement Plans. Progress is overseen and coordinated at a pan-Lothian level by the GMS Contract Oversight Group, which is a collaboration between NHS Lothian, Lothian LMC and Lothian HSCPs. In addition, Lothian Health and Social Care Partnerships continue to remobilise services locally, with full details given in their update reports submitted as part of this plan, for example:

- Supporting COVID-19 related actions
- Providing high quality and responsive professional oversight and support to care homes and care at home services
- Providing enhanced community support to home care and care homes to avoid hospital admission
- Delivering a suite of rehabilitation and Technology Enabled Care (TEC) Services
- Developing and delivering long-COVID-19 support (and post-COVID-19 rehabilitation) through rehabilitation services
- Developing pain management approaches
- Fully remobilising social care packages

Our Delivery Plan actions specify the workforce planning, HR, and workforce wellbeing actions in place and providing support across the Lothian system. The NHS Lothian Interim Workforce plan was submitted to the Scottish Government at the end of April 2021 (further details are provided in section 2.10 – workforce update). Furthermore, NHS Lothian's Wellbeing Strategy – Work Well was launched in June. The strategy sets out NHS Lothian's commitment to staff wellbeing as a key corporate objective.

Section 2.1 of this document and our delivery Plan actions describe our vaccination programme delivery and direction, with the focus from July 2021 turned to delivery of the annual autumn/winter flu programme, continuation of the COVID-19 vaccination programme; and progress plans associated with the delivery of COVID-19 booster vaccination. Our existing flu and COVID-19 vaccine Programme Boards were merged from 3rd August to a Flu and COVID-19 Booster Programme Board, and an Immunisation Oversight Board will be

established in late September 2021. The Lothian Health and Social Care Partnerships will take on delivery of the adult influenza vaccination programme in 2021 (from General Practice) as part of the delivery of Primary Care Implementation Plans.

Details of the supporting finance for RMP4 are given in section 1.6 below. Local Mobilisation Plan (LMP) processes remain for the current financial year, via which routine financial updates are provided to Scottish Government on the costs associated with COVID-19. Our RMP4 Delivery Plan sets out a range of initiatives intended to support the COVID-19 response and remobilisation. As part of the LMP process we will reconcile these plans with the current costs included in LMP submissions.

Further details of the winter assessment and winter planning, Delivery Plan, developing work with the Centre for Sustainable Delivery, activity and performance trajectories, and RMP4 finance are given in sections 1.2 to 1.6 below, and the associated appendices.

Summary of planning assumptions

In Remobilisation Plan 3 we outlined our high-level planning assumptions and scenarios for the financial year 2021-22. These included potential risks associated with staff sickness and maintaining an acceptable level of staffing, and the requirement to maintain sufficient testing capacity, sustain social care services, and maintain mutual aid arrangements. A key scenario assumption was that our vaccination programme would deliver first doses to the adult population of the Lothian's by September 2021. As outlined in the update report given in Part-2 of this document, at mid September 2021 89.7% of those aged over 18 years have received their first dose, and 83% of over 18's have received a second dose. Actions for the next stages of the vaccination programme are outlined in the Delivery Plan.

RMP3 was also based on an implicit assumption that demand for healthcare services would remain reduced in the earlier part of the financial year, reflecting the nature of the pandemic and the impact it has had on population behaviours. The risk inherent with rapidly rising demand for core non-COVID-19 services was outlined. As restrictions ease, and in the context of progress with vaccination, as predicted demand for non-COVID-19 related healthcare is increasing as we enter the second half of the year. Layering onto this is the heightened anxiety and concern among citizens who may have held off on accessing services during previous lockdown periods and are now attempting to access these services. We see this in pressure on general practice and on our unscheduled care services.

Key planning assumptions underpinning RMP4 include the need to balance responding to COVID-19 related demand with the provision of non-COVID-19 related services, specifically including patient pathway design and the maintenance of ICU surge capacity; continuing to tackle health inequalities; maintaining the enhanced and extended role for Public Health; continuing vaccination programmes and testing; safety; supporting workforce wellbeing; maximising digital, developing the key role of primary care/community-based services; and building on new ways of working and redesign. RMP4 has also been developed in the context of the Independent Review of Adult Social Care consultation, and the publication of the NHS

Scotland Recovery Plan – 2021-2026, which will guide priorities for action throughout the remainder of the financial year and beyond.

One final key assumption is that NHS Lothian will be involved in arrangements to support the COP26 event in Glasgow, with Edinburgh Airport, Edinburgh's hospitality and tourism industries, and various other parts of Lothian society involved and affected. This is subject to separate planning arrangements but is noted here as the potential for disruption is significant.

1.2 Winter Planning, and the Winter Planning Checklist

Winter funding has been allocated across community and acute services in June 2021 to support early planning and recruitment where required. In addition to specific winter investment in new schemes for 2021/22, all services continue to provide and develop a range of existing services which support prevention of Emergency Department attendance / acute admission and proactive management of flow from acute hospitals to reduce delayed discharges. All Lothian acute sites have sign-posting and redirection processes in place at front doors, and a focus on pre-12 discharges and reducing LoS. Additionally the Flow Centre supports direction of referred patients to the right site and patient transport.

Winter Planning readiness assessment template

Across NHS Lothian and Lothian Health and Social Care Partnerships the Checklist of Winter Preparedness has been completed by services, with input from specialist lead contributors, to assist further in preparing for winter 2021/22. Assessments have been completed by Lothian Acute Services, Lothian Health and Social Care Partnerships, Human Resources (workforce planning and staff testing), Infection Prevention and Control, Primary Care, Unscheduled Care, Resilience and Business Continuity leads, Respiratory Network leads, and Vaccination Programme Board leads.

An overall, system-wide, high-level assessment has been developed from the Winter Planning Checklist returns submitted by services across NHS Lothian and by the Lothian Health and Social Care Partnerships (see Appendix 1). It provides a high-level overview of the state of winter preparedness in the priority areas for winter planning as listed below:

- Resilience
- Unscheduled / Elective Care
- Out of Hours
- Norovirus
- COVID-19 -19, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing
- Respiratory Pathway
- Integration of Key Partners / Services

The summary overview shows an overall green RAG status for all areas with the exception of Unscheduled / Elective Care which has an overall amber RAG assessment currently. The amber assessment status in this area is associated with the degree of difficulty in forecasting

and planning emergency and elective demand and trends in infection rates, and managing the ongoing balance of provision across scheduled elective, unscheduled and COVID-19 activity. Most fundamentally, all of our plans are dependent on workforce availability, and as noted throughout this document, this is in significant doubt. Additionally, work continues to further improve our various proactive processes for managing patient discharge. The level of homecare packages and associated support services required over the winter and festive period are also a key risk subject to ongoing planning.

To evidence this summary assessment, a compiled version of the full Checklist of Winter Preparedness for NHS Lothian, which gives a much greater level of detail and shows individual service area / HSCP responses, has been developed. This more detailed version is available upon request.

Delivery Plan winter planning actions

The Delivery Plan, submitted as part of Remobilisation Plan 4 (Appendix 2), includes a high-level summary of our key strategic winter planning actions. These focus on the planning and allocation of winter funding to support new initiatives, and maintaining and developing existing core winter support services. Winter planning actions are supported by the wider Delivery Plan actions specified by services across NHS Lothian, Lothian Health and Social Care Partnerships, and corporate support services. The Lothian Delivery Plan outlines a range of action across settings which, amongst other things, aim to:

- Support the delivery of the 4-hour emergency access target in the face of winter pressures.
- Maintain surge capacity for COVID-19 patients and maintain the ability to stream COVID-19 and non-COVID-19 pathways across the system
- Avoid unnecessary admissions, reduce length of stay and optimise discharge
- Provide resilience for the festive period
- Support the provision of alternative forms of care for patients with urgent problems who may be better cared for closer to home.
- Prioritise COVID-19 and Flu vaccination provision to our workforce

1.3 RMP4 Delivery Plan

Appendix 2 provides the NHS Lothian Delivery Plan which outlines key issues and risks and the organisation's plans to mitigate those risks. The plan focuses on deliverables across October 2021 to March 2022, and also gives a brief progress update where applicable for actions across April to September 2021.

NHS Lothian's Delivery Plan covers:

- COVID-19, Flu and COVID-19 Booster Vaccination
- Scheduled Care

- Winter Planning
- Children's Services
- Unscheduled care, RUC and reducing Delayed Discharge
- Primary Care
- West Lothian Health and Social Care Partnership
- Edinburgh Health and Social Care Partnership
- Midlothian Health and Social Care Partnership
- East Lothian Health and Social Care Partnership
- Mental Health
- Human Resources
- Digital and IT
- Public Health and Health Policy

1.4 CfSD Heat Maps and associated Action Plans

Centre for Sustainable Delivery Heat Map

NHS Lothian is working with the new Centre for Sustainable Delivery (CfSD) to embed best practice not yet deployed. Working with the CfSD NHS Lothian has completed the Heat Map tool, attached as appendix 3.

The numerical impact of many of these actions is unknown or crudely represented. NHS Lothian is working with the CfSD to agree a robust and meaningful methodology for generation of numerical impacts, however the methodology applied to date is described within the appendix. Using the heat map as it is now NHS Lothian has identified key areas for potential support from the Centre for Sustainable Delivery to embed over the next period. The CfSD has not yet agreed what support will be available.

These areas include:

- Ophthalmology NESGAT, cataract additional procedures, imaging hub
- EQUiP in General Surgery, Colorectal, Vascular Surgery
- ERAS in General Surgery and to all specialties at the RIE (apart from orthopaedics which is already in place)
- Neurosciences ADEPt
- Cardiology Heart Failure RHP

Other pathways are already embedded, in train, or to be implemented through the Outpatient Redesign programme underway across Lothian. Others appear as actions on specialty Recovery Action & Impact plans.

There are considerable challenges to delivering some of the best practice promoted by the CfSD due to the current unstable baseline. For example whilst NHS Lothian is reviewing ophthalmology capacity to release workforce to fill gaps in urgent work on other sites an additional cataract per list will not deliver the impact previously assumed due to a reduction in overall volumes. Furthermore, achievement of BADS (which is a key performance metric for our In-patient and Day Case Recovery Board) will be difficult to improve whilst we have reduced day case capacity and what is in place is prioritised for urgent and USoC activity.

Scheduled care

Remobilisation of Scheduled Care will continue to be overseen by the Scheduled Care Programme Board and supported by the 4 constituent recovery boards - Cancer, Diagnostics, Outpatient, and Inpatient Daycase. During the first half of this year Remobilise, Recover and Redesign (RRR) Action & Impact Plans have been developed at a specialty level supplementing the work plans of the 4 extant Boards. The expectation is these plans will be maintained as live documents for review against progress by the relevant recovery boards and identification of new impactful recovery actions. These plans have directly informed the Delivery Plan Template included as appendix 2 to this document.

The number of people awaiting treatment, and length of wait for treatment will continue to rise unless there sustainably increase capacity to meet demand, non-recurrent actions to reduce backlog and workforce sustainability. Key highlights from the delivery plan included as appendix 2 include a number of recurrent and non-recurrent actions:

- Independent sector capacity and WLIs where these can be supported and staffed
- Procurement of ring-fenced orthopaedic capacity for TTG co-staffed by NHS Lothian and an external provider delivering c1,000 procedures p/a as a minimum and potential to expand. Plan to test this model for future replication for other key services prior to service commencement in the NTC, Lothian.
- Delivery of an Endoscopy additional capacity plan utilising available sessions through an insourced staffing model, continuation of cytosponge, embedding QFiT pathway and flexi cysto redesign.
- Delivery of a Radiology external capacity plan
- Procurement of external support to fill theatre workforce gaps.
- Workforce planning for NTC & pump priming aligned to recovery actions
- Outpatient Redesign Programme delivering CfSD best practice across OP services
- Centre for Sustainable Delivery Heat Map priorities
- Extension of contract for Robotic Prostatectomy with the independent sector provider to the end of March 2022 - no agreement in place beyond October 21.
- Creation of an Ambulatory Care Suite within Gynaecology services at SJH to meet increased demand in colposcopy
- Delivery of 7th Linac
- Pathology action plan to enable and support additional activity e.g. endoscopy plan

Whilst there are clear roadmaps for some specialties, such as Orthopaedics shown below, there are no solutions as yet to address the scale of the challenge for others. It is for this reason the Scheduled Care Recovery Programme will focus on supporting a programme of deep dives in priority specialties from October 21 onwards, continuing with General Surgery. The procurement exercise underway for Orthopaedic ring-fenced capacity in a co-staffed arrangement with a preferred bidder will test the market's appetite to deliver and a small

replication of the NTC clinical model in a similarly procured capacity, prior to commencement of services in the NTC Lothian at SJH.

Only actions with a high degree of confidence regarding delivery were included to establish the specific activity projections/ trajectories contained within template 3. ***The baseline from which these trajectories and plans have been derived is currently unstable and deteriorating, meaning the deliverability and impact of these actions remain uncertain.***

1.5 Updated Activity and Performance Templates

RMP4 provides projected activity and performance trajectories to the end of March 2022. Three data templates are submitted, these are:

Template T1 which provides activity projections on Unscheduled Care, Mental Health, and Delayed Discharges (Appendix 4)

Template T2 which_provides data on Monthly Actual v Planned Activity in Elective Care covering the period October 2021 to March 2022 (2nd half of FY2021/22) – (Appendix 5)

Following submission of initial data with RMP4, NHS Lothian will submit actual activity figures on a monthly basis by the 5th day (or closest working day) of each following month. The template will be signed off every month by the Waiting Times lead for the Board.

Template T3 which provides Elective Waiting Times Trajectories for patients waiting over 12 weeks (over 6 weeks for Diagnostics) and over 52 weeks. (Appendix 6)

1.6 Remobilisation Plan 4 Finance

The Local Mobilisation Plan (LMP) process as previously reported remains in situ for the current financial year. This process requires health boards to submit routine updates on a quarterly basis to the Scottish Government on the costs associated with COVID-19.

The Board continues to make funding commitments against a number of priorities, including:

- COVID-19 19 Vaccination programme;
- Test and Protect team (TAP);
- Testing and infection control capacity;
- Unscheduled Care flow;
- HSCP delayed discharges and additional bed capacity;
- Medical and nursing staffing; and
- Estates and facilities workforce;

The first submission at the end of July 2021 recognised additional costs anticipated across health in Lothian (i.e. excluding Social Care costs) of £123m in 21/22. Further work is required to monitor and update costs as these emerge throughout the year. The next update to the SG is due at the end of October 2021.

At this stage we expect all costs relating to COVID-19 to be met by additional funding in this year. Some funding has already been allocated as a 'payment-on-account' arrangement pending further clarification on costs and that further resource is expected to be released to boards following the next submission.

For the 2022/23 financial year, we await confirmation on available resources for COVID-19 at government level and the arrangements for further funding of costs in health boards. In anticipation, estimates of the likely financial impact of COVID-19 for next year are being pulled together as part of the Quarter 1 review output.

The Delivery Plan sets out a range of initiatives intended to support the COVID-19 response. As part of the submission on this year's cost profile at the end of October, we will reconcile these plans with the current costs included in the LMP to ensure they are appropriately recorded.

Scheduled Care Performance Funding

In April 2021, the Scheduled Care Remobilisation, Recovery and Redesign Programme Board agreed a proposed expenditure plan for the financial year 2021/22. This set out an estimate of anticipated internal expenditure, as well as forecast costs for WLI and independent sector usage based on requested volumes.

On the basis of this indicative plan, an allocation of £11.97m was made in June 2021 to support the recovery of elective care in Q1 and Q2, with a further allocation anticipated for Qs 3 and 4 following submission of RMP4.

The proposed applications for funding cover:

- internal NHS investments agreed initially through the 20/21 AOP;
- internal waiting list initiatives, approved and monitored through the Additional Capacity Board; and
- use of the independent sector, based on volumes requested by services to support trajectories.

For the independent sector activity, following confirmation of Q1 /Q2 funding a mini competition for requested volumes was approved by the Board and issued by procurement. Three providers responded and in May 2021 awards were made for vascular, general surgery and orthopaedics, in addition to existing local and national contracts in place with external providers. Some contracts could not be awarded due to capacity or governance constraints.

Following submission of RMP3, all services have reviewed and resubmitted their Recovery Plans, including assessment of ongoing funding requirements and proposed recovery actions. Based on these collated Recovery Plans, the sources and applications for waiting times improvement funding has been revised to show the forecast cost of delivering against recovery actions.

The table below shows the updated forecast, including an assumed £9m allocation for Qs 1 and 2. There remains a risk that this assumed funding may not be supported by the Scottish Government.

September 2021 Waiting Times - Forecast Sources and Applications

	Forecast £m	
	RMP3	**RMP4**
Sources		
NHSL Financial Plan	5	**5**
SG Allocation (£9m assumed Qs 3 & 4)	24	**21**
Deferrals	1	**1**
TOTAL SOURCES	**30**	**27**
Applications		
NHS Internal	8.8	**8.8**
Independent Sector - Awarded	14	**12**
Orthopaedics	6.1	**2**
WLI (est)	2.6	**1.5**
Diagnostics	3.2	**3.2**
Other	0.4	**0.4**
TOTAL USES	**35**	**27**
SURPLUS / (DEFICIT)	**-5**	**-**

The summary above excludes:

Cancer Waiting Times Funding of £1.5m;

Additional allocation to support Endoscopy activity; and

Activity delivered through GJNH.

NHS Lothian has established a Performance Support and Oversight Board (PSOB), which has identified business cases to support recovery actions, to be progressed as a priority:

- Procurement of ring fenced orthopaedic capacity through the independent sector. A procurement exercise was initiated in August 2021, based on indicative funding support through the Scottish Government for a 3 – 5 year period;
- Extension of robotic prostatectomy activity, delivered through independent sector capacity and currently due to conclude in January 2022;
- Options to deliver additional Endoscopy activity; and
- Short and medium-term investments in Dermatology to support performance improvement.

NHS Lothian will continue to work closely with the Scottish Government Access Support Team, through existing regular review meetings, to update on expenditure against allocations, and seek funding support as additional business cases develop.

PART 2 - UPDATE REPORT: KEY ACTIONS AND DEVELOPMENTS BUILDING ON FROM REMOBILISATION PLAN 3

This update section of Remobilisation Plan 4 can be considered as a 'stand alone' sub-report which provides a detailed update on progress and action in key areas initially outlined in Remobilisation Plan 3. The section covers updates on the vaccination programme, Public Health, workforce, the Care and Wellbeing programmes, Primary Care and Lothian Unscheduled Care Services, Health and Social Care Partnership actions, mental health services, acute services, and digital service developments and support.

2.1 Pandemic Response and Vaccination Programmes

COVID-19, Flu and COVID-19 Booster Vaccination Programme Update

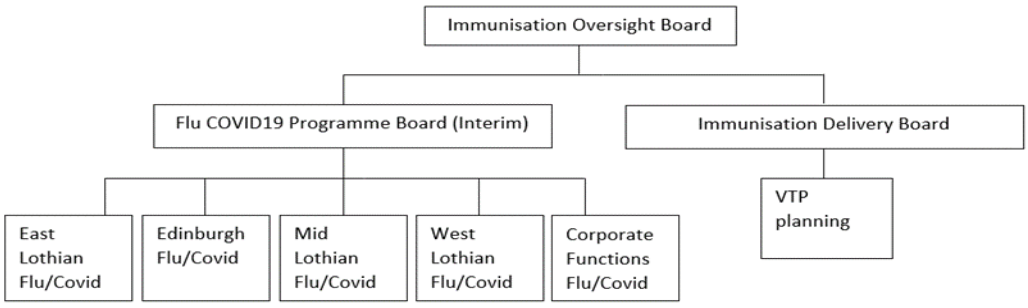
Review of Programme Board Immunisation Programme Governance Arrangements

A COVID-19 Vaccine Programme Board was established in October 2020 to implement delivery of the COVID-19 vaccination programme from early December 2020 through to September 2021 in line with UK Joint Committee for Vaccination and Immunisation (JCVI) priority cohorts.

Focus from July 2021 turned to delivery of the annual autumn/winter flu programme, continuation of COVID-19 vaccination programme (referred to as 'Evergreen' phase) and progress plans associated with delivery of COVID-19 booster vaccination.

To support transition of immunisation programme governance arrangements, the existing flu and COVID-19 vaccine Programme Boards were merged from 3rd August to a Flu and COVID-19 Booster Programme Board, co-chaired by Executive Nurse Director and Midlothian Chief Officer, supported through an operational sub group including dedicated working groups i.e. children / young people's flu, staff vaccine, workforce, vaccine supply / demand.

An Immunisation Oversight Board, to be chaired by the Deputy Director of Public Health, is to be established in late September 2021. Transition to the new structure is to be completed no later than March 2022.



COVID-19 -19 Vaccination Uptake at 23rd September 2021

The current position associated with uptake of vaccination is outlined below.

Overall Percentage Uptake: Over 18 Years

	Scotland	Lothian
1st Dose	91.8%	89.7% (666,691)
2nd Dose	85.8%	83.0% (616,988)

NHS Lothian Coverage by Age Group

Age / Priority Cohort	1st Dose	2nd Dose
Over 80 Years	41 021 (100%)	39 850 (100%)
75 – 79 Years	29 161 (100%)	28 751 (100%)
70 – 74 Years	41 236 (100%)	40 720 (99.7%)
65 – 69 Years	43 049 (100%)	42 454 (99.3%)
60 – 64 Years	52 589 (100%)	51 690 (100%)
55 – 59 Years	59 451 (99.8%)	58 105 (97.6%)
50 – 54 Years	59 541 (98.3%)	57 656 (95.2%)
40 – 49 Years	106 807 (90.7%)	100 592 (85.4%)
30 – 39 Years	116 192 (80.7%)	104 239 (72.4%)
18 - 29 Years	117 644 (73.7%)	92 937 (58.2%)
16 – 17 Years	12 343 (73.3%)	1,543 (9.2%)

Source: Public Health Scotland COVID-19 Daily Dashboard at 23 September 2021

https://public.tableau.com/app/profile/phs.COVID-19.19/viz/COVID-19DailyDashboard_15960160643010/Overview

Summary of Arrangements for Continued Vaccination Roll Out

- 9th August - start 2nd dose for 18 – 29 years
- 6th September – children's flu programme began with vaccination also offered to teachers
- 13th September – begin vaccination of student population across Lothian (c100,000) Plans in place to open vaccination sites at Edinburgh, Heriot Watt and Queen Margaret Universities for fresher's week and start of term. Pop-up vaccination arrangements at Napier University and Edinburgh College also supported
- 20th September
  - 12 – 15 years universal offer of drop in arrangements followed up with national invite to this age group with appointments from 4th October
  - 3rd dose COVID-19 vaccination for severely immunosuppressed supported through drop-in arrangement via vaccination bus at Western General Hospital week commencing 20th September and national invite letter from 4th October
  - flu and COVID-19 Booster vaccination started in care homes
  - opportunistic staff vaccination flu and COVID-19 Booster)
- 21st September – go live of health and social care worker national self-registration portal to allow workers to book vaccination appointments

- 27th September - national invite for over 70s flu and COVID-19 booster if eligible

Drop-in and Outreach Vaccination

- All vaccination centres are supporting drop-in arrangements, uptake is particularly good at EICC and Gorebridge
- Mobile vaccination bus is available and has been used at numerous locations including Ikea, Football Stadiums, Cameron Toll Shopping Centre, Fort Kinnaird Shopping Centre with circa 300 attendances at the bus per day, plans for use of the vaccination bus to support drop in / mop up continue to be planned.
- Targeting of hard to reach communities through pop-up in churches, mosques, community halls and Craigroyston School,
- Examples of 'Pop-Ups' / Vaxi Taxi venues include North Edinburgh Arts, Leith Links Community Project, Whale Arts (Wester Hailes), Edinburgh Mosque, Whitburn Bowling Club, Mitsubishi Factory, Blackburn Partnership Centre, Monaghan Mushroom Factory, Fringe-by-the-Sea North Berwick.

Additional Vaccination Venues

- Gyle Shopping Centre until 26th September
- McArthur Glen, Livingston until 31st August
- St James Quarter Retail Centre until 27th August

Footfall through drop-in arrangements across Lothian has ranged between 1,000 – 1,500 citizens per day, though during September drop-in activity has significantly reduced.

Communication was issued from the National Delivery Director on 18th August requesting NHS Boards to continue with drop-in and out reach to encourage citizens to attend for 2nd dose vaccine and increase 1st dose uptake. Consideration needs to be given when pop-up arrangements will cease due to staffing requirements to support delivery of Tranche 2 (flu and COVID-19 booster) phase of the programme.

Vaccination 17 – 18 Years

On 20 July 2021, the Scottish Government indicated those who turn 18 years of age from 1 August – 31 October were eligible for vaccination, supported through drop-in arrangements across Lothian which have been widely publicised on social media.

Vaccination 16 – 17 Years

On the 4th August 2021, the JCVI announced all those aged 16 – 17 years (at 31st August) were to receive an initial 1st dose vaccine (Pfizer). Estimated number within this cohort in Lothian is 16,834 individuals. Arrangements for vaccination are supported via the following:

- 6th August – NHS Inform Self-Registration portal went live to register for scheduled appointment
- 10th August – drop in with no appointment across all vaccination centres in Lothian

- 25th August - those who do not come forward for vaccination will receive a national invite letter with an appointment
- Drop in offered at a school in East Lothian and Edinburgh College
- Aim for completion by mid-September

Vaccination 12 – 15 Years at Risk (Neuro-disability and Learning Disability)

On 19th July, JCVI recommended vaccination of those aged 12-15 years at risk, it is estimated circa 937 young people should be offered vaccination within this cohort in Lothian. Vaccination clinics are taking place at the Royal Hospital for Children and Young People during the weekends of 21st / 22nd , 28th/29th August and 4th/5th September. There has been feedback from other NHS Boards to indicate a number of vaccination invites have been declined, parents wish to have a discussion with specialist / GP before consenting and invites for vaccination at this current time may not be suitable due to underlying health conditions.

Vaccination 12-17 Years Sharing Households of Immunosuppressed

On 7th August, a national letter was issued to household members who are immunosuppressed to indicate eligibility for vaccination for those age 12 – 17 years sharing household inviting to contact the National Call Centre to request vaccine appointment. Current indication there has been a low response to the invite with 378 appointments scheduled following contact with the national call centre, however individuals are also attending drop in facilities.

Universal Vaccination 12 – 15 Years

On the 17th of September 2021 the Chief Medical Officer recommended universal vaccination of those aged 12-15 years with an initial first vaccine dose. NHS Lothian began offering drop in vaccination for this cohort from 20th September, with 1,622 within this age range dropping in for vaccination from 20th -23rd September.

Vaccine Hesitancy in Younger Ages

The Edinburgh HSCP have undertaken engagement with local youth groups to identify reasons for vaccine hesitancy, responses indicate opportunistic appears to be the best approach. Summary of feedback from Q&A with young people:

- Feel like they are not so affected by COVID-19. Most of them either know 2 to 3 people that have had virus - with no long term or serious effects. Or they have had it themselves. So perception is COVID-1919 is not that bad
- Those young people that are getting inoculated seem to be someone who is essential worker, have parents relative who are essential worker, are young carer or have LT condition themselves (or again family/friend who does)
- They are reluctant to travel far for vaccine. Perception is they might have to sort out travel, time off/out and this requires support from someone else i.e. parent. So can't be bothered
- There are small cohort who think vaccine is "too experimental". Are influenced by peers and other family members.

- They think they are invincible and that the virus just attacks older/frail people

Flu and COVID-19 Booster Vaccination Planning

The Lothian Health and Social Care Partnerships require to take over delivery of the adult influenza vaccination in 2021 from General Practice as part of the delivery of the Primary Care Implementation Plan. The HSCP plans will be supported through NHS Lothian corporate vaccination programme functions i.e. pharmacy, analytics, public health, facilities, communications, and procurement.

The 2021-22 Season Flu Programme includes additional eligible cohorts, specifically:

- 50-64 year olds
- Prisoners and Prison Officers
- Teachers and Pupil Facing Assistants
- Secondary School Students

The flu and COVID-19 Booster programme is to be delivered in two stages:
Stage 1 (assumed dual vaccination)

- Adults aged 16 years and over who are immunosuppressed
- Those living in residential care homes for older adults
- All adults aged 70 years or over
- Adults aged 16 years and over who are considered clinically extremely vulnerable
- Frontline health and social care workers

Stage 2 (de-coupling of vaccine administration)

- All adults aged 50 years and over
- All adults aged 16 – 49 years who are in an influenza or COVID-19 at-risk group (as set out in the Green Book)
- Adult household contacts of immunosuppressed individuals

The Scottish Government provided the following timelines for delivery of the flu and COVID-19 booster programme on 12th August with expectation flu vaccination will be completed by early December with co-administration of flu and COVID-19 booster where possible which adds to planning complexity.

Updated Planning Assumptions

Dates (week commencing)	Action	Notes
6th and 13th September	Focus on childhood Flu vaccinations	The initial focus on the pre-school (2-5 year olds) and School Flu programme should decrease the population risk from Flu and decrease the vaccination burden later in the year, freeing up capacity.
13th September	Online booking/registration system will go live for frontline Health and Social Care Workers	
20th September	Flu and COVID-19 booster vaccinations offered to those living in residential care homes for older adults	
	Flu and COVID-19 third dose co-administered to immunocompromised.	If we target all immunosuppressed people for co-administration, this is a fairly significant number of people and may give NHS Boards more than enough cohort size to start the co-administrative programme. We use the flexibility signalled by the JCVI for immunocompromised people and go ahead with co-administration in keeping with other UK countries even if some of them may not have had their 2nd dose at least 6 months before their 3rd dose/flu vaccines are due.
27th September	Start of appointments for remaining Stage 1 groups flu and COVID-19 boosters – co-administered	Those in priority groups 1 and 2 in phase 1 could be next for co-administration given that most of them were offered the 2nd dose at around March/early April, so majority would have got their 2nd dose 6 months before we offer them any booster at around October time with the flu vaccine
6th December	Completion of Flu programme	

The HSCPs have outlined delivery plans which are subject to ongoing review with any revisions of delivery arrangements and mitigation of risks being addressed as necessary. Bi-weekly meetings have been established with NHS Lothian and HSCP teams to manage on-going review of plans, recognising requriement for the need for consistent delivery model across partnerships given complexity of planning.

A programme wide recruitment drive is underway to support HSCP delivery plans and establishement of a dedicated corporate function team.

Those aged over 80 received 2nd dose vaccination in late April 2021 therefore will be eligible to receive 6 month booster in mid- Octover therefore there is a need to consider careful scheduling to support co-administration where possible and the need to de-couple co-administraion of flu and COVID-19 Booster vaccine for younger ages resulting in requirement to increase vaccination capacity due to need to scheudle 2 separate vaccine appointments.

A Service Level Agreement for community pharmacy support for flu vaccination has been issued with c100 pharmacies signed up to support delivery of flu vaccination from 27th September through drop in arrangements. Community Pharmacy will have access to national Vaccination Management Tool to record vaccine administration.

Those over 70 years will receive letter with vaccine appointment, staff and those under 70 are required to self-register for a vaccine appointment via NHS Inform website. There is potential for individuals who self register to be scheduled vaccination to another area in Lothian i.e. outwith HSCP area as has been experienced with COVID-19 vaccine scheudling. NHS Lothian continues to highlight the requirement to limit vaccine clinic bookings to specific

cohorts and HSCP populations to support appointment management, the position continues to evolve as the national digital and data team undertake amendements to the national scheudling system. It is expected citizens who do not self-register for vaccination will receive a follow up national invite appointment letter.

Children and Young People Flu Vaccination

Plans for delivery of the children's flu programme is well established with expansion of the programme to cover secondary school pupils with delivery of the programme through extended Community Vaccination and Child Health teams to organise appointments. It has been confirmed sufficient vaccine will be available to start the programme from 6th September. Staff in nursery, primary and secondary schools will be offered vaccination on the same day as pupils.

Communication and Engagement

The need for a comprehensive communication plan is recognised given changes in programme flu programme delivery from pervious years and the potential for citizen confusion. This is under development as national flu programme resources become available given the need for local communication plans to dovetail with the national communication campaign. The Scottish Government provided an update on the national communications and engagement plan on 19th August:

- Children's Flu – national campaign began on 19th August trageting parents and secondary school children and supported through local social media channels
- Seasonal Flu – national campaign began on 20th September supported through local social media channels
- COVID-19 Booster – the Scottish Government are currently developing campaign activity

Programme Risks

Mitigating actions are being addressed through discussion and liaison with Scottish Government officers, weekly national FVCV Delivery Group meetings, weekly NHS Lothian Programme Board and Operational Group meeting and informal bi-weekly meetings with health and social care partnership planning teams. Key risk highlighted associated with current planning relate to:

Risk	Mitigating Action
Programme Staffing to meet local and Scottish Government requirement with particular risk associated with vaccinator and administrative staff	A substantive vaccine programme recruitment drive is underway. Request for military support has been submitted to the Scottish Government
Co-administration or de-coupling of flu and COVID-19 booster and impact on capacity /scheduling	On-going review of health and social care partnership capacity and demand modelling

Pressure on home visiting teams associated with those who are housebound and complexities of administering COVID-19 booster vaccination	Demands will be kept under local review
New Programme Co-ordination (moving away from GP delivery model) results in citizen dis-satisfaction	NHS Lothian and HSCP communication plans outlining change in delivery model
Move to national appointment scheduling system leading to citizen and health and social care staff confusion	information for citizen and staff promoted through NHS Lothian/ HSCP / Council websites and internal vaccine all staff bulletins
National scheduling system allocation of appointments out with area of residence	On-going review and discussion of national cohort scheduling with National Services Scotland

2.2 Remobilisation of acute services

Safe/Segregated Pathways

Segregated high and medium risk ward and critical care pathways are provided on all acute hospital sites. The number of beds/wards allocated to these pathways is dynamic in response to infection incidence and hospital presentation, and to wider community prevalence

Maintenance of Surge Capacity

We will continue to provide as required surge capacity but with beds closed on our Acute Sites due to workforce gaps and high numbers of patient delays, delivery of previous plans are increasingly challenging.

Critical Care

Critical Care will continue to operate from a core footprint of 55 beds across the 3 adult acute sites, pending the establishment of 4 additional ICU beds prior to winter 2021, as per agreement with Scottish Government. Critical care have established agreed protocols for safe transfer of patients with Covid-19 to another critical care unit of and when required to support capacity management.

Well established critical care surge plans provide an incremental increase up to 113 beds, which will remain unchanged regardless of additional base beds. However the staffing required to support surge capacity will not be as readily available due to the current workforce position and ongoing clinical pressures at the Front Door. The ability to provide surge capacity in critical care at this stage will directly impact the ability to continue delivery of urgent elective care.

CPAP Continuous Positive Airway Pressure

An outline clinical model has been agreed to deliver CPAP in safely staffed and ventilated areas for deteriorating patients until such times as a critical care bed becomes available

Long COVID-19

We aim to develop a consistent pathway across Lothian for patient diagnosed with Long COVID-19.

After a successful pilot a Pan Lothian multidisciplinary critical care recovery service has been established to support patients post discharge from ICU through to discharge to community.

Theatres

All theatre capacity will continue to be prioritised to deliver urgent and cancer surgical activity, as well as the longest waiting patients who have been reprioritised as needing urgent intervention. A Short Life Working Group has been established to oversee and ensure maximise theatre utilisation across sites. Theatre planning meetings will continue to provide a single point of access to prioritise and optimise sessions. The roll out of TRAK theatre module commencing Q3 2021/3 will streamline theatre booking processes.

Pre-operative testing process, in line with national guidance, remains embedded for planned surgical procedures The service will rapidly review and implement any change in infection prevention guidance which may support increased green pathways.

Detailed patient information is provided as part of informed consent to ensure patients fully understand the risk of COVID-19 in scheduled care.

As outlined in previous remobilisation the critical care surge plan will have a direct impact on theatre availability due to the shared staffing model.

Significant work is underway to address theatre workforce gaps including international recruitment.

Scheduled Care

Introduction

Before the COVID-19 pandemic, waiting times for scheduled care were improving in NHS Lothian with implementation of the Board's Waiting Times Improvement Plan.

The impact of addressing the COVID-19 pandemic, however, resulted in a significant reduction in scheduled care services to release workforce to support and expand critical care and other inpatient activity. Critically whilst responding to the COVID-19 challenge the Board continued to prioritise elective care for the most urgent patients.

In line with the clinical prioritisation framework, introduced in February 2021, NHS Lothian elective services continue to prioritise:

- Urgent suspicion of cancer (USoC) referrals (additions), which remain at higher levels than pre-COVID-19;
- Urgent referrals;

- P2 Urgent and P2 suspected/ diagnosed cancer;
- As well as the longest-waiting patients who have either been reprioritised as needing urgent intervention or as capacity allows booking of longest waiting routine or P3 and P4 in-patients/daycases.

It must be noted that during September the Board has had to suspend the surgical programme for all P3 and P4 patients, including in paediatrics.

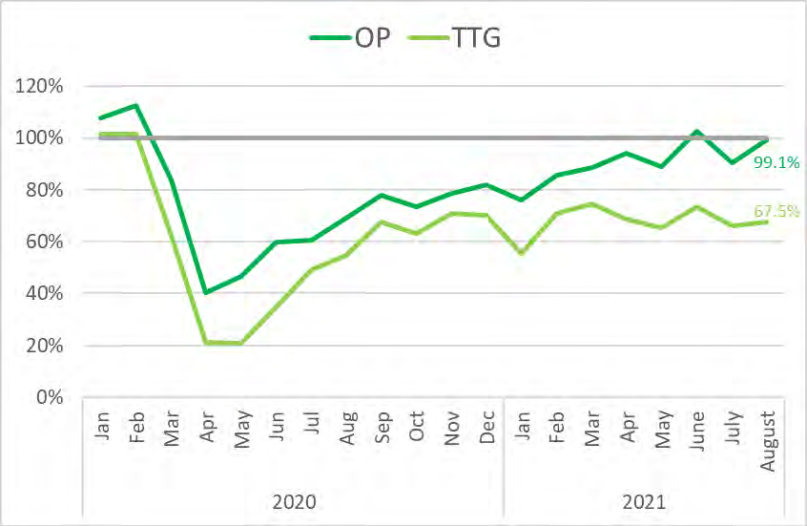
NHS Lothian's ability to fully deliver recovery actions outlined in RMP3 and in this RMP4 submission whilst also continuing to meet demand for urgent and USoC activity are considered by the Board as high-risk. This is due to the ongoing cumulative impact of the following key factors:

- Significant and worsening workforce gaps,
- Rising unscheduled care demand and increasing acuity of presentations exacerbated by easing of restrictions and deferred demand
- Uncertainty re COVID-19 activity forecasts,
- Capacity constraints (beds, critical care and theatres),
- Rising number of delays and occupied bed days alongside increasing community pressures,
- Infrastructure inadequacies which pre date COVID-19 e.g. shared occupancy rooms, limited isolation spaces, and non-compliant ventilation, fragility of support services e.g. HSDU
- Limited external capacity- independent sector & GJNH or Regional Endoscopy Unit. Demand outstrips capacity and all impacted by similar workforce challenges.

The baseline is unstable and the Board is planning from a deteriorating position which makes forecast of waiting times positions and any assumed impact of recovery actions uncertain.

Graph 1 below shows the percentage activity levels in 2020 and 2021, thus far, against 2019 activity levels. Whilst Out-patients are achieving similar levels of activity to 2019 TTG is not. NHS Lothian's TTG capacity has significantly deteriorated due to staffing constraints across all areas with staff moved from lower priority theatre sessions to maintain increasing emergency, urgent and cancer activity and support critical care beds. Continuing to provide adequate skill mix for complex activity is an increasing concern and restrictions on number of elective cases deliverable per day remain due to bed capacity issues. Our trajectories and activity forecasts for RMP4 take account of the recent deterioration in activity.

Graph 1: TTG and Outpatient activity vs 2019 activity:

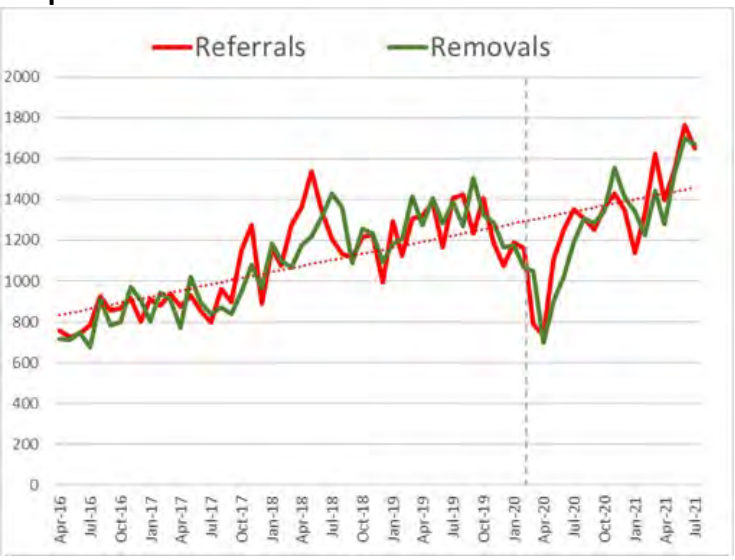


It is important to highlight here that not all capacity sought by NHS Lothian from the independent sector was picked up by the market and most recently GJNH and the Regional Endoscopy Unit have been unable to deliver activity in line with previously agreed SLAs due to their own workforce pressures. The impact of winter is also unknown but any impact will be on top of current challenges.

Scheduled Care Activity & Performance

Urgent Suspicion of Cancer (USoC) referrals were increasing prior to COVID-19 and this trend continues (Graph 2). USoC referrals are now significantly above previous levels, particularly in Dermatology, Gastroenterology, Gynaecology, Respiratory Medicine. We continue to meet this demand, by using a great proportion of our capacity for these, further impacting on routine waits. Approximately five new cancers are diagnosed from every 100 USoC referrals received.

Graph 2: USoC Referrals and Removals from the New Outpatient waiting list:



Cancer - Systemic Anti-Cancer Therapy (SACT) and Radiotherapy Services continue to operate at full capacity with patients being treated closer to home where possible. Investment from

national funding has been requested for radiotherapy to deliver new treatment regimens to meet increasing and targeted demand, e.g. breast and lung cancer. A national funding bid for MRI Radiotherapy was supported from a capital investment perspective pre-pandemic. A funding source for additional revenue costs are yet to be agreed nationally. SCAN Health Boards have also been informed by the Cancer Policy Team of potential funding to support SACT in response to pandemic pressures. SCAN Boards have been asked to submit to the policy team evidence of increased demand, reduced capacity and stage shift and NHS Lothian await feedback from SG colleagues on next steps.

National cancer recovery funding was applied for in round 1 in parallel with RMP3 but no NHS Lothian proposals were funded. National Cancer Action Plan submissions were requested for a 2nd round in August 21. These were submitted via SCAN, confirmation of successful bids is due on the 22nd October. National Cancer waiting funding has been received and prioritised via the Cancer Recovery Board to support cancer access on a non-recurring basis.

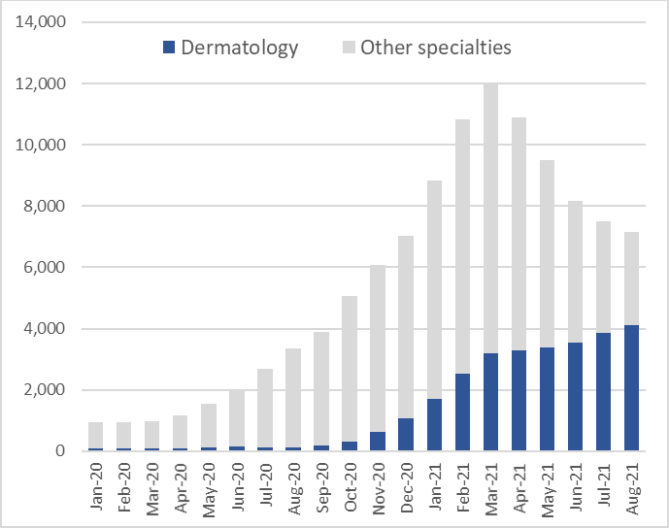
From October 2021 onwards the re-classification of robotic prostatectomy (no longer a new technology) will have a negative impact on reported performance.

Physical distancing guidance was updated by Scottish Government at the end of August 2021, reducing out-patient requirement to 1 metre. Outpatient departments are currently implementing this guidance, which is expected to increase activity further in some areas, however the space and layout of the majority of our facilities will not see a significant impact in activity gain.

The outpatient waiting list size and the number waiting over 52 weeks has decreased in August 2021 as shown in graph 3 below. However, the number of long waiting patients continues to increase in Dermatology, which has seen a significant increase in USoC referrals in recent months (together with Gastroenterology, Gynaecology and Respiratory Medicine).

NHS Lothian's Out-patient redesign programme is a comprehensive plan across all specialties that will deliver CfSD best practice including ACRT, PFB, PIFU whilst also ensuring TRAK Clinic templates are fit for purpose and effectively record and mange mixed clinics to deliver face to face, telephone and near me consultations within one clinic.

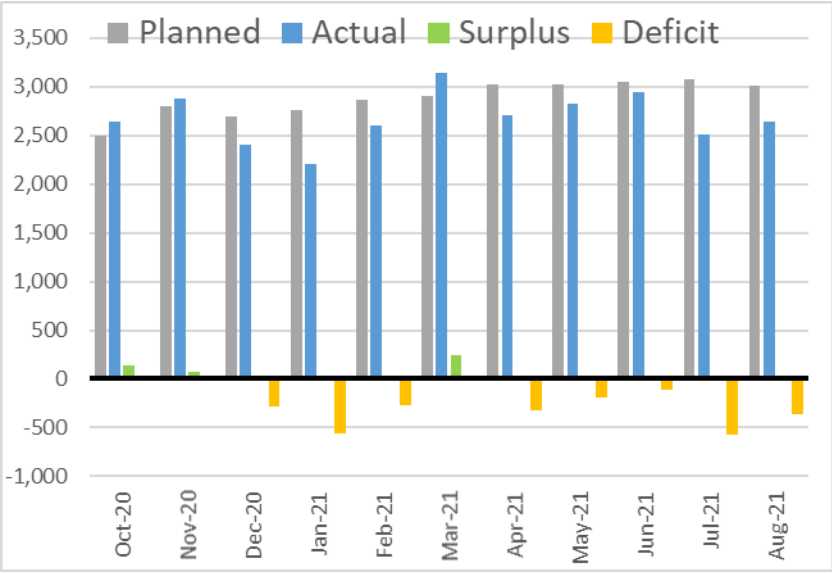
Graph 3: New Outpatients waiting over 52 weeks:



TTG – recovery of Inpatient/Day case activity remains a significant challenge with the current system wide pressures. There has been a sharp reduction in TTG activity in August and September and these sustained pressures are reflected in our Trajectory.

The ongoing monitoring of planned TTG against the actual activity that specialties have been able to achieve, shown in graph 4 below, indicates that NHS Lothian delivered a surplus against planned activity in March 2021 and a deficit in all subsequent months.

Graph 4: TTG activity vs planned:



Cancer recovery

National cancer recovery funding was applied for but no funding was supported for NHS Lothian proposals. National Cancer waiting funding has been received and prioritised via the Cancer Recovery Board to support cancer access.

The QFIT pathway will be strengthened and embedded within colorectal and endoscopy throughout 2021QFIT Team currently being established, clinical agreement on triage pathways reached.

Delivery Against Framework for Recovery of Cancer Surgery

Theatre sessions supporting cancer workload are prioritised with staff working flexibly to support.

All pre-COVID-19 theatre sessions supporting cancer workload are open and will be maintained throughout 21/22. Additional capacity will be provided where possible through weekend sessions for breast, plastics. Spire Murrayfield will provide robotic prostatectomy for 5 patients per week up to mid July. The Spire contract has been extended to 31st March 2022.

Additional capacity will continue to be provided where possible through weekend sessions for cancer and other priority patient groups.

The recommissioning of the original DCN at WGH site is no longer considered an option for protected elective capacity on that site.

Additional capacity requirements through the independent sector will be assessed through existing processes and governance structures and submitted to the Scottish Government for consideration against available funding.

The business case for the 7th Linac has been approved and we aim to have this installed and operational by March 2022.

2.3 Primary Care

This section provides an update against RMP3 Section 10 - Re-mobilisation of Primary, Community and Social Care, which covers a range of contracted and related services. Page references shown in brackets refer to the respective section in the RMP3 document. Update is given where there has been significant change or development in the respective service area. Aspects of the update, given later in this report, from Lothian Health and Social Care Partnerships also refer to Primary, Community and Social Care services.

Primary Care Remobilisation Plan (p20 of RMP3)

The Primary Care Remobilisation Plan reflects the work undertaken by the NHS Lothian remobilisation groups and planning in response to COVID-1919. This will continue to be updated in line with new and available information either clinical advice, Scottish Government or NHS Lothian Policy and guidance. This plan has been developed from ongoing work with the 4 Health and Social Care Partnerships and the individual contractor plans across GMS, Dental, Optometry and Pharmacy.

The original plans for remobilisation have been revised in response to the upsurge in COVID-19 cases at the end of 2020, the second wave and national lockdown, and the roll out of COVID-19 vaccination to most adults in Scotland. In general, contractor services first reverted to the position adopted in response to the first wave and first national lockdown in 2020.

Plans for remobilisation were reviewed as vaccination was implemented and are now broadly similar to those that were partially implemented last year.

The position at July 2021 is that vaccination programmes are now well advanced throughout the adult population, together with widespread availability of Lateral Flow and PCR testing. Although numbers of infections with the delta variant are now increasing in Scotland, there has been only minimal impact on hospitalisation and deaths. Social distancing guidelines remain in place but may be relaxed in August. COVID-19 vaccination has largely been delivered through mass vaccination centres and HSCP teams. GP practices have helped with housebound elderly patients. There are however major logistical challenges for HSCPs and contractors in delivering seasonal flu vaccination and probable COVID-19 booster vaccination in winter 2021/22.

New GMS Contract (2018) Implementation

Priority areas for implementation are Vaccination Transformation, Pharmacotherapy and CTACs. HSCPs have set out the implementation process for their areas in the HSCP Primary Care Improvement Plans. Progress is overseen and coordinated at Lothian level by the GMS Contract Oversight Group – a collaboration between NHS Lothian, Lothian LMC and HSCPs.

An updated national Memorandum of Understanding is awaited (Scottish Government, BMA, Integration Authorities and Health Boards).

All parts of the system are currently under acute pressure from increased demand, ongoing PPE restrictions on productivity and staff absences due to self-isolation and COVID-19 contacts. The backlog of out-patient and elective surgery work is also impacting on GP demand leading to poor morale.

Public messaging on ongoing constraints to service delivery and realistic expectations is needed. It is likely that GPs will continue to triage access to services and provide a mix of face-to-face, telephone, video and e-mail consulting, although patients who need to be seen face to face will always be accommodated.

Governance and Decision Making (p21)

Resumption of regular Primary Care Joint Management Group meetings, and GMS Contract Implementation Oversight Group, with sub groups. This is a tri-partite structure with representation from NHS Lothian, HSCPs and LMC/GP Sub-Committee. The focus for 2021/22 is the three priority areas of the contract for implementation – Community Treatment and Care Centres (CTACs), Pharmacotherapy and VTP (Vaccination Transformation Programme)

Essential/non-essential services (p23)

All GMS services resume and practices encouraged to resume Enhanced Service Activity (if reduced or postponed). Assurance on payment levels extended to September 2021, with review of activity data from Quarter 4 2020/2021.

Cervical screening and Bowel Screening – continue in line with Scottish Government advice and other national screening programmes

Practices submit a weekly Sit Rep on service status.

COVID-19 Pathway (p24)

The COVID-19 pathway in Lothian consists of a telephone triage service and a face to face assessment facility in the COVID-19 Assessment Centre which is co-located with SDEC at the Western. Case numbers for telephone triage and face to face assessment settled to a manageable level over Quarter 1 but have now started to increase again. This has coincided with a reduction in availability for COVID-19 triage pathway staffing, partly delivered by recently retired GPs returned to the workforce. The COVID-19 triage service is staffed by GPs and operates 24/7 except for midnight to 8am overnight when the calls are taken by LUCS GPs. There is increasing difficulty in staffing COVID-19 triage shifts, and CAC shifts leading to reduction in service and additional pressure on LUCS. Direction on COVID-19 pathway provision by Boards is awaited from Scottish Government.

NHS24 and Urgent Care (p26)

The Redesign of Urgent Care (RUC) programme has been initiated in Lothian (see separate section).

GP roles and Responsibilities in Medical Care for Residents of Care Homes for Older People (p27)

A proposal to review remuneration for GP practices that provide enhanced anticipatory care to care home residents, and Lead Practice support to care home managers has been approved for one year by HSCP Chief Officers. It is hoped that this will help with retention and morale for GP practices that have taken on extremely difficult and time consuming roles in relation to frail elderly residents of care homes, including the inpact of COVID-19 and measures to help reduce spread of COVID-19. This programme sits within the Lothian wide HSCP care home services and governance framework.

Dental (p29)

Dentistry has been particularly badly affected by the pandemic because of the nature of dental treatment and the fact that many dental procedures generate aerosols requiring new and much more time-consuming infection prevention and control measures. Further extension of clinical activity will be driven by Scottish Government decisions in line with policy change around the pandemic response.

The delivery of dental care will remain challenging while the current infection prevention and control measures (IPC) are in place. At this time there is no indication of when these might change and those changes will be driven by NHS Scotland infection prevention and control advice delivered through the Chief Nursing Officer.

GDS practices are all remobilised into Phase 4 of recovery and are currently tasked by SG to provide a minimum of 20% of prior clinical activity to support the urgent care needs among their client groups. The Health Board is aware that the average level of activity from NHSL practices is around 43% currently with a range from zero to 143%

Further extension of clinical activity will be driven by Scottish Government decisions in line with policy change around the pandemic response and particularly changes in IPC requirements for Aerosol Generating Procedures.

Access

Dentists are working hard to manage the urgent care needs of their patients and to cope with the backlog of care that is a result of 12-months of national lockdown/limitation of service. As a result patients are finding it hard to access routine dental care if they are not registered with a dentist.

Some practices in Lothian have withdrawn from their commitment to the NHS citing professional/business reasons. This affects around 20,000 people in the Lothians currently.

NHS Lothian are engaging with local dental practices to compile a list of those practices currently registering new NHS adult and child patients with a view to publishing this on the NHS Lothian website. In the meantime the dentist finder on the NHS Inform website will list all the practices in Lothian and Borders https://www.nhsinform.scot/scotlands-service-directory/dental-services

NHS Lothian have a dedicated service for people who are not registered with a dentist run by the NHS Lothian Oral Health Service through the Chalmers Dental Centre in Edinburgh. This service has been enhanced by the Oral Health Service to meet the urgent care needs of this group of the population who are growing as the pandemic continues though it does not extend to registration with a dentist. Current levels of activity in this Unscheduled Care Service and through the Out of Hours team are running at around 400% of the activity levels prior to the pandemic.
https://services.nhslothian.scot/Dentists/Pages/EmergencyDentalCare.aspx

All dental practices are currently being asked to deliver a minimum of 20% of their "pre-COVID-19" activity and are being provided with 85% of their prior NHS financial payments. All practices will be sent a 3-monthly aggregated payment schedule from the "July Paid August" dental schedules (10th August 2021) so they are aware of the level of activity they are delivering. The Chief Dental Officer (CDO) wrote to all dentists on the 29th June 2021 outlining this expectation. Health Boards have been in receipt of some prior activity data and are tasked with engaging immediately with any practices who have no recorded activity and then with those who have between 0 and 20% after the 10th August. The intention of this engagement is to understand specific barriers to achieving he activity targets and to develop a relevant action plan with the practice to enable them to achieve the minimum 20% target required.

At present the aggregated level of activity across NHS Lothian NHS dental practices is around 43% of pre-COVID-19 delivery with a range from 0 to 143%.

PPE

The Chief Dental Officer has asked National Procurement to increase the free PPE made available for the dental contractors in the Boards by 50% from July 2021. This will be provided until March 2022. Where practices require more than their allocations they continue to

provide the PPE from their resources. Additional PPE is provided to those training practices involved with the Dental Foundation Training Programme and Dental Nurse training

Practice Inspections

The programme of combined practice inspections will restart in Lothian on 1 September 2021.

Oral Health Service

The Oral Health Service has around 7,400 patients who are waiting for a 1st appointment on referral from their general dentist. A recovery plan has been developed at the request of the NHSL Performance Oversight Board to significantly reduce over 12 week waits, and clear all over 52 week waits, within both the Public Dental Service and for the secondary care referral service by March 2022. There are specific challenges in delivery of these targets in Oral Surgery, both through the Oral Health Service for East Lothian, Mid Lothian and Edinburgh and through the OMFS unit at SJH for people living in West Lothian

All patients requiring to be seen urgently are being prioritised by the service and those who require being made dentally fit to enable other aspects of health care (Cancer pathways and cardiac surgery) are being managed within normal timescales

All patients who are unregistered can access the NHS Lothian Unscheduled Dental Care Service that runs out of the Chalmers Dental Centre in the centre of Edinburgh to manage issues associated with pain and discomfort. NHS Lothian's Oral Health Service has bolstered this service significantly to support the additional demand we are facing from people who currently do not have a regular NHS dentist with whom they are registered.

The Public Dental Service and secondary care dental services have also remobilised. Activity levels are running at around 70% of pre-pandemic capacity largely to do with supporting social distancing among both patients and the staff cohort within the building, issues around ventilation in buildings and limitations of yellow treatment pathways in a hospital setting.

Prioritisation of care has been focussed on the delivery of care to patients who require care for medical reasons and on the support and delivery of education for undergraduate and postgraduate learners.

Oral Health Improvement and NDIP

Oral health improvement programmes and NDIP should/will be remobilised as a matter of urgency/from Autumn 2021. Recognition of the limitations of continued restrictions in the different settings may limit some activity. In order to achieve this there is a need to return oral health staff to their substantive duties.

Health Improvement

The Oral Health Improvement team are remobilising. Programs targeted at older adults in residential care have restarted, Childsmile is scheduled to restart at the beginning of the new academic year in August 2021. The Childsmile team have ensured that all children from SIMD 1 and 2 backgrounds have continued to receive oral hygiene kits throughout the pandemic alongside school meals provision. Any changes in these programmes will be affected by IPC requirements in place at the time.

National Dental Inspection Programme in Schools

The National Dental Inspection Program (NDIP) will restart in August /September 2021. This is an annual program of inspection of the teeth of children in local authority primary schools. For academic year 2021/22 basic inspections will be carried out on Primary 1 and 2 children and not Primary 7 children. A SOP and Risk Assessment is in place with updated IPC requirements.

Optometry (p32)

Routine eye care resumed in practices in August 2020.

Mobile providers resumed visits to patient's own homes in August 2020 and visits to care homes, with further precautions, in September 2020.

Future remobilisation for general ophthalmic services will be guided by the Scottish Government. Activity continues to increase and because of this a minimum activity threshold to continue to receive the financial support available to practices and mobile providers was introduced. The threshold will increase over June, July and August 2021 to phase out the support. Practices are still able to request an exception from the threshold from the Board.

The EETC has not been required in the current level of restrictions. Practices have continued to see emergency patients on their own premises.

Pharmacy (p34)

Pharmacy First

Pharmacy First successfully launched in July 2020. Since commencing, the levels of activity have increased with the community pharmacy network in Lothian prescribing around 200,000 items and dealing with 30,000 requests for advice. Patient Group Directions (PGDs) have been approved and implemented in June ’21 to allow treatment of uncomplicated shingled and minor skin infections.

Pharmacy First Plus

Pharmacy First Plus is an extension of the above service and aims to embed Independent Prescribing (IP) pharmacists in community pharmacy to treat a range of conditions, including common clinical conditions. There are 16 pharmacists currently actively prescribing across Lothian under the auspices of the Pharmacy First Plus service and work is underway to develop peer support networks and prescribing governance arrangements for these prescribers. Training additional IP pharmacists will be required to enhance the coverage of the service and this will require significant support from clinical colleagues to act as Designated Medical Practitioners.

Public Health Services

In early Autumn of 2021 an additional service will be introduced enabling pharmacists to provide bridging contraception to patients. This will support the existing provision of

Emergency Hormonal Contraception and C-Card Condoms, services which are already embedded in the Public Health Service from community pharmacies.

Digital Enablers

Community pharmacists were equipped with access to the Emergency Care Summary at the outset of the pandemic and has been used to enhance the quality and safety of services in the out of hours period. Community pharmacists were provided access to Near Me to allow remote consultation with patients but uptake of this option has been low, with patients continuing to access pharmacy premises that have remained open throughout the pandemic and utilise an increased number of delivery services that were available throughout the first lockdown. We need to build on the success of implementing new clinical systems to support patient care, by considering wider read/write access to clinical systems, eg Vision/EMIS/TRAK that may give scope to develop other services including pharmacy first and chronic disease monitoring.

Electronic Prescribing

Electronic prescribing removes the reliance upon "wet signature" paper prescriptions. The benefits of such a system are plentiful, including quicker processes, increased audit and reduced travel and footfall for patients. A national scoping exercise is underway, led to NHS Digital and National Services Scotland, to ascertain the current legislative and practical barriers to implementing electronic prescribing in Scotland, prior to further testing and development of systems. Pharmacy services will continue to engage with the national steering groups and feed back to local stakeholders. It should be noted that no timescales are available at present.

Serial Prescribing

Work is being led by GP practice based pharmacy teams on developing serial prescribing across Lothian. Serial prescriptions allow a patient on regular medication to have a prescription written for up to 56 weeks of medication, negating the need for the patient to attend the practice or order repeat medication monthly/bi-monthly. Moving suitable patients to serial prescription will reduce footfall into practice, improve repeat prescribing processes in both GP practice and community pharmacies, reduce over-ordering of medication and improve patient access to medication. Pharmacy services will continue to support development of efficient prescribing systems alongside GP colleagues.

Vaccines

Many community pharmacies supported the 2020 flu vaccination campaign and administered around 20,000 vaccines. Pharmacy services have engaged early with HSCPs in the planning phase for the 2021 flu vaccination season, to ensure community pharmacy sites are available to support patient access to vaccines. Additional discussions are ongoing around potential community pharmacy involvement in the wider vaccine transformation pathways, including potential support for COVID-19 vaccination.

Winter Planning 2020/21 (p37)

Primary Care continues to plan for winter pressures through the unscheduled care Lothian wide processes.

- Enhanced support for care homes.
- Increased availability of OOH staffing at key times.
- An increased flu immunisation programme (adults and children)
- Significant changes to delivery of unscheduled care and impact on primary care – await Scottish Government guidance in due course.
- Contingency planning for all contractor services in case of COVID-1919 and other resilience challenges.

Flu vaccination (p38)

Seasonal flu vaccination in 2020/21 was the last year before responsibility for vaccinations is removed completely from GP practices. It was also an extremely challenging logistically due to infection control and social distancing requirements. A hybrid approach across Lothian was adopted. In Edinburgh, the HSCP delivered most of the flu vaccines through bespoke locality sites that were set up to allow vaccination to proceed in a socially distanced way. Other HSCPs across Lothian used models with more reliance on GP delivery. These developments are overseen by the Vaccine Transformation Board and will be retained and developed for 2021/22.

A COVID-19 booster vaccine will be offered to some patient groups in Autumn 2021, and if possible will be delivered at the same time as flu vaccines.

Emerging Risks and Themes (p40)

The key risks to delivery of this remobilisation plan at a whole system level are:

1. Risk of COVID-1919 further spike or clinically significant variant
2. COVID-19 19 vaccine deployment
3. Risk of continued build-up of 'backlog' of patients unable to be treated during restrictions on services
4. Risk of reduction in productivity as a result of ongoing PPE and social distancing requirements
5. Risk of staff availability due to sickness absence and TAP isolation requirements

Our Approach to Rehabilitation (p66)

Proposal to develop referral guidelines and specialist pathway for long COVID-19 rehabilitation, taking content of NICE guidance into account.

Practice based action plan

The latest version of the Practice based action plan is available on request as a separate document.

2.4 Lothian Unscheduled Care Services (LUCS) – Out of Hours Services

LUCS works out of its usual five bases at the RIE, WGH, SJH, ELCH, and MCH to provide primary care out of hours across Lothian. The intention is to continue with these five bases but there are increasing workforce challenges and development of increased triage capacity is required. Much has been learnt from dealing with the COVID-19 pandemic and LUCS are developing plans to manage this new landscape, especially as we head to a potentially difficult Winter 2021 and increasing numbers of paediatric cases.

LUCS continues to cover all COVID-19 home visits in the out of hours period. In addition, since August 2020 LUCS has been the COVID-19 Assessment Centre out of hours, and between midnight and 8am it manages all COVID-19 triage calls. Currently there is an increase in COVID-19 calls coming to LUCS outwith these times due to difficulties staffing the COVID-19 pathway – LUCS is helping manage the rota and also putting in additional staffing.

LUCS has expanded its telephone triage capacity. All routine appointments and Home Visits to LUCS are now phoned in advance, if demand allows, to ascertain if they can be managed remotely either by telephone or by Near Me. LUCS is involved in further development of triage capacity, learning from the approaches that worked during the height of the pandemic.

LUCS have flexed the capacity of its overnight District Nursing service in line with the demand. The demand is monitored weekly, and extra teams and co-ordinators are provided (staff resource permitting) when demand increases. This is particularly to support care homes. LUCS continues to work with the care home group to develop services to care homes.

LUCS have developed a home oxygen policy in collaboration with hospital@home services to provide urgent oxygen for COVID-19 positive patients who would not benefit from or who would not wish admission to hospital. LUCS also helped develop palliative care pathways for patients dying rapidly from COVID-19.

LUCS has continued to develop home working. All admin staff can now work from home and a number of selected clinicians also have the capability to work from home, clinically managing patients remotely. LUCS are currently looking to extend home working to cope with increased demand.

Rotas are becoming less stable as a shortage of sessional GPs has developed; GPs are drawn back to busy daytime practice, to vaccination centres and are showing clinician fatigue. Life is not back to normal but opening up of restrictions has impacted on the rotas. LUCS has therefore increased recruitment of salaried GPs and nurses to ensure an ongoing robust and sustainable service. There is ongoing work reviewing the terms and conditions of salaried doctors. Nursing education has been prioritised and LUCS has successfully recruited and trained nurses to work in the service. HCSW are also in post and a further round of recruitment is ongoing.

Work continues to comply with all PPE requirements and to keep up to date with PPE and infection control guidance. LUCS participates in Lateral flow testing and all staff have been requested to do this. LUCS staff have received their second vaccines.

LUCS continues to provide monthly updates and educational events for staff, although these are now on Teams rather than face to face. LUCS management team have provided personal support for staff facing any difficulties due to the pandemic and have ensured all staff are aware of the wellbeing resources on offer both locally and nationally. We are looking at providing continuing support and space for staff to ensure that they feel able to continue working with the service post pandemic.

2.5 Health and Social Care Partnerships: East Lothian HSCP

Remobilisation

East Lothian HSCP teams continue to remobilise services locally and are:

- Supporting COVID-19 related actions
- Providing high quality and responsive professional oversight and support to care homes and care at home services
- Providing enhanced community support to home care and care homes to avoid hospital admission
- Delivering a suite of rehabilitation and Technology Enabled Care (TEC) Services
- Developing and delivering long-COVID-19 support (and post-COVID-19 rehabilitation) through rehabilitation services
- Developing pain management approaches
- Fully remobilising social care packages
- Awaiting SG guidance and policy announcements regarding delivery of the Independent Review of Adult Social Care recommendations, to guide Strategic Planning Group (SPG) and Integration Joint Board (IJB) responses.

East Lothian Community Hospital (ELCH)

ELCH wards continue to operate at Amber, with one ward available to mobilise to Red if necessary and with the flexible ward layout continuing to provide bed capacity to respond to increased acute sector or community demand.

Clinical departments continue to operate at Amber level, with capacity managed in line with current COVID-19 guidelines.

Expansion of face-to-face patient attendance at Outpatients is happening as circumstances allow. Most clinics still run with one face-to-face appointment and with the majority of follow-up appointments utilising 'Near Me' video.

Continued professional oversight and support for Care Homes and Care at Home services

Care Homes

The nurse-led care home team continues to support East Lothian Care Homes in maintaining high quality services and appropriate IPC approaches (some of which require significant investment in view of building design limitations) to protect residents and staff, while responding to easing of restrictions. The visiting restrictions and testing requirements continue to place additional stress on Care Home providers and staff.

The team continues to manage activity which might otherwise be directed to GP practices, by responding to acute illness, providing anticipatory care and managing many long-term conditions. In doing so, the team is reducing admissions and supporting discharge from hospital.

All care homes continue to receive tailored education and training input from the Care Home Team.

Governance of Care Homes continues through the HSCP Chief Nurse. East Lothian Care Home Operational Group continues to manage Care Home occupancy, staffing, infection control and oversees responses to changes in COVID-19 outbreak status.

Care at Home

There is increased demand on Care at Home services, resulting from continued restrictions on day support, carers not coping and a reluctance to accept residential respite or care home permanent placements. High levels of demand are being met by an increase in the HSCP's homecare service and Hospital to Home funding and by block contract awards to external providers.

The sector is experiencing significant strain, with all providers struggling to recruit adequate staff and to continue to deliver services while dealing with waves of absence resulting from COVID-19 self-isolation.

Work is underway to improve efficiency in assessments for service support, in application of eligibility criteria and in continuing the drive to ensure efficiency in use of resources.

Community Support

Transformation of community resources for under and over 65s continues, with service redesign focussed on the challenges and costs of delivering a blended model. New opportunities arising from COVID-19 responses are being pursued, focussed on: community support; direct access to community physiotherapy and the possibility of third sector co-ordinated volunteers providing support.

Social Care Packages

The team continues to support care providers as they experience issues in recruiting staff and shortages, many the result of staff self-isolating.

Delivery of adult social work continues, with these conducted by telephone and video conference as indicated by assessment of need. Face-to-face appointments remain focussed on statutory and urgent assessments. Each client is risk assessed on an individual basis.

As previously reported, where direct care provision requires face-to-face contact, this is fully risk assessed before commencement, with staff using appropriate PPE, in line with current guidance.

COVID-19 Service Delivery - Vaccinations

The ELHSCP vaccination team, bolstered by clinical and administrative staffing, secured through HSCP internal secondment and redeployment, continues to manage the public COVID-19 vaccination programme including drop-in clinics.

In line with the JVCI, a prioritised approach to vaccination worked through all the Phase 1 and Phase 2 cohorts, supported by national and local booking processes.

A local and targeted approach to vaccination of high priority groups has included the housebound, those experiencing homelessness, people with substance misuse issues or with learning disabilities.

Primary Care

A Primary Care Improvement Plan (PCIP) outcomes report describes delivery of GMS contract, strategic and other commitments within the plan to support Primary Care as practices bring services on stream and as they experience increased demand from previously unmet need.

The PCIP has:

- Fully established a Community Link Worker service to all GP practices
- Delivered the flu vaccination programme - planning is underway for delivery of all previously GP delivered vaccinations and for existing and new COVID-19 jags
- Provided pharmacotherapy services to all practices, with further increases planned
- Established Community Treatment and Care (CTACs) bases around East Lothian
- Expanded the Care When It Counts same-day, Nurse Practitioner-led primary care service from one GP practice to four (47% of East Lothian population) with high satisfaction among service users
- Provided direct access MSK Services, so driving down waits
- Established a CWIC mental health service - greatly improving access by providing direct access for patients.

East Lothian Rehabilitation Service (ELRS)

ELRS continues to deliver a suite of services to support patients across a growing and aging population, in recovering from illness and injury and in regaining and maintaining independence. All of ELIRS services use integrated approaches, delivered where possible in partnership with other teams.

A new BT Cloud-based telephone contact centre, launched on 14th June, provides patients with a single point of contact, giving rapid access to a clinician who can deal with enquiries immediately, book an appointment/allocate for further assessment or place on a waiting list for:

- Musculoskeletal Physiotherapy
- Community Occupational Therapy

- Domiciliary Physiotherapy
- Post-COVID-19 rehabilitation (via Advanced Practice Occupational Therapy and Physiotherapy).

The system also provides ELRS with metrics to understand demand variation, which assists with capacity planning.

MSK (Musculoskeletal) Service

The service provides direct, first point of contact access to specialist MSK physiotherapy assessment and treatment, significantly decreasing routine MSK waits.

It delivers a safe, effective, responsive and cost effective MSK physiotherapy model, providing physiotherapy input to patients in a timely manner, with input determined by assessment of individual clinical need. The service while directing activity from primary care, so decreasing GP workload. In house escalation protocols ensure direct referrals to secondary care if indicated

As all of the Advanced Physiotherapy Practitioners are accommodated within the physiotherapy service, there is no pressure on practices to provide rooms or equipment.

Post-COVID-19/Long COVID-19

A short-life working group has developed an evidence-based and multidisciplinary post-COVID-19/long COVID-19 pathway for East Lothian. This provides assessment and rehabilitation responsive to client demographics. The group is functioning as a post-COVID-19 network and is developing competencies and in-service training framework for staff across all services to ensure equity of knowledge and resources. The Group's post-COVID-19 directory acts as a resource pack for clinicians and patients to draw on.

Frailty and Admission Prevention

Integrated (OT/PT) clusters in-reach weekly to GP practices, improving communication, with a direct referral pathway established for prevention of admission through same day assessment

Winter monies are supporting a 5-month test of change to enhance the existing Discharge 2 Assess pathway providing 7-day support with daily activities. This provided positive outcomes in reducing length of stay and in negating long-term packages of care.

Advanced Practice Physiotherapists are working to address long-term conditions, such as frailty and an Advanced Practice Occupational Therapist will create a proactive, early intervention model within primary care – initially focusing on frailty. In addition, a project lead for falls commenced in June.

The pain management service is providing a GP accessible community service, with remote access for any age.

Digital and Technology Enabled Care Innovation

The Occupational Therapy (OT)/Physiotherapy (PT) teams continue to use a digital monitoring tool to assess patient mobility and function at home, allowing in some cases reduced packages of care

Remobilisation of Wellwynd Technology Enabled Care (TEC) clinic is allowing recommencement of OT assessments and application of necessary interventions for patients, alongside the continuation of remote consultations and home visits to explore smart TEC options to support independence. The team is also providing support and advice across East Lothian HSCP teams to support and promote TEC solutions to support clients

The TEC team continues to respond to critical technical service visits and referrals for telecare installations to facilitate hospital discharges and to prevent hospital admissions.

2.6 Health and Social Care Partnerships: Edinburgh HSCP

Remobilisation of services

The EHSCP Route Map Group was re-established in April to oversee our remobilisation and recovery process. Submissions for reopening services with risk assessments are scrutinised, captured for audit purposes and referred to other governance routes when required. Any unresolved issue/risk is escalated to the weekly EHSCP Executive Management Team meeting.

Planning now is focused on the period following the expected reduction and then subsequent removal of restrictions on the key dates of 19 July and 9 August 2021 respectively.

Care Homes

There are 67 care homes in the City (9 internal). In response to Scottish Government guidance on Care Homes, Problem Assessment Groups (PAGs) and Incident Management Teams (IMT) were set up to support the EHSCP response team, in partnership with NHSL Public Health and Health Protection colleagues, to provide direct support to all our care homes. The Edinburgh Care Home Oversight Group (ECHOG) meets weekly with a daily operational group also in place and these continue to provide a platform to address issues through deployment of the local specialist resources such as the Edinburgh Care Home Support Team, and Residential Review Team, as well as for escalation of any issues to the Strategic Oversight Group, or to Scottish Government as required. The ECHOG has also:

- Delivered a programme to deliver assurance visits in all care homes and care plan reviews as directed by Scottish Government.
- Daily Safety Huddles (Rapid Rundowns) continue to review progress on staff and resident testing and staffing and infection control issues.
- Commenced weekly summary reporting of COVID-19 testing providing information on staff and resident testing numbers and testing route.

In addition, there is considerable communication and engagement with care home providers. This includes regular engagement sessions with providers to provide support in relation to PPE, Test and Protect, national guidance and other related issues as they arise. A team has been stood up to prioritise and consider claims received from care homes –

reflecting the challenges that they have experienced during the pandemic – significant income loss as well as expenditure. For any providers in acute crisis we have a mechanism agreed to facilitate emergency payments within 48 hours.

A Care Home Transformation Board for CEC care homes has been set up which folds into the overall EHSCP transformation programme. The aim remains to ensure appropriate balance in the bed base across all care home and bed-based capacity and to have in place Intermediate Care Facility capability to support flow from both the community and from hospital. Work is underway in relation to this under the ongoing Bed Base Review and link to the Care Home Transformation Board. Our engagement over the COVID-19 period with external care home providers enabled strong partnership work and this will remain a feature of how we develop an appropriate bed base in relation to remobilisation, winter and potential future COVID-19 surges.

Care at Home

Care at Home has been under significant pressure over the summer months with an estimated 8% decrease in available capacity against a 30% increase in demand between January and May. Capacity issues relate to several factors; Brexit and EU nationals leaving Edinburgh, Summer and Term time leave and self-isolation of staff due to contact tracing. We are monitoring this closely and working with providers on mutual aid etc to ensure service continuity for the most vulnerable and those in crisis. In terms of performance our delays from acute have increased as a result of both this and the increasing complexity and frailty of people requiring support.

A new contract framework for care at home is in development - called 'One Edinburgh'. Contract scoping and timeline to be approved at SRO level. Extension requests for current framework agreements will be required to align with project timeline and will be scrutinised via Programme Board 3.

The 'One Edinburgh' Charter draft is complete and ready to present to stakeholders. This document defines the rules of engagement and standards required to adopt a new co-productive and partnership approach. A new timeline has been developed with the target start date in October for the new contracts to commence. This will align with work on the internal Home Care service to ensure balance across the city as the two elements of our provision are interdependent.

Current external pressures on providers caused by COVID-19 and Brexit are being monitored for the impact on capacity and sustainability of providers' service levels. A cautious approach to tendering will be adopted to prevent further delays to service users packages of care.

Unmet need role recruitment complete with all positions filled. Anticipated start date October 2021.

Delayed discharge

The delayed discharge position in Edinburgh has worsened primarily due to the challenges in matching Packages of Care (POC). Demand for POC to support hospital discharge increased by 31% from January 2021 to June 2021. This demand outstripped the supply available from

in-house services and contracted providers despite Edinburgh HSCP meeting 22% of the increased need.

External providers are experiencing significant challenges with recruitment (down by 25%), retention (staff returning to the hospitality sector or to the EU or leaving for jobs in the NHS) and capacity (an increase in staff self-isolating or with COVID-19).

In tandem with this we have a significant waiting list for intermediate care beds and those with guardianship taking 6-8 weeks to go through the court processes. To assist in building capacity, we have enhanced flow through our urgent care pathways, Hospital @Home and Discharge to Assess service and EHSCP has speedily mobilised a new community respiratory service to support COVID-19 patients on oxygen therapy at home.

Edinburgh updated delayed discharges trajectories - Sep 2021

Data Template T1 submitted with RMP4 gives the Lothian delayed discharge estimated trajectory to the end of March 2022. Much of the volume of activity reflected in those Lothian total numbers relates to Edinburgh. Delayed Discharge trajectories for Edinburgh have been created using modelling that assessed factors likely to affect the numbers of delays either positively or negatively. The estimated impact of these factors was modelled to determine the expected net change in delays.

This modelling was further updated in September 2021 to take into account the latest trends in delay figures (which have trended upwards since previous estimates were calculated in July '21). This revise also incorporates an updated understanding of the full impact of the system pressures that were starting to appear in July.

Current system pressures are resulting from a combination of increasing levels of demand and complexity and decreasing care capacity available. Drivers for increasing demand include people being de-conditioned (i.e. frailer, less confident) following periods of lockdown, family/unpaid carers who have cared for people during the pandemic returning to work following furlough and a general, build-up of demand emerging as messaging about services being 'open as usual' have been released.

Capacity issues are due to reductions in staff available across the sector with both our internal and external provision seeing as much as a 30% reduction in capacity. This is due to EU nationals returning home, people moving to jobs in other parts of the economy, and fatigue and absence related to COVID-19 and the pressures of the pandemic on the workforce. Delays and community capacity are inextricably linked, with delays rising through the reductions in capacity that have been seen in recent weeks and providers being unable to provide care at home. Delays have grown significantly - almost exclusively due to the challenges with capacity necessary to keep pace with demand.

Given these pressures, the revised modelling has resulted in trajectories at a higher level than forecast in July 2021. The model output does reflect a great deal of work underway to reduce delays including easing pressure on capacity within the care sector, for example, through an

engagement campaign to raise awareness of employment in social care sector; working with providers to ensure efficiency and optimise the care already available; and enhancing multi-disciplinary teams such as District Nursing in-reach, Home First and Discharge to Assess models.

Despite this work there will continue to be considerable pressure on capacity and increasing demand over the winter period that will offset some of the gains achieved from these initiatives. The trajectories proposed (209-244) are slightly higher than average delays per month in 2019 (176-218) and higher than levels seen in 2020 (108-137). However, given the unique circumstances this year and significantly increased sector pressures from 2020, maintaining delays at existing levels and resisting significant increases over winter, represents a realistic but challenging forecast.

Rehabilitation (hospital based)

The development of ongoing symptoms of more than 4 weeks duration and post COVID-19 syndrome were not predicted. Expectations in mid-2020 were that rehabilitation needs would likely focus on respiratory issues and effects of physical deconditioning and that these would be mainly evident in the post hospital/ICU discharge population. There is now clear evidence that symptoms of COVID-19 are multi-faceted and are impacting a larger population and for longer than was expected.

Some existing services adapted and flexed access criteria to meet this new increased demand. However, as demand remained consistently high for post COVID-19 rehabilitation, services responded reactively resulting in a shift in ability to resource core business. A single point of access (SPOA) was put in place with patients triaged to the most appropriate service.

Funding was made available during winter to support administration for the SPOA and for evaluation. Pulmonary Rehabilitation and Lothian Work Support Services accommodated the greatest number of referrals from the SPOA although other services received referrals too including occupational therapy, physiotherapy, and the Lothian ME-CFS service.

A decision was taken to close the SPOA on 31 July 2021 when the funding ceases and to share our data with Strategic Planning in NHSL to inform a Lothian wide service should there be future funding to enable this.

Rehabilitation (community based)

Hospital bed-based rehabilitation is delivered by EHSCP via an intermediate care facility (ICF) model and as part of the hosted rehabilitation service which is managed by EHSCP on behalf of all Lothian HSCPs and for some non-Lothian patients, particularly in the neurorehabilitation and amputee rehabilitation services.

Our core ICF capacity is 64 beds although we still have an additional 6 beds open at Liberton Hospital to assist with continuing pressures beyond winter The Home First team is still reviewing all referrals before patients are considered for bed-based rehabilitation. Around 55% of patients referred do not require admission to ICF.

The allocated Home First Navigator for the ICFs finished at the end of March 2021 as it was provided by fixed term funding. However, there has been an agreement to fund this role for

a further 18 months alongside another similar role in the Hospital Based Complex Clinical Care units. Recruitment is underway for a senior social worker and 2 social workers to undertake these roles from the end of July 2021.

Fillieside, which is one of the ICF wards, is participating in the pilot for Planned Date of Discharge and the team will be undertaking PDSA cycles with the aim of maintaining a Home First focus, earlier discharge planning, reducing delays and shortening length of stay.

Community Vaccinations

EHSCP continues to actively support the national COVID-19 vaccination programme. Planning now is focused on the future COVID-19 booster vaccinations combined with flu vaccinations. This work is being coordinated centrally by NHSL.

Primary Care

Near Me is now embedded into day to day care across NHSL, adopted across all General Practice and acute services. A new model of integrated services is being rolled out to ensure an appropriate mix of telephone, Near Me (video) and COVID-19 safe, physically attended appointments is offered to patients in both acute and primary care settings.

The Edinburgh Primary Care Support Team (EPCST) continues to respond to EHSCP, NHSL and Scottish Government direction and guidance. Whilst remaining accountable to EHSCP, the team co-ordinates actively with the primary care functions of other Lothian HSCPs through the weekly Lothian Primary Care Tactical Group. Primary Care has continued to function throughout the pandemic, turning physical visits into telephone support on an enormous scale, with an estimated 170,000 telephone appointments being delivered by Edinburgh practices each month. As predicted, the balance between F2F and telephone appointments is shifting gradually more towards F2F.

Working with the support of Medical Practices and Community pharmacists, we were able to deliver the adult flu vaccination programme to c100,000 people across the city from late September into November 2020.

Our major capital projects have continued to progress with one now in construction and another scheduled to begin in June 2021.

Edinburgh's Primary Care Implementation Plan (PCIP) has continued to be implemented during the pandemic, with an additional c47WTE employed and embedded across city practices during 2020/21.

Mental Health

The Edinburgh Thrive four locality based Welcome Teams have been established during COVID-19. The enactment of Living Well Systems in Edinburgh currently consists of four locality-based multi-agency and multi-professional Welcome Teams that deliver holistic mental health and wellbeing support to people and connect them to other resources and support in the community wherever possible. The multi-agency Welcome Teams are currently supporting people who have been referred to the Locality Mental Health Services by their GP. People are given choice and control over the work they do with the Welcome Team using

tools such as the Thrive Plan. Following on from the independent evaluation of the prototype teams we are now finalising plans to increase capacity. This will ensure we can increase the reach of the teams, respond in a timelier manner and offer a wider range of support, care and treatment for people in a collaborative and person-centred way. We are also working closely with our GP partners to increase the range of options that are available to GPs and Primary Care Teams to directly access; this will include the national distress brief interventions programme and will be supported by our online ithrive platform which will have a dedicated staff space to promote real time referrals and establish a community of practice across statutory and third sector agencies.

Work is progressing on creating an Urgent Mental Health and Distress Care Service which will have a shared referral pathway. It will retain the statutory function of providing urgent mental health assessment by experienced mental health nurses. These nurses will be joined by other staff called 'Navigators' employed as part of the Thrive Collective, whose role will be complementary. Focussing on alleviating and containing distress and linking people to appropriate support, thereby releasing the mental health nurses to focus on areas where their specialist expertise can add most value.

The 'Place to Live' work stream focuses on ensuring that people with mental health problems have a safe place to call home in which they feel safe, receive the support they need and can connect to and be part of their local community. This work is closely aligned to the strategic principles of Home First and seeks to minimise institutionalisation, maximise community provision and ensure that when hospital care is required, it is a safe and therapeutic experience, which reflects the person's needs, levels of acuity and functioning. Supported accommodation including visiting support services are essential services to people with complex mental health needs. These services enable people to move on from hospital and live in a place in the community. It helps them with their recovery and with the improvement of their personal outcomes if they have a place to live that is supportive and a base for meaningful activities including work and volunteering opportunities.

The EIJB supported the sign up to the Royal College of Psychiatrists Standards for Adult Community Mental Health Services (ACOMHS). This is an accreditation programme which works with staff to assure and improve the quality of community mental health services for people with mental health problems and their carers. Accreditation assures staff, service users and cares, commissioners and regulators of the quality of the service being provided. It engages staff in a comprehensive process of review, through which good practice and high-quality care are recognized, and teams receive support to identify and address areas for improvement. The programme has involved service users and carers as a priority, and people with first-hand experience of using community mental health services have been encouraged to get involved in all stages of the development process. There has been a delay in commencing this work due to COVID-19.

Risk

EHSCP continues to identify and mitigate risks which are then reflected in the respective EIJB, CEC and NHSL risk registers. Active resilience planning continues through scenario-based planning which takes account of lessons learned from the COVID-19 response.

Any significant operational risks are discussed at the Operational Oversight Group and fed into the Executive Team or the Partnership Risk Committee for mitigation depending on the nature and urgency. Risks are also fed through the Care Home Oversight Group. The resumption of services is currently being co-ordinated through the EHSCP Route Map Group and any risks are highlighted, mitigated or escalated accordingly through EHSCP governance structures.

Strategy and Transformation

Despite the pandemic, work has been progressed in our transformation programme and planning has started on our next strategic planning cycle. Engagement activity continues and the intent is to publish the next 3-year EIJB Strategic Plan 2022-25 in March 2022.

The second phase of the transformation programme began in January 2021 and focused on the following workstreams:

- A focused piece of work to strengthen supports and services in the community for those with dementia and frailty.
- Our community mobilisation project seeking to build on the lessons learned throughout COVID-19 and develop new ways of supporting and investing in third sector and community supports.
- Our Future Focused Infrastructure project, which will work with housing developers and other key stakeholders to set out a clear infrastructure strategy for the EIJB.
- The redesign of our current Medical Day Hospitals model, as part of a spectrum of community-based services and supports to help keep people at home and avoid unnecessary hospital admissions.

In addition, we continue to push ahead with key transformation priorities, including the development and enactment of our Edinburgh Wellbeing Pact, the continued roll-out of the 3 Conversations model, the embedding of our Home First model (including the redesign of urgent care pathways) and the creation of our Bed Base Strategy, the first phase of which was submitted to the EIJB in June 2021 and will be progressed further from August in 2021.

Extensive engagement has taken place in recent months with providers regarding the redesign of our over 65s care at home contract. This key project is on track to deliver a new, innovative contract focused on partnership working, collaboration and improved outcomes for people, in line with the priorities recently outlined in the Independent Review of Adult Social Care.

2.7 Health and Social Care Partnerships: Midlothian HSCP

Care Homes

The **HSCP Assurance Group** chaired by the Chief Nurse continued to operate. It met daily until May when the frequency was reduced to three times a week, except when changes to Scottish Government guidance or the COVID-19 situation warranted an additional meeting. The

meeting continues to include a rundown on each Care Home to discuss any issues that have arisen and consider any support required.

Care Home Support Team are in the process of liaising with all Midlothian care homes to ensure Palliative Care Champion link person identified and network established.

Care Home Strategy has been implemented and includes the full establishment of the Care Home Support Team, including Palliative Nurse Specialist, Nurse Practitioner, CPN, Occupational Therapist, Community Staff Nurse and Quality Assurance Officer. Range of actions by new Care Home Support Team with a key aim of reducing and preventing unnecessary hospital admissions have progressed, , including training and projects.

Care at Home

Within the Care at Home service a reablement model was adopted and this enabled MERRIT carers to co-work with intermediate care to facilitate patient flow. This work continues.

By 31 March 2021 the Invitation to tender for external Care at Home Services had been issued. The specification was for block contracts across three geographical lots. The block contract should improve terms and conditions for staff, thus improving staff retention, capacity, and consistency of care. Unpaid carers are involved as part of the evaluation panel. The service specification includes a human rights framework and key activities are set out that aim to support the full range of rights held by people who receive a service. The evaluation and monitoring framework supports this approach and will be refined now that contracts have been awarded to allow continued effective monitoring of contracts in terms of capacity, efficiency and quality.

Improving patient flow

Midlothian **Intermediate Care** Services continued to develop in order to meet the changing needs of the Midlothian population and create opportunities to deliver care in people's local community as opposed to acute hospitals. This included the following:

i. Single Point of Access was implemented (was up and running by 1 December 2020 and further enhanced mid February 2021). Workforce planning continued regarding the broader Home First approach. Stakeholder groups held in May 2021. Review of intermediate care is under way.
ii. Additional posts have been recruited to including drivers, admin and AHP posts. Band 3 capacity was increased by 16wte. Data shows that the increased capacity within the team is facilitating early discharge from acute sites.
iii. The Community Respiratory Team (CRT) continues to successfully manage COPD exacerbations in patients own homes and the development of a new Scottish Ambulance Service pathway has led to a reduction in acute respiratory admissions. Expansion of the team has meant that this has also facilitated early discharges to home.
iv. The Home first approach includes a focus on early recovery and rehabilitation within all intermediate care teams.

Additional beds opened in Glenlee Unit, Midlothian Community Hospital.

Rehabilitation and Support to People to Stay Well at Home: AHP

Dietetics

Dietetics service continues to use a blend of digital and face to face approaches. Whilst recognising that Near Me is suitable for one to one consultations, it is not suitable for group programmes as part of a weight management service. Work with NHS Lothian eHealth team progressed and the use of MS Teams was approved as a suitable digital platform for group education.

A waiting list action plan was implemented (with additional staffing) for treatment of obesity and type 2 diabetes (co morbidities that influence COVID-19 recovery) and essential for Long COVID-19 rehabilitation. The waiting list for tier 3 weight management service has been significantly reduced as a result.

A further priority has been to remobilise Get Moving With Counterweight (Tier 2) and referrals are picking back up which is encouraging. This is also a hybrid digital and face-to-face model

Let's Prevent (Type 2 Diabetes programme), also a hybrid model, has re-started.

Additional dietetic funding has been secured from NHS Lothian to provided complex nutritional care to the increased critical care bed compliment across the three acute sites.

Physiotherapy and Occupational Therapy

Musculoskeletal Advanced Practice Physiotherapy service is available in all 12 GP practices. The Musculoskeletal Advanced Practitioner Physiotherapy service has increased capacity each year with over 16,000 appointments between April 2018 and January 2021 (4176 in 18/19, 5654 in 19/20, 6337 in 20/21 till January).

Work is underway alongside NHS Lothian to redefine pathways for Musculoskeletal Physiotherapy.

Significant work is underway to bring Intermediate Care Physiotherapy and Occupational Therapy teams together and Midlothian Community Hospital Physiotherapy and Occupational Therapy teams together to provide a flexible approach to work, provide cross cover, ensure business continuity, maximise development opportunities for staff and reduce barriers for patients. Single Point of Access to Intermediate Care teams established Dec 2020.

Midlothian Community Physical Rehabilitation Team (MCPRT) brought under the Intermediate Care umbrella May 2021, work underway to streamline, reduce duplication and ensure clinical capacity is maximised.

Midlothian Community Hospital AHP team now enhanced. Teams now data driven. Further development work underway.

2.8 Health and Social Care Partnerships: West Lothian HSCP

The West Lothian Health and Social Care Partnership has continued to respond to the COVID-19 pandemic whilst ensuring that services have continued as far as guidance allows. The partnership has reviewed its operations and strategic plans at two key points in the pandemic and have refined approaches to reflect learning.

Reflections workshops were held with strategic planning partners in September 2020 and again in April 2021 to focus on what needed to change as a result of learning from the pandemic. Those workshops highlighted four key propriety areas:

- Growing evidence of impact on inequality
- Supporting the health and social care workforce
- Digital and technology
- Partnership working

Impact of COVID-19 on Inequality

There continues to be increasing evidence that the impact of COVID-19 is likely to widen existing inequalities and may have a disproportionate impact on groups of people already facing challenge and disadvantage. The partnership is working closely with public health colleagues to identify priorities which will focus on reducing inequality. Work is being done via the Community Planning Partnership's Health and Wellbeing Group focussing on the impact of the pandemic on physical and mental health and what work can be done to improve outcomes for communities.

Care Homes

The delivery of safe and effective care to people who live in care homes remains a priority. The partnership continues to deliver enhanced support to the care home sector and has daily oversight via the West Lothian Care Home Clinical and Care Professional Oversight Group.

Planning has taken place to develop a model of care home assurance which will be sustainable for the future and allow the range of supports developed during the pandemic to continue in a sustainable way.

Care Home Staffing & Mutual Aid

The position across care homes in West Lothian has been relatively stable over the past 6 months. The number of care homes experiencing a COVID-19 outbreak over this time period has remained low. More recently, increased community COVID-19 infection rates in West Lothian have had an impact on numbers of staff requiring to isolate due to contact with COVID-19 positive individuals in the community. To date, however, this has not resulted in any significant staffing shortages but the situation is kept under daily review through assurance processes.

All care homes continue to have up to date business continuity plans that include staffing and are able to secure absence cover where necessary through their own bank and agency arrangements. Where internal channels have been exhausted, mutual aid staff can be requested (registered nurses, care assistants and domestic staff) from the NHS Lothian staff bank.

Social Care Capacity

Focus continues to be placed on system flow and building capacity in the system to prevent unnecessary hospital admission and allow people to return home at the earliest possible opportunity. The partnership has worked hard at reducing delayed discharges and has sustained a positive position in this regard over the past year.

Regular meetings take place with care at home and care home providers to review operational service delivery and engage over key service developments. In addition to daily, multi-disciplinary daily flow meetings on the St John's Hospital site, weekly care at home review meetings have been introduced at the beginning of each week to review outstanding requests for packages of care and allow a planned approach to matching to take place with providers. The use of data is being developed to better understand demand, capacity and flow through the care system which will be used to improve operational service delivery and in planning the supports required to deliver the partnership's Home First programme.

The partnership continues to monitor the economic impact of the pandemic on the sector, to identify recruitment opportunities and to ensure the critical role social care staff have to play in the health and social care system is reflected in local and national workforce plans. A recruitment campaign has been developed to support recruitment to internal teams, especially within the reablement service which plays a critical role in ensuring flow from hospital and the community

Intermediate Care Facility

The partnership continues to review its approach to intermediate care.

Home First Programme

The Older People's Commissioning Plan approved by the IJB in November 2020 sets out how the partnership will develop services in line with Home First principles. A 'Home First' workshop was hosted for 48 staff from the West Lothian Health and Social Care Partnership (WLHSCP) and St John's Hospital in February 2021 to share good practice and learning around discharge planning. The event has paved the way for further progress to be made in the development of sustainable and person centred, integrated community pathways.

The partnership has developed an ambitious programme of change to deliver the 'Home First' approach to health and social care in West Lothian. The programme comprises three work streams:

- Community hubs and single point of contact
- Community based intermediate care services and supports
- Bed based models of care

The partnership is working closely with colleagues on the St John's Hospital site to ensure whole system planning is in place to shape unscheduled care and inform future hospital and community provision and service delivery.

Primary Care

2021/22 will witness the further roll-out of the Primary Care Improvement Plan (PCIP) in West Lothian. During the past year there have been notable achievements in primary care such as:

- Practices maintaining service continuity despite some challenges with no GP practices closing due to illness or staff self- isolating
- New ways of working, including remote working. This includes examples of GPs and pharmacists successfully consulting with patients and even issuing prescriptions and fit notes remotely for collection at the practice or pharmacy
- Voluntary participation by all West Lothian practices in the COVID-19 vaccination effort. Uptakes rates were very high and waste was minimised by the use of "short notice" lists of patients who were prepared to attend for unused doses.
- The collaborative development of a suite of performance indicators for primary care to provide assurance to the IJB with the next steps involving development of a reporting template and baseline data collection.

Digital Strategy

The partnership has embraced opportunities to develop its approach to technology and digital healthcare. Engagement activity took place with a range of stakeholders to consider what was working well, digital challenges and opportunities and risks.

Working well:

- Resilient workforce who want to use technology
- Rapid change and upscaling of use of digital
- Remote and flexible working
- Use of digital technology for patients
- Use of the partnership's website

Challenges:

- Lack of access to digital technology when required: devices, connectivity and wi-fi
- Lack of confidence in the use of technology
- Lack of interoperability between NHS and council systems
- Anxiety about replacement of face to face activity

Opportunities

- Greater use in early intervention and prevention
- Opporunities to extend the use of technology for self-management

Significant capital investment has been secured to roll equipment out to community nursing and mental health teams to allow more remote working and maximise time spent with patients. An implementation programme has been developed to ensure people are well trained and supported in the roll out and to ensure the benefits and impact of the investment are captured.

Working from Home and Hybrid Models

The pandemic has provided an opportunity to test new ways of working which would never have been possible before the pandemic. The partnership is working with staff to consider all roles and determine where there are opportunities for roles to be done in different ways, at home or a combination of approaches.

Community Supports

The partnership recognises the very valuable contribution families and carers have made during the pandemic and published a new strategy for carers during 2020/21. Links have also been strengthened with the voluntary sector and the partnership will seek to build on the positive work done during the pandemic and strengthen those relationships further.

2.9 Mental Health Update

This section provides an update for the Lothian system in key areas outlined on pages 60-101 of RMP3.

Adult Psychological Therapies

- The main waiting lists challenge was in the General Adult Mental Health Outpatients Service
- Overall total assessment and treatment waits are down by 1,020 since the peak in February 2020 but progress needs to be accelerated

Improvement work undertaken in 2020:

- Strengthened leadership
- Individual and team capacity models to give new patient targets
- Target mean durations of treatment
- Performance reporting at individual and team levels
- Monthly review meetings at HSCP / locality level
- Improving case management supervision
- Improving data recording to allow outcomes assessment

Future Plans for Improvement

- The £751k already provided by the Scottish Government for the Psychological Therapies Backlog has been deployed to retain 16 existing fixed term staff through to March 2023 and the intention is to make these staff permanent
- The plan submitted to Scottish Government identifies a requirement for:
    - £1.5m spread over 21/22 and 22/23 for additional fixed term staffing (18 WTEs) to address the General Adult Mental Health Outpatients Backlog
    - £1.2m spread over 21/22 and 22/23 to increase supervision, provide additional capacity in some specialist services (Clinical Psychology, Neuropsychology, Veterans 1st Point) and strengthen service management and administration

- The Scottish Government's response is awaited

CAMHS

- CAMHS was very heavily impacted by COVID-19 disrupting improvement work as attention focused on patient safety and maintenance of services – waiting lists have continued to rise during this period
- Some low risk mental health cases were paused and neurodevelopmental assessments were disrupted by inability to undertake observation and school closures
- Urgent referrals rose significantly, particularly towards end-2020 when schools re-opened and there has been an increased demand in resource intensive areas such as eating disorders
- Scottish Government has provided £4.2m for CAMHS Backlogs and Development (May 21)

CAMHS Plan – Major Components

Implement the Change and Partnership Approach (major transformation project)

- CAMHS specific delivery and capacity methodology supported by Scottish Govt.
- Work has commenced to embed the CAPA approach and capacity methodology
- The required performance improvements represent a significant challenge, but should address waiting times by March 2023

A New Neurodevelopmental (ND) Pathway

- Relocate patients on the mental health waiting list requiring a ND service from Tier 3 locality MH pathway to an integrated ND pathway

Tier 2 / Primary Care Service

- Engage with community partners to develop a Tier 2 Service offering, providing multiagency single point of contact for children & young people with mental health need

Other Developments

- New Unscheduled Care Team, Eating Disorders development, Advanced Nurse Practitioner roles, Group Work investment

Mental Health and Learning Disability Programme Board

The Mental Health and Learning Disability Programme Board has taken oversight of improvements within the Adult Psychological Therapies and CAMHS. As described above, there are positive signs of improvement for psychological therapies despite the challenge

presented by the COVID-19 pandemic, and significant plans underway to improve access to CAMHS. In light of this, the Programme Board is developing its focus, namely to:

- Monitor the Psychological Therapies and CAMHS recovery progress and adjust as required
- Scope and implement arrangements for Scottish Government's forthcoming Neurodevelopmental Plan and Mental Health and Wellbeing Standard
- Increased focus on joint NHS Lothian and HSCPs information sharing and planning for those services that require integrated delivery and / or economies of scale – commissioned by Programme Board
- Work to be led and delivered by the Operational Recovery Group of senior operational managers from REAS and the HSCPs reporting to the Programme Board
- Joint work to feed into each organisation's plans and governance arrangements

Support for staff

The NHS Lothian 'Here for You' helpline remains in place for NHS Lothian, HSCP, hospice and care home staff, staffed by Psychology Mon-Fri 9am – 5pm, as well as the Staff Listening Service, staffed 7 days a week.

Mental Health Inpatient Beds

As described in previous re-mobilisation plans, there has not been a major surge in demand for inpatient bed capacity for most services, although occupancy rates have remained high. However, there is a clear increase in demand for inpatient beds for people with eating disorders, across young people and the adult population. There is also a detrimental impact on flow through hospital beds as the capacity for mental health rehabilitation has been limited due to the reduced ability to access public amenities and ability to see friends and family. With the easing of lockdown this issue should be somewhat addressed.

REAS continues to participate in the national mental health beds project led by Healthcare Improvement Scotland. This benchmarking is informing discussions with the four Lothian IJBs about bed numbers required moving forwards.

Digital Developments in Mental Health

Hardware distribution. Following £200k of hardware to regain PT and CAMHS capacity using Near Me, a further £500k has recently been approved for further hardware (£c400k for REAS and the CEC/ML/EL HSCPs, £c100k for WL HSCP) to support new digital ways of working. As a result of anticipated reduced travel costs from the increased use of technology, REAS are expecting to make savings of £100k in 2021/22 Within WLHSCP mental health teams a saving of £70k is anticipated in 2021/22.

Paperlite development. Requirements are almost complete for a PaperLite Pathway within TRAK for use across all mental health services, regardless of business unit. This will then be

designed over the summer, with a plan to build over the winter (it is on the eHealth plan) and then implement in the first half of 2022.

TRAK OPD Redesign. eHealth have begun a major 12-month redesign or 'rebuild' of the administrative parts of TRAK. This is driven by the need to schedule phone and video appointments but will also be a general housekeeping exercise and bring some new functionality such as text messaging.

2.10 Workforce

NHS Lothian Interim Workforce Plan

The NHS Lothian Interim Workforce plan was submitted to the Scottish Government on 29th April 21, which in line with the Scottish Government guidance set out:

- Regional and local engagement in workforce planning
- How we are supporting staff physical and psychological wellbeing and how we are promoting both physical and psychological wellbeing, including the anticipated workforce implications such as:
    - monitoring performance and evaluating impacts on staff wellbeing;
    - projections of future staff retention and turnover;
    - staff availability and absence levels
    - the impact of staff annual leave deferred during the pandemic
- Short –term workforce requirements to support the response to the COVID-19 pandemic and areas of short term workforce risk.
- Medium-term workforce drivers in terms of workforce capacity, challenges in responding to the substantial backlog within elective care and future service developments.
- Examples/opportunities of how we have transformed the delivery of health and care services during the pandemic and how best practice in these areas is being maintained and shared.
- Local developments to advance practice and introduce new roles to help sustain the workforce.

Staff Turnover

The impact of the COVID-19 pandemic on staff turnover and has changed typical patterns of turnover with a c440wte - 21% drop in the number of staff leaving the organisation across all job families, reflecting the commitment of staff to support the population. Within this overall decrease there has also been a reduction in retirals within both the medical and nursing workforces which has helped sustain capacity. However working through the pandemic has undoubtedly put pressure on the physical and mental health of the workforce and as pandemic recedes it is likely that retirals will increase as staff that have postponed retirals choose to do so. Whilst this could potentially be a significant risk it is as yet difficult to quantify.

Job Family	2016	2017	2018	2019	2020	Grand Total
Admin Services	85	67	71	76	81	380
AHP Bands 1-4	2	9	7	5	4	27
AHP Bands 5+	24	25	18	22	22	111
Executive/Senior Managers	6	2	5	6	5	23
Healthcare Sciences	30	25	17	24	17	114
Medical	19	30	28	42	34	153
Medical & Dental Support	6	2	7	6	7	27
Nursing Band 1-4	51	58	53	69	45	276
Nursing Band 5-7	189	154	173	211	176	903
Nursing Band 8+	6	4	14	14	7	45
Other Therapeutic	5	10	7	10	8	40
Personal & Social Care	2	2	3	3	3	13
Support Services	40	39	53	45	42	218
Grand Total	**464**	**426**	**454**	**536**	**450**	**2,330**

Changes to training pipelines for clinical staff to increase capacity are only solutions in the medium to long terms and flexible approaches to retiral can offer valuable support for workforce capacity. A group will be established shortly to look at what additional measures can be taken to support the retention of staff following retiral on a flexible basis.

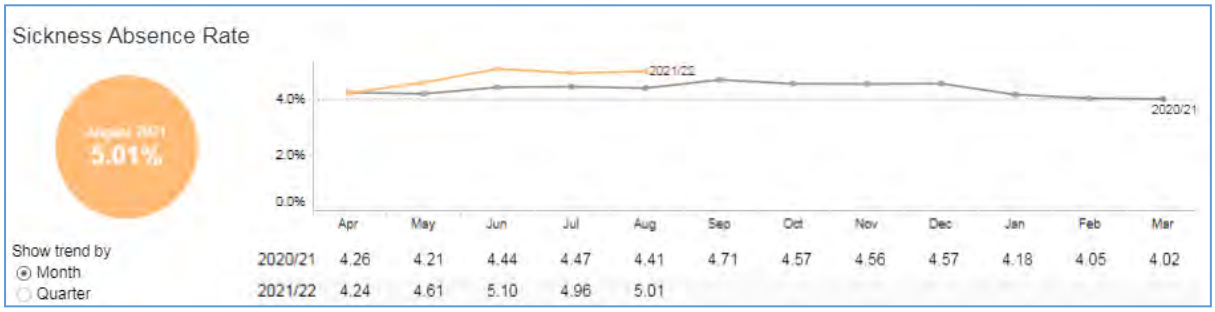
Further detail is contained within the interim workforce plan 2021-22 which was submitted to the Scottish Government Workforce Unit.

https://org.nhslothian.scot/KeyDocuments/WorkforcePlanning/InterimWorkforcePlan2021-21.pdf pgs 9-11

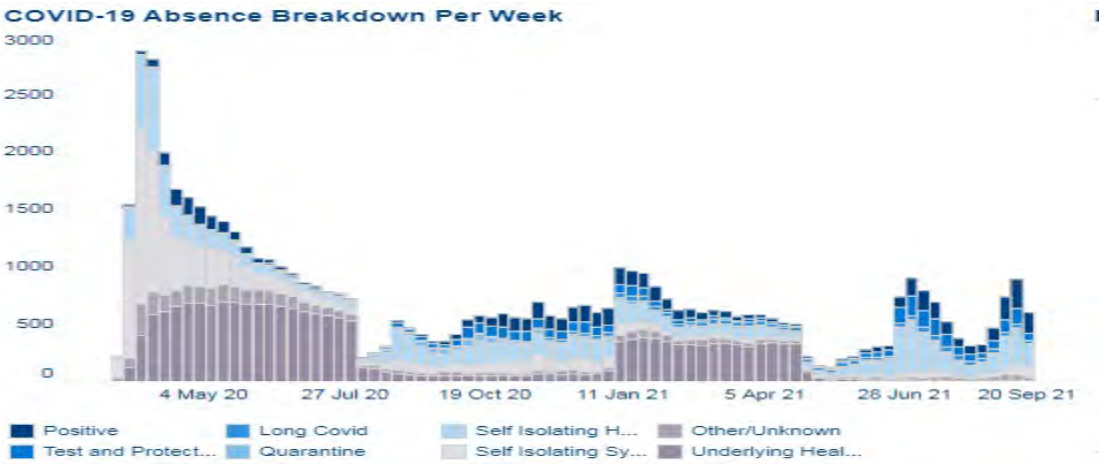
Staff absence

As with staff turnover the absence levels have not reflected typical patterns. Sickness absence excluding COVID-19 related absence reduced from an average of 5.0% in 2019/20 to 4.33% in 2020/21 and reaching the lowest level recorded - 3.74% in February. However levels have increase gradually from May 21- 4.61% to 5.01% in August 21, reflecting the removal of restrictions in relation social distancing, mask wearing outwith work, travel restrictions and the opening of retail and hospitality sectors.

Nationally the largest declines have been cough/cold/flu 53% and gastro-intestinal problems 32%. There has however been a 9% increase in anxiety/stress/depression/ other psychiatric illness, reflecting the intense pressures staff have been under throughout the pandemic.



Since the end of June 21 COVID-19 related absence has also increased substantially reflecting both prevalence of the COVID-19 delta variant phasing out of most restrictions. However as long as isolation guidance applies increased rates will impact on workforce capacity.



The number of staff absent with diagnosed long COVID-19 appears to increasing be relatively low (c31 headcount) and as such it is not anticipated that this will have a significant impact on workforce availability, it does however represent a real impact for those staff members affected.

Services are currently under severe pressure from the impact of both the increase in all forms and a substantial reduction in our ability to close workforce gaps through supplementary staffing.

	Apr-20	Jul-21
In-post wte	7,098	7,246
Establishment wte	7,556	7,732
Gap wte	458	486
Gap %	6.1%	6.3%
Supplementary Staffing wte	523.6	381.8
Gap wte	66	-104

COVID-19 recovery plan

RMP3 set out the wide range of workforce expansion that had been undertaken to support tracing, testing, care homes, vaccination, service redesign in urgent and unscheduled care, most of which will be time limited. Whilst given the on-going nature of the pandemic it remains uncertain how long many of these additional capacity measures will be required, there is a need to plan for returning to the underlying workforce establishment. An outline process has been identified which will identify workforce increases specifically associated with the pandemic and confirm the duration of original funding, identify any changes to scope/timescale and where necessary reconfirm funding/support. Where requirement for services is likely to diminish timescales and associated funding reductions can be planned in partnership with consultation with affected staff. In doing so there is however a potential opportunity to retain staff to help fill longstanding establishment gaps in some areas such as facilities.

Care Homes

A core team to support quality of care within care homes and support for HSCPs has been established. The number of educators has been increased from 4 to 6 and additional staff have been employed to help support care homes. A Health & Social Care Academy Project

Manager has also been recruited who will be heavily involved with providing enhanced training and development.

Medium Term Workforce Drivers

The plan also set out in detail the range of workforce drivers including:

- Service redesign based on lessons learned from COVID-19
- Primary Care
- The impact of social distancing on outpatients and planned care
- Mental Health workforce planning
- Workforce Planning considerations associated with the NHS Lothian National Treatment Centre
- Recruitment and retention within pharmacy
- Preparation for the implementation of the Healthcare Staffing Act

https://org.nhslothian.scot/KeyDocuments/WorkforcePlanning/InterimWorkforcePlan2021-21.pdf

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Supporting the workforce through transformational change

The plan also set out how NHS Lothian is supporting the workforce through transformational change, including:

- Home Working
- Near Me
- Young Person's Guarantee
- Kickstart
- Physician Associates

https://org.nhslothian.scot/KeyDocuments/WorkforcePlanning/InterimWorkforcePlan2021-21.pdf

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NHS Lothian Workforce Action Plan

NHS Lothian has a very extensive workforce action covering all professions and key service priorities areas. This details the action, outcome, measurement and identified Lead and can be found on the following link.

https://org.nhslothian.scot/KeyDocuments/WorkforcePlanning/InterimWorkforcePlan2021-21.pdf

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2.11 Care and Wellbeing Programmes –

NHS Lothian Staff Wellbeing Strategy

NHS Lothian's Wellbeing Strategy – Work Well was launched in June following approval at a series of internal governance committees. The strategy sets out NHS Lothians commitment to staff wellbeing as a key corporate objective, we have a named Corporate Director with responsibility for staff wellbeing and an established Board wellbeing champion who will lead the strategic implementation of the strategy. In recognition of the importance of this agenda, we have secured funding for a whole time, dedicated senior leadership role (band 8a) to lead on the operational implementation of the Work Well Strategy and to support local Work Well leads.

The Work Well Strategy has a set of deliverable actions aimed at developing and enhancing our wellbeing activity beyond the reactive COVID-19 response, and shifting to a more proactive, sustained, and planned commitment to staff wellbeing.

NHS Lothian Peer Support Service

An early key deliverable of the strategy is the establishment of a Lothian wide Peer Support Service. In February this year we commenced a series of externally commissioned and accredited Peer Support training sessions. Our aspiration was to spread and scale this evidence-based intervention at pace. Between February – June 2021 we trained 108 staff in Peer Support across all sites, service and HSCP's. Governance processes, monitoring, supervision and CPD are all in place for the Peer Support Service and we presented our progress at the recent NHS Scotland Event.

Psychological Support for Staff Wellbeing

In terms of psychological interventions to support staff wellbeing we have implemented a psychology service as part of our existing OHS service. The current waiting list has been re-triaged and appropriate care has been matched to need. This has brought our staff counselling wait list down from five months to one month.

Our Organisational Development and Staff Support Psychology team have been working together to explore how both functions can collaborate to augment support offered to teams according to need. We are about implement a test of a development programme aimed at better enabling managers to support their teams based on psychological first aid, trauma informed leadership and compassionate leadership.

Shielding Staff

When the second lockdown was announced in January 2021, we realised the potentially traumatic impact that this might have on staff who required to shield during lockdown one and were now entering a second phased of shielding. In response to this we created a Shielding Virtual Network. Our first few sessions were focused on listening and seeking to understand and then actions were informed by the network such as guidance for managers and teams, communications stories about shielding and practical support to enable meaningful working when not on the workplace.

Organisational Culture

Whilst governance issues such as mandatory compliance and appraisal compliance raise up the agenda, we are acknowledging the need to recover our people before we recover our services and aim to keep messaging balanced and sensitive to this reality.

We have continued our successful leadership network which has grown during COVID-19 to over 500 members. Monthly meetings are well attended and engaged with.

NHS Lothian invested in becoming a member of the IHI Global Learning Network on Joy in Work. We have supported over 30 staff to develop skills in creating the conditions for healthy, happy, productive people using quality improvement methodology in the past 18 months.

Living with COVID-19: IPC, PPE, Physical Distancing

We will continue to implement precautions advised by the COVID-19 addendum to National IPC policy - this currently includes maintenance of segregated high (red) and medium (amber) risk patient pathways, and extended use of PPE by patients, visitors, and staff where required. Wider precautions around physical distancing and restrictions for public spaces and non-clinical services will similarly continue. The current IPC policy position remains fluid in response to community prevalence of COVID-19 19 and wider easing of restrictions within society. We will adapt our response to updated policy once available.

Management of Nosocomial Infection (Including implementation of Testing Strategy)

Enhanced screening protocols have been rolled out in line with current guidance. All emergency and planned patient admissions will be tested on or prior to admission, with serial testing of all adult inpatients. Additional point of care testing for other seasonal infections is planned to assist with rapid identification and safe placement of patients over winter.

Safe/Segregated Pathways

Segregated high and medium risk ward and critical care pathways are provided on all acute hospital sites. The number of beds/wards allocated to these pathways is dynamic in response to infection incidence and hospital presentation, and to wider community prevalence. The impact of other seasonal infection demands (e.g. influenza, RSV, norovirus) are not yet known and winter planning work continues to consider this.

2.12 Public Health, including Test and Protect

Action referenced in RMP3	Update
Workforce and Public Health remobilisation priorities The Public Health department is organised into three teams; Business and Administration, Population Health and Health Protection. The Directorate has completed a review of workforce and is currently in the final stages of moving into a new structure.	The new Director of Public Health started in June 2021. A new team, Healthcare Public Health, has been added to the structure. Most of senior team appointed to their roles within new department structure. Final stages of the organisational review underway. It is hoped all staff will be matched to roles within the new structure within the next few months.
The Population Health group will include new teams working in each HSCP/CPP area with a significant focus on COVID-19 recovery priorities such as mental health, poverty and place. The Population Health teams will also continue to provide support for continuing re-mobilisation of health and social care services as well as leading Lothian teams for programmes such as screening and smoking cessation.	Lead Consultant for Population Health appointed along with two new Partnership area Consultants so that each partnership area now has a Consultant lead. Teams being established and workplans will be formulated in coming months. Public Health will also be leading the new NHS Lothian Maternal and Infant Nutrition team which will ensure better integration of nutrition teams and services across acute and community settings. Screening programmes continue to operate (see below). 'Quit Your Way' team has been slotted into departmental structure and progress being made to develop a wider tobacco control approach. ,
The Health Protection Team capacity for pandemic outbreak management has been boosted by a new group of dedicated health protection nurses and Consultants and the ongoing integration of Test and Protect services.	Lead Consultant for Health Protection appointed and new Consultant in post along with Consultant for Testing. Additional Band 6 nurses appointed. HPT now co-ordinating Community Testing and Test and Protect.
The department also continues to support Lothian programmes for vaccination, shielding and community testing as part of the Board COVID-19 response. Over the coming months we will be enhancing our health intelligence capacity to strengthen our public health offer to the Board and partners.	Significant new work taken on to deliver COVID-19 booster and annual flu vaccination programme underway. Vaccination Transformation Programme also included in work of new Healthcare Public Health Team. Existing staff matched to roles in the new Health Intelligence Team and new Band 7 Senior Intelligence staff have been appointed.

Test and Protect workforce Test and Protect in NHS Lothian has scaled up the service rapidly from its original Tier 2 staffing requirements to achieve the current Scottish Government target set for NHS Lothian of 80 wte contact tracers on duty daily, 8-8 on 7 days per week plus Team Leads to support the service. Lothian now has a Test and Protect staff complement of approximately 140 wte contact tracers and 35 wte Team Leads employed on 12 month contracts (to November 2021) to achieve the SG daily staffing targets. Ongoing recruitment of contact tracers is required to maintain target numbers as the current job market has resulted in high turnover. Use of supplementary staffing at present is balanced daily against current case numbers. The original core group of Test and Protect will have fully returned to their substantive NHS posts areas by mid-February. Some of these staff retain their equipment and will be available to support any surge in demand.	Workforce numbers are roughly the same but at 30 wte team leads most of the time. An almost continuous programme of recruitment is required to maintain target numbers. All contracts now confirmed until March 31st 2022 and surge capacity is now provided centrally. NHS Lothian additional capacity has now been stood down other than some skilled Bank staff who can supplement when workforce falls below target levels. Funding from SG is unlikely to be available for any surge staffing utilised in Boards above mandated establishment. Digital solutions are also being explored nationally as additional for surge situations in future.

Test and Protect Tactical In August 2020 there was a shift from the two tier system of Test and Protect which had required Boards to undertake enhanced contact tracing of complex cases with all Tier 1 tracing of simple cases done at the National Contact Tracing Centre (NCTC). Now, with a substantive Lothian workforce in place with capacity to handle Tier 1 tasks, Test and Protect has also established six teams to undertake enhanced (Tier 2) contact tracing; each team focuses on a specialist area such as care homes, education or workplaces and this has seen the team integrate more closely with the Health Protection Team working on these areas and also with the local authorities while working on schools outbreaks. In addition, one of the Test and Protect teams now supports the Occupational Health Service by undertaking enhanced contact tracing of all staff testing positive and we anticipate continued close working across both teams as well as Health Protection and Infection Prevention and Control teams. An escalation plan is being put in place for additional contact tracing activities that can be undertaken when case numbers are lower such as contact failure reviews and isolation follow up.	TaP has reduced from six teams to four as the vaccination programme roll out has altered the volumes of cases seen in each specialty, notably in the healthcare settings. Digital enhancements and changing guidance as Scotland reduces protection levels will require regular review of the TaP structure to ensure resources are utilised appropriately. Recent significant surges in activity have required frequent, rapid decision making about contact tracing priorities. This led to the establishment of a contact tracing Tactical Operating Group (TOG). The TOG is accountable to DsPH, and has system wide oversight and a decision making remit on changes to contact tracing practice nationally to manage changing demand and competing priorities and ensure the system is working effectively across Scotland. NHS Lothian contact tracing clinical lead is one of the East region representatives on this group.
Screening All screening programmes face capacity issue due to the need to adjust operations for a COVID-19 pathway.	Capacity issues have improved but issues remain, in particular whilst social distancing remains in place. Unclear as yet whether repurposing of outpatient staff will have an impact
<u>Cervical</u> Cervical cancer screening capacity in primary care has been enhanced by funding to support temporary recruitment of new staff to run additional sessions to adapt to additional time required for a COVID-19 compliant service. But demands on primary care to deliver vaccination mean short-term pressure on cervical screening staff. There	**Primary care:-** Funding delivered from SG to support additional capacity in the short term. Capacity remains lower but improved and sample numbers reaching the lab are in line with the business case re implementation of the HPV pathway. **Colposcopy-** SG funded 1 WTE locum in place for 6 months supported a partial reduction in waiting times alongside

has been additional Consultant recruitment to address the backlog of colposcopies.	reconfiguration of 3 senior medical staff job plans to increase capacity and a Board funded Consultant (1 year in gynaecology/colposcopy). 40 WLI clinics provided although the recent cervical screening incident required repurposing of 7 waiting list clinics. (backfill funding supplied by SG). The impact has been to reduce routine waits from 17+ weeks down to an average of 14 weeks (11 weeks achieved in June) but there remains work to do on this and current resources are about to reduce in a range of ways. As such there is likelihood waiting lists will increase again. • As we move forward the 3 gynae Consultants will need to revert in the longer term to usual activities including USOC • SG funded 6 month Consultant Locum – finishes in July – this post has been made substantive by the Board but will cover a wider range of activities rather than just Colp and will therefore represent a reduction in colp capacity as of August – (reduction of 5-6 session/week) Board funded 1 year gynae/colp locum post- due to finish in November with a further reduction in capacity (2-3 sessions/week). Current gynae plans include: Bid to NHSL for 1:3 WTE cons (and asking that it's approved now) to support sustainability in Colp. There is also a gynae onc vacancy and the locum picking up that work is delivering a small number of colp sessions – so if this extended and not permanently recruited to then we'd continue to get capacity (temporarily) from that role. In addition from a screening specific perspective we have put in a request for further SG funding (1-2 Consultants) put in to SG – awaiting response.
<u>Breast</u> Reintroduction of breast screening services saw an initial increase in attendance and	Scotland level data demonstrates attendance remains high. Temporary 6th mobile in South East, is now up and running

associated increases in cancer detection rates are being tracked nationally. To address the backlog due to both the COVID-19 pause and previous backlog due to population increases, a new mobile screening unit has been supplied by NSD as part of the efforts to increase provision for breast cancer screening. The National Breast Screening Review will report later this year and will make recommendations on future breast screening delivery Routine appointment planning in Edinburgh has been adjusted to increase the number of appointments offered at the screening centre.	with staff etc and additional sessions are being held. This is helping to reduce the backlog towards the 3 year cycle length; however this will take an extended period of time (estimated over several years). 6th mobile allocated by NSD for 12 months to Jan 2022. Estimate a further 6-9 months would be required to recover pre-COVID-19 position (which was already running at 3 years 4 months cycle). Recovery to date has seen a 3yr 9month position in August 2020 improved to 3yr 6 month position by July 2021. Breast screening review has been released in draft and awaiting final recommendations -options under consideration likely to include work in a number of areas including, changes to patient recall patterns to be more person centred, integrated services and technological and workforce developments
<u>Bowel</u> Screening kits continue to be distributed. A backlog of symptomatic patients adds to pressure on colonoscopy capacity at hospitals. There is national planning work to address the shortage of colonoscopy appointments across Scotland; Lothian is currently able to cope with demand locally	Referrals with positive results peaked in March following increase in invitation numbers to accommodate elements of COVID-19 pause. Referrals appear to be reducing to pre COVID-19 levels. Service managing demand via coordinated approach across other USOC services but remains a challenge to meet 31 days target.
<u>Diabetic Retinopathy screening and AAA screening</u> Clinics for DRS and AAA run from community premises which are currently being used for vaccination clinics. In the short-term this may cause some delays to screening but there is ongoing liaison with HSCPs to minimise impact. COVID-19 compliance means capacity per session is reduced	**<u>AAA</u>**: backlog of screening but anticipate working through this within resources and timescale. **<u>DES</u>**: backlog is increasing. Requires Board funding and additional fixed term staff (2 years)/equipment. Even with additional resources will take more than a year to relieve backlog.
<u>Pregnancy and Newborn screening</u> With the exception of a brief interruption to newborn hearing screening, pregnancy and new born screening programmes continued throughout the pandemic. The backlog in hearing screening has been erased.	No need for update

2.13 Digital

This section provides an update on key areas outlined in section 16 of RMP3 - Digital Health.

Principles and Assumptions

We will schedule whatever elements of care and treatment we are able to and will use new digital services and more common technologies (such as the telephone) to do so.

Workshops have been undertaken with over 300 services in Acute, Community and Mental Health to review requirements for revised Outpatient / Clinic Services in light of COVID-19 working. This involves review of current Trak Clinical Template setup, appointment services, triage outcomes, mixed templates (Face to Face, Telephone and Near Me), Patient Initiated Follow Up (PIFU), Return waiting lists, and appointment / GP letters.

We are undertaking Speciality by Speciality review of eTriaging functionality, Appointment Scheduling processes, PIFU, Return Waiting Lists, PFB and Back to Referrer. If specialities are not currently using these current pieces of functionality we are ensuring that these are made available to them. Most Specialities are embracing all pieces of Trakcare functionality. However these are not mandatory, but where clinically appropriate Specialities can choose to mandate these.

This work to redesign Outpatient services started In Feb 2021 and extends to mid-2022 and follows an agreed process to review existing service arrangements, hold workshops with each specialty to document their plans (given the new list of clinic options), agree and sign-off, them build new clinic services in Trak and move to service implementation and go live in their new clinics. Redesign work in each specialty taking approx 12 weeks, and specialties staggered every 1-2 weeks

TRAK Templates - As part of the Clinic Template review, there will be the option for multiple modes of contact in the same clinic session. There is no one standard fits all, we can alter as required by the speciality.

We are updating Appointment letters and reviewing to ensure they match the mode of contact, we are providing SMS reminders at 7 days and 1 day from appointment to assist with reducing DNA's, and implementing Back to Referrer functionality to ensure detailed electronic communication back to referring GP's.

In addition to this, we will also be rolling out in the near future Personal Community (Patient Access to agreed EPR details, Letters and Results) and Online Appointment Booking, Intersystems are due to deliver this to us for testing by end of July 2021, with a view to implementing in September 2021.

Soprano (BT partner) SMS use is up and running alongside the national notification service to notify patient groups of key results.

Digital innovations

The points below outline how we are using digital innovations to support service remobilisation and new ways of working:

- Digital consultations using Near Me: improving service delivery and patient experience (covered later)
- High level plans for completing eIRD, Badgernet and CTG
- eIRD (electronic Initial Referral Discussion) Child protection System upgrades will be completed In Aug 2021, to enable additional usage by NHS Borders (and potentially other Health Boards) , we have updated the IG / ITSEC details for the existing product and as originally focused use in NHS Lothian and associated agencies.
- The electronic inter agency discussion (EIRD) system is a web-based form to allow police officers, social workers and NHS paediatricians to collaborate in child or adult protection concerns
- K2 Guardian (CTG) Pregnancy monitoring system - Critical issues are currently being addressed with the Service and Supplier, expected completion date December 2021 including software upgrade, testing, implementation & review,
- training and user access strategy / processes, CTG archiving usage and antenatal usage
- Badgernet, (RIE) Philips medical devices and infrastructure will be in place July / Aug 2021. Testing to start on the interfacing mid July 2021. EDT / SCI store interfacing – dependant on Neonatal Badgernet upgrade, Interface testing and neonatal monitor integration will continue through 2021/22, and to bring on St John's medical devices.
- Interagency Information Exchange (IIE) – A System that enables NSH to request services from Social Work, and for each agency to view summary patient / Client information. Plans are being made to upgrade some ageing hardware and focus on an Upgrade to the SWIFT Integration (for West Lothian Social Services) and to implement a new Mosaic integration for East and Mid Lothian Social Services.
- Clinical Viewer (CV) – A system that provides summary (portal) access to Trakcare patient information from one or more health boards, and from Local GP Systems (Vision / EMIS) – for Vision 85 out of 103 are using CV and 10 out of 17 EMIS practices are using CV
- Currently we are extending CV functionality to support Optometrist access to agreed summary clinical information to assist with referrals and to provide access to Patient National vaccination records (Currently COVID-19 dose 1 and 2)
- ReTIS Team (Adaptive systems / Wheelchair system) Release new version containing patients, referrals, episodes, notes and actions features in NHS Lothian, Rollout ReTIS to NHS Highland during 2021/22
- Digital Options to reduce unnecessary travel: MS Teams deployed at scale across NHS Lothian
- Remote patient monitoring: NHS Lothian is working with DHI/ Storm ID to provide a choice of local and National applications, including Trak and Trace, and condition specific applications such as Dermatology, supporting COPD monitoring of patients via pulse oximeters in the patient's home and customisation of patient information

(Tailored Talks) for Long COVID-19 Patients. NHS Lothian will also look to develop their own applications and/or add additional remote monitoring options.

- **Cancer Information Systems:** We are supporting a Chemocare (Chemotherapy prescribing system) upgrade by ensuring the reporting application continues to work against the new version, and to look at upgrading the reporting application to more modern technology by the end of Dec 2021. Aria (Radiotherapy system) is also undergoing a National procurement to replace the current system and provide increased integration with other Patient systems. This will follow agreed National timelines to complete procurement and enable call-off implementations by NHS Lothian and other relevant health boards.
- We are also contributing to the specification and beta test of a National Cancer Treatment Summary system, working with NES digital to better inform patients and GPs about patient's current cancer treatments, with an initial focus on Head and Neck cancer in Lothian, in conjunction with NHS GG&C who are focusing on Urology Treatment Summaries
- Clinical Services also have the support of the Digital Innovation Team for rapid application developments.

The nationally procured InHealthcare solution has been reviewed and agreed. There are two additional areas to explore in NHS Lothian (in the first instance) to support the recovery of outpatient and primary care services:

- Using this approach in East Lothian and Midlothian respiratory MCN work, similar to that available in Edinburgh through Lighttouch, which has saved >700 appointments
- Using the diabetes and asthma chronic disease monitoring pathways already developed in 4 Edinburgh practices who are keen, to determine how this supports the recovery of primary care
- Further review of Information Governance aspects of the solution, Integration with the existing Patient EPR and future licensing arrangements past the initial 12-month period

On-line services (including appointment booking)

- GP on-line services - 88 from 103 General Practice locations are now using InPractice Systems (InPS) Vision On Line services for repeat prescription services as part of a standard rollout We are picking this up with the various HSCP's to encourage their practices to sign up. All 17 EMIS Practices are providing on-line Repeat Prescriptions. No Practices have as yet opted to deploy on-line appointment booking.

- Secondary Care appointment booking services will be implemented using Intersystems Personal Community system later in 2021

Primary Care

Digital solutions have been deployed across COVID-19 assessment hubs and all existing NHS Lothian GP Practice locations in support of a wide range of primary care services. Near Me utilisation in NHS Lothian Primary Care has had a significant uptake across services as noted across National Health Board activity reports, and has been supported by a range of IT infrastructure 124 upgrades, digital equipment deployment, the provision of online services (repeat prescriptions / appointments), review and provision of telephone capacity / equipment and utilisation of e-consulting / SMS communications). Setup shielding searches have been setup on NHS Lothian GP Practice Systems to improve patient communications and patient care services.

GP Service – Technology for Digital Working

NHS Lothian is working with NSS on a "Model Practice" initiative to fully kit out reference practices (Craigmillar) and for NHS Lothian Out of Hours services with Near Me / MS Teams equipment. This was sponsored by the RCGP and involves full deployment of equipment to support all consulting rooms (such as integrated video monitors) and additional AV kit as required.

Primary care Services

Primary Care services have produced local implementation plans which are working to National timescales on GP System re-provision. There is active review and participation in National forums. However, there is also significant delays in supplier accreditation of new General Practice systems.

- Migration to new national contract for GP systems is still in planning due to COVID-19 delays. An NHS Lothian Cohort Decision Group continues to meet to progress GP IT Reprovision activities, and GP system suppliers continue to present updates on their plans to deliver the required functionality to all Health Boards/NSS.

- We have had two demos from Vision and one from EMIS. Vision have demonstrated the new Vision Anywhere desktop coming in Tranche 2. EMIS used Powerpoint to outline what they have to offer at this point in time. The Cohort now need to decide whether to go with Vision Direct Award or wait until EMIS are accredited in Summer 2022 to make a decision on which system. The Cohort due to decide around Sept 2021.

- South East Region is working collaboratively with ophthalmology services regarding appropriate access to clinical information to support referrals, and digitisation of retinal images at regional A&E / Clinic locations for remote review by on-call ophthalmologists. We had over 200 Lothian ophthalmology electronic referrals in the last 3 months. This is down on routine activity due to COVID-19 restrictions and is only dealing with urgent referrals.

- GP SMS started to pick up again since patients starting to be seen more in the practice. Near me used mostly along with telephone consultations although Near Me. Approx 15-20 practices using or about to start using eConsult / a few use Ask MY GP. SG are piloting these systems with a view to funding if the pilots justify it. Dermatology image initiatives are underway in General Practices in conjunction with dermatology services

- GP2GP Record transfer - after 5 years we are finally about to complete activation/training for all EMIS and Vision practice by end of August 2021

- GP ePrescribing - electronic communication between GP and Pharmacies. NES asking for GP volunteers to sense check these initial workflows, technical solutions , and planning for future pilot implementations.

- We are due to start Server replacements/upgrades to Server 2016 for the 17 EMIS practices late August 21 along with upgrading their PCs to Win 10. We will be deploying one practice per week which takes us to Dec 21 to complete. Following this we will start the upgrade of Vision servers to Windows Server 2016 and PCs to Windows 10 for all practices. The GPs already have Win 10 on the new laptops.

- Shared services scoping/implementation/training for CTACs and other teams in East and West Lothian using Vision Direct Services. Access to NHSL systems (SCI Store/Gateway) for the healthcare staff GPs/Nurses at Redford Barracks. Elemental Social Prescribing application training for GP practices in East Lothian and Edin – software purchased by EL/Edin HSCP. Vision Outcomes Manager development /training

Support for Staff - Home Working

There have been significant infrastructure upgrades and increased access arrangements for a range of staff operating at sites across NHS Lothian as well as those working from home.

Projects which are complete and have been delivered:

- Current Pre-COVID-19 NHS Lothian capability for supporting up to 1,500 home based staff was rapidly increased to support 12,000 home based staff, and rapid creation and allocation of Remote Access Software and accounts
- 250 new shared mailboxes (100 new from Aug 2020)
- 500 ECS accounts for community pharmacy and opticians
- 3500 additional user account change requests above “normal” level
- From March 20 to June 2021 - 206 change requests completed (includes the COVID-19 changes)

Trak change requests priority over next 6-12 months include:

- Plans for Mental Health EPR development – sign off requirements in Q3 2021 – then need to plan 2021/22
- Revise Anticipatory Care Plan to Treatment Escalation plan
- Neurosurgery eReferrals (internal Lothian and cross -board using SCI gateway discussion protocol)
- Maternity changes (priorities as defined by service)
- Renal Dialysis – functionality to create multiple recurring appointments
- Continued increase in user support calls due to staff not being familiar with what they were doing after being moved location / role or only have eLearning

Staff vaccination programme

- Dose 1 clinics on 13 sites
- Dose 2 clinics on 11 sites
- Transfer of 18,000 2nd dose appointments due to government change from 4 to 12-week gap

Implementation of online booking process for staff

- 10,000 registered interest
- 7,000 created accounts
- 6,100 appointments booked online

- Clinics and all process for Call MIA (Western General MIU, RIE and SJH)
- 23 clinics for COVID-19 staff testing
- Large number of generic telephone clinics created
- All clinic and location built for DCN and RHCYP OP moves configured and now Live
- Just under 10,000 SMS messages with COVID-19 results sent
- Increased Firewall and Internet Bandwidth deployed to support remote access; the Wide area Network (WAN) links at SJH & WGH were each increased to 10Gb
- Virtual Private Network (VPN) capacity increased from 1000 (Pre-COVID-19) to over 8000 currently, and enabled VPN usage through SJH as a back up to WGH to provide resilient access for remote (Home) users
- Setup temporary wireless (WiFi) on a number of sites to assist with COVID-19 working
- Enabled remote access for GP's working from home
- As part of the GP laptop deployment, GPs are now using Virtual Private Network (VPN) connections. This has been very successful, we only have 7 practices left to deploy laptops to, due to complete by end July 2021
- Additional Digital support for NHS Staff delivering reconfigured patient care services across current NHS Lothian acute, community, primary care and HSCP locations, and new locations including secure access to NHS Lothian patient information in other Health Boards, Private Healthcare locations (e.g Spire), and to support the NHS Louisa Jordan
- Enabled Adastra access / printing to COVID-19 Assessment Hub users

- Continued Regional rollout of eHealth Service Now Service desk fully implemented in NHS Lothian, to NHS Fife and Borders - NHS Fife to go live Aug 21, NHS Borders in November 21
- Soliton (Radiology Reporting Solution) implementation across all sites - We are assisting radiology with their business case to review the use of Soliton as the RIS.
- PACS upgrades completed at all sites - Testing upgrade to PACS to remove the requirement for the client on general workstations with Web access to images.
- Trak T2020 upgrade delivered
- NHS Mail Migration to Office365 for NHS Lothian NHS.NET Users in August 2020. This required moving the NHS Lothian account into Office365, which broke permissions of existing non cloud enabled users. Issues arose when people moved onto webmail managing multiple diaries.
- NHS Mail migration for Contractors using NHS.NET in December 2020
- Outpatient redesign programme just started (and may be changing direction already) to accommodate virtual appointments as well as physical clinics
- Mass Vaccination Site setup for 6 locations including WAN and LAN configuration
- Deployment of circa 600 additional laptops across the organisation - We have deployed in excess of 3,000 laptops across the organisation now in the past 15 months.
- Replacement of mail security platforms
- Migration from SEP to AMP for client security
- Implementation of additional security tools to increase client security
- Establish new contact Centre for Staff Vaccination Booking
- Unified Communications Deployment for SJH, REH, and a number of smaller locations - We have now deployed 10,000 handsets across 27 sites. Planned completion in August 21. In addition, this replaces existing Hospital Switch boards
- Implementation of Network Monitoring Solution to increase security of network
- Replacement of key storage solutions in use across the organisation
- Supply Chain - There are long lead times on hardware. We have stock of most required items.
- Any MS Teams and O365 usage / dashboard data for 2021/22 - We have access to dashboards to indicate usage

Planned for next year:

Over the next 6-12 month we will be replacing outdated servers, upgrading storage, supporting HEPMA and Unified Comms, and migrating email onto Office 365 (O365)

- Mail migration to Office 365, continued deployment in 2021/22
- Windows 10 deployment. The accelerated funding for 7,000 desktops (virtual and physical) should allow us to get to 96% completion during 2021/22
- Deployment of an additional 1,500 laptops across the organisation
- Unified Comms Deployment with major sites including the AAH, RIE and WGH
- Support for additional deployments for HEPMA.
- Go live for Royal Hospital for Children and Young People (RHCYP)

Working with Partners: Local Authorities, other NHS Boards, NHS24, Scottish Ambulance Service and National Education Scotland (NES) Digital Services

NHS Lothian is working closely with NES Digital Services as we use and deploy applications that have already been developed and participate in new work with NES which NHS Lothian will lead on.

National Test and Trace / Test and Protect developments have been through the National Integration Hub and NHS Lothian's demographic feed documentation was used as a template for other NHS Boards to follow.

The Intensive Care Unit (ICU) use of vCreate is being implemented in NHS Boards across Scotland for sharing pre-recorded Video messages from ICU patients and relatives. New work in Neurology offers vCreate to patients as an alternative to coming into the hospital to send video recordings in to help the clinicians diagnose and treat Neurological conditions. NHS Lothian is also procuring a new ICU system.

NHS Lothian has led work with Intersystems to deploy Clinical Viewer functionality, enabling sharing of local NHS Board Trak electronic patient record data across all NHS Health Boards (including GG&C access to Lothian patients at NHS Louisa Jordan)

We have also linked NHS Lothian Practice Systems to Trak through a Clinical Viewer (CV) application to ensure Practice staff are aware of patients who have recently attended A&E, Outpatient and Inpatient services. Other services (as approved) can access Clinical Viewer Directly for summarised NHS Lothian acute, community and mental health information.

Clinical Viewer – Overall Usage (including GP Access)

Clinic Viewer (CV)	Total (July 20-June 21)	
Location	**Active users**	**Records Accessed**
Borders	14	4,222
D&G	1	101
FV	3	190
GGC	20	1,002
Golden Jubilee	17	558
Lanark	0	37
Lothian	134	39,128
Lothian GPs	373	81,562
Totals	562	126,800

NHS Lothian has agreed to work with DHI/Storm regarding the Lenus Platform. The Project mandate is being provided by the DHI, and NHS Lothian will integrate a secure test environment into our clinical systems to ensure integration works smoothly.

NHS Lothian played a leading role in getting the National Notification Service and the Simple Tracing Tool up and running. NHS Lothian has been involved from the beginning of these developments and were the first board in Scotland to send a notification via the NSS. We've had senior representation on the development of this since the very first planning session.

Development of a Microsoft Form with direct integration into Tableau for reporting of Personal Protective Equipment (PPE) stock checking. The NHSL PPE Stock Monitoring Application has currently processed over 8,000 forms supplying over 115,000 items.

Risks

Risk of inadequate eHealth hardware and infrastructure: There is a risk that there is insufficient IT hardware and infrastructure to support the prompt roll-out of digital and digital-enabled service models. Demands are being effectively managed at present, however, due to the dependency on supply chain there remains a risk to provision.

We have sourced and deployed equipment across the NHS Lothian estate to enable revised working arrangements to support staff and patient social distancing, revised modes of contact with patients and home working. This was deployed to support Outpatient clinics operating mainly in a new virtual setting, new primary care Assessment Centres specifically formed to support COVID-19 related activity and to support new COVID-19 operational arrangements for General Practice consultations. This includes equipment to support revised clinic

arrangements for video consulting (Near Me) in confidential settings (Integrated monitors with camera/speakers) and where more controlled access is required (using separate headsets / cameras). We have also deployed Standard Laptops, and VDI laptops / PCs across the estate and to support home working, and initiated a range of procurement activities to source this during a time where this was often on limited supply.

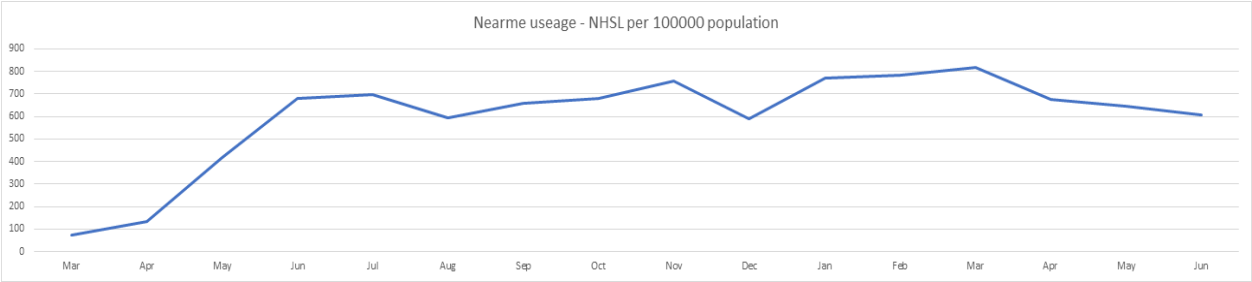
Out Patient Services – Near Me Consultations / Digital First Approach

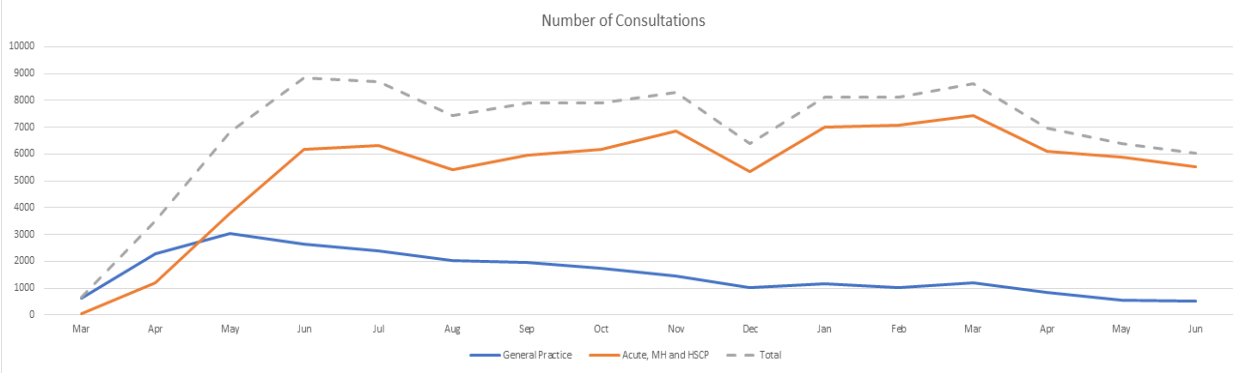
- From 23rd Aug 2020 – 9th Jan 2021 there was a total of over 34,600 Near Me consultations (7,024 by GPs)
- Over Jan-Dec 2020 4,300 Near Me service providers have been set up in over 800 Near Me waiting areas (virtual clinics) in acute outpatients and GP services
- During Jan 2021 there were an additional 100 service providers added to Near Me (total 4,400), and there were over 430 waiting areas open (services can open / close Near Me Waiting areas depending on activity); Jan 2021 NHS Lothian Near Me activity was nearly 9000 consultations / over 4,000 video hours
- To support these, we have deployed Integrated monitors (camera, mic and speakers) or separate cameras / headsets dependant on privacy arrangements in clinics, together with comprehensive training and support
- Patient outcome information available from all Near Me clinic consultations, but this has yet to be integrated into National Near Me reporting tools, this can currently be accessed to review patient experience / feedback from specific clinics. NSS have produced a Near Me Digital Dashboard to monitor Near Me usage across NHS Boards

Update Table for 2021/22

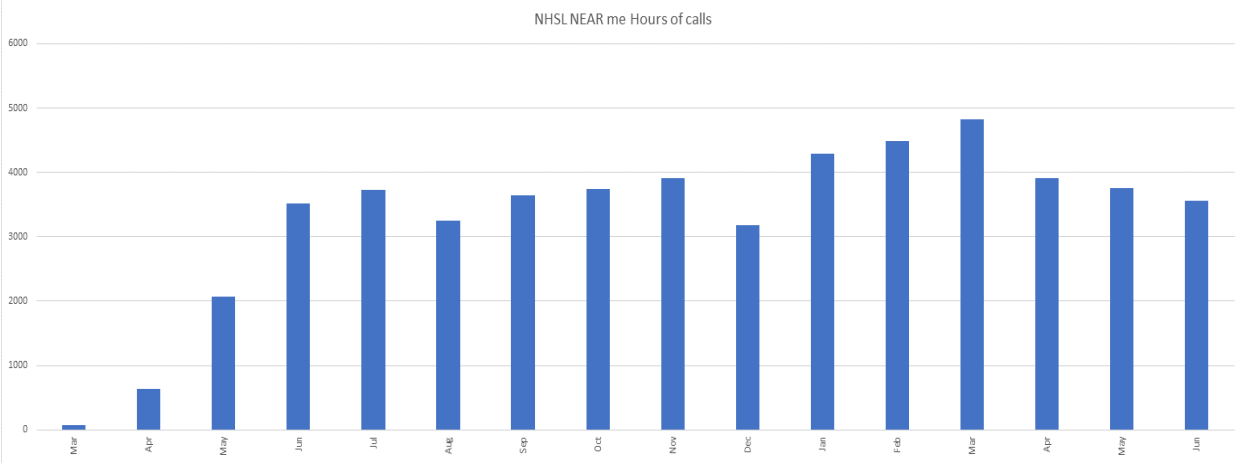
NHS Lothian Total Near Me Consultations per 100,000 Population

- NHS near me has been moved to Business As Usual (BAU) support managed by the clinical applications team since September 2020
- The use of NearMe for Group discussions: testing starting July 2021, assuming all goes well they are estimating a Sept/Oct 2021 National release.
- Updated consultation figures for 2021/22 to date (dashboard summary / 100,000 population)





Also video hours used, numbers of service providers, clinics (waiting areas) for 2020/21



NearMe Platform activity for NHS Lothian March 202 to June 2021

Adapting our Transformation Programme: Opportunities for Digital Transformation (Near Me) :

Workshops have been undertaken with over 300 services in acute, community and mental health to review requirements for revised digital services initially for outpatient / clinic services in light of COVID-19 restrictions. This will inform the investment model, future development and device strategy and deployment to support a "new normal" for these services, and will extend into support for new ways of digital working across all NHS Lothian services and locations. Near Me rollout has been at pace across a range of NHS Lothian services supporting acute, cancer, community, AHP, mental health and maternity services and is now seen a routine method of consultations, along with telephone consultations.

MS Teams has been deployed at scale across NHS Lothian with over 32,000 user accounts enabled. The MS Teams digital dashboard created by NSS digital services is used to monitor MS Teams accounts, activity, usage and licensing across Health Boards.

Support to Shielded / Vulnerable Groups via Digital Platforms

Mental Health Services across NHS Lothian have led the update of Near Me Digital consultations, ranking top in Near Me consultation uptake, notably in Child and Adolescent Mental Health Teams. Extracts continue to be extracted from GPIT Vision/EMIS systems via Albasoft for National Vaccinations and for identifying shielding patients

Mental Health and Substance Misuse

Digital solutions have been provided across a wide range of adult and child mental health specialties including Near Me and digital infrastructure to support this. Mental health Teams have been at the forefront of electronic prescribing in NHS Lothian with first Hospital Electronic Prescribing and Medicines Administration (HEPMA) deployment at the Royal Edinburgh Hospital (REH) in July 2020 as part of an NHS Lothian wide deployment. This will expand to support Medicines Reconciliation and a substance misuse HEPMA module in a future HEPMA release to bring additional benefit to Mental Health services.

Mental Health Services- Use of Technology

The Digital Mental Health business case has been completed, and is being used as a model for other services, with a range of workshops being undertaken to define the Digital services required to support for "New Normal" ways of working.

Hospital Electronic Prescribing and Medicines Administration (HEPMA)

This application is being deployed across all NHS Lothian secondary care locations to complete the patients' medication records. GP information will be exchanged with hospital staff at presentation (MEDREC), and acute prescriptions will be sent to GP's at discharge, closing the loop for medication recording. The Royal Edinburgh Hospital (REH) is live on HEPMA, followed by the Western General Hospital in Feb 2021. Thereafter there is a rolling programme to deploy HEPMA across the Royal Infirmary of Edinburgh (RIE), St John's Hospital (SJH), the State Hospital (TSH) and a number of smaller Lothian hospital sites.

National CHI and Child Health Systems

Implementation continues during 2020 with NHS Lothian National CHI Broadcast file upgrades planned in Sept 2021, and ongoing work during 2021/22 and beyond to replace the National Child Health Systems, due to go live in June 2022 and the full migration of CHI and GPPRS by Oct 2022.

Trak Upgrades and deployments

We completed the T2020 upgrade in Nov / Dec 2020, proving a platform for new Trak Theatres and better alignment with other Trak systems used by Health Boards across NHS Scotland. This replaced a significant amount of obsolete (deprecated) Trak functionality with further updates planned to the Trak User Interface, consultation component and order entry screens planned for 2021/22. Trak Theatres will replace an unsupported existing theatre system during 2020/21. In addition we will roll out Trak Outcomes Management during 2021/22, based on the initial model ward deployment established during Jan-March 2021.

- Business Continuity solution (for when both just Trak is not available and when either network and/or power are not available) – end 2021
  - Online application - is available when Trak is unavailable for read-only access to critical clinical and admin data
  - Offline application - assists in continuing patient care when Trak and/or the network are unavailable
- Replace deprecated Trak consultation functionality
  - Lothian will be using the latest version of clinical documentation software to future-proof ongoing support
- Replace deprecated Trak user interface
  - Lothian will be using the latest user interface to future-proof ongoing support. Deploy more modern user interface
- Develop/Improve user communications and training
  - Ensure full usage of current Trakcare functionality
- Investigate/deploy new T2020 functionality
  - Benefits will depend on what we deploy
- All sites will be live with Outpatient results review Lab results) – by end 2021
  - Improvement in clinical governance processes – ability to audit when a result has been signed off and link that to any action taken.
  - Reduction in medical staff time reviewing and signing results already viewed/actioned electronically
  - Reduction in clerical staff time used to process and file results
  - A reduction in the user of paper / ink for printing of results
  - A reduction in clinical waste from departments disposing of, and not filing, paper results
- Investigate possibility of switching off Outpatient Radiology results (all sites)
  - As above if we can develop a solution
- All sites will be live with new version of Order entry screen – by end 2021
  - Lothian will be using the latest version of Order Entry to future-proof ongoing support
- Trak Theatres – all theatres will be using Trak theatres instead of ORSOS – by end 2022
  - System support secured (24*7)

- Option to streamline Scheduling of Theatre Booking, Visibility of Theatre activity on a real time basis
- Visibility of patient's electronic record within Theatres, A consistent approach to reporting across NHS Lothian
- Ability to record/audit surgical pause checklist

- Change Requests - Looking at the last 2yrs we've averaged completing 32 per quarter so assume that for the next year
  - Benefits will be dependent on the project

- Model Ward – comprises the projects below
  - Patient Centred Care plans (Adults and Paeds) – all sites – Q3 2021
    - Staff will be prompted to have every patients risk assessments completed/updated within required timescales.
    - Improve compliance with person-centred care planning.
    - A consistent approach to care planning across NHS Lothian and improved communication of patient care across care teams.
    - Staff will be prompted regarding next step to be taken based on outcome of completed risk assessments
  - Replacement of paper NEWS charts – all sites – tbc but earliest will be end of 2022 for the roll-out to be complete
    - Remove errors when calculating NEWs scores, Scanning of NEWs charts significantly reduced
    - Improved management of the escalation process, The cost of the paper NEWs chart will be saved
  - Electronic observations (ie direct from monitors as a pilot at least)
    - Reduce/remove the need for observations to be recorded manually therefore releasing nursing time
    - Remove errors when calculating NEWs scores

- T2020 lessons learned – what we've upgraded (h/w and s/w), deprecated items removed
  - Application upgrade + database upgrade (Cache to IRIS) completed
  - Replace deprecated user interface (TCUI to MEUI) - no timescales at this point but investigation has started
  - Replace deprecated consultation functionality – no timescales at this point but investigation has started
  - Replace deprecated order entry screen - All sites will be live with new version of Order entry screen – by end 2021

- 1st release of the offline business continuity app for Trak. Continue to enhance the on-line continuity app (pre-op).
- Continue to enhance Trak in line with the complementary development agreement to help move us away from deprecated items and to improve ease of use for clinicians, such as those for the model ward project.
- Develop mobile apps that interface with Trak to support patient care. Potentially we could develop non-Trak apps that capture information on staff experience or on-premise patient experience.

- Continue with integration projects to support efficiencies (AIGI – now moving onto Urology) and improve patient experience (Lenus Dermatology, then further rollout).
- Support improvements in patient care with the development of emergency referrals from internal (Trak) and external (SCI Gateway) sources. At the moment this is for Neurosurgery but it will be generic for future specialties.
- Continue to archive data from legacy systems to enable the Server Team to decommission old servers, and to support system replacements such as the replacement of ORSOS with Trak Theatres.
- Plans for Trak Paperlite and business continuity
  - The only thing left for Paperlite is complete the business continuity application
    - Online – Will have included pre-operative assessment
    - Offline – aim to be live across all sites
- Plans for Trak Theatre deployment / Sites
  - By end July 2022 should be live in all theatres in WGH; PAEP and RIE
- Other recently completed / planned Trak developments
  - Business Intelligence hardware/software upgrade (Q3 2021)
  - Outpatient Lab results review – all sites by end 2021
  - Investigate Outpatient Radiology results review
- Implement priority Trakcare Advance recommendations ie:
  - Develop/Improve user communications and training
  - Investigate/deploy new T2020 functionality

Training Team – next 6 – 12 months:

- Continue to develop, adapt and enhance eLearning materials (interactive LearnPro modules with online assessments; single task video clips on the Intranet) for Trak and HEPMA.
- Continue to use MS Teams to deliver training.
- Assess tools that enable trainers to see delegates' desktops during practical exercises during Teams training so we can increase the number of delegates in interactive training sessions and assess their competence.
- The team is exploring the use of Teams breakout rooms for customer service training (nonsystem-based training).
- Support the organisation as plans develop for a return to face to face training for corporate induction and junior docs intake.
- Support the o365 rollout.

eHealth Training figures (2019-20 and 2020-21):

	Booked		Attended		DNA/cancel		eLearners	
	19-20	20-21	19-20	20-21	19-20	20-21	19-20	20-21
Apr	768	122	633	72	135	50	301	897
May	696	78	518	61	178	17	219	462
Jun	524	97	377	90	147	7	189	410
Jul	569	243	446	195	123	48	165	712
Aug	737	292	596	227	141	65	187	717
Sep	626	163	491	146	135	17	203	366
Oct	822	204	668	177	154	27	262	481
Nov	890	242	696	190	194	52	145	503
Dec	436	122	358	101	78	21	126	379
Jan	580	214	495	164	85	50	328	690
Feb	645	362	522	313	123	49	383	979
Mar	663*	298	527*	234	136*	64	228*	851
TOTAL	**7,956**	**2,315**	**6,327**	**1,970**	**1,629**	**417**	**2,736**	**7,447**
				Down 321%	**20%**	**18%**		**Up 272%**

* Estimate – figures unavailable due to the transition from PWA to eESS

COVID-19 transformed the Training Teamwork this year with the cessation of face to face training. The team were up and running delivering Trak training over Teams within a month. Capacity was much reduced as it is impractical to assess delegates' competence with hands on exercises over Teams with more than 1 or 2 delegates.

The year before classroom training was largely scheduled 6 weeks in advance; this year with Teams training we have moved to more of an on-demand model. A lot of effort went into filling the void with classroom training by rapidly developing and publishing learnPro modules for new starts to cover corporate induction, the junior doctor intake and student placements. Enhancements to these modules have been ongoing, increasing the interactivity, emphasising IG messages and making the assessments more robust. The team is exploring tools that will help them view delegates' desktops while training over Teams to enable them to increase capacity whilst maintaining the interactive element. Virtual floorwalking (phoning round the wards to ask if they had anyone who needed training) was attempted but was limited by demands for training over Teams.

Further eLearning modules were developed to support the HEPMA roll-out, and work has started on replacing older Trak Community modules.

Digital Support for Priority Vaccination / COVID-19 Initiatives

These projects have already been delivered:

- Staff COVID-19 Vaccination: Contact Centre and On-Line Appointment Booking
  - Contact Centre taking approx. 1000 calls/day (+ local team appointment co-ordination)
  - On day one of the 0800 number opening, in first two hours 77,000 calls were made to the line
  - Over 10,000 On-line Forms submitted to date over 6,000 appointments booked on line
  - Avg Call 7min, on-line booking saved over 700 contact centre hours
  - 33% of on-line bookings made out of hours
- National "Turas" Vaccination System / Planned GP (EMIS/VISION) System Integration
  - Over 78,000 individuals Vaccinated (over 82,400 doses) on-line Turas – GP data (as at 9th Feb)
  - Turas activity 2021/22 – As of Mid-July 21 we had administered 1,039,907 doses in Turas. Currently there is integration with Turas and GP info so that people can see vaccination records in Turas for anything administered in GPs and vice-versa
  - 1,000 staff set up as Vaccinators / Administrators (over 36,000 staff 1st doses given / 2nd dose planning)
  - Turas GP System Integration is being Nationally introduced Feb 2021

- Test and Protect laptops (Over 150 supplied) / Vaccination Centre laptops (Over 235 supplied)
- National Near Me Hospital Clinic and GP Video Consultation Systems
  - Jan – Dec 2020: over 73,000 Consultations with 3,000 Services and 27,000 Video Hours used
- Enhanced Internet Bandwidth, Networking, Security / Firewalls for Remote/Home working
  - Significant increase in our internet traffic with 25 TB of that being for Office 365 alone
  - Home Working: we regularly have up to 1,500 concurrent remote accesses recorded in daily snapshots

Planned/Recently Delivered:

- Local Staff Vaccination (Trak on-line "Personal Community" booking)
  - Approx. 18,000 already booked 1st / 2nd Dose (4 weeks changed to 12 weeks)
  - Rebooking 18,000 staff and additional staff to be booked for 2nd Dose
- National "Service-Now" Mass Appointment Booking System
  - Clinics Setup/Appointments from 1st Feb 2021
- Mass Lothian Vaccination Centres Infrastructure – Feb/Mar 21(including laptops + Networking)
  - Large sites: RHS/EICC (live), QMU (10thFeb), Pyramids Business Park (15th Feb), RBS Gyle (1st Mar) - (78,000 vaccinations pw)
  - Smaller sites: (WL, ELCH, MLCH, CEC) - (11,000 vaccinations pw)

- NHS Lothian Vaccination Contact centre activity - the original staff vaccination line has now stopped but a local Lothian COVID-19 team has been set up and they answer and deal with questions the national contact centre cannot handle. Since this was started, we have so far answered 33,214 calls

- National Vaccination centres in use (small and large) total number that will be open next week is 13 (RBS closes July 21) and this provides 172 station capacity in total equating to a maximum number of 14,932 appointments per day (if fully utilised)

- Travel Vaccination Services - Main change is GPs are stopping Travel Vaccination services as part of revised GMS Contract, NHS Lothian RIDU to pick up and need a geographical hub and spoke setup and enhanced Digital support
  - Hub at RIDU on WGH site, Spoke sites proposed at:
    - West Lothian – Strathbrock Partnership Centre – 6 to 8 sessions
    - East Lothian – East Lothian Community Hospital 3 or 4 sessions
    - Midlothian – site to be confirmed – likely to be Midlothian Community Hospital –3 or 4 sessions
    - Edinburgh – Sighthill Health Centre and Mountcastle Medical Centre 12 to 16 sessions

LIST OF RMP4 APPENDICIES

Appendix 1	Preparing for Winter 2021/22 - Checklist of Winter Preparedness: NHS Lothian Self-Assessment at September 2021
Appendix 2	NHS Lothian – RMP4 Delivery Plan
Appendix 3	NHS Lothian - Integrated Planned Care Mapping - Programmes, Priorities, Innovation Timeline and Workplan
Appendix 4	Data Template T1 - activity projections on Unscheduled Care, Mental Health, and Delayed Discharges
Appendix 5	Data Template T2 - Monthly Actual v Planned Activity in Elective Care
Appendix 6	Data Template T3 - Elective Waiting Times Trajectories for patients waiting over 12 weeks (over 6 weeks for Diagnostics) and over 52 weeks.

Preparing for Winter 2021/22: Supplementary Checklist of Winter Preparedness: Self-Assessment.

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **COVID -19, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing**
6. **Respiratory Pathway**
7. **Integration of Key Partners / Services**

These checklists supplement the narrative and deliverables identified in your RMP4 and support the strategic priorities for improvement identified by local systems from their review of last winter's pressures and performance and experiences of managing Covid -19.

Your winter preparedness assessment should cover systems, processes and plans which take into account the potential impacts of COVID-19, Respiratory Syncytial Virus (RSV), seasonal flu, other respiratory conditions and severe weather impacts. Plans should recognise that some of these events may occur concurrently and should take into account system wide impacts. Plans should also reflect a strategic as well as operational approach to maintain service resilience and business continuity.

The checklists also include other areas of relevance but are not exhaustive. Local systems should carefully consider where additional resources might be required to meet locally identified risks that might impact on service delivery.

NHS National Boards should support local health and social care systems to develop their winter plans as appropriate.

Winter Preparedness: Self-Assessment Guidance

- Local governance groups can use these checklists to self-assess the quality of overall winter preparations and to identify where further action may be required. This should link to the guidance available for continual provision of service available on the associated web links highlighted on the accompanying paper.

- The following RAG status definitions are offered as a guide to help you evaluate the status of your overall winter preparedness.

RAG Status	Definition	Action Required
■ **Green**	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
■ **Amber**	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
■ **Red**	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	Resilience Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action /Comments
1	NHS Board and Health and Social Care Partnerships (HSCPs) have clearly identified all potential disruptive risks to service delivery and have developed robust Business Continuity (BC) plans to mitigate these risks. Specific risks include the impact of Respiratory Infections (e.g. Covid, RSV, Seasonal Flu) on service capacity, severe weather and staff absence. Business continuity arrangements have built on lessons identified from previous events, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter preparedness to ensure that business continuity management principles are embedded in Remobilisation / Annual Operating Plans as part of all-year-round capacity and service continuity planning *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details.* This guidance Preparing for Emergencies Guidance*sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.*	☒ ☒	 	NHS Lothian's Resilience Strategy is supported by the Resilience Assurance Process, requiring sites and services to undertake a resilience risk assessment and to update Operational and Tactical resilience plans with any changes, including lessons learned, these plans are submitted annually and signed off at Director level. The resilience team are available to support and advise the sites and services throughout this process <u>Edinburgh HSCP:</u> The Partnership has a designed Resilience Lead and Co-ordinator who regularly link with both Council and NHSL resilience teams in a resilience event. The Partnership Resilience Team review the severe weather plan annually as part of a formal review, with reviews undertaken as part of any severe weather incidents to

				ensure any lessons learned are captured in future iterations of the plan (eg this year the resilience teams will work with CEC Transport and Roads colleagues to ensure optimal use of existing resources. In addition, additional seasonal resources such as hired 4x4s will be brought in at an earlier stage). There are several groups that manage/co-ordinate resilience activity included the Resilience Steering Group, Resilience Committee which includes a cross-section of the Partnership and focus on resilience events. Alongside this, a severe weather group was set up in 2019, and include a range of key stakeholders. This group specifically focuses on winter weather-related incidents. As the response to COVID19 is now being managed in a more planned way, the command centre has been stood down, however an Operational Oversight Group was stood up in its place in Summer 2020 and was changed to focus on system pressures highlighting	

				the fluid and dynamic nature of the operational response at this time. This arrangement will be kept under review. The Partnership are currently in the process of updating their resilience plans and Business Impact Assessments and aim to be completed by early October. The plans cover the arrangements for services to maintain their service in the event of a resilience event (eg loss of building, loss of IT etc). The Partnership are currently looking to create integrated resilience plans as currently the Council and NHSL have difference ways of documenting their approach to a resilience event. The Resilience Steering Group also discuss a range of potential resilience related activity that could affect service deliver (eg EU Exit, COP26) and agree / discuss mitigation strategies <u>Midlothian HSCP:</u> All services updating service resilience plans and additional winter-specific resilience	

				planning by 13/09. Winter operational briefing with services was held on 30/08 to review previous winter experiences and go over resilience planning requirements. Baseline capacity will be monitored to evaluate services' resilience planning. <u>West Lothian HSCP:</u> Resilience plans in place to support Business Continuity. These are updated annually and also cover the specific risks identified. The pandemic has allowed us to test out our business continuity in real time. <u>East Lothian HSCP:</u> Business continuity arrangements are in place across East Lothian HSCP's (ELHSCP's) services, with associated documentation available to all staff via a shared drive.	

2	BC plans take into account all critical activities across the NHS Board / HSCPs spectrum of activity and include analysis of the risks of disruption and their actual effects and demonstrate that planning has been based upon the likelihood and impact of worst case scenarios. Risk assessments take into account staff absences including those likely to be caused by a range of scenarios and are linked to a business impact analysis to ensure that essential staff are in place to maintain key services. All critical activities and actions required to maintain them are included on the corporate risk register and are actively monitored by the risk owner. The Health Board and HSC partnership have robust arrangements in place to support mutual aid between local / regional partners in respect of the risks and impacts identified	☒ ☒ ☒	■ ■	NHS Lothian's resilience strategy adopts an all risk approach but requires services to assess risk and mitigation, including loss of staff and loss of access to departments. Critical activities are identified, within the Operation Plans, by each service along with the risks and mitigations. Minimum requirements are also identified for these activities to continue and how these needs would be met. <u>Primary Care and USC</u>: Ongoing active monitoring and review <u>Edinburgh HSCP:</u> Partnership Resilience Plans cover all essential / critical services and document the risks and impact of service disruption and considers the resources needed to maintain key services in an emergency and appropriate risk assessment have been undertaken. The Partnership have also tested their call trees in terms of how long it would take key staff to arrive on site to allow	

				planning to determine minimum number of staff that could be available in a resilience situation. The Partnership resilience lead / co-ordinator is linked into the relevant Council and NHS Lothian resilience groups. <u>Midlothian HSCP:</u> As above All services completing resilience plans to maintain baseline capacity, taking into account staff sickness absence. Planning for annual leave to ensure service deliver is maintained over winter period. <u>West Lothian HSCP:</u> Business Continuity plans in place. Prioritisation system in to risk assess and prioritise people with greatest needs. EG DN – Diabetics <u>East Lothian HSCP:</u> Individual ELHSCP service	

			■	areas have resilience plans in place to ensure maintenance/ prioritisation of service delivery under all scenarios, including Covid-19 Primary Care Lockdown Plan agreed with NHS Lothian Primary Care Contractor Organisation to ensure continuity of primary care services GP Practice continuity plans and buddying arrangements are in place to maintain services through winter and in the event of Covid-19 impacts on staffing and service delivery.	
3	The NHS Board and HSCPs have appropriate policies in place to cover issues such as : • what staff should do in the event of severe weather or other issues hindering access to work, and • arrangements to effectively communicate information on appropriate travel and other advice to staff and patients • how to access local resources (including voluntary groups) that can support a) the transport of staff to and from their places of work during periods of severe weather and b) augment staffing to directly or indirectly maintain key services. Policies should be communicated to all staff and partners on a regular basis. *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*	☒	■	There is an HR Policy Group document: Adverse Weather and Major Transport Disruption Policy and Procedures <u>Acute Services</u>: Severe weather policies, in place and available via intranet. In addition are proactively shared at appropriate time of year with all acute teams via Site Leadership teams . <u>Primary Care and USC</u>	

			■	LUCS Business Continuity Plan <u>Edinburgh HSCP:</u> Both CEC and NHS Lothian have appropriate procedures in place which are held on the orb /intranet. The procedures are regularly communicated with staff about what they should do in the event of adverse weather/ access to work. The Partnership also ensures that any key communications relating to accessing travel arrangements are cascaded through the management line (eg bus strike) or via colleague news. ■ <u>Midlothian HSCP:</u> Working with Midlothian Council teams and local voluntary groups for access to transport in severe weather. Service level agreement has been updated and SOP for accessing 4x4s is being produced. Individual services are maintaining lists of staff who can drive other staff. Services also prepared for staff to work from home or change work base as required.

			■	West Lothian HSCP: Business Continuity plans in place that cover severe weather and staffing. Staffing is well exercised. Local communication arrangements in place including the use of social media to communicate general messages.	
			■	East Lothian HSCP: ELHSCP Winter plan is in place for all services. This includes contact details for all staff, and operational guidance to cope with all scenarios, communication approaches, escalation policies and utilisation of voluntary group/partner assets in maintaining key services.	
4	NHS Board/HSCPs websites will be used to advise patients on any changes to service access arrangements or cancellations of clinics / outpatient services due to severe weather, reduced staffing levels etc,	☒	■	Services would use these as appropriate Primary Care and USC Flow Centre and NHS24 messaging	

			■ ■ ■	<u>Edinburgh HSCP:</u> There are communication plans in place and in the event of severe weather impacting on service delivery, access to services, the Partnership website as well as NHS Lothian and CEC would be updated accordingly. The Partnership would also utilise relevant twitter accounts to communicate any issues. This is included the Council's Severe Weather plan. <u>Midlothian HSCP:</u> Communications via social media and website. All staff communication mechanisms for the HSCP are in place. Process for any emergency/urgent comms in place and draft scheduled comms plan including holiday closures being developed. <u>West Lothian HSCP:</u> Communications directly with those affected, along with use of social media. <u>East Lothian HSCP:</u>	

			■	ELHSCP website and social media feeds are kept updated on all changes to service delivery arrangements as soon as these become known.
6	The NHS Board, HSCPs and relevant local authorities have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.	☒	■ ■	<u>Acute Services:</u> Enhanced body storage capacity by purchasing Nutwell units at the earliest phases of the pandemic. These remain available. Risk re bariatric patient storage across system <u>Midlothian HSCP:</u> Midlothian Council have developed plans for this <u>East Lothian HSCP:</u> ELHSCP used local funeral directors and capacity above the expected mortality norms is available

2	Unscheduled / Elective Care Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	**Clinically Focussed and Empowered Management**			
1.1	Clear site management and communication process are in place across NHS Boards and HSCPs with operational overview of all emergency and elective activity and visibility of other key performance indicators *To manage and monitor outcomes monthly unscheduled care meetings of the hospital quadrumvirate should invite IJB Partnership representatives and SAS colleagues (clinical and non-clinical) to work towards shared improvement metrics and priority actions. A member of the national improvement team should attend these meetings to support collaborative working.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☒	■	<u>Acute Services:</u> USC committee in place with whole system MDT representation to oversee winter planning and monitoring of outcomes. Clear communication processes are in place across all Acute AHP services. Evidenced by existing operational huddles, safety pauses teleconferences and escalation routes on all sites. Continue to focus on daily senior review, EDD/PDD with Site Triumvirate focussed on safe patient flow. Good links with e.g. Gold and Silver and good links with other Acute sites. Process in place for minimum of once / day pan acute

				teleconference to ensure across system flow and decision making. Tactical and strategic decision making taken through Bronze, silver and Gold command. GOLD is overarching whole system.
			■	<u>Primary Care and USC:</u> Ongoing Clear operational lines of escalation and communication processes are in place within EHSCP including regular Executive Management Team meetings and Senior Operational Team meetings. <u>Edinburgh HSCP:</u> Note: All of the tactical daily operational meetings (e.g., huddles, teleconferences etc. can be stepped up out of hours or more frequently when required.)
			■	<u>Midlothian HSCP:</u> Winter EMT established and meeting weekly w/c 13/09 as avenue for escalation and

				dissemination of information; performance monitoring is a key part of this Daily huddles for intermediate care services and delayed discharges All staff communication channels established Monthly IJB Brief commencing 07/10 to include winter information <u>West Lothian HSCP:</u> Daily Flow Huddle in place Monday to Friday with representation from the acute sites and other partners focused on supporting patient flow. Oncall Manager Rota in place for out of hours and weekends <u>East Lothian HSCP:</u> Daily 8am huddles are held by ELHSCP management 7 days per week. These can be increased to twice daily if required. The huddles support rapid rundowns across all acute wards in East Lothian Community Hospital

				Robust site management policies are in place in all ELHSCP premises and with partners responsible for other premises utilised by HSCP services and staff.
1.2	Effective communication protocols are in place between clinical departments and senior managers across the whole system, to ensure that potential system pressures are identified as they emerge and as soon as they occur departmental and whole system escalation procedures are invoked with key actions and timescales assigned to individuals.	☒	■	<u>Acute Services</u>: Acute Medical Director engaged to support senior decision making. Robust on call system. Confident that there are effective communication protocols in place between AHP teams/clinical departments and senior managers across the whole system. Evidenced by existing daily operational huddles, teleconferences and escalation routes on all acute sites. . Good links with e.g. Gold and Silver and good links with other Acute sites.

				Evidenced in DATCC by regular teleconference/teams meetings, escalation routes in place for all services to SMT. Good links with Gold and Silver and Site Teams <u>Primary Care and USC:</u> Need to share escalation policies <u>Edinburgh HSCP:</u>
			■	Daily tele- or video conferences will be scheduled if there are significant pressures across the system. Individual services have systems in place for daily for the communication and escalation of pressures or issues, for example via daily huddles. From these actions are identified and followed up.
				<u>Midlothian HSCP:</u>
			■	As above Involved with NHS Lothian Gold Command and local authority Gold when initiatied <u>East Lothian HSCP</u>:
			■	ELHSCP Site and Capacity Team works 7 days per week to support

				staff deployment and to escalate issues in real-time. Well-established and regular communication channels between clinical departments, community services, independent contractors and senior managers in ELHSCP ensures early discussion of any and all pressures, escalation of issues as appropriate and commencement of actions to address pressures. ELHSCP has clear communication channels in place with GP Practices including identified Service Manager contacts for practices. It uses established levels of reporting as per PCCO guidelines to establish when practices are under pressure and may have difficulty in to delivering core and enhanced services.
1.3	A Target Operating Model and Escalation policies are in place and communicated to all staff. Consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.*	☐	■	<u>Acute Services</u>: Clinical prioritisation embedded for Scheduled Care. Daily risk assessment in place taking account of unscheduled demand and available capacity

	Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care, with PDDs (planned dates of discharge) visible and worked towards, to ensure patients are discharged withouth delay.			in each site / service – workforce, beds, theatre, critical care to determine scheduled care activity. AHP teams will use appropriate prioritisation criteria to support discharge and enhance patient flow. N.B: Process would be RAG status green – reality and impact red <u>Primary Care and USC:</u> LUCS Business Continuity Plan Specific PDD Project looking at effective discharge and patient transfers is still in the early stages of planning and implementation. Test of Change within an Acute site and Intermediate Care Facility will form the process to establish an effective and standardised approach in line with the new Person Centred Care Planning model within Trak. <u>East Lothian HSCP:</u> East Lothian Rehabilitation Service (ELRS) proactively screens the admission lists on a daily basis (Mon-Fri) to highlight those with

				potential to be supported on discharge home (These are highlighted on Trak).
1.4	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. HSCPs should consider any requirement to purchase additional capacity over the winter period. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☐	■	<u>Acute Services</u>: Sustainable staffing discussed daily at operational huddles with engagement from clinical teams and partnership leads to ensure safe staffing in all areas, however this remains an ongoing concern given sickness absence and vacancy rates across acute and community services. On nursing home closures and number of delays on the site - There are a high number of delays on Acute site plus inability to support now pre winter, we need clarity that the action can be put in place from partnerships. Difficult to answer fully as we do not have access to the community surge plans.

			■	<u>Edinburgh HSCP:</u> Care Home admissions are managed centrally matched to available capacity and information about capacity in private care homes is also utilised to match service users to places dependant on price and funding available. Should exceptional pressures develop these will be escalated to EMT. Senior Mgt is in regular contact with the AAH Discharge Hub throughout the day especially over winter and has knowledge/early sight of any specific issues in community hospitals which could impact on flow and assist the team in finding solutions. There are no plans to increase the capacity in Liberton Hospital over winter. Any escalations will be via Head of Operations to the EMT/Chief Officer. The Partnership is in the process of reviewing how any excess capacity in internal care homes might be utilised to the best effect over winter, and working closely with other providers to secure additional interim care placements should the need arise

			■	Midlothian HSCP: Full HSCP strategic winter plan by 18/09 to cover capacity and workforce, substantiated by robust action plan. Going to IJB in October. West Lothian HSCP: Community hospital and Care Homes continue to have capacity, the challenge is the infection status. WL have access to Step down beds in both care homes and community hospitals. Over 100 beds are sitting empty within the system. East Lothian HSCP: ELHSCP has established efficient processes for the utilisation of step-down, community hospital and care home beds.

2	**Undertake detailed analysis and planning to effectively manage scheduled elective, unscheduled and COVID-19 activity (both short and medium-term) based on forecast emergency and elective demand and trends in infection rates, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.**			
2.1	Pre-planning and modelling has optimised demand, capacity, and activity plans across urgent, emergency and elective provision are fully integrated, including identification of winter surge beds for emergency admissions *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place.* *Weekly projections for COVID demand and the capacity required to meet this demand including an ICU surge plan with the ability to double capacity in one week and treble in two weeks and confirm plans to quadruple ICU beds as a maximum surge capacity.* *Plans in place for the delivery of safe and segregated COVID-19 care at all times.* *Plans for scheduled services include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times deteriorating. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *NHS Boards can evidence that for critical specialities scheduled queue size and shape are such that a winter or COVID-19 surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.*	☐	■	Acute Services: Limited surge capacity with areas identified for covid red pathways and mobilisation of amber patients to other areas creating strain on rest of hospital system specifically on scheduled care. Local site winter plans are traditionally based on activity trends for recent years, however, there is added pressure anticipated due to red and amber flow requirements, the lack of capacity in the community, the high prevalence of Covid in the community and hospital attendances and increase in usual winter attendances. Sites are already seeing a higher number of attendances, back to pre covid levels, with increase in acuity. There is no bed-based model to support this year with 45 beds

				currently (in September) closed across the acute base due to staffing pressures. There are variable but traditionally higher numbers of beds closed due to IPCT advice over winter period further compounding flow. Ability to staff wards and if surge capacity not already in use for ongoing COVID management, there will be an impact on urgent elective activity (P2) not just P3 and P4 Ability to deliver elective workload remains vulnerable and is likely to remain so throughout Winter. Staffing remains a challenge and we do not anticipate this improving soon. Winter bid discussions have taken place with local evaluation of proposals and approval at Emergency Access followed by final sign off at SMT. For example these included: 7 Day Discharge Facilitators; Winter boarding teams and inpatient diabetes service to

				support improvements in length of stay. Review surgical staffing model to identify potential for additional surgical presence at front door to address rising surgical presentations Continue to deploy additional medical shift at front door (twilight shift) to support reduction of risk/delays to first assessment Working alongside EHSCP Home First to enhance capacity to support discharge. Development of PT and OT targeted team to support Health delays on RIE site. Processes in place across DATCC services to deliver workload demand. Prioritisation in place in both A&T and Radiology. Staffing availability remains vulnerable. <u>Primary Care and USC:</u> Ongoing development required

				to better understand the impact of changes in delivery of care on capacity for in and out of hours triage and face to face assessments <u>Midlothian HSCP:</u> Building performance monitoring and KPIs to be regularly reported to weekly winter EMT, looking for risks/bottlenecks in delays, beds, capacity, demand, etc. relating to HSCP community performance <u>East Lothian HSCP:</u> ELHSCP has experience of quickly redeploying staff from non-essential to essential services. Red, Amber and Green Zones have operated East Lothian Community Hospital wards. These will be reintroduced if necessary.
2.2	Pre-planning created pathways which provide an alternative to admission, and optimised the use of inpatient capacity for the delivery of emergency and elective treatment, including identification of winter / COVID-19 surge beds for emergency admissions and recovery plans to minimise the impact of winter peaks in demand on the delivery of routine elective work.	☐		<u>Acute Services</u>: Each HSCP has a range of existing services which support prevention of ED attendance /

	This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring. Where electives are cancelled consideration should be given on whether the Scottish Government Access Support team should be informed in order to seek support and facilitate a solution. *Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of adverse impact on waiting times for patients waiting for elective Inpatient/Day-case procedures, especially for patients who are identified as requiring urgent treatment.* *Management plans should be in place for the backlog of patients waiting for planned care in particular diagnostic endoscopy or radiology set in the context of clinical prioritisation and planning assumptions*			acute admission and proactive management of flow from acute to reduce delayed discharges Each acute site has sign-posting and redirection processes in place at front doors, and a focus on pre-12 discharges and reducing LoS, and additionally the Flow Centre supports direction of referred patients to the right site and patient transport Flow Centre has the following alternative pathways: SDEC at WGH, Hospital at Home Edinburgh, Ambulatory Care RIE, Respiratory Hot Clinic. Vascular "Hot Clinics" delivered in OPD and supported by clinical staff across the week. Recruitment underway for expansion of four Critical Care beds as agreed nationally. Enhancing supported discharge capacity at RIE and WGH with B4 post in collaboration with

				EHSCP Home First. Evidenced by EMA model at SJH. Preventing admission into inpatient bed. Fragile model given limited space and staffing challenges (SJH Team) Continue to maximise use of SDEC as alternative to attendance at front door areas to allow WGH and RIE GP medical flow to be supported – aiming to extend SDEC service later into the day to support later GP presentations. SDEC as part of the future plan is moving to a later in the day and covering Saturday Model. This will support capacity and demand of the appointment slots and an ability to pull from the front door later in to the evening. There is a strong focus on sharing the risk at the front door. They have just had approval for a Team Lead 8a Advanced Nurse practitioner and have recruited to full nursing establishment for current model. Increase in resource is required

				to assist the new model. The plan is with finance to cost and a paper will be presented to the UCCB to support authorisation. Inpatient diabetes enhanced services have been agreed to be prioritised through Emergency Access as part of WGH winter plan. Work underway to schedule all self-presenters to Minors with an in-house triage and local communications being developed. Continue to provide CallMia service for virtual consultations and scheduled appointments to prevent need for attendance at acute sites supporting reduction in overcrowding and staff and patient safety with potential COVID-19 surges. <u>Primary Care and USC:</u> Ongoing development required <u>East Lothian HSCP</u>: ELRS provides same day OT/PT assessment to prevent admission,

				by taking referrals from GPs or for patients seen under the H@H caseload. Urgent assessments are also accepted under other caseloads such as Domiciliary Physiotherapy, Advanced Practitioner Physiotherapy pathway and Community OT.
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned capacity and demand and projected peaks in demand. These rotas should ensure continual access to senior decision makers and support services required to avoid attendance, admission and effective timely discharge. To note this year the festive period public holidays will span the weekends.**			
3.1	System wide planning should ensure appropriate cover is in place for Consultants (Medical and Surgical), multi-professional support teams, including Infection, Prevention and Control Teams (IPCT), Social Workers, home care and third sector support. This should be planned to effectively manage predicted activity across the wider system and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☐		<u>Acute Services</u>: Enhanced consultant cover rota to be finalised at SJH, with recruitment to additional frailty team and discharge team posts ongoing. Aimed at supporting increase in activity and working 6 day model. Well established festive period staffing models (normally funded via non-recurrent winter funding and supported again this year) at the RIE. (RIE Team) Well established festive period staffing models with appropriate levels of senior management on

				duty for DATCC. At the WGH updating CSM, CNM and SMOC Rota. Medical rota 1st draft has been created for winter period encompassing the OOH period. Continue to support wider system, including RIE with mutual aid for GP flow and proportion of MoE beds where capacity is available. New General Manager not starting until January which is a risk. On- call rotas being finalised moving to day about to support staff resilience over festive period <u>Edinburgh HSCP</u>: EHSCP will map annual leave arrangements for all teams to ensure there is adequate cover in place. There will be clearly defined points of contact across the system for the duration of the festive period; providing assurance there is

				adequate leadership in place for the purpose of immediate decision-making, responding to any unexpected situations that may arise as well as programmed activity. <u>Midlothian HSCP:</u> Winter operational briefing with service managers on 30/08 as reminder for holiday cover. Resilience planning templates to be completed by 13/09. All services to have holiday cover plans by 01/10. <u>East Lothian HSCP</u>: Planning across ELHSCP is actively underway to secure appropriate staff cover at all grades. Additional staff are being recruited to the Hospital to Home team. Posts within Home Care are being recruited to on 30hrs a week contracts, an increase from the usual 20hrs. A currently unused floor in Crookston Care Home is available to provide 20 beds if demand

				increases. Planning of Public Holiday cover by OT/PT is underway and will provide priority cover for inpatient and community caseloads.
3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements across Primary, Secondary and Social Care services.	☒	■	<u>Acute Services</u>: Factored into festive leave planning – All services. CSM, SMOC and CNM rota and Medical rota sin development for winter period. Orthopaedic plan supporting trauma activity requirements for out-patient activity (Ortho team/ OAS) Provision of plaster technician to Orthopaedic wards across festive period agreed each year (OAS/Ortho) <u>Primary Care and USC:</u> Reminder letter will be sent to GP practices to ask them to plan appropriately for the "return to

				work" days Edinburgh HSCP: As above Midlothian HSCP: As above Services planning/approving annual leave currently for winter period. East Lothian HSCP: Standard cover will be in place and agreed across inpatients, outpatients and community OT and PT in East Lothian adhering to minimum staffing levels. Other ELHSCP service rotas are being finalised.
3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *NHS Boards and HSC Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☐		Acute Services: NHSL retains good links with partner organisations including Police Scotland. Edinburgh HSCP: EHSCP now has a tactical resilience plan and an Incident Management Team. The resilience plan includes collaborative links with Police Scotland, for example

			■	during severe weather. <u>Midlothian HSCP:</u> Working with NHS Lothian within their Cat. 1 responder responsibilities <u>East Lothian HSCP</u>: There is close working between ELHSCP and partners.
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinicians and managers including on call to ensure alternatives to attendance are considered. *Dental and pharmacy provision should be communicated to all Health and Social Care practitioners across the winter period to support alternatives to attendance at hospital.*	☐	■	<u>Primary Care and USC:</u> Care Home cover by GPs will be arranged over festive period as in previous years Community Pharmacy opening hours over festive period will be collated and shared Details of emergency dental service cover over festive period will be collated and shared <u>Edinburgh HSCP</u> This is communicated via NHS Lothian Primary Care Contracts Office (PCCO) at Waverley Gate. PCCO communicate community

				pharmacy hours of service to relevant parties, including updating NHS Inform. ■ Midlothian HSCP: Communications plan in place to disseminate information and emergency comms process in place. ■ East Lothian HSCP: Primary Care contact details and opening hours, including HSCP managed services (CWIC, CWIC MH, CTACS) and independent contracted services included in local operational winter plan
	Develop whole-system pathways which deliver a planned approach to urgent care ensuring patients are seen in the most appropriate clinical environment, minimising the risk of hospital associated infection and crowded Emergency Departments. **Please note regular readiness assessments should be provided to the SG Unscheduled Care team including updates on progress and challenges.**			Acute Services: Flow Centre co-ordinates other alternatives to hospital, including access to SDEC, and redesign of urgent care is in place 24/7 Midlothian HSCP: ■ Representation on NHS Lothian Unscheduled Care Programme Board Local planning in place to support key pathways

				Continued development of Home First models and pathways
3.5	To ensure controlled attendance to A&E services a 24/7 Health Board Flow Navigation Centre will offer rapid access to a senior clinical decision maker and be staffed by a multi-disciplinary team, optimising digital health when possible in the clinical consultation and should have the ability to signpost to available local services, such as MIU, AEC, GP (in and out of hours), pharmacy and ED if required. Self-care / NHS inform should be promoted where appropriate. Referrals to the flow centre will come from: • NHS 24 • GPs and Primary and community care • SAS • A range of other community healthcare professionals. If a face to face consultation is required, this will be a scheduled appointment with the right person and at the right time in the right place based on clinical care needs. Technology should be available to book appointments for patients and provide viable appointments / timeslots at A&E services. The impact on health-inequalities and those with poor digital access should be taken into account, mitigated, monitored and built into local equality impact assessments.			<u>Acute Services</u>: SDEC, other alternatives to hospital and redesign of urgent care are in place 24/7 Covid-19 triage still has gaps but the Flow Centre is working on providing a more consistent service. Also, working on having a Senior Clinical Decision Maker based in the Flow Centre. Flow Centre has capacity to book patients for scheduled VC and face-to-face appointments Implementation of test of senior medical decision-maker in Flow Centre to identify improvements to referral pathways for patients with a view to reducing attendances at acute site / ensuring patients are seen at the right place first time. <u>Primary Care and USC:</u> Lothian has an established FNC operating 24/7. The FNC can

				accept and processing referrals from NHS24, GP's, HCP's and SAS The Senior clinical decision maker within FNC is a combination of Covid Triage clinicians from 8am – midnight, and ED teams at RIE and RHCYP from midnight – 8am. The exploration of an acute physician within the flow centre is being explored. Planning is currently underway to undertake further scoping of this in Sept / Oct 21. We are experiencing workforce challenges with fully staffing the covid triage/RUC SCDM rota, and there are also workforce challenges with GP OOH – as per longstanding GP sustainability issues. We are discussing how best to manage the NHS24 referrals across GP OOH, Covid and RUC flows with potentially moving to one clinical triage workforce to try to improve workforce sustainability, but early in planning process. The FNC can schedule attendance to MIU / ED / SDEC and other urgent care services. Plans are progressing to expand the opportunity for further scheduled urgent care attendance.

				A local equality integrated impact assessment has been completed and reviewed / monitored on a regular basis. <u>Midlothian HSCP:</u> As above Representation on RUC Project Board Working with acute, primary care, and flow centre colleagues to build professional to professional pathways to Midlothian's Single Point of Access <u>East Lothian HSCP</u>: ELHSCP is engaging with the Scheduling Unscheduled Care workstream to ensure regional coordination. ELHSCP is developing a single point of contact for its HSCP managed Primary Care services in response to phase 2 of the Scheduling Unscheduled Care services, to ensure East Lothian patients are directed to the most appropriate member of the MDT.

				A pathway is in place for ELHSCP's Advanced Practice Physiotherapy in the community. D2A supports discharges from A&E and MAU (having had minimum AHP input) referrals are accepted outwith core hours (e.g. weekends). A single point of access (SPOC) is in place for patient access to OT & PT including MSK, intervening to potentially prevent patients from attending A&E. The designated D2A phone line is available for GPs to directly refer for same day OT/PT assessment in the community to prevent admission.
3.6	Professional to professional advice and onward referral services should be optimised where required Development of pathways across whole system for all unscheduled care working with Scottish Ambulance Service to access pathways and avoid admission.			<u>Acute Services</u>: Scottish Ambulance Service is able to access Prof to Prof advice via the Flow Centre paramedics and able to make direct referrals for remote consultation or face-to-face through agreed clinical pathways e.g. for falls Opportunities for P2P as part of

				the acute physician in FC test of change as part of the RUC work. SAS referrals via FC to SDEC being developed: Scottish Ambulance Service is able to access Prof to Prof advice via the Flow Centre paramedics and able to make direct referrals for remote consultation or face-to-face through agreed clinical pathways e.g. for falls Opportunities for P2P as part of the acute physician in FC test of change as part of the RUC work. SAS referrals via FC to SDEC being developed <u>Primary Care and USC:</u> NHS Lothian is currently reviewing prof to prof advice and referral pathways to ensure all required advice and referral pathways are in place. We are working collaboratively with SAS to optimise use of appropriate alternative pathways to ED attendance. This includes scheduled attendance to MIU / SDEC / H@H etc.

				LUCS has a robust Prof to Prof line through the Flow Centre <u>Edinburgh HSCP</u>: Work is continuing and ongoing as part of the Redesign of Urgent Care Phase 2 workstream to redirect appropriate community pathways through the Flow Centre . There has been refinement to Urgent Care pathways via the Flow Centre to support Prevention of Admission (Home First, Hospital at Home and the Community Respiratory Team). There have been additional pathways established including that from SAS direct to Hospital and Home, ED direct to Hospital at Home, and the SAS Falls Pathway. Hospital at Home takes referrals from SAS crews to prevent transporting to hospital and therefore avoiding admission. They have also enhanced weekend referrals to the service by taking GP referrals from care homes. Additional resource has been sourced and obtained from HIS and

				RUC for additional posts in Hospital at Home, the Flow Centre Home First Team and the Community Respiratory Team which will provide increased capacity and support. Development of a frailty nurse post in the Flow Centre to redirect admissions to hospital at home and rapid assessment. <u>Midlothian HSCP:</u> As above. Single Point of Access now in place CRT/SAS pathway established to avoid admissions Funding secured to develop pathway with paramedics within Hospital at Home <u>East Lothian HSCP</u>: East Lothian communities have direct access to some Primary Care services without the need to contact their GP Practice, most notably Mental Health and MSK services.

4	**Optimise patient flow by proactively managing Discharge Process utilising PDD (Planned Date of Discharge) and associated discharge planning tools such as – Daily Dynamic Discharge, to shift the discharge curve to the left and optimise in day capacity,and ensure same rates of discharge over the weekend and public holiday as weekday.**			
4.1	Discharge planning in collaboration with HSCPs, Transport services, carer and MDT will commence prior to, or at the point of admission, using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.* *Utilise Criteria Led Discharge wherever possible.* *Supporting all discharges to be achieved within 72 hours of patient being ready.* *Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process – this should include third sector partners (e.g. British Red Cross) Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*	☐	■	Acute services: AHPs committed to MDT involvement in Discharge planning. Communication with HSCP to determine community therapy capacity to ensure optimal discharge planning. Evidenced by existing daily flow huddle with SJH and WL HSCP and associated escalation process. Evidenced by Discharge Hub processes in collaboration with Edinburgh HSCP as well as daily huddles. Escalation through snr management. RIE discharge hub in operation but ability to discharge can be

				reliant on downstream capacity which we cannot influence. However, downstream capacity currently a bottleneck, as of 7/9/21 there are >230 delays on acute sites which represents c7 wards of removed capacity. Programme of work underway re planned date of discharge across whole system. . PDSA cycle 3 for PDD at WGH is scheduled to include patients and families in the discharge planning <u>Primary Care and USC:</u> Through a PDD SLWG, currently piloting a PDD approach to support effective discharge planning within one acute and one ward within Intermediate Care. The following discussions are still in the early planning stages: - Particular focus on MDT meetings, ward round structure and timely requests for services such as diagnostics, medicines and transport.

				- In the initial stages of scoping potential alternative transport support/suppliers to alleviate transport delays including third sector/volunteering. <u>Edinburgh HSCP</u>: Onsite presence of Home First Navigators on both RIE and WGH acute sites with ED/MAU and wards working as part of the MDT to support POA. Home First Navigator working within discharge hub in WGH to manage people on acute medical wards. Discharge to Assess pathway and service fully utilised to create an alternative pathway to admission. Tests of change currently underway to begin the roll out of PDD in WGH (Wd 51) and ICF (Fillieside) with a further plan for the RIE site. PDD approach is heavily invested in the involvement of the patient and family/carer. Additional SW resource allocated for WGH and RIE sites as well as ICF to promote the Home First

			■	approach and early supported discharged maximising community assets. <u>Midlothian HSCP:</u> Daily delayed discharge calls to discuss plans Enhancement of Home First Model 7-day operation of Single Point of Access and Flow Hub Recruitment of additional HCSWs into D2A to move delays out of RIE Investment in Frailty GP project from HSCP Additional OT working with frailty GP to review A&E attendances of those with severe/moderate frailty Intensive assessment of top 10 frequent attenders to A&E over 75 Enhanced services from British

				Red Cross to support discharge Improving anticipatory care planning Plans in development for top 5 potentially preventable admissions Delays part of performance monitoring system built into weekly EMT tracking <u>West Lothian HSCP:</u> WLHSCP work to Home First and a planned discharge date aiming to avoid a delay. Patients are discussed daily at the Flow huddle – led by the Partnership. The local carers centre works with families via the integrated discharge hub to support involvement in discharge planning. <u>East Lothian HSCP</u>: ELHSCP Patient Flow and Site and Capacity support has expanded to work 7 days a week.

				Inpatients in East Lothian Community Hospital have a dedicated case coordinator to act as the link across all medical and social care professionals and the designated family contact. In ELCH, ward rapid rundowns occur daily, to ensure necessary actions are tasked to individuals and carried out as quickly as possible. Collaborative MDT discharge planning is in place for all patients in the Community Hospital. Teams already carry out effective 'in-reach' and active 'pulling' of East Lothian patients from the three acute hospitals in Lothian.
4.2	To support same rates of discharge at weekend and public holiday as weekdays regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Criteria Led Discharge should be used wherever appropriate. *Ward rounds should follow the 'golden hour' format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge. Criteria Led Discharge should be used wherever appropriate.*	☒	■	<u>Acute services</u>: Key areas that affect patient flow (Acute Front door/MOE/Ortho) have robust weekend and festive period Physio and OT cover. At SJH currently recruiting to frailty team and discharge hub team posts to support flow through system. Aimed at working 6 day model. Daily flow

				huddle with SJH and WL HSCP weekdays. Focus on pre-12 discharge profile in medicine and use of 'Golden Patient' initiative. Winter proposal to increase discharge facilitators to support weekend discharges PDD initiative/ programme of work underway to support MDT discharge planning including SW and criteria for discharge <u>Primary Care and USC:</u> Early discussions are underway to undertake a QI approach in Sept/Oct reviewing specific wards to reduce LoS and increase capacity and flow. This work will directly inform the overall PDD Project Plan. Current LoS pilot underway within one acute ward which is focussing on early discharging and 'the golden patient'. <u>Edinburgh HSCP</u>:

			■	Hub therapy weekend working will re-convene in November (Sat and Sun) and Social Work (SW) on Saturdays. There will also be public holiday SW cover over the festive period for acute sites. SWs will work closely with the D/C hubs. There is a low level of system wide discharge at weekends. The Lothian wide PDD work stream will drive improvements in performance as it rolls out. CRT operates a 7 day service as routine <u>Midlothian HSCP:</u> ■ Home First, Flow Hub, and SPOA now covering 7 days per week <u>East Lothian HSCP</u>: ■ A multi-disciplinary approach is established on all ELCH wards, facilitating 7-day discharge.

4.3	Discharge lounges should be fully utilised to optimise capacity. This is especially important prior to noon. *Processes should be in place to support morning discharge at all times (e.g.) breakfast club, medication, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.* *Extended opening hours during festive period over public Holiday and weekend*	☐	■	<u>Acute services</u>: Discharge Lounge on all 3 Acute Sites. SJH lounge open on site with ability to take patients waiting medication, provide meals etc. Opening times Mon-Fri 10-6pm. At RIE Lounge open but utilisation is sporadic and rarely to full capacity. Work ongoing to improve this facility and understand barriers to access. At WGH Discharge lounge present on site with capacity for 21 patients per day. However use is variable and could be improved. Staffing challenges mean that discharge lounge staff are sometimes redeployed which impacts ability to improve utilisation. Furthermore

				increasing risk lounge will need to close if staff required to support inpatient areas <u>Primary Care and USC:</u> Specific focus on clear communication pathways between health and social care, pre-12 discharges and increasing the use of the discharge lounge on all acute sites.
4.4	Key partners such as: pharmacy, transport and support services, including social care services, will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process over winter period. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. e.g. surge in pre-Christmas discharge *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*	☐	■	<u>Acute services</u>: Pharmacy: Winter funding money allocation being utilised to support the 3 acute adult sites for additional locum shifts for additional hours after the departments close weekdays and weekend rotas. However, the staff resource and funding required to optimally support patient discharge across the acute sites is not available. Additional pharmacy technicians, pharmacy support workers and independent prescribing pharmacists is still needed but permanent funding to attract these posts to NHS Lothian is needed in the tight

				recruitment environment that exists for this smaller specialist workforce. Working with the 4 HSCP around enhanced capacity for public holiday service <u>Midlothian HSCP:</u> As above HSCP Pharmacy recruiting to vacancies to increase capacity for winter surge Recruitment for additional D2A capacity commencing (risk in any recruitment delays) <u>East Lothian HSCP:</u> ELHSCP has increased Discharge to Assess capacity and planned prevention of admission slots – this is assisting in maintaining the HSCP's consistently good Delayed Discharge performance. ELHSCP continues to commission additional transport support for vulnerable patients to access Primary and Community Care services.

			■	<u>Edinburgh HSCP:</u> The NHS Lothian Community Pharmacy Core Group review demand and adjust Community Pharmacy opening hours accordingly. Pharmacists and Technicians are deployed across GP Practices to support pharmacotherapy services, medicines reconciliation at discharge and acute prescription requests.
5	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**			
5.1	Close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet all discharge levels. *This will be particularly important over the festive holiday periods.* *Partnerships will monitor and manage predicted demand supported by enhanced discharge planning and anticipated new demand from unscheduled admissions.* *Partnerships should develop local agreements on the direct purchase of homecare supported by ward staff.* *Assessment capacity should be available to support a discharge to assess model across 7 days.*	☐	■ ■	<u>Acute services</u>: Continue to utilise D2A capacity within community to reduce LOS programme and facilitate effective PDD. <u>Primary Care and USC:</u> Ensure adequate staffing of CRT and H@H etc <u>Edinburgh HSCP</u>: Provision of care packages in Edinburgh is an ongoing challenge, in keeping with the trends across

				much of the Health and Social Care sector. The sector as a whole continues to struggle with the impact of COVID and Brexit on the available workforce and this is evidenced by the increasing levels of unmet need in the community and hospital delays. To mitigate some of the challenges and pressures EHSCP are working in close partnership with providers of these support services, and other wider groups of stakeholders to support at a minimum stability in the market and the existing capacity that they deliver. Measures currently being implemented to support and hopefully improve the situation are: • EHSCP funded and led campaign to promote employment opportunities in Edinburgh across the Health and Social Care sector targeted to start end Sept/early Oct and run through to Jan/Feb at a minimum. A landing page on EHSCP website will provide an understanding of what working in Health and Social Care means, rewards of the career, skills, values and attributes required and linking to roles organisations advertise through

				My Job Scotland. . • Additional CCA resources in post - 1WTE each for SE/SW/NW localities to start in Oct. This will replicate the successful “unmet need officer” role piloted in NE Locality which delivered a significant reduction in unmet need and hospital delays through a single point of contact and pro-active approach to building of relationships with providers, assessors, other health professionals and people waiting for support. The aim being to come to practical solutions to enable support to be put in place rapidly where previously there were barriers indicated. Also tracking hospital admissions where care arrangements exist and ensuring that these are re-started at earliest point of fitness to discharge, or where no discharge planning is in place to free up the capacity to match to another individual to support discharge home or prevention of admission. • Mapping exercise of existing care capacity both internally and externally, and new process implemented to

				increase collaborative working between all organisations delivering support. Maximise efficiencies that can be delivered through more joined up approaches to use of existing workforce to increase the number of individuals who can be supported to remain at home through provision of appropriate support arrangements. <u>Midlothian HSCP:</u> Workforce issues relating to Covid currently impacting significantly on availability of packages of care across the system. Plans in place to review current processes and systems to free up additional capacity. Use of RAG risk assessment for all clients when required. Recruitment of additional 20 HCSWs to support care for our Home First team. Working within Scottish Government guidance. Regular status communication to local authority and NHS Lothian Gold Command in line with other partnerships.

			 	<u>West Lothian HSCP:</u> Care at Home remains a risk around the flow within the system. Weekly meeting are currently in place to ensure oversight of care at home supply as part of the whole system approach. Data is used to track demand and capacity. <u>East Lothian HSCP</u>: A winter-monies funded test of change was completed over 4 months ending in June 2021. This enhanced the existing Discharge to Assess (D2A) pathway with Rehabilitation Support Workers in one geographical cluster. A report is available on request. Volunteer Development East Lothian provide a collaborative model alongside the D2A pathway to provide additional capacity and exit strategies. ELHSCP has increased Hospital to Home provision and internally managed and provided Homecare An Integrated Care Allocation Team was established to ensure

				the Independent Sector are fully engaged with care package allocation. Winter monies have been allocated for Occupational Therapy resource for ICAAT to expand the capacity of this team to work more proactively with the acute as well as identify digital alternatives to care. This is proposed across 7 days. The Business Continuity Plans of care at home providers will be updated. Cars are available for use by Internal Homecare Provision to provide rural care packages as well as bad weather responses. Providers are aware of increase in demand if families cannot return home to support service users due to Covid-19 restrictions on household visiting.
5.2	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised over the festive and winter surge period, wherever possible. *Partnerships and Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*	☐	■	<u>Acute services</u>: Physio and OT - n/a but Amber for SLT as very difficult within current resource as above – AHPs

	All delayed discharges will be reviewed for alternative care arrangements and discharge to assess where possible		■	<u>Edinburgh HSCP:</u> Additional Assistant Practitioner posts have been agreed and are currently being implemented to increase therapy capacity to support Discharge to Assess. The additional skills mix will ensure that the therapists are made available to provide additional rehabilitation, supporting better outcomes in a shorter duration. Patients considered through a variety and increasing range of pathways and services, including Discharge to Assess, Hospital at Home, Intermediate Care, and the Community Respiratory Team to reduce the length of hospital stay and to prevent a delayed discharge.
			■	<u>Midlothian HSCP:</u> These processes are in place
			■	<u>West Lothian HSCP:</u> Baillie Step Down unit focused on intermediate care rehab and ongoing assessment.
			■	<u>East Lothian HSCP:</u> As above, a winter-monies funded test of change was completed over 4 months ending in June 2021,

				enhancing the existing Discharge to Assess (D2A) pathway with Rehabilitation Support Workers, 1 geographical cluster. A report is available on request. 7day OT input into ICAAT is currently being recruited to.
5.3	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. *Key Information Summaries (KIS) will include Anticipatory Care Planning that is utilised to manage care at all stages of the pathways.*	☐	■ ■	<u>Acute services</u>: Physio and OT - n/a but Amber for SLT as very difficult within current resource as above – AHPs <u>Primary Care and USC:</u> Ask practices to update their patients' KIS <u>Edinburgh HSCP:</u> The Long Term Conditions (LTC) Programme has worked with health & social care professionals and third sector organisations to improve ACP conversations and models for sharing/accessing information across the integrated system. COVID19 ACP bundles with educational guidance, information for citizens, and resources for sharing/accessing ACP quality criteria across the integrated

				system have been developed for health and social care professionals, GP practice teams, care homes and third sector partners. The care home ACP model has been shared nationally and recently updated with learning and improvements gained during the pandemic, available on the NHS Lothian care home website: 7 steps to ACP: Creating Covid-19 relevant ACPs in Care Homes - Implementation Guide and Resources All other ACP bundles are available on the NHS Lothian intranet and will be soon be available on the HIS Midlothian HSCP: Process in place for SAS/acute services to view this information if developed by the practices East Lothian HSCP: An Advanced Physiotherapy Practitioner for long term conditions is embedded into ELRS core services, targeting frequent attenders to the acute setting. Current test of change in 1 of the 3 geographical clusters by ELRS, using the skills of an Advanced Practice OT to focus on frailty and

				frequent attenders.
5.4	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *KIS and ACPs should be utilised at all stages of the patient journey from GP / NHS 24, SAS, ED contact. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge process to inform home circumstances, alternative health care practitioners and assess if fit for discharge.*	☐	■	<u>Primary Care and USC:</u> Ask practices to update their patients' KIS <u>Edinburgh HSCP</u>: There are 259,301 active Key Information Summaries (KIS) in place for people in Edinburgh, a 287% increase since March 2020. Guidance has been shared with GP practices on how to review and update the volume of KISs in place, including when to obtain consent to prevent KISs for high risk individuals created under the COVID19 protocol being deleted. The Long Term Conditions Programme is facilitating the scale and spread of ACP across community, primary, acute, and 3rd sector services. Providing improvement and implementation support to utilise the ACP bundles (see 5.3), working with teams to test and embed ACP across the patient journey (eg Medicine of the Elderly, Old Age Psychiatry, Emergency Medicine, Clinical Genetics Service, Community Nursing, Lanfine Service (neurological conditions), District Nursing, Home Care, Carer

				Support Services, Adults with Complex and Exceptional Needs Service, Care Homes, and Home First teams, Dementia Link Workers, Admiral Nurses, and Improving the Cancer Journey Link Workers). The Edinburgh ACP Stakeholder Group meets quarterly to drive ACP improvements in practice and during the pandemic has focused on improving information sharing at the interface between acute and primary care. During winter 2021-22 an ACP model will be tested with: falls practitioners to improve information shared through ACP on falls prevention and management; and with social workers to improve the quality of social care information shared for people with severe frailty, including Power of Attorney arrangements. Both tests of change aim to decrease avoidable admissions and delayed discharges from hospital through ACP. 800 KIS magnets and wallet cards have been given to people who are at risk of hospital admission to display in their home, prompting SAS, OOH, ED to check KISs for quality criteria that will improve shared decision-making on

				providing quality care at home or as close to home as possible. <u>Midlothian HSCP:</u> ACPs in place for care homes. Specific focus on frail patients who have them as part of innovation models currently in place. <u>East Lothian HSCP</u>: Daily MDT rapid rundowns are in place at East Lothian Community Hospital. At the outset of the pandemic GP practices reviewed ACPs for vulnerable groups (e.g. shielding, care home residents)
5.5	COVID-19 Regional Hubs fully operational by end November. Additional lab capacity in place through partner nodes and commercial partners by November. Turnaround times for processing tests results within 24/48 hours.			<u>Acute services</u>: Partner nodes stood down Maintaining staff group is integral to maintaining turnaround times. Risk of temporary staff leaving for permanent posts. New testing pathway for all winter respiratory viruses to be introduced for patients exhibiting recognised symptoms;

				• New central laboratory testing pathways from ~Oct 21 for winter respiratory viruses incl. – SARS-CoV, – Influenza A & B, – RSV • POCT – – Cepheid machine SAR-CoV2 cartridges will be replaced with **multiplex** respiratory virus cartridges once surveillance data indicates these are in circulation; – All other testing capability (SARS-CoV2 only) will remain unchanged; – New staffing model for Laboratories POCT incl. Site Coordinator roles to support machine installation & maintenance, consumables management and training of clinical

				staff.
6.0	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
6.1	Effective communication protocols are in place between key partners, particularly across emergency and elective provision, local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector and into the Scottish Government. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.* *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐	■ ■ ■	<u>Primary Care and USC:</u> Each service has escalation policies which impact on other services. Sharing of escalation plans between LUCS, Flow Centre, EDs and SAS <u>Edinburgh HSCP:</u> Managed at a corporate level across the whole system through Gold Command and at a partnership level though the winter command centre group. <u>Midlothian HSCP:</u> Work with communications teams in NHS Lothian and Midlothian Council around key messaging <u>East Lothian HSCP</u>: A Primary Care Mental Health Pathway (and accompanying protocol) was updated to improve referrals from GP Practices into secondary care. There is ongoing work to develop care navigation

				routes.
6.2	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around direction to the appropriate service are effectively communicated to the public.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.* *Promote use of NHS Inform, NHS self-help app and local KWTTT campaigns*	☐	■	Edinburgh HSCP: EHSCP will amplify the Scottish Government campaign promoting flu vaccination and promote Public Health Scotland's range of promotional materials aimed at the different audiences. As well as that, EHSCP will promote preventative or operational messages around seven key topics; winter resilience messages and arrangements, winter vaccination programme, falls prevention, hospital avoidance/signposting, anticipatory care planning, keeping safe and healthy over winter, and support and advice for carers. We will target communications to some of our most vulnerable residents, who are among the largest users of health and social care resources. This includes vulnerable older people, people who receive a care at home service, those who receive technology-enabled care and equipment from us, people with long-term health conditions or who are at higher risk of falls.

				The most effective route to such a wide audience is through the health and social care workers, their unpaid carers and organisations that support them to live their daily lives. For that reason, we plan to communicate with our primary audiences through general practice, social work, occupational and physical therapists, pharmacies, care at home agencies, care home staff and ATEC24. We will also support GPs in their messaging on websites and social media. In addition we will link with the Carer Support Team to ensure that carer organisations are kept informed to allow them to support unpaid carers who often struggle at this time of year. We will keep the EHSCP workforce informed through regular internal communications and briefings to staff on winter arrangements, including the winter vaccination programme. And we will work closely with the City of Edinburgh Council communications team on resilience messaging around severe weather etc to ensure we more effectively reach people in Edinburgh with time critical messages.

			■	Midlothian HSCP: Working with NHS Lothian and Midlothian Council communications team that uses all available media to communicate with staff and public HSCP Public website will be launched 09/09/21 Winter communication plan in place to disseminate information East Lothian HSCP: ELHSCP maintains an up to date website, has an active social media presence and publishes a regular Chief Officer blog. These approaches bring key messages and information to the attention of public, patients, staff and partners. Rehabilitation services communicate with the public via the East Lothian Community Hospital Rehab twitter page and the ongoing development of the HILDA (Health Independent Living Daily Activities) system.

3	Out of Hours Preparedness *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	The OOH plan covers the full winter period and pays particular attention to the festive period and public holidays. *This should include an agreed escalation process.* *Have you considered local processes with NHS 24 on providing pre-prioritised calls during OOH periods?*	☐	■	Acute services: Process in place with Flow Centre being a 24/7 model Key areas that affect patient flow (Acute Front door/MOE/Ortho) have robust weekend and festive period PT and OT cover Robust OOH respiratory cover Mon- Fri and weekend Primary Care and USC: Systems Processes fully in place & tested where appropriate. Routine monitoring Midlothian HSCP: Midlothian HSCP will ensure key services are working over the festive period and will work with LUCS for OOH pathways.
2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☐	■	Primary Care and USC: Systems Processes fully in place & tested where appropriate. Routine monitoring

3	There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☐	■ ■ ■	<u>Primary Care and USC:</u> Systems Processes fully in place & tested where appropriate. Routine monitoring <u>Edinburgh HSCP:</u> Additional capacity has been put in place provide seven-day working in areas of key demand Operational managers will ensure that there is sufficient capacity to provide front-line services over the festive period. <u>East Lothian HSCP:</u> NHS OT and PT staff have volunteered to work to support inpatients at East Lothian Community Hospital and community patients on Public Holidays over the festive period. The ELC Community Occupational Therapy service will also provide cover over festive bank holidays if demand is required, which will keep people at home for longer
4	There is reference to direct referrals between services.	☐	■	<u>Primary Care and USC:</u> Redirection in place between

	For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?			ED and LUCS
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☐	■ ■	<u>Primary Care and USC:</u> Systems Processes fully in place & tested where appropriate. Routine monitoring <u>Edinburgh HSCP:</u> Processes are in place to ensure availability of robust management information and this will be monitored by senior management on an on-going basis.
6	There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa	☐	■ ■	<u>Primary Care and USC:</u> Systems Processes fully in place & tested where appropriate. Routine <u>Edinburgh HSCP:</u> Pharmacists have established professional to professional lines in place and LUCS has access to the Community Pharmacy Palliative Care Network of pharmacies providing an emergency call out service. NHS24 algorithms updated to include details of the community pharmacy first service, treating UTI and impetigo infections.

7	In conjunction with HSCPs, ensure that clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☐	■ ■	<u>Primary Care and USC:</u> Systems Processes fully in place & tested where appropriate. Routine <u>Edinburgh HSCP:</u> Emergency mental health assessment is provided 24/7 via the Mental Health Assessment Centre at REH. Referral is via GP or phone call; and includes self-referral. Due to COVID19 MHAS is not at present offering a 24-hour walk in service but individuals needing a face-to-face assessment will be offered a specific time slot to be seen as soon as possible. Intensive Homecare Treatment Team can provide intensive crisis service into people's homes following an MHAS referral. The crisis centre is a third sector commissioned service that is operational 52 weeks of the year and provides people with advice and support, it also has the capacity for people to stay over in the building. This service is accessed by people in distress, services can refer but it

			■ ■	is a not clinical area and people need to be self-determined <u>West Lothian HSCP:</u> ACAST in place to support urgent mental health assessment. <u>East Lothian HSCP</u>: ELHSCP offers a direct access Primary Care Mental Health service. This can refer directly onto Secondary Care if required and works closely with the Intensive Home Treatment Team if an acute mental health assessment is required.
8	Ensure there is reference to provision of dental services, that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☐	■	<u>Primary Care and USC:</u> Increased provision for emergency dental services needed
9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☐	■	<u>Primary Care and USC:</u> Confident that shifts will be filled closer to the time with enhanced festive rates available for GPs However less confident of nursing rotas due to high level of resignations of nurse practitioners in last few weeks – emergency recruitments

				underway Edinburgh HSCP: EHSCP will map annual leave arrangements for all teams to ensure there is adequate cover in place. Operational managers will ensure that there is sufficient capacity to provide front-line services over the festive period. East Lothian HSCP: East Lothian HSCP is confident that rotas will be filled as planned and agreed with staff.
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☐		Primary Care and USC: Increased comms required and reminders
11	There is evidence of joint working between the HSCP, the Board and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☐		Primary Care and USC: LUCS need sight of escalation plans from SAS Edinburgh HSCP: The Home First navigator posts are well established within the RIE and WGH (4) alongside the In-Reach Nurses (4) in a Home First Team providing a link between acute and community services.

				Additional SW resource has been allocated for WGH and RIE sites as well as ICF to promote the Home First approach and early supported discharged maximising community assets. Additional capacity has also been obtained to support the Flow Centre Home First Navigator not only support POA, also to support the flow out of hospital, a reduced length of hospital stay and prevention of delayed discharge by utilising community assets. The Hospital at Home team has been successful in obtaining funding for resource to increase its capacity for an ANP and APP/AHP. There have been additional pathways established for Hospital at Home and other EHSCP services including that from SAS direct to Hospital and Home, ED direct to Hospital at Home, and the SAS Falls Pathway. These pathways and services are bedding in and demonstrating increasing success and it is

				anticipated that they will help avoid admissions for the aging patient with underlying frailty, and co-morbidity, in addition to those with a risk of infection, deconditioning and loss of independence.
12	There is evidence of joint working between the Board and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☐		
13	There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		<u>Primary Care and USC:</u> As above
14	There is evidence of joint planning across all aspects of the partnership and the Board in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		<u>Primary Care and USC:</u> Sharing of BCP and discussions with LUCS/Flow centre/ED/NHS24 <u>Edinburgh HSCP</u>: The Winter Planning Group includes multi-agency and pan-system representation, including membership from acute sites, Social Care Direct, and includes leads for flu, carers, third sector, resilience, and communications. The group leads on the planning, monitoring and evaluation of the winter plans. Members of the

				group have all contributed to preparing the plan and this checklist.
15	There is evidence that Business Continuity Plans are in place across the partnership and Board with clear links to the pandemic flu and other emergency plans, including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☐	■	<u>Edinburgh HSCP</u>: All Partnership services have resilience plans/business impact assessments in place, and are in the process of reviewing and updated through September / and October. All resilience plans are held by the Resilience Lead in a confidential shared space and can be accessed in an emergency situation.

4	**Prepare for & Implement Norovirus Outbreak Control Measures** *(Assessment of overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	NHS Boards must ensure that staff have access to and are adhering to the national guidelines on Preparing for and Managing Norovirus in Care Settings *This includes Norovirus guidance and resources for specific healthcare and non-healthcare settings.*	☐	■ ■ ■ ■	IPC: Well established systems & processes in place for Norovirus management. Information reinforced to staff via safety huddles/intranet and speed read Edinburgh HSCP: All EHSCP staff have access to appropriate guidance depending on care setting and report cases via local reporting system's e.g. Huddles, care inspectorate reporting. Bed based areas - Escalation to local infection control teams Care Homes – Escalation to Public health Midlothian HSCP: In place East Lothian HSCP: The guidelines were shared with ELHSCP staff who are aware of and compliant with their requirements.
2	IPCTs and HPTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their IPCTs and Health Protection Teams (HPTs) are supported to undertake the advance planning to ensure that Norovirus outbreaks in hospitals and care homes are identified and acted upon swiftly. Boards should ensure that there are sufficient resources to provide advice and guidance to ensure that norovirus patients are well looked after in these*	☐	■	IPC: No comment / but marked the qn. RAG Green

	settings.			
3	PHS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff	☐	■ ■ ■ ■	IPC: No comment / but marked the qn. RAG Green Edinburgh HSCP: All EHSCP staff have access to appropriate guidance. In hospital settings staff are required to access most up to date information on line with the exception of daily outbreak records which are kept through the course of the outbreak. In other settings paper copies may be held for ease of access. Local outbreaks are discussed and recorded at daily safety huddles. Midlothian HSCP: In place East Lothian HSCP: The Control Measures are available to all ELHSCP staff, who are all aware of their duties and responsibilities arising from these.
4	How are NHS Board communications regarding bed pressures, ward closures, kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☐	■	IPC: Twice daily summary of hospital closures distributed by IPCT. Updates provided out of hours by on call virology staff. In collaboration with Communications teams, key messages are shared via social media, internal and external comms

			■ ■	Edinburgh HSCP: Local sit rep reports are in place detailing capacity and any pressures. Staff also have access to NHS Lothian infection control sit rep which is circulated at least twice a day or more frequently if necessary. This advises on ward closures. Midlothian HSCP: Communication in real time via flow hubs regarding bed capacity.
5	Debriefs will be provided following significant outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital will also merit an evaluation.*	☐	■ ■ ■	IPC: No comment / but marked the qn. RAG Green Edinburgh HSCP: Outbreak management systems are in place for all settings • Problem assessment groups (PAG) • Incident management teams (IMT) These are led by IPCT and include local clinical management teams. Midlothian HSCP: Business as usual within clinical areas
6	IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation via the PHS Norovirus Activity Tracker.	☐	■ ■	IPC: No comment / but marked the qn. RAG Green Edinburgh HSCP: This information is available and shared as appropriate

7	Are there systems in place that would ensure appropriate patient placement, patient admission and environmental decontamination post discharge in ED and assessment areas	☐	■ ■	IPC: Note that planned pathways are influenced by wider activity and occupancy across ED, hospital and wider system. Risk based approach adopted Primary Care and USC: LUCS will use current infection control measures in place for COVID when dealing with Norovirus
8	NHS Boards must ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards should consider their local IPC arrangements.*	☐	■	IPC: Staffing constraints within IPCT, virology highlighted within Board. 7 day working suspended due to skill mix/activity. A winter plan/festive cover plan will be in place by end Oct.
9	The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple bays / wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☐	■ ■	IPC: A risk based approach is adopted. The impact of all seasonal infection pressures and COVID 19 are considered as part of dynamic risk assessment Edinburgh HSCP: Surge capacity planning is incorporated in the EHSCP resilience plans
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation.	☐	■	IPC: IPCT provide site-based support & input to Adult Care homes. There are established meetings/briefings on a daily/weekly basis between IPCT/HPT

11	Are there systems in place to deploy norovirus publicity materials information internally and locally as appropriate,	☐	■ ■ ■	IPC: No comment / but marked the qn. RAG Green Edinburgh HSCP: Materials are available on NHS internet and CEC Orb for staff to access. Any communications are cascaded through operational and professional lines to front line staff Midlothian HSCP: In place
12	Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of COVID-19.		■ ■	IPC: No comment / but marked the qn. RAG Green Midlothian HSCP: Will communicate any NHS Lothian communications from the Directorate through all available channels to our community

5	COVID -19, RSV, Seasonal Flu, Staff Protection & Outbreak Resourcing *(Assessment of overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	Staff, particularly those working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients and other staff, as recommended in the CMOs seasonal flu vaccination letter published on Adult flu immunisation programme 2021/22 (scot.nhs.uk) and Scottish childhood and school flu immunisation programme 2021/22 . Further CMO letters will be issued before the flu season begins to provide further details on aspects of the programme, including the marketing campaign and details of education resources for staff administering vaccinations.	☒	 	Staff communication plan has been developed for flu vaccine campaign. This will be reviewed and updated following JCVI announcement (expected w/c 13 September) relating to Covid booster vaccination given potential requirement to co-administer both flu and Covid booster vaccine. Acute services: Green – AHPs <u>Edinburgh HSCP</u>: EHSCP is working closely with colleagues from NHS Lothian and nationally to implement the winter vaccination programme, starting in September and aiming to have all eligible people vaccinated by 6 December 2021. This will include existing eligible groups, NHS Lothian staff and social care staff delivering direct personal care, and additional groups added this year such as independent contractors, teachers and prison officers. The winter vaccination programme will be offered acute sites, through peer vaccination and by self-registering to attend one of 11 vaccination sites/2 drive-through sites being made available across Edinburgh. <u>Midlothian HSCP:</u> Planning assumptions in place but awaiting final

				guidance form Scottish Government to finalise plans for flu and Covid-19 vaccination programmes for staff and patient cohorts. <u>East Lothian HSCP</u>: Work is progressing well on providing the flu vaccine to ELHSCP clinical and support staff, with some areas (for example Rehabilitation Services) having already completed.
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; that staff fully understand the role flu vaccination plays in preventing transmission of the flu virus and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.* *Vaccine uptake will be monitored weekly by performance & delivery division*	☒		There are clinics planned at the following hospital locations and times: • Western General Hospital 08:30- 16:00 • Royal Infirmary Edinburgh 07:00- 21:00 • Royal Edinburgh Hospital 07:00- 16:00 • Royal Hospital for Children and Young People- TBC • St John's Hospital Livingston 07:00 18:45 • The Lauriston Building 08:30- 16:15 • A drop in schedule is being formulated and the call for peer vaccinators will be going out w/c 13th September. • Staff have the ability to choose an appointment that suits them once they register on the national online portal therefore this should mitigate against staff not being able to attend appointments. They will also have the ability to call the Lothian enquiries line to reschedule

				their appointment if they cannot attend. • The processes for dealing with staff once they get to the vaccinations centres (booking in, vaccinating, recording on TURAS) are tried and tested amongst the majority of sites and for those who need TURAS/SNow support we are providing training or posting a Team lead at the site for support. Acute services: Green – AHPs <u>Edinburgh HSCP:</u> Online booking for self-registration will go live on 13 September with vaccinations offered on acute sites, through peer vaccination and by self-registering to attend one of 11 vaccination sites/2 drive-through sites being made available across Edinburgh. The aim is to ensure the programme is as accessible as possible and provide flexibility around work commitments. The Community Vaccination Team will lead on the school programme covering both staff and pupils in primary and secondary schools. Full guidance is still awaited from the JCVI and centrally, including whether there will be a need for COVID booster doses, so there may still be alterations to these plans as that position becomes clearer. <u>Midlothian HSCP:</u> Planning assumptions to tun two mass vaccination

				sites operating 6 days a week with extended hours for staff to attend, but awaiting final Scottish Government guidance Care home staff will be vaccinated in care homes <u>East Lothian HSCP:</u> Access arrangement for all East Lothian HSCP staff are good, with numerous clinics in all work settings at times to suit shift and office workers, those who need vaccination at short notice and those working from home. Regular communication has supported staff awareness and high uptake of the vaccination programme.

3	The winter plan takes into account the predicted surge of seasonal flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period. *If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. SG procures additional stocks of flu vaccine which is added to the stocks that Health Boards receive throughout the season, which they can draw down, if required. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals co-ordinated and issued by the Vaccinations Strategy Division.)*	☐	  	<u>Primary Care and USC:</u> Stock issue of antiviral medication at LUCS, understanding that LUCS are not swabbing CH residents, or providing outbreak control and medication requests to entire CH <u>Edinburgh HSCP:</u> EHSCP has sufficient capacity to meet the demands of the winter vaccination programme and is ensuring that appropriate training is in place to facilitate it. <u>Midlothian HSCP:</u> Midlothian HSCP Winter Plan to be finalised and agreed by Senior Management Team 15/09
4	PHS weekly updates, showing the current epidemiological picture on COVID-19, RSV and influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Public Health Scotland and the Vaccinations Strategy Division within the Scottish Government monitor influenza rates during the season and take action where necessary, The Outbreak Management and Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. PHS produce a weekly influenza bulletin and a distillate of this is included in the PHS Winter Pressures Bulletin.*	☐	 	<u>Edinburgh HSCP:</u> Regular updates from NHS Lothian Public Health and Infection Prevention and Control Teams regarding outbreaks and availability of flu vaccines. <u>Midlothian HSCP:</u> Weekly Winter EMT will monitor PHS updates Midlothian Public Health Team involvement

5	Adequate resources are in place to manage potential outbreaks of COVID-19, RSV and seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☐	■ ■	<u>Edinburgh HSCP:</u> Partnership resilience plans are now in place (subject to review / updating) and detail the required resourcing / response to dealing with concurrent events which may include prioritisation to essential services only. <u>Midlothian HSCP:</u> Outbreaks managed under Public Health processes
6	Ensure that sufficient numbers of staff from high risk areas where aerosol generating procedures are likely to be undertaken such as Emergency Department, Assessment Units, ID units, Intensive Care Units and respiratory wards (as a minimum) are fully aware of all IPC policies and guidance, FFP3 fit-tested and trained in the use of PPE for the safe management of suspected COVID-19, RSV and flu cases and that this training is up-to-date. ***Colleagues are reminded of the legal responsibility to control substances hazardous to health in the workplace, and to prevent and adequately control employees' exposure to those substances under all the Regulations listed in the HSE's 'Respiratory protective equipment at work' of HSG53 (Fourth edition, published 2013). https://www.hse.gov.uk/pUbns/priced/hsg53.pdf***	☐	■ ■	<u>Acute Services</u>: DATCC – GREEN evidenced by Adult Critical Care face fit testing and training processes established. Note consistent supply chain is a key enabler <u>Edinburgh HSCP:</u> All staff have access to PPE and training. This is monitored via safety huddles, Care Inspectorate, care home support teams, PQIs, IPCTs and informally by team leads, senior charge nurses, care home managers. <u>Midlothian HSCP:</u> HPS guidance in place at all times Local PPE Hub established with processes in place Staff communications of guidance continue to be in place

7	Staff in specialist cancer & treatment wards, long stay care of the elderly and mental health (long stay) will also will be required to continue to undertake asymptomatic weekly testing for COVID-19 throughout this period. We are actively reviewing the current asymptomatic Healthcare Worker testing Operational Definitions to ensure they are still fit for purpose.	☒	■ ■ ■	Weekly PCR testing remains in place for staff in the high risk areas identified. Testing uptake in these areas remains regularly over 94% of eligible staff. Weekly LFT testing is also available to this group. <u>Edinburgh HSCP:</u> Weekly PCRs continue to be undertaken in HBCCC - frail elderly and old age psychiatry areas. This is supplemented by LFT testing <u>Midlothian HSCP:</u> Staff testing in place at Midlothian Community Hospital and monitored
8	Ensure continued support for care home staff asymptomatic LFD and PCR testing and wider social services staff testing. This also involves the transition of routine weekly care home staff testing from NHS Lighthouse Lab to NHS Labs. Support will be required for transfer to NHS by end of November, including maintaining current turnaround time targets for providing staff results. *Enhanced care home staff testing introduced from 23 December 2020 . This involves twice weekly LFD in addition to weekly PCR testing review of enhanced staff testing underway. PCR testing - transition to NHS lab complete. Good level of staff participation in PCR testing.* *Testing has been rolled out to a wide range of other social care services including care at home, sheltered housing services.*	☐	■ ■	<u>Edinburgh HSCP:</u> Weekly PCR testing of care home staff has now transferred from NHS Lighthouse to the NHS Lothian Lauriston Hub. <u>Midlothian HSCP:</u> Staff testing in line with national guidance with support for asymptomatic care home testing
9	NHS Health Boards have outlined performance trajectory for each of the eligible cohort for seasonal flu vaccine (2020/2021) which will allow for monitoring of take up against targets and performance reporting on a weekly basis. The eligible cohorts are as follows: • Adults aged over 65	☒		Trajectory planning is covered by the national FVCV programme planning systems. Disregarded in this template return, in line with updated advice from Scottish Government in Sept.

	• Those under 65 at risk • Healthcare workers • Unpaid and young carers • Pregnant women (no additional risk factors) • Pregnant women (additional risk factors) • Children aged 2-5 • Primary School aged children • Frontline social care workers • 55-64 year olds in Scotland who are not already eligible for flu vaccine and not a member of shielding household • Eligible shielding households The vaccinations are expected to start this week (week commencing 28th September), and we will be working with Boards to monitor vaccine uptake. This will include regular reporting that will commence from day 1 of the programme utilising automated data collection methods for performance monitoring. Public Health Scotland will report weekly.			
10	**Low risk** – Any care facility where: a) triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the test date OR b) Individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR c) patients or individuals are regularly tested (remain negative) **Medium risk** Any care facility where: a) triaged/clinically assessed individuals are asymptomatic and are waiting a SARSCoV-2 (COVID-19) test result with no known recent COVID-19 contact OR b) testing is not required	☐	■	Edinburgh HSCP: EHSCP follows NHS Lothian guidance on classification of wards with all areas classed as Amber (medium) risk. We follow COVID pathways for those in, admitted to or transferred into our service using both local and national infection control standards and risk assessments. http://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-infection-prevention-and-control-addendum-for-acute-settings/#a2732

	or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals decline testing **High risk** Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing So all emergency admissions where COVID-19 status is unknown/awaited will fall into the medium risk pathways until testing can be undertaken to allow them to transition into green.			
11	All NHS Scotland Health Boards have provided assurance that all emergency and all elective patients are offered testing prior to admission. *Testing after admission should continue to be provided where clinically appropriate for example where the person becomes symptomatic or is part of a COVID-19 cluster.*	☐		
12	Staff should be offered testing when asymptomatic as part of a COVID-19 incident or outbreak investigation at ward level when unexpected cases are identified. This will be carried out in line with existing staff screening policy for healthcare associated infection: https://www.sehd.scot.nhs.uk/dl/DL(2020)01.pdf *In mid-February 2021, the scope of the LFD testing pathway was expanded further to include patient facing primary care staff (general practice, pharmacy, dentistry, optometry), hospice staff, and NHS24 and SAS call handlers. Some hospice staff had been included in the original scope where staff worked between hospitals and hospices, so this addition brought all patient facing hospice staff into the testing programme.* *On the 17 March Scottish Government announced that the scope of the HCW testing pathway would be further expanded to include all NHS workers. The*	☒	■	In outbreak situations mandatory PCR testing is in place. Since December 2020 twice weekly lateral flow testing has been available to asymptomatic staff. All eligible groups have been targeted as part of the roll out and since April 2021 this has been available to all NHS Lothian staff and volunteers with the exception of those who are full-time home workers. The number of kits ordered suggests good participation levels. NHS Lothian is making preparations for the

	roll out is currently underway and we expect that all Boards across Scotland will have fully implemented the roll-out of twice weekly lateral flow testing to eligible staff by the end of June 2021. This will include staff who may have been shielding or working from home and is in line with national guidance. Current guidance on healthcare worker testing is available here, including full operational definitions: https://www.gov.scot/publications/coronavirus-COVID-19-healthcare-worker-testing/		■ ■ ■	change from current Innova kits of 25 to the replacement Orient Gene kits of 7. <u>Edinburgh HSCP:</u> These decisions are made at IMTs in conjunction with IPCT and partnership (union) representatives <u>Midlothian HSCP:</u> In Place <u>East Lothian HSCP:</u> Arrangements are in place for staff testing where indicated.

6	**Respiratory Pathway** *(Assessment of overall winter preparations and further actions required)*		RAG	**Further Action/Comments**
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☐		Acute services: Green – AHPs Primary Care and USC: Respiratory pathway needs clarifying nationally Edinburgh HSCP: ■ Multi-disciplinary Community Respiratory Hub is well established in Edinburgh. Annually, GPs, Out of Hours, SAS receive winter reminder of service available to prompt clinicians to access this highly effective community service. Fortnightly MDT meeting held at RIE to discuss COPD patients at risk and strengthen links between RIE and community services. Between April 2020 and March 2021 414 people who were at immediate high risk of hospital admission were assessed by the Community Respiratory Team within the hub. 84% of these people were able to be safely kept at home. ■ Midlothian HSCP: Community Respiratory Team remain operational within Midlothian East Lothian HSCP:

			■	An Advanced Physiotherapy Practitioner (APP) Community Respiratory Pathway is in place and followed across East Lothian, interfacing with the acute medical teams and primary care colleagues.
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐	■	<u>NHSL Respiratory MCN:</u> There is community respiratory team model (or similar) for all parts of Lothian and COPD patients (along with some other chronic respiratory condition patients) would be looked after at home when suitable including earlier facilitated discharges from the hospital <u>Acute services:</u> Green – AHPs <u>Edinburgh HSCP:</u> ■ Multi-disciplinary Community Respiratory Hub operates 7 day week, 8am-6pm weekdays and 0830am-4pm weekends with acute response to COPD exacerbations. 90min response pathway in place for COPD exacerbations referred from Scottish Ambulance Service and Flow Centre. Prof to Prof support line set up with Respiratory Consultant for Community Respiratory Hub to escalate decision making if necessary and/or fast track to hot clinic during winter period. The Community Respiratory Hub will increase staffing capacity to support a larger group of patients to include all those with acute respiratory

				illness over the winter period, including at the weekend. This may include supporting appropriate hospital discharge of COVID-19 patients, with an existing respiratory condition. Enhanced staffing is also planned for over the festive weekend periods to support respiratory care in the community. <u>Midlothian HSCP:</u> Additional investment in Community Respiratory Team which may support 7-day working, dependent on recruitment
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*			<u>NHSL Respiratory MCN:</u> Treatment escalation plans are discussed with suitable patients when in the hospital in respiratory Unit of RIE ...GPs are encouraged to complete ACPs in the community. Suitable high risk COPD patients are given self management plans to implement for escalations through CRTs <u>Acute services:</u> Green – AHPs <u>Primary Care and USC:</u> LUCS have a home oxygen policy in collaboration with H@H, and palliative care policy for rapid COVID dying <u>Edinburgh HSCP:</u> Individuals at high risk of admission identified via

			■ ■	COPD frequent attender database. High risk patients reviewed at consultant led multi-disciplinary team meeting using care bundle checklist. ACP/KIS generated for high risk patients shared across the health system via TRAK alert and ACP created using KIS. Special notes of KIS created to alert all staff across the health system to contact Community Respiratory Team for COPD exacerbation. Patients issued with self management ACP and 'Think COPD Think CRT' fridge magnet to prompt them to **'MyCOPD'** is an app to support people living with Chronic Obstructive Pulmonary Disease (COPD) to remotely self-manage their condition. <u>Midlothian HSCP:</u> In place <u>East Lothian HSCP:</u> These plans are in place and available to East Lothian HSCP staff.
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*	☐	■	<u>Edinburgh HSCP:</u> Key messages are sent to all patients with COPD known to CRT including fridge magnet of CRT contact details as first point of contact should the patient feel unwell with their COPD. Simple advice given by all HCPs to keep warm and hydrated over the winter period

			■	Midlothian HSCP: Fact-sheet for patients specific to winter time Working with NHS Lothian and Council communications team around key messaging
2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*	☐	■ ■ ■	NHSL Respiratory MCN: Most high risk COPD patents have Trak alerts and these patients if needed are discussed through the virtual MDT IN RIE (for East Lothian, Edinburgh City and Midlothian) to reinforce plans including smoking cessation, self management plans, checking compliance and inhaler techniques. Some of this is facilitated through the CRTs as well. Patients on oxygen are reviewed by the respiratory nurses periodically through the LTOT clinic as well. Acute services: Green – AHPs Edinburgh HSCP: Community respiratory Hub will support the discharge plan by ensuring a holistic assessment and management plan is put in place, This may include medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation.

				Midlothian HSCP: In place East Lothian HSCP: A community respiratory pathway is established. Additional recruitment is underway for Advanced Physiotherapy Practitioners (APPs).
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☐		NHSL Respiratory MCN: We have a dedicated a pharmacist in the Respiratory Unit in RIE and a couple of community pharmacists in CRT who act in sync to facilitate this. Edinburgh HSCP: Dedicated pharmacist within community respiratory hub. Medication review will be carried out at initial assessment by the Community Respiratory Hub. Access to specialist pharmacy review available if required Midlothian HSCP Pathway in place from hospital to home. Expanded Community Respiratory Team in place (MCRT+) for discharge planning for any respiratory patient. East Lothian HSCP: A request for assistance pathway and single point of contact is included in the Community Respiratory Pathway. Non-medical prescribing qualifications are completed for 2 of the 3 APPs.

				Increased emphasis across ELRS, led by the Early Intervention and Prevention Team, on use of technology to prompt patients when self-medicating to reduce the need for care.
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data,* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☐	■ ■ ■	NHSL Respiratory MCN: End stage patients with COPD are often discussed through MDTs and looked after sometime by the CRTs or the IMPACT nurses, often in conjunction with Marie Curie and similar services in the community. In RIE we have the palliative team that work simultaneously with us to do a ward round twice a week to facilitate this in end stage in patients. Primary Care and USC: LUCS have a home oxygen policy in collaboration with H@H, and palliative care policy for rapid COVID dying LUCS may need to adapt palliative care policy for rapid COVID dying to include other respiratory issues Edinburgh HSCP: Individuals with COPD at high risk of admission are proactively identified via COPD frequent

				attender database which is refreshed every 6-8 weeks. KIS accessible by primary & secondary care, LUCS and SAS out of hours. TRAK alert as prompt for prompt to acute services COPD KIS in place. COPD patients issued with ACP self management plan and 'Think COPD Think CRT' fridge magnet to prompt contacting CRT in event of exacerbation as alternative to emergency services. 918 of patients actively managing their condition using LiteTouch telehealth – with dedicated CRT support line should their condition deteriorate. <u>Midlothian HSCP:</u> In place <u>East Lothian HSCP</u>: This is a core aspect of the Advanced Physiotherapist Practitioner role.
4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			

4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☐ ☐ ☐ ☐	■ ■ ■ ■	<u>Primary Care and USC:</u> LUCS have home oxygen policy <u>Edinburgh HSCP:</u> Patients with COPD should aim to have oxygen saturations on air of 88% or above at rest if doesn't have LTOT at home. If a patient is acutely unwell with lower oxygen saturations they should be referred to hospital for treatment which may include acute oxygen therapy If a patient is stable and oxygen saturations on air are 88% or below then they should be referred for an LTOT assessment at the respiratory outpatient clinic. There is no evidence for only ambulatory oxygen for patients with COPD. Once a patient receives LTOT they will be given the appropriate system for their requirements. <u>Midlothian HSCP:</u> This is managed by our Hospital at Home team. CRT have developed COVID oxygen weaning pathway. Staff have access to community respiratory team and the team is available over the festive period. <u>East Lothian HSCP</u>: Home oxygen pathways are clear for staff within community services

5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☐	■	<u>NHSL Respiratory MCN:</u> High risk COPD patients are often given an oximeter through the CRT pathway. We also have a robust home ventilation team that look after patients on NIV in the community o help look after these patients as a good support system**.** ■ <u>Primary Care and USC:</u> LUCS home oxygen policy <u>Edinburgh HSCP:</u> ■ Currently 918 CRT patients on Lite Touch/ Self Referral have a pulse oximeter at home. There is capacity for this to increase and pulse oximeters are available**.** ■ <u>Midlothian HSCP:</u> In Place ■ <u>East Lothian HSCP</u>: This is established and accessible within the East Lothian service

7	Key Roles / Services		RAG	Further Action/Comments
	Heads of Service			EHSCP: ■ MHSCP: ■ ELHSCP: ■: All in post in ELHSCP
	Nursing / Medical Consultants			EHSCP: ■ MHSCP: ■ Inability to recruit to some trained nursing roles within HSCP has and will continue to impact on ability to safely maintain and maximise bed numbers. Mitigation plans in place but recruitment challenges remain a risk.
	Consultants in Dental Public Health			EHSCP: Not applicable, done through PCCO
	AHP Leads			Acute services: : ■ – AHPs MHSCP: ■ ELHSCP: ■: AHP Lead in post in ELHSCP
	Infection Control Managers			EHSCP: ■ MHSCP: ■
	Managers Responsible for Capacity & Flow			EHSCP: ■ MHSCP: ■ ELHSCP: ■: Responsibility allocated in the ELHSCP team
	Pharmacy Leads			EHSCP: ■ MHSCP: ■ ELHSCP: ■: In post in ELHSCP
	Mental Health Leads			EHSCP: ■ MHSCP: ■ ELHSCP: ■: In post in ELHSCP
	Business Continuity / Resilience Leads, Emergency Planning Managers			EHSCP: ■

				MHSCP: ■ ELHSCP: ■: In post in ELHSCP
	OOH Service Managers			<u>Primary Care and USC:</u> Ongoing work required as above EHSCP: ■ MHSCP: ■
	GP's			EHSCP: ■ MHSCP: ■ ELHSCP: ■: Liaison arrangements in place with GP reps and individual practices
	NHS 24			EHSCP: ■
	SAS			EHSCP: ■
	Other Territorial NHS Boards, eg mutual aid			EHSCP: Not applicable
	Independent Sector			EHSCP: ■ MHSCP: ■ ELHSCP: ■: Liaison and planning arrangements in place
	Local Authorities, incLRPs & RRPs			EHSCP: ■ MHSCP: ■ ELHSCP: ■: Liaison and joint working arrangements in place
	Integration Joint Boards			EHSCP: ■ MHSCP: ■ ELHSCP: ■: Oversees strategic delivery of its priorities
	Strategic Co-ordination Group			EHSCP: ■ Through Chief Officer MHSCP: ■
	Third Sector			EHSCP: ■ MHSCP: ■ ELHSCP: ■: Liaison and planning

				arrangements in place
	SG Health & Social Care Directorate			EHSCP: ■ Through Chief Officer

COVID-19 Surge Bed Capacity Template **Annex A**

		Baseline ICU Capacity	Double Capacity and Commitment to deliver in one week	'Triple plus' Capacity Commitment to deliver in two weeks	ICU Max Surge Beds	Y - Correct / N Incorrect with comment	Please list assumptions & consequences to other service provision to meeting these requirements
PART A: ICU	Please confirm that your NHS Board can deliver the stated level of ICU Capacity in the time periods set out	29	58	87	113	**Note 4 new ICU beds not included in baseline until staff recruited**	**We have appropriate workforce to sustain service delivery with agreed skill mix depletion** **We have appropriate supplies of PPE, clinical consumables and equipment** **We have sufficient isolation space and early testing capacity to maintain and separate red and amber flow** **There will be an impact on non-emergency services as staff are drafted in to support critical care expansion – recovery and theatre teams in first instance**

PART B: CPAP	Please set out the maximum number of COVID-19 patients (at any one time) that could be provided CPAP in your NHS Board, should it be required		

PART C: Acute	Please set out the maximum number of acute beds that your NHS Board would re-provision for COVID-19 patients (share of 3,000 nationally), should it be required		

Annex B

Health Protection Scotland

Infection Prevention and Control COVID-19 Outbreak Checklist

(Refer to the National Infection Prevention and Control Manual (NIPCM) for further information http://www.nipcm.hps.scot.nhs.uk/)

NHS National Services Scotland

This COVID-19 tool is designed for the control of incidents and outbreak in healthcare settings. **Definitions: 2 or more confirmed or suspected cases of COVID-19 within the same area within 14 days where cross transmission has been identified.** **Confirmed case: anyone testing positive for COVID-19** **Suspected case: anyone experiencing symptoms indicative of COVID (not yet confirmed by virology)** **This tool can be used within a COVID-19 ward or when there is an individual case or multiple cases.**						
Standard Infection Control Precautions; **Apply to all staff, in all care settings, at all times, for all patients when blood, body fluids or recognised/unrecognised source of infection are present.**						
Patient Placement/Assessment of risk/Cohort area **Date**						
Patient placement is prioritised in a suitable area pending investigation such as for a single case i.e. single room with clinical wash hand basin and en-suite facilities						
Cohort areas are established for multiple cases of **confirmed** COVID-19 (if single rooms are unavailable). Suspected cases should be cohorted separately until confirmed. Patients should be separated by at least 2 metres if cohorted.						

Doors to isolation/cohort rooms/areas are closed and signage is clear (undertake a patient safety risk assessment for door closure).					
If failure to isolate, inform IPCT. **Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout patient stay.**					
Patient placement is reviewed as the care pathway changes. NB: Patients may be moved into suspected or confirmed COVID-19 cohorts or wards to support bed management.					
Personal Protective Clothing (PPE)					
1. PPE requirements: PPE should be worn in accordance with the **COVID 19 IPC addendum** for the relevant sector: • **Acute settings** • **Care home** • **Community health and care settings** 2. All staff should wear a FRSM in accordance with the updated guidance on face coverings, which can be found **here**.					
Safe Management of Care Equipment					
Single-use items are in use where possible.					
Dedicated reusable non-invasive care equipment is in use and decontaminated between uses. Where it cannot be dedicated ensure equipment is decontaminated following removal from the COVID-19 room/cohort area and prior to use on another patient.					
Safe Management of the Care Environment					
All areas are free from non-essential items and equipment.					
At least twice daily decontamination of the patient isolation room/cohort rooms/areas is in place using a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.).					
Increased frequency of decontamination (at least twice daily)is incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g. “frequently touched" surfaces such as door/toilet handles and locker tops, over bed tables and bed rails.					
Terminal decontamination is undertaken following patient transfer, discharge, or once the patient is no longer considered infectious.					
Hand Hygiene					
Staff undertake hand hygiene as per WHO 5 moments: using either ABHR or soap and water					
Movement Restrictions/Transfer/Discharge					

Patients with suspected/confirmed COVID should not be moved to other wards or departments unless this is for essential care such as escalation to critical care or essential investigations. Discharge home/care facility: Follow the latest advice in COVID-19 - guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.					
Respiratory Hygiene					
Patients are supported with hand hygiene and provided with disposable tissues and a waste bag					
Information and Treatment					
Patient/Carer informed of all screening/investigation result(s).					
Patient Information Leaflet if available or advice provided?					
Education given at ward level by a member of the IPCT on the IPC COVID guidance?					
Staff are provided with information on testing if required					

RMP4 Appendix 2 - NHS Lothian – RMP4 Delivery Plan

NHS Lothian – Covid-19, Flu and Covid-19 Booster Vaccination - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Grey - Proposal – New Proposal/no funding yet agreed
Red - Unlikely to complete on time/meet target
Amber - At risk - requires action
Green - On Track
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RAG Status (mandatory)	Deliverables (mandatory) *these can be qualitative or quantitative*	Lead Delivery Body	Risks (mandatory) *list key risks to delivery and the required controls/mitigating actions*	Outcomes (optional) *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	Strategies, plans & programmes *repeat for each applicable deliverable/add multiple programmes if required*

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
	Complete 1st and 2nd dose Covid-19 Vaccination for Lothian population aged over 18 years	Continue with scheduled 2nd dose appointments and drop in outreach activities to offer 1st and 2nd dose vaccination	SG milestone for completion of 2nd dose vaccinaton for those aged 18 – 49 by 22 September 2021	Overall popylation % update at 23 September against SG target of 90% Scotland Lothian 1st Dose 91.8% 89.7.4% (666,691) 2nd Dose 85.8% 83.0% (616,988)	Flu and Covid-19 Vaccination Programme Board Operations and HSCP Groups	Cohort of population remain unvaccinated particularly in younger ages who are currently at risk of coronavirus outbreaks	Continue with communications plan to promote vaccine uptake via social media, NHS L website Dedicated vaccination clinics at universities / colleagues from 13th Sept for fresher's week / term start	Over 90% of population over 18 years receives double vaccination	National Recovery Plan to support lifting of cornovirus restribtions National Covid -19 Vaccine Programme NHS L Remobilisatoin Plan NHS L Immunisation Progamme
	Covid -19 Vaccination of 16 – 17 Years	JCVI announcement of initial 1st dose vaccination of this age group on 4th August	Completion of vaccination of this cohort by mid September	Self-registration for appt via NHS Inform from 6th August, drop in arrangments with no appointment at all vaccination centres from 10th August Cohort size: 16,834 individuals % Uptake at 23 September Scotland Lothian 1st Dose 70.0% 73.3% (12,343)	Flu and Covid-19 Vaccination Programme Board Operations and HSCP Groups	Cohort of population remain unvaccinated particularly in younger ages who are currently at risk of coronavirus outbreaks Release of pupils from school to attend national invite with vaccination appt	Continue with communications plan to promote vaccine uptake via social media, NHS L website Engagement with education authorities and parents / young people Test of change outreach at schools and Edinburgh college in late Augut National appointment letter for all those who have not come forward from vaccination w/c 23 August	High uptake of vaccination	National Recovery Plan to support lifting of cornovirus restribtions National Covid -19 Vaccine Programme NHS L Remobilisatoin Plan NHS L Immunisation Progamme
	Covid-19 Vaccination of 12 – 15 years at risk	JCVI recommended vaccination of those aged 12-15 years at risk on 20th July	Completion of this cohort by early September	Opted for local appointing for clinics at RHCYP weekends 21st, 22nd 28th, 29th August and 4th and 5th September. Cohort size: 937 At 22nd September, 611 (65.2%) of this cohort had	Flu and Covid-19 Vaccination Programme Board	Many parents seeking conversation with paediatrician/	Subsequent CMO recommendation of universal offer of initial 1st dose for all aged 12-15 years may assist with	High uptake of vaccination and protection of those who are vulnerable	National recovery Plan to support lifting of cornovirus restribtions National Covid -19 Vaccine Programme NHS L Remobilisatoin Plan NHS L Immunisation Progamme

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				been vaccinated with at least one dose.	Operations and HSCP Groups	GP prior to consenting to vaccination, many refusing vaccination and young people due to underlying health condition may be currently unwell to recived vaccination	further uptake for this group.		
	Vaccination 12-17 Years Sharing Households of Immunosuppressed	7th August, a national letter was issued to household members who are immunosuppressed to indicate eligibility for vaccination for those age 12 – 17 years sharing household inviting to contact the National Call Centre to request vaccine appointment.	Completion of vaccination of this cohort by mid September	National update on 20th August indicates low response rate to national letter invite. Continuing to promote via drop in / no appointment arrangements at vaccination centres No details of uptake associated with this cohort available.	Flu and Covid-19 Vaccination Programme Board Operations and HSCP Groups	Potential for covid spread within households of those who high risk	Continue to keep under review and discussion via FVCV National Delivery Group	High uptake of vaccination and protection of those who are vulnerable	National recovery Plan to support lifting of cornovirus restribtions National Covid -19 Vaccine Programme NHS L Remobilisatoin Plan NHS L Immunisation Progamme
	Children and Young People Flu Vaccination	Vaccination of children and young people via the nursery and school programme including offer of vaccination of staff during school visits	Programme to commence 6th / 13th September with completion of flu programme by 6 December	Plans in plans and community teams expanded to support flu vaccination of secondary school pupils in 2021-22 Programme has commenced as planned from 6 September with data submission via template each Monday.	Flu and Covid-19 Vaccination Programme Board Children's Flu Sub Group	Poor uptake	National campaign targeted at parents and pupils commenced 19th August and will be complemented by local communications and engagement plan	High uptake of flu vaccination	National Vaccination Programme NHS L Immunisation Progamme
	Flu Vaccination and Covid-19 Booster of those aged over 50 years, staff and at risk	Delivery of flu and covid-19 booster vacciatnion programme by early December CMO letter issued 17 September outlining delivery expectations	21st Sept –opening of national portal for self registrationof health and social care workers 20th Sept – vaccination of care home residents and staff 27th Sept – start vaccination of stage 1 cohorts Complete by 6 December for flu vaccination. Completion of Covid booster dependent on eligibility for booster at 24 weeks	Flu and covid booster delivery plans outlined by four Lothian HSCPs. Readiness templates submitted to Scottish Government on 3rd August. Bi-weekly meetings involving NHS L and HSCP teams to review / update plans as national guidance on planning assumptions evolves. Staff vaccine sub group established and have developed staff vaccination plans, vaccination began w/c 20 September. National invite letters for flu issued for over 70s for w/c 27 September who were not yet eligible for Covid Booster National flu and eligible booster invite letters to be issued from w/c 4 October in line with priority cohorts 100 community pharmacies supporting flu vaccination through drop in arrangements	Flu and Covid-19 Vaccination Programme Board Operations and HSCP and Staff Groups	Poor Uptake Requirment to de-couple coadministration of flu and covid booster requiring additional vaccine appt capacity Citizen / staff confusion due to change in delivery model for 2021-22 Potential for citizens to be scheduled for appointments outwith HSCP	National flu campaign to launch on 13th Sept and will be complemented by NHS L / HSCP communications and engagement plan National Covid-19 Booster – CMO recommendation to offer booster 24 weeks following 2nd dose ommunication plan unknown until JCVI recommendation available Local communication on HSCP and NHS L website outlining change in delivery model for 2021-22	High uptake of flu and Covid-19 booster vaccination	National Vaccination Programme NHS L Immunisation Progamme

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						locality	Support citizens to reschedule inconvenient appointments through Lothian vaccine call centre On going engagement with national scheduling team to review cohort uploads and checking files prior to invites going to print where time allows.		
	3rd dose Covid Vaccination for Severely Immunosuppressed	Cohort identified for national invite letter and identification of a individuals via local clinical teams	Offer 3rd dose at least 8 weeks after 2nd dose	National invite letters for vaccination from w/c 4 October and drop in arrangements via vaccination bus at Western General Hospital from w/c 20 September	Flu and Covid-19 Vaccination Programme Board Operations / HSCP Groups	Poor Uptake	On going engagement with clnical teams and provide support to individuals to access convenient 3rd dose appointments	High uptake of 3rd dose vaccination	National Vaccination Programme NHS L Immunisation Progamme
	Universal vaccination of all those aged 12-15 years	CMO letter recommendating universal of 12-15 years vaccination issued on 17th September	NHS Boards asked to offer drop in from 20 September followed by national invite to all in this age range.	NHS Lothian offering drop in at community clinics from 20 September with national invite letters to be issued for vaccination appointments from week commencing 4th October. 1,611 vaccines have been administered through drop in arrangments from 20 – 23 September.	Flu and Covid-19 Vaccination Programme Board Operations and HSCP Groups	Poor Uptake	Promotion of clinics via social media Supportive discussion with vaccinators during informed consent process	High uptake within this cohort	National Vaccination Programme NHS L Immunisation Progamme

NHS Lothian – Scheduled Care - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Grey - Proposal – New Proposal/no funding yet agreed
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RAG Status (mandatory)	**Deliverables (mandatory)** *these can be qualitative or quantitative*	**Lead Delivery Body**	**Risks (mandatory)** *list key risks to delivery and the required controls/mitigating actions*	**Outcomes (optional)** *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	**Strategies, plans & programmes** *repeat for each applicable deliverable/add multiple programmes if required*

Sept 21 Status	Key Deliverable Description	Summary of activities etc.	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/ Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
	Additional short-term CT capacity, funded by Scottish Government, will be provided on the WGH campus for a 6 week period from the end of June 2021.	Delivered	Delivered by and for a period of 6 weeks in July/August 2021.	Delivered.	NHS Lothian	N/A	N/A	c620. Scans delivered over the 6 week period-supporting CT waiting list management. This is less than anticipated, initially aiming to have reached 1000 over the six-week period. The service met and overcame several logistical challenges associated with getting the unit in. However learning for the next opportunity which if arose in the future would be supported again.	
Proposal	Mobile MRI - currently located at Mid Lothian Community Hospital will continue at least until the end of quarter 1 21/22.	Delivered and extended to the end of the calendar year. Intention to extend to end of financial year bit TBC. This is a shared resource with Fife and Borders.	Delivered	Delivered Extended to end of calendar year We have, via Scottish Govt (South East Scotland resource, Tayside, NHSL and Fife - 15 days per month, Oct-Dec 2021, MR van Ambition to extend to end of financial year – Availability TBC.	NHS Lothian	Ambition to extend to end of financial year – Availability TBC.	Progress monitored via Diagnostic Recovery Board	ACHIEVED supporting MRI waiting list management.	NTC imaging department includes MRI for elective capacity across Lothian to support mitigation of recurrent capacity gap pre covid. This was envisaged as a 5 day service but as we continue to see rising demand consideration of a workforce model to deliver extended working underway, as part of NTC workforce review.
	A specific action plan is in place to sustain and improve the MRI prostate scanning pathway.	Seek external capacity to support prostate scanning. Improve internal process.	External capacity in place as of August.	Focus on MR for prostates being provided by the department, with six prostate MRI scans (with contrast) being undertaken within University of Edinburgh (CRIC). Scanning starts 03/08/21 and urgent patients will be allocated as priority appointments. Sourcing of eight CT non-contrast MRI scans per week from The Edinburgh Clinic is displacing activity from NHS Lothian internal capacity that is being reallocated to MRI contrasts (including prostate scans).	NHS Lothian	No risk identified	Progress monitored via Cancer Recovery Board and Diagnostic Recovery Board.	Urology still not meeting 62 days but consistent reduction in MRI waits for urgent patients over 6 weeks and routines over 6 weeks.	As above.

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	Dexa scanning will return to pre COVID-19 activity levels between May and July further to incremental increases in activity	Replacement of the 2nd Dexa scanner. Increase staffing capacity for scans. Mitigation around the high DNA rate (estimated at 27% Dec / Jan) through telephone reminder service.		Replacement of 2nd Dexa complete. Updated refhelp in line with SIGN guidelines to ensure suitable referrals coming through, less time triaging, potentially reduce number of referrals. Same staff scanning and reporting. An additional band 5 funded temporarily for 1 year to support increased throughput and improved turnaround. This may be suitable for recurrent funding following test of change. B5 to start 20/09/21. Text reminder across NHSL Out-patient appointments will extend to Dexa and should be in place by end of March 22. Support Required for moving from Trak Hybrid to Radiology Trak to standardise Trak use within DATCC. Agreement/Support to alongside Radiology to look at Soliton to improve clinical governance issues. Service Review/Funding Required	NHS Lothian	Workforce constraints e.g. Could not deliver planned activity in July and August due to absence and A/L. Band 6 staff have prioritised radioactive cancer therapies. Backlog & batching of workload from Fracture Liaison Service impacts WL.	Progress monitored via Diagnostic Recovery Board. Text reminder service monitored via Out-patient Recovery Board.	DNA Rate reduced to 6% May and June but increased during the summer to between 16-19%. Overall WL increasing with waits under 12 weeks increasing but waits over 52 weeks reduced.	
AMBER	Radiology will pursue the procurement of Radiology Information System software.	N/A	To be in place within 6 months to a year	Procurement of tailored IT solution for Radiology delayed but clinical evaluation now complete. Ease of information exchange minimising current admin processes and improving governance.	NHS Lothian	Competing demands and releasing clinical time for evaluation etc.	Progress monitored via Diagnostic Recovery Board.	To improve information exchange and improving operational efficiency.	
	Expand available capacity for CT & MRI internally.		Extended working days Progress case for additional CT at SJH	Sustainable extended working in Radiology has been established at the WGH – not interim measure but permanent rota. Internally plan to run additional extra evening and weekend lists as well, which will provide additional capacity - Quantification of volumes unknown. Planning for and developing IA& then SBC for additional CT at SJH for delivery 22/23 underway and planned to coincide or enable efficient replacement of current CT. Radiology workshop complete with actions below underway - Improving prioritisation process on Trak orders to expedite USOCs - Reduce average waiting time for USOC diagnostic imaging reporting - Reduce DNA/Cancellations – patient information "be prepared"	NHS Lothian	Workforce. Availability of capital and revenue for additional CT at SJH – resources to progress the case also a risk.	Progress monitored via Diagnostic Recovery Board.	Additional internal capacity for CT and MRI. For CT & MRI actual has exceeded planned activity over the last 6 months.	NTC imaging department includes MRI for elective capacity across Lothian to support mitigation of recurrent capacity gap pre covid. This was envisaged as a 5 day service but as we continue to see rising demand consideration of a workforce model to deliver extended working underway, as part of NTC workforce review.
Proposal	Increase capacity for ultrasound to meet increasing demand.	Explore options for insourcing/ outsourcing staffing model.	In place by the end of March 2022.	Explore options for insourcing/ outsourcing model to increase access to more US capacity – potentially at the weekends. - Recently doubled our offer from GJNH – from 5- 10 US a week - WLI's difficult to maintain and workforce burnt out with alternative and more lucrative options available in the independent sector. Sonographers are AFC and do not receive financial benefits of WLIs.	NHS Lothian	Limiting factor is workforce availability and competition with more lucrative independent sector employment available e.g. private baby scans. Commercially not dynamic market.	Progress monitored via Diagnostic Recovery Board & Cancer Recovery Board.	Additional capacity for ultrasound and reduced WL.	

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				- Increasing headcount for sonographers but a year and a half training – so not a short term fix and finite pool to recruit from. Considering new ways to manage demand: - focussed scans – although there is a clinical risk to be considered - Extending parameters for some review WL e.g. benign ovarian cysts.					
Proposal	Deliver Additional External Capacity Plan for Radiology	Secure external capacity to supplement internal capacity.	TBC	Request for October onwards: o 50 CT scans (with contrast) per week o 35 MR scans (with contrast) per week - We have agreed via Scottish Govt (national) from Golden Jubilee National Hospital o 60 MR scans per week o 10 US scans per week - We have ad hoc support from University of Edinburgh CRIC(@ Little France) o PET MR (variable volumes)	NHS Lothian/ External Providers	Market availability. External workforce availability. CT Colon previously delivered by Spire will not be available for the next few months as Spire undergoing replacement of their CT Scanner. (bring in CT Colon but outsource other work)	Progress monitored via Diagnostic Recovery Board and Additional Capacity Board.	Additional internal capacity for CT and MRI.	
AMBER	Additional capacity requirements through the independent sector will be assessed through existing processes and governance structures and submitted to the Scottish Government for consideration against available funding.	Identify need, agree ask and seek from market requirements in line with NHS Lothian process and governance.	Various timelines.	Additional capacity has been a core recovery action for NHS Lothian. There is disparity between what the Boards require and what the market can currently provide. Overall NHS Lothian have only been able to secure around 1/3 of the specialty ask. From those secured: TEC Cataracts (S&T), Ortho (Treat) - F&A and Ortho knee arthroscopy, Vascular (S&T) are proceeding as expected and capacity is being well utilised. Vascular Treat only capacity has been challenging to fill, however EPO is working with the service team to understand the requirement. Looking ahead to new contracts include seeking: - external capacity for Flexi Cysto (2 sessions a week) and circumcision; - Endoscopy	NHS Lothian & awarded providers	Availability of workforce in the independent sector, developing business models and competition from self-funding activity which can be more lucrative to the independent sector. Numbers secured differ from activity sought and this may occur again.	Additional Capacity Board overseen by Scheduled Care Recovery Programme Board.	Additional capacity through a number of external contracts.	
	Dermatology, ENT and Ophthalmology legacy insource contract activity will continue in to the 1st quarter of 2021 at a minimum.	N/A	Delivered	**Insource Medicare** **Medinet – ENT** **Medinet – ENT theatres** **Medinet – Dermatology**	NHS Lothian & Insource Provider	Workforce availability/ competition.	Additional Capacity Board overseen by Scheduled Care Recovery Programme Board.	Additional activity delivered through in source contracts.	
Proposal	Spire Murrayfield will provide robotic prostatectomy for 5 patients per week up to mid-July.	N/A	Extended beyond July to the end of October but agreement beyond TBC.	Spire Robotic Prostatectomy contract is proceeding as expected and beyond the end of July as per RMP3. NHSL has streamed 144 patients as of August 2021. ***NEW Proposal*** Given the benefit of released capacity already seen it would be our ambition to continue with this additional capacity. Expansion of Spire capacity to include half day Friday	NHS Lothian/ Spire Murrayfield	Dependent on market/ independent provider business model to continue. Not yet agreed beyond October 21. If Spire activity not available beyond 31st January 2022 then gap would increase and waits will deteriorate, otherwise	Additional Capacity Board overseen by Scheduled Care Recovery Programme Board.	NHSL has streamed 144 patients thus far as of August 2021.	NHS Lothian will use DCAQ to inform requirement after March 2023 and before the NTC. Potential need to continue with additional capacity until services transfer to NTC Lothian - should funding be available to support.

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				also to be considered to release theatre space (not currently funded). Also potential inclusion of an additional robot. Procurement & Finance working with the service to secure an extension to the contract for the above. Challenges Cautiously optimistic this will be in place by January 2022 assuming funding via RMP4 to the end of March 22 and potentially another year to the end of March 2023. DCAQ will inform requirement after March 2023 and before the NTC.		RARP will be undertaken in TURBT Theatre session resulting in deterioration of TURBT position – currently WL of 50 Prostate Cancer performance further affected by change in NST application for RARLP from October 2021			
Proposal	Secure Protected Orthopaedic Capacity over the next 5 years (co-staffing model with an independent provider) c1000 procedures p/a minimum. Funding agreed with AST/SG.	Delivery of a Public Procurement Exercise for ring-fenced ortho capacity. Establish Procurement User Group to deliver key steps below: **Stage 1**: Public Issue of Advert and Single Procurement Document (SPD) **Stage 1** Evaluation of submissions **Stage 2** - Issue Invitation to Tender to Shortlisted Suppliers (min number 3, if 3 meet our selection requirements) **Stage 2** - Evaluation of tender submissions *Potential for negotiation* **Award**	Award Dec 2021 assuming no negotiation. First Patients early 2022	Public Issue of Advert and Single Procurement Document (SPD) ACHIEVED Detailed Patient Pathway in development for Stage 2 issue of tender. *Potential for procurement exercise to test the market for more than 1000 procedures p/a- not funded.* *Potential for this procurement exercise to test the model for other specialties assuming funding available.*	NHS Lothian	Market availability. Challenging timescales. Current pressures on availability of SLWG members. Fragility of HSDU services.	Director in place as SRO to provide leadership. SLWG established with clear roles and responsibilities.	Protected Capacity for between 800- 1000 procedures p/a for Arthroplasty as a minimum. Reduction in TTG waiting list and reducing longest waits.	NTC, Lothian co- staffing model with external provider will support advanced and phased recruitment to NTC, Lothian. Also supports testing the NTC model for Orthopaedics prior to the NTC opening.
AMBER	WLIs - Additional weekend sessions will continue to be provided where staff and beds are available to support.	Identify need, capacity, workforce, timeframes & cost and agree expected deliverables and funding through internal governance structure.	Various timelines.	A number of WLI are in place across out-patient services to provide OP capacity. Challenges with both theatre staffing and beds limiting delivery of inpatient/day case WLIs in any significant volumes.		Theatre and nursing workforce availability and beds. Medical staff availability with competing priorities Mon-Fri and the availability of private sector work. Lack of incentive for AFC staff.	WLI requests, ability to staff and deliver and activity against planned monitored and prioritised via Additional Capacity Board.	Minimal capacity gain and do not foresee significant improvement in the next 6 months.	
RED	Additional surgical capacity has already been secured for Orthopaedics, Ophthalmology, and Plastics in GJNH for next year.	N/A	In place with GJNH for the duration of 21/22.	Surgical capacity at GJNH secured for Orthopaedics (less than pre covid), Ophthalmology, and Plastics with small number of General Surgery & Colorectal (as of July) and additional weekend cataract capacity agreed to be delivered since RMP3 submission. However, GJNH workforce constraints impacting delivery as planned: For Ortho See & Treat model at the end of August GJNH currently 96 joints behind SLA with 231 joints to be appointed over the next few months. Referrals paused at the request of GJNH due to workforce challenges and requirement to focus on cancer work	GJNH & NHS Lothian	GJNH Workforce availability to support as planned. GJNH for Colorectal challenging capacity to fill with only ~50% converted from a phone call to an appointment. COP26 in Glasgow- risks patients cannot access services for this 2 week	Regular meetings with GJNH and NHS Lothian to monitor progress against SLA.	**Q1** -Ortho – 196 DC/IP delivered at GJNH (90% joints) -Plastics - 61 C/IP booked -Ophthalmology – 363 Day cases/IP **Q2** -Colorectal – 11 patients booked for surgery -General Surgery – 15 booked	

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				for all boards. Paused as of mid-September with no new referrals accepted for next few months. GJNH currently indicating they will restart clinics at the end of November but this will be reviewed month to month. This may very well result in these patients not receiving treatment until April 2022. (Consideration to overall wait must be given as these patients may be waiting longer due to being streamed to GJNH) The current pause also included plastics agreement – specifically hands but GJNH numbers delivered are ahead of planned currently and impact should be manageable. Currently ophthalmology agreement 273 cataracts behind planned due to workforce constraints. Recently agreed increase for Lothian currently being delivered at wknds with in source staffing (Synaptic) in GJNH at wknds. GJNH pathway may be impacted by COP26 and NHS Lothian in discussions about frontloading out of area patients the weeks before and after to reduce risk to capacity.		period. Uncertainty regarding future allocations for NHS Lothian beyond March 2022. Booking processes.		-Plastics – 48 booked -Ortho – 76 patients attended for DC/IP	
	The qfit pathway will be strengthened and embedded within colorectal and endoscopy throughout 2021.	qFit team established Clinical agreement on triage pathways reached.	Embedded within colorectal and endoscopy throughout 2021.	Secured funding for qFit team and new processes in place advancing to identify patients with 2 negative tests and prioritise the most urgent patients.	NHS Lothian	No risk identified	Progress monitored via the Diagnostic Recover Board.	This has supported reduction in growing WL. No. of urgent in colorectal was increasing and now decreased with fit pathway a contributing factor supporting the decrease.	CfSD best practice and deployed on NHS Lothian Heat Map.
	Increase Cystoscopy Capacity	Measures to increase cystoscopy capacity include regular weekend lists and appointment of additional specialty doctor and locum Consultant staff. The Cystoscopy service will also implement an outpatient delivered redesign in May 2021 enabling release of theatre capacity. Nurse led follow up in line with Scottish Access Collaboration Waiting List Validation work-stream will commence for bladder cancer patients.	TBC / Various	Cystoscopy - Urology Locum Consultant Interviews 29/1/2021 unsuccessful –will re-advertise post and aim to have successful candidate in post from end of summer 2021 Cystoscopy WLI with all day Saturday taking place but not deliverable weekly due to workforce constraints. Seeking external capacity from the independent sector for flexi-cysto in the next period but volumes TBC. Cystoscopy service out-patient redesign underway to deliver Flexi Cysto workforce required to test OP test of change- ambition in place April 22. Nurse led follow up in line with Scottish Access Collaboration Waiting List Validation work-stream in place for bladder cancer patients. Band 7 Nurse Cystoscopist for surveillance Botox procedures assuming funding could be in place for Dec 21. Band 7 Sonographer for one stop clinic		Cystoscopy capacity remains under significant pressure with USOC referrals for cystoscopy now exceeding pre COVID-19 levels and numbers per list reduced by 15%. USOC referrals continue to rise from an average of 177 per month (Jan-April 2021) to 196 per month (May-July 2021) Market unavailability for external capacity.	Progress monitored via Diagnostic Recovery Board.	Increased capacity and now meeting planned activity as per RMP3. Continued decrease in patients waiting over 12 weeks – from 1069 at end of January 2021 to 773 in August 2021 – however increase in routine patients waiting over 52 weeks (178 in May 2021 to 212 in Aug 2021) Continued increase in referrals - average of 330 per month in March and April 2021 rising to 348 May-July 2021 Out-patient delivered redesign will increase throughput c1300 patients per annum by increasing 12 patients per list to 14 patients per	CfSD best practice and in; line with National Endoscopy Recovery Plan – moving all activity that does not need to be in an Endoscopy Unit to appropriate setting.

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								list and release theatre staff for other activity. It is hoped this will also release capacity for increased Bronchoscopy activity at SJH. Volumes of external capacity TBC and dependent on market availability.	
	Endoscopy- Implementation of LumeraDX testing is planned for February 21.	This will start in East Lothian Community Hospital and SJH.	Feb 21	ELCH and SJH but not at WGH and LCTC as yet.	NHS Lothian	No risk identified	Progress monitored via Diagnostic Recovery Board.	Support reduction in turnaround time and return to pre COVID-19 numbers per session for green pathways.	
	Cytosponge will be operational in Endoscopy Service by May 2021.	Implement use of Cytosponge.	May 2021	Delivered and will continue.	NHS Lothian	N/A	N/A		This appears on the CfSD Heat Map and marked as deployed on NHS Lothian's submission.
AMBER	Endoscopy operating at 85% capacity pre covid. Expand Endoscopy Capacity to address growing waiting list.	Recruiting to 4th room at the WGH as sustainable recovery/ delivery model. Utilise capacity at Regional Endoscopy Unit including wknds. Exploring options for additional capacity including potential mobile unit and externally provided staffing model to in-house available sessions.	TBC / Various	Recruitment to 4th Room at the WGH successful in part with 3 new endoscopy nurses recruited. However service currently operating with a gap of 7 Band 5 nurses. New Locum secured to cover A/L across service provision and support sessions in 4th room. Weekend sessions identified in East Lothian Community Hospital and SJH. Procurement of in sourced staffing model to support at least 8 weekend sessions planned, alongside recruitment of NHS Lothian substantive wknd posts to support insource teams on site. QMH Fife additional capacity extended to mid-2021 at a minimum however capacity under threat due to workforce pressures at QMH with all activity cancelled w/c 21st September and The Aberdeen Clinic to be confirmed to support lists the following week.	NHS Lothian	Workforce gaps - *2 x Nurse Endoscopist posts at advert/ 1 x consultant/ B5 x 7, B2 x 6 Improving throughput reliant on reduction of 2m distancing which although in OP has not been accepted by IPCT as applicable in Endoscopy.	Progress monitored via the Diagnostic Recovery Board Service working with recruitment to improve adverts/ presentation of opportunities as competitive workforce market.	Additional capacity delivered from combination of measures.	
Proposal	Increase activity, reduce demand or release capacity in Urology.	Use of Rezum to increase patient throughput as an alternative for TURP/GLL patients Urology Band 7 Surgical Practitioner for circumcision.	TBC	Urology - Rezūm has been proven to reduce urinary symptoms for many men who have been diagnosed with an enlarged prostate or benign prostatic hyperplasia (BPH) and can be delivered with LA. Urology Band 7 Surgical Practitioner for circumcision. 2nd Bladder consultant starting in October will support OP activity.	NHS Lothian	Recruitment to Band 7. Projected to be ongoing challenges with Theatre and Anaesthetic staffing as well as access to HDU and Urology Inpatient beds – likely to deteriorate further. Additional capacity for OP with new bladder consultant starting in October will result in more patients being seen with potential conversion to IP WL	Progress monitored by IP/DC Recovery Board.	Increase throughput by providing alternative to GA. Address growing WL for circumcision. OP position has improved from July to September and is ahead of OP trajectory for October including a reduction in patients waiting over 12 weeks	

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	Address backlog in urology brachytherapy.	The introduction of HDR brachytherapy in March 2021 will release LDR brachytherapy capacity and reduce waiting time in the prostate cancer pathway.	N/A	The backlog in urology brachytherapy has been addressed and these services will meet projected demand in 21/22.	NHS Lothian	No risk identified	Progress monitored via Cancer Recovery Board		
AMBER	Clinical Prioritisation - In broad principle and in line with agreed clinical prioritisation, we will continue to prioritise urgent suspicion of cancer referrals (additions), which remain at higher levels than pre-COVID-19, and urgent referrals.	Whilst urgent referrals (additions) are slightly lower than pre-COVID-19 levels we will focus on further reducing the proportion which are waiting over 12 weeks (currently 25% of total urgent referrals). Urgent patients will continue to be prioritised for inpatient day cases, continuing a sustained reduction of over 4 week waits for this category (currently 44% of Urgent patients are waiting over 4 weeks) of the overall waiting list.	Ongoing throughout 21/22	Clinical prioritisation delivered and embed. All theatre capacity will continue to be prioritised to deliver urgent and cancer surgical activity, as well as the longest waiting patients who have been reprioritised as needing urgent intervention Realistic medicine- programme of work with surgeons to look at criteria for clinical prioritisation adding to IP/DC WL and when patients should be upgraded. Programme starting with plastics and GS. Clinical prioritisation & upgrading information available (dashboards)	NHS Lothian	No of patients upgraded continues to increase and at some point exceeds available capacity for urgent activity. Also includes competition for available capacity with increasing CEPOD/ emergency and unscheduled workload. Very little P3 & P4 resulting in increasing number of long waits for routine patients. Recent postponement of cancer surgeries due to workforce and bed pressures.	Monitored via Site Theatre Matrix Meetings	Available capacity focussed on delivery of P1 & P2 activity.	Aware of national review of clinical prioritisation.
AMBER	Dermatology will be a priority of improvement focus for urgent, USOC performance.	N/A	TBC / Various	Recovery plan developed and includes: Process of keeping in touch/ WL validation underway. Increased external provision started in May and increased activity levels sought beyond the end pf the contract c1200 in Jan/Feb and c6,000 in 22/23 assuming funding. 1200 new appointments planned in 2021 from WLIs. Re-advertise consultant gaps and job planning commenced in August to build in ACRT and review to align with BAD in terms of clinic templates/ increased throughput of News in clinic etc. ACRT expected to deliver 10% reduction in WL. Requirement in the medium to longerterm to increase nursing workforce and specialist nursing with internal career path in order to release consultant workforce to pivot job plans from return to new patients. Testing Tele dermatology using dermascopic images with 6 GP practices (July – September) before extending further. The aspiration is that all cancer referrals will include a high quality image to support immediate clinical decision making. Regrading of referral process to be agreed in	NHS Lothian	Availability of external capacity to meet demand. Unable to recruit previously.	Director of Improvement & Recovery responsible for focussed recovery programme in this area.	Additional capacity, reducing demand. Delivery overseen by Performance Oversight Board.	National Framework for regrading referrals underway.

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				collaboration with Margaret Kelly from a national view.					
AMBER	Routine outpatient backlog increasing, especially for long waiting patients. Targeted action to mitigate this will be focused on Oral Surgery.	N/A	TBC / Various	Increase throughput in current clinics and pivot focus from treatment to assessment. Recruit to vacancies. Additional capacity through WLI.	NHS Lothian	Workforce.	Director of Improvement & Recovery responsible for focussed recovery programme in this area.		
	Routine outpatient backlog increasing, especially for long waiting patients. Targeted action to mitigate this will be focused on Ophthalmology.		TBC	Ophthalmology tested a reduction of social distancing in the 1m distancing pilot. This was completed safely in OP areas and kept in place following a risk assessment in June 21. Service opened additional 3rd theatre to increase activity TTG activity however risk this will need to close to redirect workforce to urgent cases on other sites.	NHS Lothian	No risk identified		Reduced long wait numbers and service systematically continuing to see most urgent patients and reducing long waits.	
	Strategic work to consider an alternative clinical model for delivery of Eye Services will continue in to the 1st quarter of 21/22.	N/A	Review complete by June 21.	Externally led review complete and confirms where essential collocation required, where parts only work together and other parts are more effective (WF, kit, comms and junior cover) if together. Development of more community pathways for stable glaucoma patients and a small number of corneal per year. Updated OBC submitted and approved by CIG. Site to be agreed. Project team to be established/ remobilised and programme to achieve FBC expected to be agreed within the next 6 months. Design review required in light of new site.	NHS Lothian	Site suitability and availability. Inability to fill project team and technical roles. Available capital envelope.	Project Director and Project SRO.	OBC approved.	Whilst not part of the NTC programme will be included to ensure shared learning across programme.
AMBER	Routine IPDC referrals (additions) are unsurprisingly below pre-COVID-19 levels but the backlog is steadily increasing, especially for routine long waiting patients as activity is prioritised for patients with the greatest clinical need. Areas of improvement focus will be General Surgery and Urology.	N/A	N/A	Continuation of clinical prioritisation resulting in routine out-patients waiting longer and the overall numbers increasing month on month. The highest number in GS but with currently nowhere to go with limited WLI possible due to workforce and bed constraints and didn't get external capacity NHS Lothian sought form independent sector. Urology recovery plan in pace and includes the continuation of Robotic Prostatectomy at Spire in the lead up to services commencing in the NTC, Lothian. Scheduled Care Recovery Board will deliver a programme of Deep Dives over the next 6 months for high risk specialties starting with General Surgery and then Gynae to develop road maps for each specialty. The ambition is that the Orthopaedic Procurement exercise underway tests the model and there may be potential to secure ring-fenced capacity to replicate	NHS Lothian	Routine waits will increase and the position will deteriorate if emergency activity continues to increase, staffing pressures remain, numbers of patient delays on sites remain and the Covid context remains uncertain.	Progress monitored by IP/DC Recovery Board.	Overall routine out-patients waiting longer and number increasing month on month.	Further procurement based on the orthopaedic model currently underway might present the Board with opportunity to replicate the NTC, Lothian clinical model in the lead up to the facility at SJH opening in 2026/27.

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				the NTC, Lothian clinical model on a smaller scale in the lead up to the facility at SJH opening in 2026/27.					
	Theatre workforce, productivity and utilisation.	In terms of productivity whilst infection prevention control measures are in place we will have extended theatre time per case but expect to continue to reduce this to within 10% of pre-COVID-19 average (90 mins – currently average is 106 mins per case). Theatre planning meetings will continue to provide a single point of access to prioritise and optimise sessions. This will be enhanced with the piloting of the theatre scheduling system in the first half of the year. It is anticipated this system will increase the ability to collate multiple TRAK waiting lists and filter by priority/ IP/ DC/ operative time leading to more priority driven list allocation.	Throughout 2021/22	Theatre SLWG meeting to reduce turnaround time in theatre to ensure consistency of scheduling across sites to maximise utilisation of staffed theatre sessions – theatre matrix weekly on each site and coordination across sites. Full review held with IPCT and Staff Side: • Current practices refined to maximise efficiencies around red, amber, green flow and 2M distancing. • Conclusion – no material gain on patient throughput in theatre. • Most significant rate limiting factor is the availability of day case and in patient bed capacity to support patient flow. Progressing with TRAK theatre module for scheduling tool with implementation plan in progress. Newly recruited theatre staff expected in October but with a training lag.	NHS Lothian	Most significant rate limiting factor is the availability of day case and in patient bed capacity to support patient flow. Diverting Theatres staff from SJH to support Cancer work in Theatres at the WGH. Sustained increase in emergency activity. Pulling recovery staff from theatres to support critical care pressures.	Progress monitored by IP/DC Recovery Board & Theatre Workforce and Utilisation SLWG.		
RED	We will scope the opportunity to formally extend our core theatre capacity to either 3 session days or 6/7 day working.	N/A	N/A	Not deliverable in theatres due to workforce pressures ongoing in core capacity.	NHS Lothian	Workforce constraints.	Progress monitored through IP/DC Board	N/A	
AMBER	Enhanced Recovery after Surgery (ERAS)	ERAS will be extended beyond colorectal and orthopaedic surgery to Gynae and upper GI / hepatobiliary surgery, further to the national cancer funding bid being successful.	2021/22	NHS Lothian did not secure funding from cancer bids. Requested support for CfSD to deploy and embed but relies on workforce model to support enhanced recovery pathway.	NHS Lothian	Workforce, funding	Progress monitored by IP/DC Recovery Board.	Reduce LOS and improve outcomes following surgery.	Heat map area of focus – starting with General Surgery.
AMBER	EQUiP Pathways	General Surgical services will work to develop EQUiP in General Surgery, Colorectal, Vascular Surgery	2021/22	Clinical and service team reviewing and have identified this as an area for focussed support from CfSD on NHS Lothian Heat Map. The impact will be limited to a relatively small type of hernia and we are tertiary centre for incisional hernias which are not suitable for EQuiP.	NHS Lothian	Impact may vary as NHS Lothian a tertiary centre for incisional hernia. WL validation/ keeping in touch underway within general Surgery which has resulted in an as many patients removed from the WL as upgraded to P2.	Progress monitored by IP/DC Recovery Board.	EQuiP. pathways will assist demand management for hernia and cholecystectomy pathways.	Heat map areas of focus from CfSD and request for support made through this process for General Surgery, Colorectal and vascular.

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	All surgical services will ensure representation on the impending online Scottish Access Collaborative 'Bringing It Together' programme due to start end February.	N/A	N/A	Complete and well attended by NHS Lothian. NHS Lothian has planned deployment of an OP redesign which delivers much of the Access Collaborative best practice such as PFB, PIFU, ACRT and the functionality in TRAK to to blend templates and record virtual contacts on TRAK.	Access Collaborative	N/A	N/A	Directed focus on Heat Map and elements of NHS Lothian OP redesign e.g. FIFU, PFB etc.	CfSD Heat Map
	New Renal Dialysis Unit	N/A	N/A	Services commenced in new Unit July 2021.	NHS Lothian	N/A	N/A	Additional capacity with improved distancing and infection control measures in fit for purpose, compliant unit.	
AMBER	In terms of the Short Stay Elective Centre SSEC development at SJH, we will review the proportion of clinical specialties included to ensure the Full Business Case reflects the most appropriate case mix, in light of pandemic impact and learning.		Oct 21-January 22 refresh PSCP Brief. Reengage with PSCP early 2022.	NTC Lothian previously the SSEC- a rapid review of the in scope specialties and clinical model was undertaken in June 21 the findings of which included: - 11 Theatres remain but with increased provision of laminar flow/laser provision - All specialties remain supportive of the new delivery model with individual patient spaces - There is opportunity to allocate additional theatre sessions to accommodate a Prostate Centre of Excellence and augment the current urology case mix proposed within the NTCL, including robotic prostatectomy. Therefore, workforce model will potentially need to reflect the additional Urology activity. - In parallel a programme of work is required to reconfigure ways of working at SJH, RIE & WGH and identify what is required to deliver more complex activity at each of these sites (in the space released by transfer of activity to the NTC). - A detailed review required to consider expanding the orthopaedic case mix to include some or all arthroplasty that does not require to be delivered at the RIE due to complexity.	NHS Lothian	Inability to fill project team and technical roles to take forward FBC and service planning. Biggest risk to commencement of services - NTC Workforce	Project Director & SRO NHS Lothian NTC Workforce Group established.	Capacity for c16,000 additional procedures a year in the NTC once open.	NTC Programme.
RED	National cancer recovery funding has been applied for, and if secured will enable the following developments: -Prehab for agreed high priority pathways - providing specific dietetic and physiotherapy input pre op - Development of navigator roles	Various Bids	TBC / Timelines depend on funding being secured.	National cancer recovery funding was applied for but no funding was supported for NHS Lothian proposals submitted National Cancer waiting funding has been received and prioritised via the Cancer Recovery Board to support cancer access. CWT actions supported on a Non-recurring basis. National Cancer Action Plan submissions were requested for a 2nd round in August 21. These were submitted via SCAN and NHS Lothian await confirmation of successful bids on the 22nd October.	NHS Lothian	The success of bids.	Progress monitored via Cancer Recovery Board.		National Cancer Action Plan

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	across several selected tumour groups.								
AMBER	Our focus for maintaining our current 31 day and improving current 62 day cancer performance	Rolling programme of Deep Dives across tumour groups and support services e.g. pathology, radiology	Throughout 21/22	Lung Deep Dive undertaken & identified delays in pathway and causes rectified and meeting 100% iimproved Lung pathway – 100% for 31 & 62 days since April 21. Radiology & Pathology workshops completed with action plans for improvement. Cancer Tracking Escalation Policy being refreshed.	NHS Lothian	Urology	Overseen by Cancer Recovery Board	Maintained 31 day but not achieving and maintaining 62 days overall. In July only 5 out of 10 tumour groups achieved 62 days.	National programme to develop Optimum Cancer Pathways with Lung the first to be developed. Expected next spring.
RED	Systemic Anti-Cancer Therapy (SACT) and Radiotherapy Services continue to operate close to full capacity.	N/A	N/A	New Clinical Trials Unit delivered at the WGH releasing some pressure on capacity in Ward 1 for SACT provision. National MRI funding bid for Radiotherapy resulting in dedicated MRI for Radiotherapy in Lothian. Capital supported pre pandemic but with no indication where revenue for staff would come from. Heads of Therapeutic Radiotherapy have drafted a national approach/ bid but funding not yet agreed.	NHS Lothian	Growth - USoC referrals were increasing prior to covid and this trend continues. USoC referrals are now significantly above previous levels, We continue to meet this demand from the increasing referrals however approximately five new cancers are diagnosed from every 100 USoC referrals received. Revenue funding for MRI and ability to secure workforce.	Progress monitored by Cancer Recovery Board.		SCAN Health Boards informed by Cancer Policy Team potential funding to support SACT in response to pandemic impacts. SCAN Boards submitting to the Policy team info on increased demand, reduced capacity and stage shift to support await feedback from SG colleagues on next steps.
AMBER	We aim to complete business case approval for a 7th Linac in the first quarter of 21/22. As the space is currently available the preparation time for implementation is expected to be short.	Business Case approval. Implementation – including procure, deliver, installation and operational.	A business case approval by Q1 21/22 Delivered and installed and operational by March 2022.	A business case for the 7th Linac has been approved The service had hoped to pursue the extant PSCP route for the new accelerator, but procurement advise progress down the open tender route which may extend timelines. Procurement out for advert as of mid-September for 1 month. Ambition to have in place by the turn of the financial year. Confirmation regarding revenue for workforce for 7th Linac required with authorisation for recruitment necessary by January 2022. The service are working in the evenings on a regular basis to ensure provision of capacity required including 'Covid' slots with continued workforce pressures.	NHS Lothian	Challenging to get this in within the financial year as it is pay on acceptance. Unfortunately, they are unlikely to make the original target timeline that was set.	All parties are in place and have agreed to prioritise and monitored through the Cancer Recovery Board and Cancer Capital Board	Additional LINAC capacity	Linked to wider cancer enabling works at the WGH.
	Refurbishment & Service Redesign of Haematology Services at the WGH.	N/A	N/A	Refurbished and upgraded Haematology Unit handed over to open September 21.	NHS Lothian	Reduction in IP bed base due to redesign of services.	N/A	N/A	
Proposal	Paediatric theatre expansion Business Case	Develop case for change and funding requirements.	End of 2022	*New*	NHS Lothian	Workforce & funding.	Progress monitored via IP/DC Recovery		

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							Board		
	Reducing demand in OP.	NHS Lothian writing to patients on WL and asking if they still wish to remain on the list. Manned phone line 5 days a week will accept calls from patients who may wish to stay on WL or be removed from the list within 21 days. If patients do not get in touch within this period a further letter will be sent with 4 week window to get back in touch and be reinstated on WL.	TBC	Progressing as planned	NHS Lothian	Resource requirements to deliver and competing demands for health records staff.	Progress monitored via Out-patients Recovery Board and Waiting times Group. Extended option for patients to get back in touch within 4 weeks.	Reduction in demand/ WL review.	
	Where we have been unable to utilise theatre sessions fully we will convert clinical time to OP – F2F or virtually to reduce the OP WL.	Additional OP clinics and improved throughput.	End of March 2022 for orthopaedics	Additional clinics planned for September 21 in Orthopaedics with ambition to reduce the OP wait to within 12 weeks for routine patients by the end of March 22.	NHS Lothian	This will have a detrimental impact on TTG performance.	Progress monitored via Out-patients Recovery Board	Ambition to reduce the OP wait to within 12 weeks for routine patients by the end of March 22.	
Proposal	Pathology	Pathology Workshop identifying opportunities for improvement. Proposal/ Business Case to enhance capacity and enable additional activity in other services e.g. endoscopy	December 2021	Pathology workshop – specimen flow redesign to increase Turnaround time for USOCs. Proposal under development to enhance pathology provision.	NHS Lothian	Funding and workforce.	Progress monitored by Diagnostic Recovery Board.		
	Gynae Ambulatory Care Colposcopy- Gynae Ambulatory Care at SJH (SBC	National changes relating to HPV screening has created an increased demand for colposcopy across all Boards.	Service requires additional physical capacity and staffing resource to meet predicted demand Proposed creation of an Ambulatory Care Suite within Gynaecology services at SJH	Fully costed SBC approved in July Decant identified. 400k of revenue costs – releasing theatre time by moving activity from Day Case to ambulatory care which is a key recovery action for Gynae.	NHS Lothian	How this is shown on BADS reporting as this activity is being provided not from DC but OP. Work planned for winter and will reduce bed capacity on site at SJH (c6 beds)			BADS and principle of moving IP to DC and DC to Ambulatory/ OP.
AMBER	Reassess capacity against 1m distancing in Out-patient areas.		TBC	Outpatient departments are currently updating their plans to implement this guidance as appropriate, which is expected to increase activity further in some areas, however the space and layout of the majority of our facilities may not allow us to realise fully the benefit of reduced distancing requirements with only marginal gain.	NHS Lothian	Space and layout of the majority of our facilities may not allow us to realise fully the benefit of reduced distancing requirements with only marginal gain.	Progress monitored by OP Recovery Programme.		

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	Ref Help	Engagement with GP around Ref Help by specialty.	End of March 22	Ref Help Talks – monthly training sessions with primary & secondary care clinicians commencing Oct '21 - 3 sessions planned to date - 1st - Gynae – pelvic pain and how to prepare for referral.	NHS Lothian	Competing priorities.	Progress monitored by OP Recovery Programme.		
	Rolling deep dives across Scheduled Care specialties	- starting with high risk specialties Creating road map over next 5 years	Throughout 21/22	Orthopaedics, Urology, Dermatology and Oral Complete via Performance Oversight Board. Scheduled Care Recovery Programme will focus on supporting a programme of deep dives in priority specialties from October 21 onwards, continuing with General Surgery.	NHS Lothian	For some specialties no obvious solution.	Progress monitored by Scheduled Care Recovery Board		
Proposal	CfSD Heat Map areas of focus	Complete Heat Map agree priorities and seek support for key deliverables from CfSD	TBC / Various	NHS Lothian has completed the Heat Map tool. NHS Lothian has identified key areas we seek support from the center to embed over the next period. The CfSD has not yet agreed what support will be available. These include: - Ophthalmology NESGAT, cataract additional procedures, imaging hub - EQUiP in General Surgery, Colorectal, Vascular Surgery - ERAS in General Surgery and to all specialties at the RIE (apart from orthopaedics which is already in place) - Neurosciences ADEPt - Cardiology Heart Failure RHP	NHS Lothian	Current unstable baseline may be a barrier to delivery of some of this best practice. Funding & recruitment required to deliver e.g. establish and roll out ERAS.			CfSD Heat Map

NHS Lothian – *Winter Planning Strategic Actions* - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Grey - Proposal – New Proposal/no funding yet agreed
Red - Unlikely to complete on time/meet target
Amber - At risk - requires action
Green - On Track
Blue - Complete/ Target met

RAG Status (mandatory)	**Deliverables (mandatory)** *these can be qualitative or quantitative*	**Lead Delivery Body**	**Risks (mandatory)** *list key risks to delivery and the required controls/mitigating actions*	**Outcomes (optional)** *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	**Strategies, plans & programmes** *repeat for each applicable deliverable/add multiple programmes if required*

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Green	Plan for and allocate winter funding across the Health and Social Care system	Plan via the Unscheduled Care Committee, and with services across the system, and intergrate all winter funding sources. Complete a whole system winter readiness assessment.	Achieve funding allocation at an early stage (q1) in the year to support planning. September 2021	Through the unscheduled care committee, £2.2M of winter funding (£1.4M from SG) has been allocated across community and acute services (£361k directly to HSCPs, £1M to acute services, £337k to primary care, £132k to flu programme, £251 to POCT). This was agreed and allocated in June 2021 to support early planning and recruitment where required Checklist completed.	NHSL	Staffing & maintaining flow capacity	Early allocation of funding Continual development of winter operational plans. Daily flow management / huddles CMT oversight	System wide winter plans in place, recruitment and operational implementation of new winter schemes.	Uncheduled Care Scheduled Care
Green	ELHSCP to maintain and develop a range of existing services to support performance and flow in HSCP, Acute, and Primary Care settings.	ELHSCP to continue maintain and develop: • Hospital to Home Service • Discharge to Assess Service • Hospital at Home Service • Integrated Care Allocation Team • (ICAT) • ELCH Wards 5	Ongoing	The HSCP has a range of existing services which support prevention of ED attendance / acute admission and proactive management of flow from acute to reduce delayed discharges	NHSL / HSCP	Staffing & maintaining flow capacity	CMT oversight and system-wide planning supported via Planning, Performance and Development Committee	Continuation and progressive development and improvement of targeted support services and systems	Uncheduled Care Scheduled Care

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		and 6							
Green	WLHSCP to maintain and develop a range of existing services to support performance and flow in HSCP, Acute, and Primary Care settings.	WLHSCP to continue to maintain and develop: • REACT H@H • Care Home Team • Palliative Care Prevention of admission Pathway • Community Falls assessment • Discharge to Assess • Reablement • Flow management and flow tracker Performance • HomeFirst	Ongoing	The HSCP has a range of existing services which support prevention of ED attendance / acute admission and proactive management of flow from acute to reduce delayed discharges	NHSL / HSCP	Staffing & maintaining flow capacity	CMT oversight and system-wide planning supported via Planning, Performance and Development Committee	Continuation and progressive development and improvement of targeted support services and systems	Uncheduled Care Scheduled Care
Green	MLHSCP to maintain and develop a range of existing services to support performance and flow in HSCP, Acute, and Primary Care settings.	MHSCP to continue to maintain and develop: - Pathways and processes within Home First approach - D2A - Flow and single point of access - Hospital at Home - Care at Home -Rapid Response - CRT - Care Home Support Team - Fraility GPs -Additional 12 beds opened at MCH (Glenlee ward)	Ongoing	The HSCP has a range of existing services which support prevention of ED attendance / acute admission and proactive management of flow from acute to reduce delayed discharges	NHSL / HSCP	Staffing & maintaining flow capacity	CMT oversight and system-wide planning supported via Planning, Performance and Development Committee	Continuation and progressive development and improvement of targeted support services and systems	Uncheduled Care Scheduled Care

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		- New Care at Home Contracts starting 1st Sept - Investment in Staff Wellbeing Lead September 2021 - Development of Mental Health Single Point of Access							
Green	EHSCP to maintain and develop a range of existing services to support performance and flow in HSCP, Acute, and Primary Care settings.	EHSCP to continue to maintain and develop: • Hospital at Home Service • Discharge to Assess Service • Community Respiratory Team (CRT) • Intermediate Care Facilities (ICF): Liberton and Fillieside • Frail Hospital Based Complex Care (HBCCC) • Flow Centre Home First Navigator • Home First Navigators in ICF • Home First coordinators (Back-door) WGH /RIE • Home First coordinators (Front-door) WGH/RIE • Home First	Ongoing	The HSCP has a range of existing services which support prevention of ED attendance / acute admission and proactive management of flow from acute to reduce delayed discharges	NHSL / HSCP	Staffing & maintaining flow capacity	CMT oversight and system-wide planning supported via Planning, Performance and Development Committee	Continuation and progressive development and improvement of targeted support services and systems	Uncheduled Care Scheduled Care

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		Prevention Team • Impact • Care Homes • Care at Home • Hospital social work							
Green	Children's Services - Clinical pathway for respiratory viral infection in children	Develop and implement agreed clinical pathway	September 2021	GPs will triage under 16s with respiratory symptoms, and provide face-to-face assessment for those presenting without a cough. Those with a cough requiring face-to-face assessment are seen at the RHCYP and Children's Ward SJH via the covid community pathway.	RHCYP	May need to increase ED capacity in light of RSV planning	RSV Surge Plan	Agreed pathway and process	Uncheduled Care Scheduled Care
Green	Children's Services - Investment of winter funding & impacts	Recruit 15 B5 nursing staff and 2.6 CSWs for 4 months (Nov/Dec 21 to Mar 22 to support ED performance; reduced LOS within acute receiving unit; Number of cancelled electives.	September / October 2021		RHCYP	Staffing & maintaining flow capacity	RSV Surge Plan	Improved flow and efficiency	Uncheduled Care Scheduled Care
Green	Lothian Acute Services – implement winter investments agreed across all acute sites .	Acute Winter Plans – Themes • Non general bed based plans • 7 day cover – Enhanced AHP/Pharmacy / medical and Nursing cover • Reducing Length of Stay- Dedicated teams for Boarding patients • Admission Prevention– AHPs at front door / hot clinics • Improving flow- enhanced site and capacity / POCT / enhanced discharge facilitators • Enhanced CT capacity • Additional 4 critical beds New testing pathway for all winter respiratory viruses to be introduced for	Various	In addition to winter step-up investments, each acute site has sign-posting and redirection processes in place at front doors, and a focus on pre-12 discharges and reducing LoS. Additionally the Flow Centre supports direction of referred patients to the right site and patient transport	NHSL / HSCP	Acute pre-Winter baseline is unstable, unprecedented pressures compared to previous years & currently deteriorating Staffing & maintaining flow capacity	CMT oversight & site specific winter plans	Improved flow; reduce ALoS/OBDs; reduce cancelled procedures; reductions of delayed discharges; preventing unnecessary admission; improve 4 hr performance	Uncheduled Care Scheduled Care

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		patients exhibiting recognised symptoms; • New central laboratory testing pathways from ~Oct 21 for winter respiratory viruses incl. – SARS-CoV, – Influenza A & B, – RSV • POCT – Cepheid machine SAR-CoV2 cartridges will be replaced with multiplex respiratory virus cartridges once surveillance data indicates these are in circulation; – All other testing capability (SARS-CoV2 only) will remain unchanged; – New staffing model for Laboratories POCT incl. Site Coordinator roles to support machine installation & maintenance, consumables management and training of clinical staff.							
Proposal	West Lothian HSCP / SJH unfunded winter schemes	New. • Fast Track community social worker posts to support SPoC: 22.5k • Discharge to Assess additional investment 4 months (2 * band	TBC	New	WLHSCP	Community support	Winter plan development	New	Uncheduled Care Scheduled Care

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		6, 2 Band 4): 83k • Increase in therapy staff in SJH at weekends (2* band 6 AHP): 45k • Increase in OT rotas team front door opportunities lined to SPoC: 45k							
Proposal	Midlothian HSCP unfunded winter schemes	• Further CRT capacity - 1 WTE B6 PT or Nurse, 0.5 WTE B4 PT Asst., 0.2 WTE B8a Psychologist: 84k • Home First / Discharge to Assess - 16 WTE band 3 HSCWs (7-day working) to increase capacity of D2A team: £614k – partial funding under	TBC	New	MLHSCP	Community support	Winter plan development	New	Uncheduled Care Scheduled Care

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		discussion with IJB • Older Peoples Service - 1 WTE band 7 OT, frailty GP and third sector resource to support assessment of top ten frequent ED attenders within frailty: 77k							
Proposal	<u>WGH</u> unfunded winter schemes	• Supporting Twilight Shift – costs TBC • Proposed additional pilots - 1. PT WGH MAU Frailty project - replicate AMU project above in MAU. Cost 1 wte B6 PT = £46k per annum. 2. OT RIE AMU In Reach	TBC	New	NHSL	Acute assessment	Winter plan development	New	Uncheduled Care Scheduled Care

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		project: replicate MAU project above in AMU. Cost 1 wte B6 OT = £46k per annum.							
Proposal	<u>Flow Centre</u> unfunded winter schemes	• To support a responsive service for transporting patients and improving patient care, the following is requested. Costs TBC. Additional 1.5 x Flow Centre Vehicles to support transfers & discharges across Lothian Mon-Sun; 1 additional vehicle Mon-Sun; plus one further vehicle (0.5) running on Monday/Thursday/Friday; Plus, 0.6 wte Band 2 call handler support to manage additional booking demands.	TBC	New	NHSL	Transfer and discharge	Winter plan development	New	Uncheduled Care Scheduled Care

NHS Lothian – Children's Services - Delivery Plan Progress Report Apr-Sep 2021

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Proposal	Reduced variation in delivery of 4 hr emergency access target caused by winter pressures	Point of contact testing on presentation to A&E.	Maintain > 95% ≤4hr target to ensure flow of patients in and out of dept throughout winter months.	New	Senior Management Team	Previous supply chain issues which has affected ability of dept to deliver point of contact testing.	Intermittent problems with anticipatory procurement escalated to board.		
Green	Surge capacity for Covid-19/RSV pts is maintained to ensure resilience in the system to respond	Robust plan clearly documented for flexing capacity in PCCU and Acute Receiving Unit during surge periods and shared with key staff members. Plan to recruit additional fixed term winter nursing staff from October. Non – urgent elective activity for OP and IP to be halted if and when required to release nursing resource to the wards.	Safe staffing levels maintained throughout winter period.	Non-urgent elective IP activity halted for 2 weeks in Sept to accommodate unprecedented early surge in winter viruses by releasing nursing staff to the wards from theatres and surgical nurses to medical wards to care for acute admissions.	Senior Management Team	Staffing shortages due to self/ dependents isolation whilst PCR awaited.	Risk assessments being undertaken for staff classed as close contact and PCR negative to permit return to work ASAP. Staff resource is being allocated to where most required during bi-daily safety huddle to maintain safe staffing levels.		
Green	Maintain ability to stream Covid-19 and non-covid pathways to ensure safety	Point of contact testing on presentation to A&E. Pre-operative swabbing and subsequent isolation prior to elective admission.	Maintain > 95% ≤4hr target to ensure flow of patients in and out of dept throughout winter months. Continued ability to maintain separation of relevant patient groups.	Consistently maintained >95% target (on monthly average). Separation has been consistently maintained through either cubicles or cohorted bays.	Clinical Leads/CNMs	Previous supply chain issues which has affected ability of dept to deliver point of contact testing. Lack of cubicles	Intermittent problems with anticipatory procurement escalated to board. Reviewing pt's continued need for cubicle on daily		

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		Cohorting of patients with same virus in multi-bedded bays.				during peak surge times.	basis by ward staff.		
Amber	High quality care and support is delivered, including patient and staff experience	Reduction in elective activity (outpatient and inpatient) to release nursing and medical resource to care for acute admissions when required. Maximising OP Clinic and Theatre Utilisation when possible.	Safe staffing levels maintained on wards Reduction in breach position for OP and IP waiting lists.	Safe staffing levels consistently maintained. Breach position for OP and IP increasing due to need to suspend non-urgent elective activity during surges of winter virus admissions.	Senior Management	Significant increases in breach positions for OP and IP	WLI proposed for OP activity to reduce breach position during periods of reduced acute admissions. Conversions of IP sessions to OP sessions when elective theatre activity cancelled.		
Green	Resources provided to ensure new and effective ways or working are maintained and built upon that aim to avoid unnecessary admissions, reduce length of stay and optimise discharge without delays	Youth navigators active in A&E to reduce admissions secondary to mental health needs.	Reduction in relevant admissions.	New	Senior Management Team	Consistent availability of Youth Navigators as consequence of self isolation requirements.	Risk assessments being undertaken for staff classed as close contact and PCR negative to permit return to work ASAP.		
Green	Maintain provision of urgent and emergency care 24/7	Clinical coordinator role responsible for ensuring appropriate nurse staffing levels available out of hours. Clinical Leads responsible for ensuring appropriate medical cover available out of hours.	Urgent and emergency care consistently maintained 24/7.	Urgent and emergency care consistently maintained 24/7 to date.	Senior Management Team	Staffing shortages as a consequence of self/ dependents isolation requirements.	Staff resource is being allocated to where most required during bi-daily safety huddle to maintain safe staffing levels. Bank staff being used when required.		
Red	Resilience in place for festive period that reduces variation in 7 day working across the whole system	Unscheduled care roster/staffing levels continues to be implemented over the bank holidays and weekends.	Safe unscheduled care staffing levels to be consistently maintained over festive and winter period.	Variation continues as resources do not permit consistency in 7 day working.	ADMD/AND	Insufficient staffing resource to maintain 7 day working consistency.	Unscheduled care roster in place for weekends/bank holidays.		

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Green	Effective and robust escalation plans are in place.	Winter surge planning group meeting every 2/52. Clearly documented escalation plans for PCCU and Acute Receiving Unit. Senior management meetings following 8am safety huddle to agree degree of escalation required.	Plans consistently put in to action during surge activity periods.	Non-urgent elective IP activity halted for 2 weeks in Sept to accommodate unprecedented early surge in winter viruses by releasing nursing staff to the wards from theatres and surgical nurses to medical wards to care for acute admissions.	Senior management	Staffing shortages as a consequence of self/ dependents isolation requirements.	Staff resource is being allocated to where most required during bi-daily safety huddle to maintain safe staffing levels (including RHCYP staff being sent to SJH). Bank/Locum staff authorised to be used if/when required.		
Green	Adequate alternative care for patients with urgent problems who may be better cared for closer to home.	Stabilisation of nursing and medical staffing in SJH.	Maintaining all beds open 7/7 a week at SJH. Providing inpatient care at SJH for local children where clinically appropriate. Potential covid assessments referred from West Lothian GPs being maintained at SJH	SJH Children's Ward remained open consistently since reopening 24/7 in October 2019 with consistently stable nursing and medical staffing in place.	SJH Clinical Lead/ SJH CNM	Staffing shortages as a consequence of self/ dependents isolation requirements.	Staff resource is being allocated to where most required during bi-daily safety huddle to maintain safe staffing levels (including RHCYP staff being sent to SJH). Bank/Locum staff authorised to be used if/when required.		
Green	Support and promote the wellbeing of staff working in ED	"Wellbeing" lead working in the department putting on regular activities and events.	Good uptake and feedback from the department from the activities put on.	Strong uptake from department on wellbeing initiatives being implemented.	ED Clinical Lead, Medical CNM	Ability to maintain wellbeing activities during periods of short staffing.	Bank/Locum staff authorised to be used if/when required to maintain safe staffing levels.		
Green	Eradicate crowding and corridor care and reduce ambulance handover time.	Intermittent use of OPD department facilities when required. Additional medical staff present on site but not on call called upon to help during peak times to ensure flow from ED. Point of contact testing on presentation to A&E.	Ability to maintain 1m social distancing in waiting areas. Maintain > 95% ≤4hr target to ensure flow of patients in and out of dept.	Short lived instances of crowding relieved by opening up of OPD out of hours for A&E patients to be seen in. Consistently maintained >95% target (on monthly average).	ED Clinical Lead, CNM on call and Clinical Coordinator	Previous supply chain issues which has affected ability of dept to deliver point of contact testing.	Intermittent problems with anticipatory procurement escalated to board.		

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Amber	Prioritise covid and flu vaccination of workforce.	Staff actively encouraged and supported by direct line management to attend vaccinations provided on site during work pattern.	Majority of staff now double vaccinated for COVID. Flu and Covid booster vaccination planning for staff currently underway using onsite/ in house vaccinators.	New	Senior Management Team	Staffing shortages might affect ability to free up vaccinators from ward activity.	Staff resource is being allocated to where most required during bi-daily safety huddle to maintain safe staffing levels (including RHCYP staff being sent to SJH). Bank/Locum staff authorised to be used if/when required.		
Red	Remote patient access	Telephone and Virtual appointments have been encouraged to be offered where clinically appropriate	NHS Lothian prescribed target of 30% virtual/remote appointments	Currently sitting below 20% of all appointments offered being done remotely due to clinicians reporting an inability to effectively assess a child through those mediums offered (particularly when patient being assessed for the first time.)	Service Management Team	Increased risk of breach position deteriorating as reduction in appointments being offered whilst maintaining social distancing.	Telephone review appointments for known patients being actively encouraged. Social distancing for OP reduced to 1m from September 2021.		

NHS Lothian – Unscheduled care, RUC and reducing delayed discharge - Delivery Plan Progress Report Apr-Sep 2021

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	Phase 1 RUC Urgent Care Pathway	- Maximise reduction and scheduling of self presenter attendance - Recommend SCDM model within FNC. - Continue robust local comms to optimise stakeholder understanding of urgent care. - Schedule all minor injury attedances Pan Lothian. - Embed triage and re-direction. - Audit service user experience	March 22 November 21 Ongoing November 21 March 22 March 22	Early implementation of RUC phase 1 continues to be closely monitored taking into consideration the impact of the pandemic and the way services are accessed pre and post Covid19. Scoping in progress to review and recommend SCDM model within FNC. Local comms and stakeholder engagement are continuing in line with national comms plan. New – Implementation plan in progress to ensure robust triage / re-direction and scheduling of all adult minor injuries presentations Pan Lothian. Ongoing development and implementation of triage and re-direction policy Pan Lothian within acute front door settings and FNC. New – initial scoping commenced and implementation plan will be developed in line with national guidance.	NHS Lothian	Significant workforce pressures. Lack of public engagement increasing demand.	Ongoing monitoring of the workforce pressures and escalated where appropriate. Ongoing monitoring of demand and escalate where appropriate. Targeted communication to reduce inappropriate attendance and increase awareness of alternatives services / pathways.		RUC EA 4 (Flow through medical, surgical and interface care) EA 2 (Building capacity and capability)
	Phase 2 RUC Prof to Prof Urgent Care Referral Pathways	- Ensure clear referral pathways for GP's, SAS, AHP's to Interface Care Services i.e hot clincs, MIA, SDEC - Develop Pan Lothian SDEC model - Ensure clear referral pathways for GP's, SAS to Community HSCP and Urgent Care Pathways. - Develop MSK Urgent Referral pathways	November 21 ? March 22 November 21 March22 March 22	Referral pathways in place for GP, community pharmacy and SAS referrals to schedule MIA appointments. GP / SAS referral pathways inplace to SDEC (North Edinburgh) Review underway of current GP referral pathways to secondary care services. Options appraisal undertaken for Pan Lothian SDEC model. Recommendation to be approved and implementation plan to be developed. Developement of Lothian HSCP SPOA's established and accepting / triaging GP urgent care referrals. Edinburgh HSCP/ SAS referral pathway developed, will be rolled out across Lothian in due course. New – Initial scoping underway to review urgent MSK criteria/ pathways and processes. New - Develop and implement a Pan Lothian urgent care referral	NHS Lothian / HSCP/SAS	Significant workforce pressures. Lack of stakeholder engagement.	Ongoing monitoring of the workforce pressures and escalated where appropriate. Ongoing monitoring of demand to escalate where appropriate Regular communication/engagement to reduce inappropriate attendance and increase awareness of alternatives services / pathways.		RUC EA4 (Flow through medical, surgical and interface care) EA 6 (Care closer to home)

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		- Develop Urgent Mental Health and Distress Pathways - Optimise and Improve Community Pharmacy within Urgent Care	March 22	pathway from NHS24 via Lothian FNC to MHAS /ACAST with SCDM. New- Integrate community pharmacy into Lothian Urgent Care via promotion of self care, triage / re-direction and development of referral pathways (MIA)					
	Expanding community capacity to reduce hospital admission commencing with H@H services.	- Review of Lothian H@H service against the H@H HIS standards and principles.	March 22	New – Allocated HIS funding. Key stakeholders identified and Initial steering group arranged.	NHS Lothian	Lack of standardised and consistent operating policies across the services.	Provide uniformity and efficiency across services.		EA4 (Flow through medical, surgical and interface care) EA 6 (Care closer to home)
	Improve discharge planning by collaborative working between HSCP and acute colleagues to reduce delayed discharges.	- Test of Change with PDD model within Acute and ICF - Model Ward care planning - Monitoring trajectories - Development of a draft Pan Lothian Discharge and Transfer Policy	March 22 Ongoing September 21 November 21	- Improving data collection with current systems. Implementing a whole system approach from EDD to PDD. - Model Ward work commenced July 2021 with wide spread implementation across adult wards within acute sites. - Establish HSCP DD Trajectories and closely monitor progress. - Update the existing Discharge Policy to reflect an inclusive pan Lothian approach. - Include appropriate associated materials such as SOP's/Guidance. - Design new literature to support effective discharge planning. - Improve pre-12 patient discharges. - Draft Policy reviewed at the 2nd PDD – SLWG in August. Implementation plan progressing. - Reducing length of stay.	NHS Lothian NHS Lothian & HSCP	Significant workforce pressures and inpatient capacity affecting timeline. Challenges with local variations. Embedding same way working when there are multiple localities to consider involving a wide range of specialties.	Embedding Trak changes to avoid manual data collation. Increased use of Discharge Lounges to support pre-12 discharges Ensuring consistence in approach. Close working with Health & Social Care to identify barriers and find resolve to embed processes that align to the policy.		EA3 (Optimising Patient Flow) EA4 ((Flow through medical, surgical and interface care) EA5 (Reducing variation across 7 days)
	Review of Frequent Attenders	- Review the existing joint process for Health and Social Care Partnerships (HSCPs) and acute working to reduce presentations of people to emergency departments at point of crisis.	September 21	SLWG commenced with all key stakeholders across Acute & HSCP.	NHS Lothian & HSCP	Lack of consistency of services across partnership working.	Review all existing services to ensure all community services are maximised. Share the learning across all partnerships.		EA 6 (Care closer to home)
	Increasing flow & capacity within Intermediate Care	- Enhancing community pathways to free up capacity within acute sites	Ongoing	- ELCH Ward 5 (20 beds) and 6 (16 beds) opened to support flow - MLCH Glenlee Ward (16 beds) opened to support flow - All potential options being reviewed to create community-based capacity specifically focussing on early intervention, urgent care, prevention of admission.	HSCP	Challenges include lack of care provision, available care home capacity and recruitment and retention issues (ongoing national concern).	Review opportunities to create a sustainable reduction in delayed discharges by increasing investment in Home First rehab and bed-based pathways to enable an integrated approach to support whole system flow.		EA3 (Optimising Patient Flow) EA 6 (Care closer to home)

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						Requirement for care at home capacity within Local Authorities to underpin all approaches to ensure flow			

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Amber	GP face to face consultations	Increase access to face to face consultations in GP practices where appropriate Maintain option of telephone, video or email consultations as appropriate	TBC	All NHS Lothian GP practices are providing face-to-face consultations. This has been constrained with the IPC guidelines.	NHS Lothian PCCO/4 HSCPs/ GP Sub-Committee	Lack of understanding by public about why general practice is working differently	Updated Public Health Scotland Guidance General Practice Recovery Guidance GP Sub-Committee Practice Action Plan NHS Lothian infrographic: Why are GP practices still working differently?		NHS Recovery Plan August 2021
Green	GP Enhanced services	Clinical aspects of Enhanced Services have been maintained throughout the covid19 pandemic	From April 2022	Clinical aspects have been delivered with administrative and organisational aspects of Enhanced Services, data collection and payment thresholds to be reinstated.	NHS Lothian PCCO/4 HSCPs/ GP Sub-Committee	No risk identified			
Amber	Community covid triage service and Covid Assessment Centres		Maintain in line with SG guidance – working assumption until end of March 2022	Community Covid Pathway continues to be delivered in Lothian	NHS Lothian PCCO/Flow Centre	Workforce availability			
Amber	GP contract MOU commitment VTP		GP practices will not provide any vaccinations under their core contract from 1 April 2022	East Lothian: Delivered the flu vaccination programme - planning is underway for delivery of all previously GP delivered vaccinations and for existing and new COVID jags Midlothian: Seasonal Flu transferred from General Practice for Autumn 2021. Responsibility for some vaccinations will remain with General Practice until April 2022 or sooner if CTAC in place sooner for all practices. Cross reference to HSCP plans	NHS Lothian PCCO/4HSCPs/ GP Sub-Committee	Changing plans at national level Premises/ accommodation	PCIP Trackers		Memorandum of Understanding (MoU) 2 GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards
Amber	GP contract MOU commitment CTACS		Boards are responsible for providing a Community Treatment and Care service from April 2022	East Lothian: Established Community Treatment and Care (CTACs) bases around East Lothian Midlothian: CTAC Pilot underway with three-practices. Learning from pilot and other models across Scotland will inform preferred approach in Midlothian. CTAC provision (integrated with TRN services run by HSCP) will be established by April 2022. Cross reference to HSCP plans	NHS Lothian PCCO/4HSCPs/ GP Sub-Committee	Premises/ accommodation Workforce Funding over and above the PCIF	PCIP Trackers		Memorandum of Understanding (MoU) 2 GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards

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Amber	GP contract MOU commitment Pharmacotherapy		NHS Boards are responsible for providing a pharmacotherapy service to patients and practices by April 2022	East Lothian: Provided pharmacotherapy services to all practices, with further increases planned Midlothian: Provided pharmacotherapy services to all practices, with further increases planned. Current recruitment underway to establish a remote med recs team to provide reliable service to all practices Cross reference to HSCP plans	NHS Lothian PCCO/4HSCPs/ GP Sub-Committee	Funding Workforce Agreed definition of a pharmaco-therapy service	PCIP Trackers		Memorandum of Understanding (MoU) 2 GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards
Amber	GP contract MOU commitment		Develop and support GPs to fulfil the role of the Expert Medical Generalist (undifferentiated presentations, complex cases, clinical leadership)		NHS Lothian PCCO/4HSCPs/ GP Sub-Committee	No risk identified			
Amber	Community Pharmacy	Increasing utilisation of serial prescribing	Ensure eligible patients on chronic medication are switched from repeat to serial prescribing	New Funding of £100k secured via Sustainability and Value directorate to undertake directed project in a cohort of practices. Funding is available to create dedicated time for pharmacy/practice staff to review and switch appropriate patients. 45 practices have indicated willingness to grow serial prescribing with 37 actively taking part. Target is 10% of repeat list switched by end of 2021. Community pharmacies have been briefed to expect an increase in serial prescribing numbers and have received training on systems.	NHS Lothian PCCO/ Community Pharmacy/ 4HSCPs	Low numbers of practices taking part.	Figures for participating practices are monitored monthly via NSS data and reported regularly via Primary Care Prescribing Forum.	Serial prescribing has been shown to reduce early ordering and overordering of repeat medication. Significant overordering was noted at the onset of the pandemic, therefore serial prescribing may control medication supply at future waves. A move to serial prescribing will also reduce the footfall and prescription ordering traffic into GP practice.	NHS Recovery Plan August 2021 GMS Contract 2018 – Pharmacotherapy Lv1 Achieving Excellence in Pharmaceutical Care
Amber	Dental	Increasing activity towards pre-covid levels of activity	In line with SGHD timescales review list of practices returning less than 20% pre-covid activity each month and follow up	New Initial contact with practices at less than 20% for July paid August schedules	NHS Lothian PCCO/ Director of Dentistry	Restrictions posed by current infection control guidance/fallow time requirements Workforce-recruitment and retention	Monthly returns to SGHD Action plans to be agreed with each practice at less than 20% of pre-covid activity each month	Increase activity as measured by monthly data from PSD based on GP17 forms	NHS Recovery Plan August 2021
Amber	Optometry	New DES for Complex conditions enabling more complex anterior (front) eye conditions to be managed by Independent Prescriber optometrists in community practices instead of patients having to be referred to the Eye Pavilion The rollout of the new community glaucoma scheme allowing stable glaucoma and ocular hypertension patients to be discharged from the Hospital Eye Service and managed independently by accredited community optometrists with support from NES.	In line with SGHD timescales	New All dependent on further information from SGHD	NHS Lothian PCCO/ Ophthalmology	No risk identified			NHS Recovery Plan August 2021

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		A new national low vision service for visually impaired people provided by accredited community optometrists and dispensing opticians. Under this service patients will be assessed and provided with appropriate low vision aids in the community.							
Amber	Redesign of interface bweteen LUCS (Lothian GP OOH service), Flow Navigation Centre and Covid Hub LUCS working closely with FNC, COVID Hub, RUC, secondary care etc to provide alternatives to admission	- Maximise use of clinicians and multidiscipinary team to act as SCDM - Optimise triage points in patient journey - Minimise admissions by closer working with palliaitive care and DN services, H@H, CRT and Care Homes	March 2022	New	NHS Lothian	Staffing issues	Ongoing monitoring of flow of work through separate streams to understand feasibility and work load/work force pressures Search for Location of combined triage hub Recruitment to clinical and managerial oversight of combined triage hub		RUC EA 4 (Flow through medical, surgical and interface care) EA 2 (Building capacity and capability)
Amber	Staffing of LUCS rotas and management positions	- Ongoing recruitment to GP salaried, HCSW and nurse practitioner posts - Management roles for CSM and CNM ongoing recruitment - Continue robust pursuit of terms and conditions for GPs in OOH including study leave - Continued robust discussion of nurse renumeration to prevent loss of staff to in-hours	October 2021	Increasing proportion of GP shifts covered by salaried rather than ad hoc GPs Ongoing recruitment into nursing positions Successful appointment to nursing and HCSW positions Recruitment into CSM applications close 15/9/21	NHS Lothian	Staff morale Losing nurses to day time practice almost as soon as they finish clinical decision-making and prescribing courses with LUCS Base closures as a result of poor staffing levels	Ongoing monitoring of work force pressures, recruitment initiaitves		EA5 (Reducing variation across 7 days) EA 6 (Care closer to home)
Amber	LUCS Home triage capability	- Maximise GP work force availability to work from home during periods of surge, especially with COVID calls - Increase VC Near me consultations - Obtain ePrescribing capabilities to allow remote	October 2021	New	NHS Lothian	Cost, training issues, IT issues with lack of OOH IT support, less GPs available to work in bases or do home visits	Ongoing monitoring of surge and capacity Ongoing monitoring of available staff for PCC, base triage and home visits Ongoing advertising of availability of triage shifts Ongoing requirement for OOH IT support for ADASTRA users		EA 2 (Building capacity and capability) IT

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		triaging							

NHS Lothian – West Lothian Health and Social Care Partnership - Delivery Plan Progress Report Apr-Sep 2021

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Green	Care home assurance	Daily assurance and oversight of care home risks and required supports	Deliver a sustainable care home model of	Daily oversight of care homes continues and proposals have been developed on a model	WLHSCP	Care home closure Covid outbreaks Welfare of residents	Daily mulit-disciplinary oversight meetings of WL Care Home Clinical and Care Professional Oversight Group	Assurance delivered over infection prevention and control in care homes	Coronavirus (COVID 19): enhanced professional clinical and care oversight of care homes- Scottish Government. WLHSCP Health and Care Governance Framework
Amber	Supply of care at home	Weekly oversight meeting Weekly oversight of demand, capacity and waits. Weekly submission of unmet need to Scottish Government	Weekly monitoring	Good progress made with maintaining whole system flow with adequate supply of care at home until August 2021 when supply of care at home became more unreliable. Delayed discharges low but now rising. Recruitment and retention challenges being reported in both internally and externally commissioned services for carers.	WLHSCP	Community service users at risk. Delayed discharge.	Weekly oversight meeting of care at home supply Weekly analysis of commissioned hours and unmet need to identify risk Engagement with care providers Targeted recruitment and support via Employability Service	Improved supply of care are home	IJB Strategic Plan and supporting strategic commissioning plans.
Green	Progression of Home First programme	Transformational change programme for older people and unscheduled care – 3 workstreams: bed based, community, single point of contact & information	Programme plan in place setting out milestones until 2023.	Workstreams established and progress report due to IJB in November 2021 Exploring expansion via future investment in discharge to assess to improve whole system flow	WLHSCP	Services unable to meet demand and are unsustainable for the future	Project and Transformation Boards established Data set being developed to monitor DCAQ Oversight by Strategic Planning Group and IJB	Transformational change to deliver sustainable model of health and social care in West Lothian	Strategic Commissioning Plan for Older People and Unscheduled Care
Green	Support for carers	Implementation of new carers strategy through new Carers Strategy Implementation Group	Update to IJB in September 2021	Implementation Group established and project plan developed to progress priorities and recommend funding decisions	WLHSCP	Carers have insufficient support to continue in caring role. Risk of avoidable hospital admission	Oversight of progress by implementation group	Carers feel supported to continue their caring role Increased numbers of carewrs accessing information, advice and support Uptake of adult care support plans	IJB Strategic Plan

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Green	Support for people who use substances	Face to face and digital group supports	Services resumed in line with national guidance on physical distancing	All services have continued during the pandemic albeit some have been adapted and include online provision. Work is underway to consider what hybrid models of service delivery will look like going forwards.	WLHSCP	People unable to access the support they need	Hybrid model of support being developed to accommodate face to face and online service delivery		Substance Misuse Strategic Commissioning Plan
Green	Community nursing/health visiting	Capital investment in technology to support community nursing teams to modernise ways of working and maximise capacity	Revised ways of working embedded by March 2022	Substantial investment secured to roll out digital technology to district nursing and health visiting teams. Project plan in place for roll out of programme which includes training and support for staff in new ways of working.	WLHSCP	No specific risks to service delivery identified	Delivery plan agreed and monitoring meetings in place		IJB Strategic Plan
Green	Hybrid models of working	Review of use of office space and models of working including home and hybrid	Identify options for future models by December 2021	A review is underway of office based staff who have worked from home or via a hybrid model during the pandemic. Learning is being used to develop revised models for the future and review accommodation requirements.	WLHSCP	Staff are not supported in new ways of working Impact on staff absence	Risk assessments Line manager support iMatter survey for HSCP	Staff feel supported at work	IJB Workforce Development Plan
Green	Support for staff to remain or return to work	Develop model of support for staff within the WLHSCP through Lothian Work Support Services	Implement enhanced support model for staff by March 2022	WLHSCP will host Lothian Work Support Services from and will put in place an enhanced model of support with the aim of supporting health and social care staff to remain at work or return to work earlier.	WLHSCP	Impact on service delivery from staff sickness absence	Performance measures to be developed.	Improved attendance at work and positive impact of length of absence.	IJB Strategic Plan
Amber	Podiatry	Development of recovery plan to address waiting times	Recovery plan to be developed	Work commenced to explore demand, capacity, activity and queue (DCAQ). Work underway to explore digital opportunities for service improvement	WLHSCP	Risk to patient care	DCAQ analysis Senior management oversight	Improved access to podiatry services	
Green	LD Respite	Monitor uptake of LD respite provision to ensure carers are supported to continue in their caring role	Monitor uptake of respite provision to March 2022	LD respite provision has already remobilised but uptake is lower than it was pre pandemic.	WLHSCP	Carers are unsupported to continue in their caring role	Monitoring of respite provision and engagement with service users and carers.		Learning Disability Strategic Commissioning Plan WL Carers Strategy
Green	LD Day Services	Full resumption of learning disability day services as national guidance allows	Services resumed in line with national guidance on physical distancing	Learning disability day services have resumed albeit with reduced capacity to comply with physical distancing requirements. Next phase will to be remobilise as national guidance allows	WLHSCP	People do not have access to support	Monitoring uptake of day servie provision	More people able to access day services	IJB Strategic Plan Learning Disability Strategic Commissioning Plan
Green	OT Assessments	Full assessment of impact of pandemic on OT assessment waiting times	Reduction in waiting list.	Waiting lists for OT assessment have increased as a result of physical distancing measures during the pandemic. Work is underway to look at DCAQ activity and develop a programme to address waits.	WLHSCP	Risks associated with appropriate support being unavailable or delayed	Planning and commissioning board oversight/senior manager oversight	Shorter waits for OT assessment	IJB Strategic Plan and strategic commissioning plans

NHS LOTHIAN – EDINBURGH HEALTH AND SOCIAL CARE PARTNERSHIP - Delivery Plan Progress Report Apr-Sep 2021

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SOCIAL CARE DELIVERY PLAN ACTIONS									
GREEN	Day Opportunities for Older People - Remobilisation of safe centre based support	All centre based day opportunities were suspended, with remote and digital supports provided throughout the pandemic. Route Map Board, provided with assurance that remobilisation plans comply with the current national guidance	All Day Opportunities will safely remobilise centre based activites in a planned way July – September 2021	All Day Opportunity providers have indicated safe remobilisation plans, and are on track to resume centre based activities. This is likely to be complemented with ongoing remote support, where appropriate, and as staff availability allows.	Various third and voluntary Sector, through EHSCP Commissioned provision	Staff availability if become covid positive Pent up demand	Regular lateral flow tests as recommended Referal, triage and prioritisation. Central allocations to optimise available places	Provision delivered safely with available staff Priority cases will be managed	Prevention, early intervention Carer support through delivering a short break from caring Right care, right time, right place
GREEN	Be Able - Remobilisation of intense 6 week programme of reablement support	Be Able was suspended Route Map Board, provided with assurance that remobilisation plans comply with the current national guidance	Be Able will safely remobilise in a planned way September 2021 onwards	Remobilisation underway	EHSCP	Staff availability if become covid positive Pent up demand	Regular lateral flow tests as recommended Referal, triage and prioritisation. Central allocations to optimise available places	Provision delivered safely with available staff Priority cases will be managed	Prevention, early intervention Supporting discharge and preventing avoidable admission Right care, right time, right place
GREEN	Carer Supports - Remobilisation of face to face carer supports	All centre based day opportunities were suspended, with remote and digital supports provided throughout the pandemic.	Face to face support will safely remobilise in a planned way, August 2021 onwards	GREEN Remobilisation underway	Various Third and voluntary sector, through EHSCP commissioned provision	Staff availability if become covid positive	Regular lateral flow tests as recommended	Provision delivered safely with available staff	Prevention, early intervention Supporting discharge and preventing avoidable admission Carers support, against 6 key priority areas Edinburgh Joint Carers Strategy 2019-2022

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						Pent up demand	Referal, triage and prioritisation. Enhanced contract values in place form Jan 2020, with flflexible approach by providers to provide support	Priority cases will be managed A flexible, responsive approach will be delivered for carer support	Right care, right time, right place
GREEN	Carer Supports - Integrated Carer Support Teams remoblising with a presence in Hospitals and GP surgeries, to identify carers, complete assessment and plan, and provde immediate support where possible	This will resume to have presence as pre pandemic, as restricitions ease	To have presence again from as restrictions ease, to identify carers and complete plans and provide support	remobilisation underway	EHSCP	Staff availability if become covid positive	Regular lateral flow tests as recommended	Provision delivered safely with available staff	Prevention, early intervention Supporting discharge and preventing avoidable admission Carers being identified and supported, against 6 key priority areas Edinburgh Joint Carers Strategy 2019-2022
PROPOSAL	Carer Recovery Funding - £250k allocated form national recovery funding, to assist carer providers	plan to be determined	TBC / plan to be determined	New	Third and Voluntary sector providers through EHSCP commission	N/A	TBC	TBC	TBC
GREEN	Carer Supports Older People Day Opportunities Be Able Full remobilisation, to optimum capacity	Full resumption	Full resumption by March 2022 pending no further restricitions	remobilisation underway	Third and Voluntary sector providers through EHSCP commission	Staff availability if become covid positive Pent up demand; potential pressure on purchasing budget through spot purchases	Regular lateral flow tests as recommended Referal, triage and prioritisation. Managed allocations to optimise available places	Provision delivered safely with available staff Priority cases will be managed	Prevention, early intervention Supporting discharge and preventing avoidable admission Carer support through delivering a short break from caring Carers being identified and supported, against 6 key priority areas Edinburgh Joint Carers Strategy 2019-2022 Right care, right time, right place
GREEN	Carer Support - £2m investment in Purchasing Budget for replacement care	Investment to purchasing budget	ability to determine level of replacement care to support carers	On track	EHSCP through locality allocation	Ability to accurately record activity against this investment – to attribute to carer support	work with available systems to achieve best reporting	investment impact will be determined	Prevention, early intervention Supporting discharge and preventing avoidable admission Carer support through delivering a short break from caring Carers being identified and supported, against

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									6 key priority areas Edinburgh Joint Carers Strategy 2019-2022 Right care, right time, right place
GREEN	Day Support for adults with a learning disability	Implementing SG guidance set against the level system to increase access to day support	To return to full capacity within the Covid guidelines	All day support services are operating at the capacity available within the guidelines	EHSCP	Physical distancing leads to reduced capacity in buildings and transport	Offer a mixed response that requires less building based support		Prevention, early intervention Right care, right time, right place
AMBER	Remobilisation of bed based respite services for older people	Reopening bed based respite services for older people which were suspended during the COVID-19	Bed based respite services for older people will remobilise safely in a planned way between September and January 22	NEW – Bed based respite services tasked with developing safe remobilisation plans to resume bed based services. As bed based respite services for older people are provided by EHSCP in a care home environment, similar requirements will be in place such as testing and access restrictions	EHSCP	Staff availability (isolation requirements) IP&C Increased traffic in a care home environment	Regular testing and new isolation rules IP&C requirements to be developed as part of remobilisation plan Reduction in capacity & LOS to support distancing and IP&C measures & to ensure equity – triage and prioritisation	Provision remobilised safely with appropriate staffing numbers Safe and infection free environment Careful management and monitoring of referrals to ensure fair allocation	Prevention, early intervention Carer support through delivering a short break from caring Person centred care Managing our resources effectively Right care, right time, right place Bed based care, Transformation
GREEN	Remobilisation of bed based respite services for people with Learning Disabilities	Facilitating bed based short break services for people with learning disabilities	No plans to reintroduce bed based breaks in their previous form between now and March 2022, continuing with temporary measures to ensure alternative provision	NEW – Bed based short break services remain suspended but the facility has been used to provide continuing care and support to individuals where their living arrangements have broken down and they require a temporary place of safety until alternative supports are put in place. At present we are not using any bed based short breaks however, we are facilitating domestic properties for people with learning disabilities to access an overnight short break with a local social care provider of their choice, the EHSCP are not facilitating the support staff for this service.	EHSCP / Third sector / independent care providers	Staff availability (isolation requirements) IP&C Provider capacity	Regular testing and new isolation rules IP&C measures in place Close working relationships to mitigate any risks as they arise	Provision of emergency continuing care and support in crisis Innovative breaks through non traditional provision	Prevention and early intervention Carer support through delivering a short break from caring Person centred care Managing our resources effectively Right care, right time, right place
AMBER	Remobilisation of care home capacity	EHSCP care homes have paused admissions due to the bed based care proposals however, work has begun to identify the best use of these beds during the winter period until decision has been reached	Care home capacity to be utilised in the newer care homes; awaiting decision on whether additional care home capacity can be used on an interim basis	Admissions to newer care homes not affected by the bed based proposals underway, awaiting decision on interim use of remaining care home capacity	EHSCP	Staff availability (Isolation requirements and recruitment challenges) Covid outbreak Bed based care proposals	Regular testing and new isolation rules Recruitment planned to cover winter Following HPS guidance when there is an outbreak Decision needed on interim use of beds	Utilisation of available capacity in newer care homes Utilisation of available capacity on an interim basis for remaining care homes Supports hospital discharge	Managing our resources effectively Right care, right time, right place Bed based care, Transformation
RED	Remobilisation of care at home capacity	There are significant problems with recruitment and retention linked to COVID19 pressures, end of furlough scheme and Brexit.	To stabalise existing market enabling them to provide existing packages of care and support safely Supported engagement campaign to raise	Very limited movement due to unstable market; Recruitment and retention challenges and fatigue across the home care and care at home workforce	EHSCP Third party providers, voluntary and independent sector	Inability to recruit Staff shortages Fatigued	Supported engagement campaign to raise awareness of employment opportunities Regular testing and new	Supports hospital discharge Prevention of admission Reduction of unmet	Right care, right time, right place Managing our resources effectively Making best use of capacity across the system Person-centred care

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		Our internal services and external providers continue to experience significant pressure with staff isolation, increased sickness for other reasons from an exhausted workforce and requirement for annual leave to facilitate a break.	awareness of employment opportunities in H&SC Continuation of new over 65 care at home contract codesign with external providers for longer term improvements in care delivery within a One Edinburgh context			workforce Insufficient resources Low paid	isolation rules Data gathering and benchmarking against pre pandemic years to understand the root cause	need Partnership working	
GREEN	Community mobilisation plan	3 year programme to embed new ways of working with communities and third sector, to increase community capacity and improve partnership working. Plan approved by EIJB in April 2021. Current grants programme extended for one year with intent to develop and implement new community commissioning model to support and fund community activity in the longer term.	Extended grants programme to cover 12 months from March 2022. Public and community engagement running until end of September 21. Define community commissioning model, codesign of community anchors model and agree commissioning process – March 2022.	Plan approved in April 2021. Good progress being made. Workstreams being accelereated. Initiatives which have been successful locally and nationally being scaled up. Programme currently considering social enterprise options for delivery.	EHSCP	Fatigued third and community sector – may struggle to engage Political/ reputational risk associated with moving away from current grants process	Ongoing engagement and coproduction.	Reduction of unmet need Partnership working	Prevention and early intervention Person centred care Managing our resources effectively Right care, right time, right place
GREEN	Home First	Gradual implementation of Planned Date of Discharge in our acute settings will introduce proactive discharge planning earlier in the patient journey, this is currently being trialed in 2 settings at present with a 3rd about to come online. The implementation of PDD is following a PDSA approach and we are learning from each site. Work is also ongoing in relation to prevention of admission with existing services changing their operating models to accept direct referrals (hospital at home) meaning attendance at ED is not required. The introduction of dedicated Home First	Continuing expansion of PDD between now and March – likely to take 18 - 24 months to implement fully Hospital at Home have expanded their service offering and this is working well, consideration will be given to additional referral sources based on H@H capacity Recruitment is ongoing to the Home First navigator posts in specific services, some are in post with the remaining posts recruited to and awaiting start dates	Progress has been steady leading up to September and will continue over the coming months. PDD is being expanded a ward at a time, learning from the previous ward experience. H@H has introduced a number of different referral routes, SAS can refer directly as well as ED referrals and GP out of hour referrals (weekends) for care home residents. These are all working well and further referral sources will be considered aligned to H@H capacity. Virtual clinics have also been introduced. A test of change was completed earlier in the year with a Home First Navigator posted within our Intermediate Care service, due to the success of this trial, these posts have been recruited to permenantly in intermediate care, HBCCC and supporting the front door teams at both acute hospital sites in Edinburgh.	EHSCP	Introduction of new ways of working in the current landscape is challenging Staff fatigue Recruitment challenges	Continued support to teams adopting new ways of working and data to evidence the impact on the patient's experience Ongoing monitoring By recruiting to permenant positions rather than temporary / fixed term positions means the roles are more attractive and receive greater interest	Reduction in patient length of stay Reduction of patients becoming delayed Prevention of admission Multidisciplinary working Supported discharge planning	Prevention and early intervention Person centred care Right care, right time, right place Making best use of capacity across the system

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		navigators into services supports acute teams with discharge planning and provides a single point of contact for staff and patients to liaise with.							
PAIN MANAGEMENT DELIVERY PLAN ACTIONS									
Green	Pain Management Service - Quality of life as part of clinical prioritisation and treating pain management as essential care, recognising the links to mental health	The Pain Management Service was identified as an essential service and only stopped briefly at the start of the pandemic response. The pause in service delivery was to allow new ways of working including telephone / Near Me consultations to be established. To replace the evidence based group programme, which operated face to face pre pandemic, a digital programme via Webinars was set up. This has now been replaced by an online programme via the Cisco platform. The majority of individuals access the group programme via this model but for those who are unable to engage using technology a face to face programme was re-established in June 2021.	To remobilise within Covid regulation and guidance.	Pain Management Service continues to deliver as it did pre Covid although the model of delivery has changed.	Edinburgh HSCP	Failure of IT Numbers of individuals attending the face to face group programme are still restricted due to physical distancing requirements	Laptops issued which has improved accessibility for staff – VC fails less often (compared to Wyse) Risk assessments are in place to manage the risk of Covid transmission for staff and individuals attending. The number of face to face groups and individual face to face assessments held per week is currently reduced to manage the overall footfall in the department.		Pain Management Recovery Framework
Proposal	Pain Management Service - Communicating with, and supporting, people with chronic pain needs (including in primary and community care)	Pre Covid, community based Pain Management Programmes were piloted in East Lothian and West Lothian by delivering services in GP Practices. These pilots were successful but have not yet been funded in the longer term. During the pandemic response	TBC	New. Priority is consistent delivery of the current model at present. Also analysis of data to allow the development of a proposal for a Hub and Spoke model.		Cohort of people who would benefit from the service are not engaging	Face to face activity will increase when physical distancing restrictions change which will allow those finding it difficult to engage using technology to access the service. It is anticipated that a blended model will continue as this has allowed a different cohort to engage if they previously had difficulty		Pain Management Recovery Framework

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		the priority was to retain service delivery in the central service especially while remote delivery models were utilised, economies of scale supported the centralised service and footfall to hospital and community premises was restricted to essential face to face activity only. The Pain Management Service aims to develop a Hub and Spoke model in the future but this will require a review of allocated resources and investment to ensure it is viable. The expectation is that there would be outreach clinics to address the unmet need of individuals who are unable or unwilling to access the centralised service either due to limited access to technology or inability to travel. In other respects, accessibility has increased during Covid due to virtual appointments which individuals have embraced as it allowed them to access services without the need to travel or expose themselves to the risk of Covid transmission. Pre and post Covid accessibility is currently being analysed to assess the impact on access and engagement with the service.					travelling to the central service. Plan to review Hub and Spoke model of delivery across Lothian but may require reallocation of resources to ensure viability.		

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Green	Pain Management Service - Reducing the backlog of referrals to pain services and addressing the needs of people in chronic pain waiting longer across the wider elective care waiting list	As noted above the Pain Management Service only paused briefly at the start of the Covid response to allow a virtual model of delivery to be established (telephone, Near Me and webinars). This means that the backlog has been kept to a minimum despite the challenges of staff vacancies within the service.		Business as usual within existing delivery model. However, the service is changing the model of delivery by inviting individuals to an introductory session on Pain Management which will provide them with information enabling them to make an informed and person-centred decision on their further engagement with the service.		Clinical health psychologist vacancies Expected increase in referrals as people engage with GPs and in relation to Long Covid.	Recruitment underway with posts offered although not commenced in post yet. The changes which have already been put in place for a blended model of delivery will continue and the implementation of an introductory group aims to reduce DNA rates and consequently improve utilisation of available clinical capacity.		Pain Management Recovery Framework

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	HSCP Assurance Group	Continue to facilitate.	Group continues	Frequency reduced to to three times a week, except when changes to Scottish Government guidance or the COVID situation warranted an additional meeting. The meeting continues to include a rundown on each Care Home to discuss any issues that have arisen and consider any support required.	Midlothian HSCP	COVID impacting health and wellbeing of care home residents and staff. COVID limiting access to care homes.	Care Home assurance group and plans. Care Home Support Team. Care Home Strategy. Is there one?	MSG 2: reduce emergency admissions MSG 3: reduce unscheduled bed days MSG 5: increase percentage of last 6 months of life in community setting MSG 6: Balance of care – increase % population 65+ living at home	IJB Strategic Plan – Older people/Care Homes NHS Lothian Unscheduled Care
	Care at Home	Midlothian HSCP Daily oversight meeting Lothian oversight group once per week. Weekly analysis of commissioned hours and unmet need re (hospital discharge and community) to identify pressures and risk Daily Sit-Rep reports for internal and external services.	Reablement model to improve flow. New contracts to be awarded.	Reablement model in place. MERRIT carers now co-work with intermediate care to facilitate patient flow. Improvement work continbues. New contracts commence 1st September 2021	Midlothian HSCP	Recruitment and retention of carers. Staff absence due to track and trace or to COVID.	Midlothian HSCP Daily oversight meeting Lothian oversight group once per week. Weekly analysis of commissioned hours and unmet need re Daily Sit-Rep reports for internal and external services. Engagement with care providers Ongoing recruitment	MSG 2: reduce emergency admissions MSG 3: reduce unscheduled bed days MSG 4: reduce delayed discharges from acute sites MSG 5: increase percentage of last 6 months of life in community setting MSG 6: Balance of care – increase % population 65+ living at home	IJB Strategic Plan NHS Lothian Unscheduled Care

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		Engagement with care providers Ongoing recruitment Review of job description .							
	Intermediate Care Services Midlothian **Intermediate Care** Services continued to develop in order to meet the changing needs of the Midlothian population and create opportunities to deliver care in people's local community as opposed to acute hospitals.	i. Single Point of Access. ii. Additional posts have been recruited to iii. Community Respiratory Team (CRT) iv. Home first approach. v. Recruiting additional healthcare support workers	i. Enhance SPoA Feb 2021 ii. New staff recruited iii. CRT expansion. Evidence of acute bed days saved. iv. Home First model progressed – measures inc all MSG indicators	i. Single Point of Access was implemented Dec 2020 and enhanced Feb 2021). Workforce planning continued regarding the broader Home First approach.. ii. Additional posts recruited to including drivers, admin and AHP posts. Band 3 capacity was increased by 16wte. Data shows that increased capacity within team is facilitating early discharge from acute sites. iii. The Community Respiratory Team (CRT) successfully managing COPD exacerbations in patient's homes and the development of Scottish Ambulance Service pathway has led to a reduction in acute respiratory admissions. Expansion of the team to facilitated early discharges to home. iv. The Home first approach includes a focus on early recovery and rehabilitation within all intermediate care teams.	Midlothian HSCP	Staffing	i. Recruiting additional healthcare support workers vi. 2. Increased capacity to Community Respiratory Team (CRT)	MSG 2: reduce emergency admissions MSG 3: reduce unscheduled bed days MSG 4: reduce delayed discharges from acute sites MSG 5: increase percentage of last 6 months of life in community setting MSG 6: Balance of care – increase % population 65+ living at home	IJB Strategic Plan NHS Lothian Unscheduled
	Weight Management Service and T2 Diabetes Prevention, Early Intervention and Remission	1. Daily triage, RAG rating of waiting list by Dietitian 2. Additional	1. Dashboard of adult and children's service provision indicating validated waiting times from TRAK 2. Increased	1. Tier 3 – Adults 1593 Patients on WL – Average waiting time 61 weeks F2F and virtual service mobilised. F2F Physical activity groups now running again in each locality. 2. Child Healthy Weight Tier 3 waiting times– 6 weeks. F2F and virtual. Get going Tier 2 F2F running in Edinburgh	Midlothian HSCP (hosted NHS Lothian Dietetics) East Region Programme Board for	IG and access to technology/ digital solution Staffing levels	IG Form submitted to NHS Lothian. Recruitment and effective management of the	Digital service for MY DESMOND on hold meantime Use of Staff Bank, extra hours and overtime.	IJB Strategic Plan NHS Lothian Objectives for East Region Programme NHS Lothian Scheduled Care OP Redesign Scottish Government Early Adopter Diabetes Framework through East Region Programme. Scottish Government Child Healthy Weight

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		Band 5 posts have been recruited for Tier 3 adult and child healthy weight 3. Service Lead appointed 4. OP Redesign Programme with dashboard data cleansing. 5. Tier 2 SLA signed off and remobilised with a blended approach. 6. Prevention of Type 2 Diabetes "Let's Prevent" established. 7. Early Intervention DESMOND transferred from MCN and mobilised Remission and Gestational Diabetes Mellitus	capacity for assessment and interventions 3. All patients offered a blended service in all localities 4. IG agreement on use of digital services and platforms e.g MSTEAMS and MY DESMOND	and West. Plans to recommence in Mid& East. 3. Laurie Eyles/Audrey McGregor appointed August '21 4. Tier 2 Adult – 694 Patients on WL – Average Waiting time is 39 weeks. F2F and virtual groups running, waiting list consolidated into one to ensure longest waits are offered groups first as no groups were running in mid and east. 2 x F2F groups starting at the end of Sept 21 in midlothian (signficiant progress). East Lothian - no groups running at present but new lead recruited. Patients are engaging and the service is filling groups better. July 21, 10 Groups – All full. (4 F2F and 6 Virtual) Offering 68 places. August 21, 93/95 spaces booked digitally September 21, 100 spaces to offer. 5. Let's Prevent Diabetes established and no waiting list, virtual and F2F 6. DESMOND Caselaod includes 194 patients that were booked into groups cancelled due to COVID March 2020. 388 on MCN spreadsheet and there are now 800 + on SCI Gateway so at least 1400 referrals on WL which has yet to be set up as TRAK template. - mid, east and west venues booked for October F2F groups. "MY DESMOND" virtual programme IG approval awaited to support blended approach and increase capacity. All educators to have additional training to deliver virtually. Reported to MCN Sept '21 7. Remission (Counterweight+) - 8 Patients on WL for initial contact. Waiting time 12 weeks. Virtual but would accommodate F2F if necessary but hasn't been needed yet. 8. Gestational Diabetes Mellitus – no Waiting List all new patients contacted same week all virtual using NEAR ME.	Type 2 Diabetes Prevention, Early intervention and Remission.	SLA partners mobilising fully Ability to provide blended service	team, low absence levels Service Leadership with coaching and quarterly monitoring review meetings. Access to sutiable accommodation in all localities	Service Lead appointed full time Situation improving in all localities	Standards/Framework

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		(GDM) digitalised with NEAR ME and continued throughout Pandemic as priority.							
	Support to Unpaid Carers - respite	i. Implement new contracts. ii. Improve respite and short break options iii. Seek approval for commitment of carer additional resource from the SG to investigate alternative/new models of respite delivery. iv. Progression of volunteer programme to offer at home support to attendees of the former Highbank Day Service, enabling a break	Update to Strategic Planning Group in September and November 2021 Agreement for allocation of additional resource to take forward work/working group to investigate and implement expanded models and resources to support respite and breaks from caring. Further funding being sought to extend duration of the volunteer programme, including work to support breaks from caring.	Strategic Group in place. Strategy developed. Allocation of additional funds progressing – with partners. Needs agreement from management/IJB to initiate action. Residential Respite flat identified and staff being recruited. Short breaks options being reviewed. Short Breaks Service continuing in new unpaid carer support contract. During 2020-21: • 1,623 carers received an adult carer support plan (VOCAL and Adult Social Care combined). This more than doubled of previous year. • 2,278 carers received 1 to 1 support by VOCAL. 18.71% increase from previous year. • 316 carers accessed short breaks. • Additional carer income generated through CAB in 2020-21 was £415,208.	Midlothian HSCP Carer Strategic Group Third sector Partners	Reduced options for respite risks the health and wellbeing of carers and could increase demand on care services. Clients/cared-for enter institutional care earlier than planned due to unsustainable care arrangement in the community. Current lack of HSCP SDS Development Worker advice and guidance, reducing liason with Third sector partners and carers seeking alternatives to residential respite.	Oversight my SMT as well as Carer and by Respite Groups. Action to increase opportuntities for breaks from caring, including for overnight breaks. Engagement with carers who previously received a break through overnight respite, exploring alternative supports whilst resources continue not to be available	Carers feel supported to continue their caring role Increased numbers of carewrs accessing information, advice and support Uptake of adult care support plans Increased respite and short break provision.	IJB Strategic Plan Carer Strategy Respite Plan (in development) Short Breaks Service Statement (policy)

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		for carers.							
	Day services for people with a Learning Disability	Full resumption of learning disability day services as national guidance allows	Services resumed in line with national guidance on physical distancing	Learning disability day services have resumed albeit with reduced capacity to comply with physical distancing requirements. Next phase will to be remobilie as national guidance allows. Provision of transport to services is however a potential limiting factor.	Midlothian HSCP	People do not have access to support and their wellbeing deteriorates.	Monitoring uptake of day servie provision	People with a learning disability have access to day support.	IJB Strategic Plan
N/A	*Primary Care*	*Part of central return*				N/A			
	Day services for older people	Day services for older people maintained regular contact with clients, offering essential support. The Red Cross developed new ways of working. Day Services Planning Group in place.	Older people supported Day Services to be fully operational by April 2022 if SG Guidance allows.Capacity currently reduced.	Day services for older people maintained regular contact with clients, offering essential support. EG doorstep visits, meal delivery, clients phonecalls daily, help with shopping and prescriptions, delivered activity packs, including knitting and jigsaws. Some groups moved online eg Tea & Blether to Football Memories. Outdoor walking groups and wellbeing support, as an alternative day services. The Red Cross delivered food and library books to & made over 5,000 welfare calls to elderly people.	Midlothian HSCP and third sector partners	People do not have access to support and their wellbeing deteriorates Increased demand on hospital and other services	Monitoring uptake of day servie provision	Older people have access to day support.	IJB Strategic Plan
	Justice - groups	**Midlothian Spring Service** -women who offend or are at risk of doing so.. **Peer Support** **Unpaid Work**		**Midlothian Spring Service** adapted to support women. Delivered lunch bags and socially distanced chat on the doorstep with 13 women. A weekly activity pack developed. All women on a Community Payback Order are considered for the Spring service. The service offers one to one support and programmed group work. Through support offered, opportunities are created to cope with difficult and stressful situations, manage complex emotions, build self-esteem and reduce isolation, improve health, wellbeing and safety and access a range of supports. In 19/20 there were 20 women referred to spring with 18 active users. Women made progress in all ten areas of the Outcome Star assessment tool (e.g. managing mental health, progress made was 64%). 25 women started phase 2 (group work), up from 12 the previous year.	Midlothian HSCP	No specific riks to service delivery identified other than Covid impacting on staff health and wellbeing. Mitigating factors in place.	Covid highlighted the necessity for Justice to RAG rate all clients. This determined when individuals would be seen related to risk. As we work through our local Route Map, this will continue to be the default position. Justice have a clear Route Map that sits alongside wider national and local guidance. Each core business is outlined within this map and details the different stages of progress (office working/ seeing clients/ home visits).	people who offend or are at risk of doing so can access services which will help them address underlying health and wellbeing challenges.	IJB Strategic Plan Community Justice Outcome Improvement Plan 2020-23 National - National Outcomes for Community Justice Services

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				Peer Support training was put on hold in March 2020 then tailored for delivery on Zoom. Delivered to 5 peer workers in Nov/Dec and 7 peer volunteers Jan/Feb 2021. **Peer Volunteers** - 9 people actively volunteered during the reporting period. Roles included telephone support. **Unpaid Work** Team delivered certified training eg Health & Safety in the Workplace SCQF Level 4 Qualification to 32 Clients, and 3 clients achieved the Emergency First Aid Certificate at SCQF level 6. Six clients gained Construction Skills Certificate Scheme Card & 3 obtained full-time employment. Despite the reduction in work placements and face to face contact the Unpaid Work Team developed and implemented a training pathway for clients. This new pathway starts with all clients undertaking a Scottish Credit and Qualifications Framework (SCQF) award at Level 4 in Health and Safety. This not only promotes safe working practices whilst clients are on their Unpaid Work Placements but is a qualification that can be used to assist with gaining employment or accessing further training opportunities. The pathway then allows clients to undertake further SCQF qualifications including various first aid, advanced level health and safety training and manual handling. Working with the Community Lifelong Learning Team (CLL) a further pathway has been developed to allow clients to undertake a variety of training courses including: an adult achievement award, CSCS card (needed to work on building sites), digital skills, an introduction to wellbeing or to work to improve their literacy and numeracy skills. In the 2020/21 financial year, despite the national lockdowns, 35 clients gained SCQF recognised qualifications delivered by our team. A further 15 clients completed an award through a referral to CLL. An example of the success of this approach, integrating training into a client's Unpaid Work, is demonstrated by PW (anonymised initials). PW as part of his Order was placed at a local foodbank helping to sort donations and make up food parcels. PW also undertook training as part of his Order completing his SCQF level 4 health and safety and SCQF level 5 First Aid qualifications. He was then referred to CLL where he completed his CSCS card training. Towards the end of his Order PW had 6 job			Risk Assessments for all core business tasks are on council site- Sephera. The team is set up for home working. Staff are encouraged to carry laptops to and from the office to avoid laptops being left in the office. A/ B working patterns are going to be sustained going forward with the default position of staff working at home when possible/necessary. National training programme for Justice is accessed. All staff are encouraged to uptake vaccination programme. A new Unpaid Work Supervisor has been recruited to assist us with addressing the backlog in UPW hours. '0 hours' contracts for unpaid work are being considered to increase the flexibility around unpaid work hours. This will also assist with potential staff absences over winter. Spring (women's service) and Stride (men's service) have identified space available within the Arts Centre to enable both group services to operate group work.		

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				offers and accepted one position working as a labourer on a building site. He also continued to volunteer at the foodbank over the festive period despite his Order coming to an end.			The Arts Centre allows for extra capacity and enables a workers to use this space for core business.		
	Substance Misuse	Services used phone, video platforms and essential 1 to 1 meetings to provide care and support	Services operating within national guidance	Across Midlothian and East Lothian, MELDAP provided 381 phones, 37 tablets and 553 digital top ups to assist those most at risk to keep in contact with treatment and support agencies. Key services in Number 11 continued including outreach treatment, injecting equipment provision, naloxone, information/advice and door step deliveries of Opiate Substitute therapy and other medication. Outreach to those most at risk. This included the trialling of Buvidal. Face to face appointments resumed – risk assessed and in line with guidance.	Midlothian HSCP	People unable to access the support they need. Increased demand on acute services. Reduced health & wellbeing	Range of options to provide support to people – face to face and electronic/phone. Risk assess client referrals and existing caseload ??		IJB Strategic Plan ADP PLan
	Mental Health	Services used phone, video platforms and essential 1 to 1 meetings to provide care and support	Services operating within national guidance	Mental Health services continue to offer face to face appointments as per risk assessments and in line with guidance. Services also continue to use a blended model using digital and face to face contact	Midlothian HSCP	People unable to access the support they need. Increased demand on acute services. Reduced health & wellbeing	Range of options to provide support to people – face to face and electronic/phone. Risk assess client referrals and existing caseload ??	People provided with a service as appropriate.	IJB Strategic Plan
	Physical Disability	Support and care provision for adults with Physical Disabilities and Long Term Conditions.	Service provision as per assessed needs.	New	Midlothian HSCP	Dependency on care provided by 'Care at Home' and 'Intermediat e Care Services'	Continue to monitor availability of care provision with 'Care at Home', 'Intermediate Care Services' and other third party providers	Individuals accessing support as per assessments	IJB Strategic Plan – Older people/Care Homes NHS Lothian Unscheduled Care
	Community Nursing	Capital investment in technology to support community nursing teams to maximise capacity	Revised ways of working embedded		Midlothian HSCP	No specific riks to service delivery identified	Service fully operational		IJB Strategic Plan
	Health Visting	Capital investment in technology to maximise capacity A;lternatives to indoor face to face visiting employed	Revised ways of working embedded	All Health visiting staff now have laptops and smartphones. Flexible working is supporting the delivery of the service, allowing staff to work from home if required to self isolate etc. Face to face visiting is now undertaken on risk assessed basis and 13-15 month checks are now being delivered – ie service levels higher than immediately pre-covid	Midlothian HSCP	Universal pathway still to be fully employed although: SG guidance on service delivery was	Workforce continues to be monitored locally and pan Lothian by community nursing workforce group		IJB Strategic Plan

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				Continue to delveop use of virtual consultation (near me) and work in development to deliver online support for parents – e.g. weaning webinar Successful recruitment os newly qualified health visitors has improved staffing position		fully maintained throughout period where restrictions were in force.			

NHS LOTHIAN – EAST LOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Grey - Proposal – New Proposal/no funding yet agreed
Red - Unlikely to complete on time/meet target
Amber - At risk - requires action
Green - On Track
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RAG Status (mandatory)	**Deliverables (mandatory)** *these can be qualitative or quantitative*	**Lead Delivery Body**	**Risks (mandatory)** *list key risks to delivery and the required controls/mitigating actions*	**Outcomes (optional)** *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	**Strategies, plans & programmes** *repeat for each applicable deliverable/add multiple programmes if required*

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SOCIAL CARE DELIVERY PLAN ACTIONS									
GREEN	Safe and COVID compliant Remobilisation of Day Centres for Older People and delivery of a suite of alternative supports to support older people at home.	All Day Centre opportunities were suspended and replaced with regular contacts with carers and clients through remote and digital approaches and targeted support as necessary. Continuation of funding to maintain sustainability of services.	Phased and COVID-safe opening of Day Centre provision. Development of a four year framework for a blended model of older people's day services. Support to small organisations in responding to tender processes.	Work is underway on the development of a blended model of centre based and outreach support for people over 65 across East Lothian. Consideration is being given to how best the nine current centre can respond to the needs of local communities in; Dunbar, East Linton (Lynton), Gullane, Haddington, North Berwick, Ormiston (Primrose), Port Seton (John Bellany), Prestonpans (Harlawhill) and Tranent. A proposal is in development for a new (Dementia) Meeting Centre, (initially for Musselburgh, but with satellite provision in phase 2 in Dunbar, North Berwick and Fa'side) to provide extra support for this client group and carers.	ELHSCP with input from third and voluntary sector partners and commissioned services	Staff absence through sickness (COVID or otherwise) and self-isolation. Impact of localised COVID outbreaks and associated service closures.	Management of COVID absence. Reallocation of staff. Maintenance of support to clients assessed as having highest need (RAG scale) and to their carers.	Step up of day centre capacity and delivery of alternative supports as available with high need clients prioritised	Prevention, early intervention Carers Strategy Strategic Plan Right care, right time, right place
	Options appraisal for future building-based services for Adults under 65 with complex needs under 65.	To be achieved with full engagement of users, carers, providers and ELHSCP staff, to develop and appraise options.	Building based services to be delivered to those only with the most complex needs – to be established through a review of existing assets to identify areas for redistribution of investment in community models from April 2022.	Asset review commenced Discussions underway with East Lothian Council on opportunities to redistribute investment in high cost services (such as transport) and to develop and commission new supports	ELHSCP with input from third and voluntary sector partners	Progress against project plan delayed by external factors – such as COVID Redistribution opportunities more limited than projected.	Project team is overseeing current actions and planning developments, consultation and communication.		Prevention, early intervention Carers Act and Carers' Strategy Strategic Plan Right care, right time, right place Transformation
AMBER	Reestablishment of provision and stabilisation of Care at Home services.	Demand was being met by an increase in internal homecare service and Hospital to Home funding and by block contract awards to external	To provide sufficient care home capacity to support acute and community services to meet the needs of patients requiring residential care.	Significant strain on sector, with all providers struggling to recruit adequate staff. Some providers at crisis point. Work is underway to improve efficiency in assessments for services, in application of eligibility criteria and in continuing the drive to ensure	ELHSCP	Continuing increase in demand on Care at Home services, arising from continued	A range of management actions and operational interventions are in place and reviewed regularly.		Prevention, early intervention Carers' Act and Carers' Strategy Strategic Plan Right care, right time, right place

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		providers. Current shortfall in provider performance being actively managed by HSCP managers. The impact of some staff shortages are being addressed through HSCP staff providing input to clients and through prioritisation of support through RAG-rating. Stability of some Care at Home (CAH) providers remains extremely fragile, with all providers affected to a greater or lesser extent.		efficient use of resource. ELHSCP is involved in discussion at local, regional and national level to secure solutions. Action has been taken to increase ELC Care at Home provision in anticipation of continued pressures faced by external providers. A Care at Home Crisis Team oversees rapid, coordinated responses to emergent issues. HSCP staff (from Adult SW / Acute & Ongoing Care) are working alongside commissioned services to make provision for those most at risk. Providers submit daily information regarding their status and have also been required to RAG rate their service users. A daily HSCP Care at Home huddle meets to identify risks and to direct available resources.		restrictions on day support and carers not coping. Families reluctance to accept residential respite or care home permanent placements.			Transformation
AMBER	Increase from current care home capacity to previous levels to meet patient and service needs.	Support to Care Homes through the East Lothian Care Home Team to maintain IPC approaches and to monitor and respond to COVID outbreaks	To step up provision to meet needs of East Lothian residents, ensuring limited disruption to patient flow and delayed discharge performance.	Some bed capacity lost following a home closure. At any point, a small number of care homes are often closed to admissions. This is greatly affecting discharge plans, creating a backlog of people waiting in hospital, who would otherwise be dealt with. This is managed via the daily Care Home huddle. Future medium to long term capacity likely to be available through planned commercial care home development and associated 'Care Village' developments. Existing care home capacity is reduced due to continuation of social distancing and reduced demand.	ELHSCP/ Care Home Team	Limitations to staff availability arising from COVID isolation/ outbreaks and from difficulties in recruitment Provider failure	Maintenance of support to care homes to manage patients and to maintain IPC Regular testing of all staff and adherence to outbreak guidance Application of all COVID requirements	Sufficient bed capacity to meet local need, to maintain patient flow and to reduce delays.	Right care, right time, right place Strategic Plan Transformation
GREEN	Support to carers	Focus over last few months has been to design approaches to increased support to carers to maintain their key role.	Link to and reflect developments to remobilise Day Centre provision and respite availability and the establishment of a Dementia Meeting Centre and its satellites.	A review of the current adult carers support plan is being scoped, with a group to be formed to progress the work and to establish a single point of access. The Carers Change Board is oversee planning and establishment of new projects.	ELHSCP/ Carers Change Board	Delays, as a result of operational difficulties (as described above) in stepping up availability of supports to reduce carer burden.	Remobilisation of those services providing support to carers		Carers' Act and Carers' Strategy Strategic Plan
GREEN	Supporting patients with post-COVID/long-COVID issues	Development of an evidence-based and multidisciplinary post-COVID/long COVID pathway for	Establishment of a COVID rehabilitation service for patients referred from primary care.	New arrangements provide assessment and rehabilitation interventions overseen by an MDT post-COVID network The development of a competencies and in-service	East Lothian Rehabilitation Service (ELRS)	Increasing numbers of referrals as COVID infection	Monitoring of referral rates and quality and appropriateness of referral.	Management of demand and of waits, post-referral.	

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		East Lothian	Development of a post-COVID directory for use by clinicians and patients.	training framework for staff across all services to support local responses.		numbers expand			
	Adoption of 'Home First' principles within the ELCH discharge avoidance and planning arrangements	Coordinated action is established between the care home team, hospital at home, hospital to home, ELCH and others to intervene early in the identification of patient needs, mobilising support as necessary to avoid emergency department attendance or unnecessary admission. Where admission is unavoidable, the teams work together to make arrangements to discharge home once clinically indicated.	Expansion of ELHSCP Patient Flow and Site and Capacity support to allow work to expand to 7 days a week. Improved case management through integrated approaches to prevent admission, or to accelerate discharge with support. Allocation of a case coordinator to all patients in East Lothian Community Hospital (ELCH), tasked to link across all medical and social care professionals and to be the primary family contact.	The ELCH team holds daily 'rapid rundowns' within the MDT to identify and take action to deliver efficient planning for discharge over 7 days. The East Lothian Teams work in a coordinated fashion to support active and effective 'in-reach' and active 'pulling' of East Lothian patients from the three acute hospitals in Lothian.	ELCH/ ELHSCP	Challenges in responding to increased winter demands.	Regular meetings of all teams, to assess and address demand, to identify and take action on barriers to discharge.	Maintenance of efficient patient flows, efficient use of resources, patient centred care.	
PAIN MANAGEMENT DELIVERY PLAN ACTIONS									
Green	Development of alternative delivery options for Pain Management to reduce need for in person clinic attendance.	Establishment of digital delivery of pain management via Video Conferencing, through a 6 week, 90 minute interactive group.	Blended offer available to all patients as indicated by their clinical presentation, assessed needs and circumstances.	Pain Management delivered where possible virtually in groups. In response to individual need, some patients receive one-to-one sessions via telephone or NearMe or a face-to-face session in the Physiotherapy Department. Duration of support is tailored to individual goals as are pain management strategies and, where indicated, functional exercise. Follow on interventions include: Home Exercise Programme, Gym Sessions, PACE, Fundamental Rehabilitation Programme. An onward referral option is available if required to sustain behavioural change, or for further opinion, including to the Edinburgh Chronic Pain Service at AAH.	East Lothian Rehabilitation Service (ELRS)	Maintenance of delivery if referrals rise too steeply to allow a timely response. COVID-related staff shortages.			Pain Management Recovery Framework

NHS Lothian – Mental Health - Delivery Plan Progress Report Apr-Sep 2021

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Children and Adolescent Mental Health Services (CAMHS)									
On Track	Implement anEnhanced Neurodevelop-mental Pathway Within CAMHS Increase capacity and reduce waiting times in the Neurodevelop-mental pathway.	• A Neurodevelop-mental service development group has been established with broard multi-agency representation with the Director of Nursing as Chair • The previous Waiting Lists have been reorganised into separate Core Mental Health and Neurodevelop-mental lists with new assessment and allocation processes • Staff job plans are being reviewed to make commitments between the two service areas / lists clear • Trajectory analysis has been undertaken and will be refined further based on ongoing work to better define capacity • Further redesign will be undertaken to respond as required to the Scottish Government's forthcoming CAMHS Neurodevelop-mental Service	The primary target is for 90% of patients to be seen for assessment and, where required, treatment within 18 weeks of referral by April 2023 Initial trajectories are developed but will be further developed to achieve reductions in the number of patients waiting > 18 weeks over the period to April 2023 with progress monitored monthly Recruitment to additional staff posts in the CAMHS Outpatient Teams is underway. Primarily this is focused on Core Mental Health and is expected to complete during the 4th quarter of 2021, however Neurodevelopmental services are likely to benefit to an extent. The forthcoming Scottish Government CAMHS Neurodevelopmental Specification is expected soon and is understood to include associated resourcing to support capacity growth. Negotiations are underway to procure additional	Waiting lists for Core CAMHS Mental Health and for Neurodevelopmental assessment have been separated and are in use. Job plans are currently being reviewed. Some clinicians already have dedicated time for neurodevelopmental work however this will be enhanced by clearly identifying commitments for other staff and new additional staff. Work has been undertaken to define and review the Neurodevelopmental assessment process within each geographic Tier 3 outpatients team. Proposals are in place to expand capacity at Tier 2 with a view to earlier intervention and reduction in in appropriate referrals to Tier 3. The Development Group has commenced work with a view to putting in place a better integrated mutli-professional, multi-agency structure and working arrangements. The private sector contribution of additional assessment capacity is expected to commence within the next 3 months.	NHS Lothian	The multi-agency collaboration required for effective ND assessment and support provides challenges. Success of the recruitment programme. Skilled CAMHS staff are in great demand (particularly psychiatrists). Additionally, staff retention also remains a challenge. CAMHS referral levels and acceptance to treatment levels are high in Lothian. Any further increases in demand will impact trajectories.	A multi-agency group has been established to approve and guide development proposals. The proposed recruitment programme has a wide range of roles and targeted professions to broaden the possible recruitment pool. The proposed Tier 2 service development (see below) has potential to manage and reduce demand to Tier 3.	Increased dedicated forcus on Neurodevelopmental services. Achievement of the Local Delivery Plan waiting times standard. Improved outcomes for patients in terms of service quality, clinical improvement and achievement of personal goals. Improved working environment for staff from a better controlled and less pressured psychological therapies service.	Scottish Government CAMHS Neurodevelopmental Service Specification

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		Specification.	Neurodevelopmental assessments from a private sector provider for a limited period of time to assist in addressing the current waiting times.						
On Track	Embed the Choice and Partnership Approach (CAPA) Within CAMHS Tier 3 Services Increase capacity and reduce waiting times in the CAMHS Core Mental Health pathway.	• Establishment of a Project Board, Clinical Advisory Group and a Project Team with dedicated Programme Manager and Clinical Lead. • Training activities including CAPA conference attendance, engagement with SG advisers and CAPA Masterclass(es). • Sequential approach adopted to implementation and plans developed for each of the five Tier 3 Teams. Presently being rolled out to teams with associated support. • Waiting list trajectories developed based on CAPA capacity parameter assumptions. • Additional staffing capacity requirements identified and application to SG for funding.	Recruitment to additional staff posts in the CAMHS Outpatient Teams is underway and is expected to complete during the 4th quarter of 2021, including revised job plans for all clinicians and clear team and individual capacity targets. Completion of the transition to CAPA approaches and processes is expected to complete in first quarter 2022. Improved and more effective clinical pathway through adoption of CAPA Choice, Core and Specific Partnership, Goal Setting and Letting Go philosophies, practices and processes with better outcomes for patients. To be achieved as the CAPA model is settled into normal practice and experience is gained. The target is for 90% of patients to be seen and have started treatment within 18 weeks of referral by April 2023	The recruitment programme has commenced. At this stage it is not possible to predict the speed / success of recruitment as competition is likely to be intense given all other Boards have also been provided with significant additional funding. CAPA implementation, in particular job planning, has commenced with the Edinburgh North and South Teams with the other teams monitoring progress / experience through the Clinical Advisory Group. Trajectories for the Core Mental Health area are in place based on the recruitment and CAPA capacity assumptions. To date broadly the teams are ahead of trajectory, however the major challenges to overcome remain associated with putting additional capacity in place through recruitment.	NHS Lothian	The key risk is the retention of existing staff and successful recruitment to the additional staffing posts. Demand has remained fairly constant through Covid-19 and in general Lothian has relatively high levels of referral and acceptance to treatmentHo wever, any changes upward in levels of demand would adversely impact trajectories. Further lockdown requirements could impact treatment duration.	The recruitment programme has a wide range of roles and targeted professions to broaden the possible recruitment pool. The proposed Tier 2 service development (see below) has potential to manage and reduce demand to Tier 3 which will benefit the trajectories.	Better matching of demand and capacity. Achievement of the Local Delivery Plan waiting times standard. Improved outcomes for patients in terms of service quality, clinical improvement and achievement of personal goals. Improved working environment for staff from a better controlled and less pressured CAMHS service.	Scottish Government CAMHS Specification
On Track	Develop a sustainable CAMHS Tier 2 Service	• Undertake a review of the current configuration and capacity of Tier 2 services and the integration with Tiers 1 and 3. • Work with the Children's Partnerships to identify the target future configuration of Tier 2 services and the operating arrangements for effective integration with broader	The model for Tier 2 services is currently in development and should be available shortly. The envisaged recruitment involves 18.5 WTE staff who will come from across the health professions including nursing, applied psychology and AHPs.	Work to identify potential solutions such as single point of access and location and roles of new CAMHS Tier 2staff is already underway and is already in effect in some areas. Preparation for recruitment has commenced and is expected to complete by end 2021.	NHS Lothian	Ability to recruit sufficient staff to provide Tier 2 services across 4 Lothian community planning areas. Failure to integrate effectively into local children's services.	Recruitment to Senior Project Manager with a focus on developing and implementing CAMHS Tier 2 plans. Close collaboration with Children's Services in the development and integration of Tier 2 services.	The primary care workforce will promote early recognition, intervention, and management of child mental health problems. The model will further - through a single point of access for all but the most extremis presentations (e.g. eating disorder and active suicide risk) -	Scottish Government CAMHS Specification

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		Children's Services. • Establish a collective overall system of operating CAMHS services that maximises the contribution to improving the mental health and wellbeing of Children and Young People. • Engage with community planning partners to develop a multi-agency single point of contact for all children and young people with mental health needs.						acts as gate keeper to Tier 3 CAMHS and will identify referrals that meet the specification for specialist CAMHS Tier 3 and Tier 4 intervention. The overall impact of the new service model and associated workforce cannot be certain but experience elsewhere shows earlier access to services and intervention with an associated significant reduction in referrals to Tier 3.	
On Track	Establish a 24/7 CAMHS Unscheduled Care Service	• A pilot of the proposed service was carried out during the Covid-19 lockdown. • The evaluation demonstrated success in terms of improved access, timeous response to crisis and positive stakeholder and patient feedback. • A clinical lead for the service has been appointed. • Further recruitment is being undertaken to provide the required resource / team. • The service is in the process of being established and will be integrated into the wider Lothian unscheduled care structure and arrangements.	Appointment of a clinical lead for the service and further recruitment to provide the required resource / team. Definition of service operating arrangements and integration with wider unscheduled care services, CAMHS and wider Children's Services. Launch of the new service.	A Clinical Lead has been appointed. The service was launched on 2nd August 2021 with a phased approach to implementation: • Phase 1 from 2nd August : 9am-5pm 7 days a week; • Phase 2 from 30th August: 7.30am – 8.30pm 7 days a week; • Phases 3&4 To Be Confirmed – building to 24/7 once recruitment takes place to get to required establishment – these posts to get to 24/7 are currently live advertisements. Recruitment continues to complete the full complement required of 18.5 WTE staff to allow 24/7 operation. Further wok is ongoing to fully integrate into Lothian's unscheduled care arrangements which are presently undergoing review and into local HSCP and third sector support services.	NHS Lothian	Recruitment success is a key pre-requisite.	Mitigation is to incorporate a rage of professions into the team which broadens the potential recruitment pool as well as providing a balanced range of skills and experience.	There will be a much improved response (timely and more expert) to crisis for children and young people and their families both within normal hours and out-of-hours. Some pressure will be relieved on Tier 3 and 4 teams who are required to respond at present.	Scottish Government CAMHS Specification
On Track	Eating Disorders Pathway Redesign	• Develop a redesigned service model to provide a Hub and Spoke model with expertise located in the Tier 3 teams (spokes) but	Develop the new service model and associated operating arrangements including lisison arrangements between the parts of the service. Resource requirements	A model for the new service has been documented but requires to complete evaluation and governance processes. Recruitment is underway for the required 8.4 WTE staff. This is expected to complete by … The revised model is anticipated tocome into	NHS Lothian	Recruitment success is a key pre-requisite.		There will be increased capacity to treat eating disorders. Cases will be better segmented according to severity and the	Scottish Government Eating Disorder Services Review.

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		supported by a specialist Hub. • Expand staffing to provide the revised model and associated increased capacity.	have been estimated at 8.4 WTE staff to deliver the revised model. The new service will be brought into operation as the staff resource becomes available.	operation …				degree and expertise of intervention required. Improved access to expertise and support for staff in the Tier 3 teams. Improved outcomes for patients.	
Perinatal Mental Health and Maternity									
On Track	Expansion of the community Perinatal Mental Health Team	Recruitment	Psychology posts to be advertised following job evaluation Deputy Team Lead post will be developed as a test of change for one year	Recruitment to the community team is almost complete with psychology posts still to be recruited to.There has also been a temporary increase in nursing capacity as a result of high demand. Job description is being worked on at present with expectation the post will be advertised by the end of September	NHS Lothian	Availability of staff to recruit to posts			Perinatal and Infant Mental Health Programme
On Track	Enhance provision of care within regional Mother and Baby Unit	• Recruitment of nurse therapist to MBU • Recruitment of nurse consultant to MBU • Introduce peer support worker following additional funding from SG • Recruitment of a permanent Music Therpist		Development of this post underway. Post appointed to – awaiting start date. The service is in the early stages of reviewing the role and planning a stakeholders meeting to develop the post. Post approved and will be advertised soon.	NHS Lothian	Availability of staff to recruit to posts			Perinatal and Infant Mental Health Programme
On Track	Establish an Infant Mental Health Team	• Recruitment to key posts • Determine pilot location • Planning the service	Post to be advertised following Job Evaluation approval. Pilot site to be confirmed September 21.	New	NHS Lothian	Recruitment timeframe and availability of staff	Taking a flexible approach to recruitment in that the roles are about skills rather than job title		Perinatal and Infant Mental Health Programme
On Track	Establish the Maternity and Neonatal Psychology Service (MNPI)	• Recruitment to key posts • Agreement on management arrangements	Post to be advertised following Job Evaluation approval. Interim governance arrangements confirmed. Service to be expanded with additional posts.	New	NHS Lothian	Recruitment timeframe and availability of staff	Taking a flexible approach to recruitment, including offering aditonal hours to current staff		Perinatal and Infant Mental Health Programme The Best Start: Five-year plan for maternity and neonatal care
Mental Health Unscheduled Care									
On Track	Redesign of MH Unscheduled care services	• Identification of clinical lead and planning support • Review of current services • Future proposal		Clinical lead and planning resource identified. Initial conversations across IJB areas underway.	NHS Lothian and 4 Lothian HSCPs	No risk identified			
On Track	Set up flow centre to operate in new way	• Identification of resource required • Identification of new process and		Future way of working proposed to Unscheduled Care board, further decision required around Competent Clinical Decision Maker	NHS Lothian and 4 Lothian HSCPs	No risk identified			

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		key posts							
On Track	Establish Wellbeing Hubs or equivalent in each Lothian IJB/HSCP area				4 Lothian HSCPs	No risk identified			
Psychological Therapies									
On Track	Reduction in Waiting Times for Psychological Therapy	• Adoption of improved activity management system • Focus on monitoring and increased standardisation (where appropriate) of duration of therapy • Expansion of capacity (existing fixed term staff made permanent and recruitment of additional staff • Improved and better supported case management process • Increaseddelivery of computerised CBT for mild to moderate presentations and supportthrough Lothian Wellbeing Website to provide psychological education and guidance on self-care • Increased use of Group therapy	The primary target is for 90% of patients to be seen and have started treatment within 18 weeks of referral by April 2023 All major services have detailed trajectories for reductions in the number of patients waiting > 18 weeks over the period to April 2023 and progress is monitored monthly Recruitment to additional staff posts is underway and is expected to complete during the 4th quarter of 2021	All of the Psychology teams now have team and individual activity targets with monthly reporting and review of performance. The trend of rising numbers waiting for the main Adult Psychological Therapies Outpatients Services which accounts for the majority of long waits (> 18 weeks) was reversed in early 2020. The total numbers waiting for Psychological Therapies (assessment and treatment) has reduced by 1,027 from 6,272 to 5,245 over the period from February 2020 to July 2021. Computerised CBT and wellbeing treatments continue to grow; there is scope for this to expand with the change in SCI Gateway to promote a new range of interventions for increased access. The Psychological Therapies website was launched in 2020 and now has circa. user visits per month. The Group Programme was re-established in September 2020; the size of the groups remains limited with 2m social distancing, although the number of groups being run has increased. .	NHS Lothian and 4 Lothian HSCPs	The key risk is the retention of existing staff and successful recruitment to the additional staffing posts. Changes upward in levels of demand, which have shown significant variation as a result of Covid, would adversely impact trajectories. Further lockdown requirements could impact the Group Programme.	A Project / Service Manager is being recruited to Psychological Services to enhance management capacity. A recruitment campaign is underway including a social media programme. Demand is being monitored on a monthly basis. If there is a rise in demand beyond assumed levels further recruitment will need to be considered. Work is being undertaken to secure a suitably secure Group Digital Delivery Platform.	Achievement of the Local Delivery Plan waiting times standard. Improved outcomes for patients in terms of service quality, clinical improvement and achievement of personal goals. Improved working environment for staff from a better controlled and less pressured psychological therapies service.	Scottish Government Mental Health Strategy 2017 – 2027 Forthcoming Scottish Government Mental Health and Wellbeing Standard
On Track	Increased Standardisation of Therapy and Assurance of Service Delivery	A Psychological Therapies Governance, Standards and Training Board was established in 2020 with a wide representation in its membership from the NHS Board and the HSCPs	The Board will act as the vehicle to ensure that all therapies delivered within Lothian are evidence-based The Board will also assure that performance targets are appropriate to service delivery quality and achievement of appropriate outcomes for patients The Board will also assure	The Board is operational and now meets monthly to consider relevant matters. It continues to work through a review of existing practice and will consider all new therapies / practice prior to their introduction.	NHS Lothian and 4 Lothian HSCPs	Further investment into primary and community care delivery of mental wellbeing services will lead to more complex care pathways and transitions.	Representation on the Board from all relevant parts of the Lothian Health and Care System.	Improved outcomes for patients.	Scottish Government Mental Health Strategy 2017 – 2027 Forthcoming Scottish Government Mental Health and Wellbeing Standard

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			training arrangements and programmes for staff						
On Track	Redesign of Psychological Therapies Services	A review of arrangements within Edinburgh HSCP is underway	Revised arrangements within Edinburgh are anticipated to come into place over late 2021 / early 2022. Its impact will be mostly confied to matrix Levels 1 / 2 patients. A further programme of review and redesign work is to be commissioned following further Scottish Government guidance.	New	NHS Lothian and 4 Lothian HSCPs	HSCP delivery arrangements for Mental Health and Wellbeing are likely to vary and transition arrangements with REAS will need to accommodate this.	Governance for significant changes is provided through the: • Psychological Therapies Governance Board • The Lothian MH&LD Programme Board • Each organisation's individual governance arrangements	Earlier interventions with intensity of therapy and skills matched to patient needs Broader psycho-social support for patients who do not meet current referral / acceptance criteria Improved patient flow, transitions and outcomes	Forthcoming Scottish Government Mental Health and Wellbeing Standard
Mental Health Primary Care									
East Lothian IJB/HSCP									
On Track	Continue to develop and embed the single point of access CWIC Mental Health Primary Care Service	• Finalise sustainable workforce and organisational development plan • Recruitment of additional posts to support GP Cluster based teams • Establish links with PTS to ensure psycholigcally informed supervision for CWIC MH team • Development of community based groups to offer Tier 1 and Tier 2 group interventions • Develop sustainable infrastructure (telephony & premises) for service	• 90% of initial appointments offered within 72 hours	Primary Care Mental Health Clinical Lead post approved. Workforce Plan drafted for consideration at WCOD. Psychological Supervision agreed Test of Change underway in collaboration with East Lothian Council; Premises review to start shortly	East Lothian HSCP	Workforce pressures	Escalation and safe staffing process in place Workforce plan in development		GMS contract Primary Care Mental Health
On Track	Review pathways across CWIC MH and Adult MH services in line with RUC work	• Review roles and remits of teams • Improve and streamine pathways • Review operational interfaces and ceilings of care across CWIC MH, CMHT and IHTT		MH Review underway	East Lothian HSCP	No risk identified			
Midlothian IJB/HSCP									

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On Track	Continue to develop and embed the Primary care Triage and follow up model in each GP practice within Midlothian	• Recruit and retain workforce • Development of community based groups to offer Tier 1 and Tier 2 group	• 100% of initial triage assessment appointments offered within 72 hours	Primary Care Mental Health Team Lead post reappointed	Midlothian HSCP	Workforce pressures	Escalation and safe staffing process in place	Earlier interventions with intensity of therapy and skills matched to patient needs Broader psycho-social support for patients for Mild to monderate mental health issues Improved patient flow, transitions and outcomes Reduce impact of General practice	GMS contract Primary Care Mental Health
On Track	Review pathways across Primary care and Adult MH services this will include the interface with RUC	• Review roles and remits of teams • Improve and streamine pathways • Review operational interfaces across MH, CMHT, PTS and IHTT	• Attendance at MDT • Visiting each team meeting to improve pathways, build on relationships • Seamless pathways • Invovled in consultation with RUC	Referral pathways/Criteria Audit of current referral activity	Midlothian HSCP	Failure to integrate effectively	Audit Communication of pathways Teams meetings Team lead s	Sleamless access to services Matched care to the pateitns needs Reduce inappoprorate referrals	Mental Health and Substance use services
On trak	Redesign of IHTT working in collaboration and partnership with Third sector to provide same day access to mental health, crisis and distress model this will include the interface with RUC	• Developmen t of new model	• Workshops with IHTT • Consultations with IHTT and Penumbra • Staff recruitment • DBI training • Impact asssessment and SLA • Invovled in consultation with RUC	Development and workforce plan Development of service delivery Communications	Midlothian HSCP Penumbra RUC	Workforce pressure	Governaqnce involvement Audit National DBI data set	Improve same day access being seen by the right person at the right time	Mental Health and penumbra
On Trak	1 year Dual diagnosis role	*recruited to 1 WTE band 6 Review operational interfaces across MH, CMHT, PTS, IHTT, Justice and housing	• Viasabilty in the homless accomadation addressing SMU • Low threshold access to serivces • Working inclusively with the HIT team and the Dual diagnooisis nurse • Mat standard 9	Test of Change underway in collaboration with SMU, MH and Housing	Midlothoian HSCP Housing	Work force pressure Poor engagement	NFO huddles Audit involvement QI Project Audit via MIST Access to mental health and SMu supervison	Matched care and seamless accsess to care and treatment Reduce DRDs	Mental Health and Substance use services

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On trak	Out reach model from SMU to homeless accomadation subject to NFO	• recruited 0.8 band 6 • Review operational interfaces across MH, CMHT, PTS, IHTT and Justice	• Viasabilty in the homless accomadation addressing SMU • Low threshold access to serivces • Working inclusively with the HIT team and the Dual diagnooisis nurse • Mat standard 3	Workfoce plan developed to continue role after pilot Reduce barriers to treatment and referral Quicker access to treatement options	Midlothoian HSCP Housing	Work force pressure Poor engagement	NFO huddles Audit involvement QI Project Audit via MIST	Matched care and seamless accsess to care and treatment Reduce DRDs	Substance use services
On trak	Pathway Redesign of ASD assessments	Review and sustain the new redesign pathway	• Established core group • Reduced 1 year wait to month on month • Increase access to assessments until reduction in waiting list	Reduce barriers to assessment Improve waiting times	Midlothian HSCP	Workforce pressures	Core monthly group Review of pathways Feedback	Reduced waiting times now month on month	Mental health
On Trak	No 11 integration of health, social care and Justice	All services Based and operating within No 11 Shared care Processes and referral pathways	• Presenting each serice to each team to have ashared understanding of roles and responsibilities	Reduce barriers improve coordinated care Improve communication Shared risk assessing Shared care	Midlothian HSCP	Unclear expectations which could lead to conflict	No 11 building meetings Staff engagement / feedback	Improve service users expeareince Seamless care Joinued up working Improve working relationships	No 11 services
On Trak	Restablishment of group activites across mental health and smu	MH, OT , PTS and SMS restablished groups that were postponed due to Covid 19	Reenable groups in keeping with covid 19 guidance and risk assessments	Provide access to group intervention that had been postponed due to covid	Midlothian HSCP	Increase Waiting list if covid 19 restrictions increase	Covid 19 risk assessments Reduced numbers per group	Improve waiting times Improve access for pateints to accsess group interventions	Metnal health and substance use

NHS Lothian – *Human Resources* - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Grey - Proposal – New Proposal/no funding yet agreed
Red - Unlikely to complete on time/meet target
Amber - At risk - requires action
Green - On Track
Blue - Complete/ Target met

RAG Status (mandatory)	**Deliverables (mandatory)** *these can be qualitative or quantitative*	**Lead Delivery Body**	**Risks (mandatory)** *list key risks to delivery and the required controls/mitigating actions*	**Outcomes (optional)** *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	**Strategies, plans & programmes** *repeat for each applicable deliverable/add multiple programmes if required*

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GREEN	Development of an NHS Lothian Wellbeing Strategy which will set out NHS Lothians commitment to staff wellbeing as a key corporate objective.	Appointment of a named Corporate Director with responsibility for staff wellbeing and a Board wellbeing champion who will lead the strategic implementation of the strategy. Recruitment of a whole time, dedicated senior leadership role (band 8a) to lead on the operational implementation of the Work Well Strategy and to support local Work Well leads. Establishment of a Lothian wide Peer Support Service	TBC	Responsible Corporate Director and Champion are now in place. The senior leadership role has now been appointed. The peer support network is now in place.	Staff Engagement and Experience Programme Board.	Time delay in development Service pressures impact on individuals ability to engage.	Escalation Effective communication and flexibility of approach.	The Work Well Strategy has a set of deliverable actions aimed at developing and enhancing our wellbeing activity beyond the reactive Covid response, and shifting to a more proactive, sustained, and planned commitment to staff wellbeing.	NHS Lothians Wellbeing Strategy NHS Lothian Interim Workforce Plan 2021-22 NHS Lothian Corporate Objectives
GREEN	Psychological Support for Staff Wellbeing	In terms of psychological interventions to support staff wellbeing we have implemented a psychology service as part of our existing OHS service.	TBC	The current waiting list has been re-triaged and appropriate care has been matched to need. This has brought our staff counselling wait list down from five months to one month. Our Organisational Development and Staff Support Psychology team have been working together to explore how both functions can collaborate to augment support offered to teams according to need. We are about implement a test of a	Staff Engagement and Experience Programme Board.	Lack of capacity Covid related service pressures impact on teams ability	Triaging of witing list and new referrals. Delay until services feel they have the capacity to meaningfully engage.	Staff receive the personal psychological support they need. Effective development programmes for managers to support their teams.	NHS Lothians Wellbeing Strategy NHS Lothian Interim Workforce Plan 2021-22 NHS Lothian Corporate Objectives

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				development programme aimed at better enabling managers to support their teams based on psychological first aid, trauma informed leadership and compassionate leadership.		to engage.			
GREEN	Shielding Virtual Network	Creation of a virtual network to support those staff that had been required to shield. Engagement with the network to understand challenges followed by communications and stories about shielding and practical support to enable meaningful working when not on the workplace.	On-going	Network in place and whilst shielding is not currently in place the network continues to support staff with the challenges and anxieties they face.	Staff Engagement and Experience Programme Board.	Lack of engagement with managers	Comunications throught weekly brief and other forms	Staff that fall within shielding categories continue to feel supported.	NHS Lothians Wellbeing Strategy
GREEN	Organisational Culture	We have continued our successful leadership network which has grown during Covid-19 to over 500 members. Monthly meetings are well attended and engaged with. NHS Lothian invested in becoming a member of the IHI Global Learning Network on Joy in Work.	On-going	On-going, Monthly on-line sessions continue to be well attended. We have supported over 30 staff to develop skills in creating the conditions for healthy, happy, productive people using quality improvement methodology in the past 18 months.	Staff Engagement and Experience Programme Board.	Lack of engagement with managers	Further communication where necessary	Multidisciplinary network that brings staff together to personally reflect and learn from others how to be more effective and caring leaders.	Staff Engagement and Experience Framework
GREEN	Develop 3 year NHS Lothian Workforce Plan covering 2022-25.	Develop a 3 year plan in conjunction with the members of the Workforce Planning and Development Programme Board, which sets out the Planning Context, Key workforce challenges faced in the medium to long terms and key steps that will be taken to reduce workforce sustainability risks.	End of March 2022	The process for developing an outline skeleton of the plan has just commenced , which will enagage with rofessional leads and service leads to idenfity key challenges and associated SMART actions, this intial syage is anticipated to take 6 weeks.	Workforce Planning and Development Programme Board	Capacity to deliver within relatively short timescale (By early December), given requirement to pass through necessary government routes. Scottish Government (SG)Guidance is delayed.	Scheduled plan for the development of the plan. Escalation to the SG	Agreed 3 year workforce plan approved by the Workforce panning and Development Programme Board, Corporate Management Team, Partnership Forum and Staff Governance Committee.	SG Direction and Guidance NHS Lothian Corporate Objectives

NHS Lothian – Digital and IT - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Grey - Proposal – New Proposal/no funding yet agreed
Red - Unlikely to complete on time/meet target
Amber - At risk - requires action
Green - On Track
Blue - Complete/ Target met

RAG Status (mandatory)	**Deliverables (mandatory)** *these can be qualitative or quantitative*	**Lead Delivery Body**	**Risks (mandatory)** *list key risks to delivery and the required controls/mitigating actions*	**Outcomes (optional)** *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	**Strategies, plans & programmes** *repeat for each applicable deliverable/add multiple programmes if required*

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Green	Healthshare Patient Portal OP on-line appointment booking	Local Staff Vaccination (Trak on-line "Personal Community" booking) moving to on-line patient appointments	2021/22 Q3	Vaccination appointments for staff POC successful Approx. 18,000 already booked, Rebooked 18,000 staff. New - Testing for Patient appointment bookings in line with OP modernisation. Also includes MyGov registration.	Digital and IT and Clinical Services	MyGov registration proposal being reviewed	Project Plan run by Trak Sys Admin team progressing along with Other Digital and IT Teams (IG / health records)	On-Line Patient Appointment booking in place	Patient Portal / On-Line Appointments and results. Post Covid OP Modernisation
Green	Trakcare OP Modernisation	Redesign all OP service clinics (started Feb 2021). Redesign work in each specialty taking approx 12 weeks, and specialties staggered every 1-2 weeks	2022/23 Q1	Speciality by Specialty review of eTriaging functionality, Appointment Scheduling processes, PIFU, Return Waiting Lists, PFB and Back to Referrer. Appointment letters being reviewed to ensure these matches the mode of contact, SMS reminders. Personal Community (on-line booking) and GP communications	Digital and IT and Clinical Services	Service capacity to review clinic templates	Programme structure / Plan – Programme Manager, Trak Sys Admin team progressing along with Other Digital and IT Teams (IG / health records, Desktop etc)	Clinic Template reviewed and updated templates in place, supporting multiple modes of contact in the same clinic session	Post Covid OP Modernisation
Green	Vaccination Systems – Travel Vaccination	Stabilise current RIDU system, and deploy across hub and spoke model	2021/22 Q3	Travel Vaccination Services - GPs are stopping Travel Vaccination services as part of revised GMS Contract, requiring RIDU Services to take this up, and update their system – testing underway to support hub / spoke model	Digital and IT / RIDU Service WGH	System requires more updates than planned	Project run by Digital and IT Dev team	Working hub and spoke model, supporting HSCP activity	Vaccination Systems and infrastructure
Green	Post Covid Digital and IT Technical Infrastructure , organisational and Department updates	Continue to deploy upgrades as required / forecasted	2021/22 Q4	Enhanced Internet Bandwidth, Networking, Security / Firewalls for Remote/Home working also Digital initiatives to enable return to Workplace including Seat Booking apps for open plan areas (incl. Waverley Gate / Comely Bank) and dept Rotas/ Risk assessments for covid-safe working / LFT testing and well-being assessments for Digital and IT staff.	Digital and IT	Increased users / service reconfiguration and Traffic from Cloud based systems (e.g. Office 365 / MS Teams)	Monthly operational performance / utilisation KPI trend review	Acceptable performance and Availability of Digital Systems	Digital and IT Infrastructure and Operations, Programmes and Innovation. Covid Safe working - home working and return to the workplace.
Green	Digital and IT Training design and Delivery	Manage the transition and redesign of training materials and on	2021/22 Q4	Covid transformed the Training deployment this year with the cessation of face to face (down over 250%) training and increased on line / eLearning (LearnPro) modules (up over 250%).	Digital and IT	Manage Training DNA's which reduce capacity, Service availability,	Monthly KPI activity Monitoring	Staff have ready access to required Training for safe and proficient use of Patient /	Digital and IT Training

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		line competence assessments				need for on - demand training		Corporate Digital and IT systems	
Green	Covid Vaccination T1 support	Manage continued infrastructure updates for Covid Vaccination sites	2021/22 Q4	Tranche 1/Evergreen is focusing on the people who were supposed to be vaccinated but who for what ever reason are yet to be vaccinated. The vaccination sites across Lothian requiring Digital and IT Support will have circa 6,000 slots available a week for this cohort	Vaccination Transformation Programme with Digital and IT support	Demand on Service	Monthly VTP Project Board Monitoring	Acceptable Population Vaccination rate	Vaccination Systems and infrastructure
Green	Covid and Flu Vaccination T2 support	Manage continued infrastructure updates for Covid and Flu Vaccination sites	2021/22 Q4	Tranche 2 is focusing on the booster/dose 3 for Covid and Flu vaccinations. This will have circa 35K a week in appointments on vaccination sites across Lothian requiring Digital and IT Support	Vaccination Transformation Programme with Digital and IT support	Demand on Service	Monthly VTP Project Board Monitoring	Acceptable Population Vaccination rate	Vaccination Systems and infrastructure
Green	Remote Patient monitoring	Digital and IT innovation team will also look to develop own applications and/or add additional remote monitoring options	2021/22 Q2	NHS Lothian is working with DHI/ Storm ID to provide a choice of local and National applications, including Trak and Trace, and condition specific applications such as Dermatology, supporting COPD monitoring of patients via pulse oximeters in the patient's home and customisation of patient information (Tailored Talks) for Long COVID-19 Patients	Digital and IT Innovation team	Service and Patient engagement to undertake and monitor remote monitoring activities	Project Board monitoring progress.	Patient held monitoring contributing to their EPR	Remote Patient monitoring
Green	Cancer Information Systems	System procurement, Upgrades and Testing	2021/22 Q4	Chemocare (Chemotherapy prescribing system) upgrade by the end of Dec 2021. Aria (Radiotherapy system) is also undergoing a National Procurement and Participating in Cancer Treatment Summary (TSUM) beta with NES Digital and GG&C	Digital and IT	Service capacity to review requirements	Project Board monitoring progress.	Operational systems upgrades and in Place, beta testing of National Cancer TSUM system	Cancer Information Systems
Green	GP Information Systems	System configuration, Testing and user training	2021/22 Q4	GP on-line services – 105 from 120 General Practice locations are now using on-line Repeat Prescriptions – None opted to deploy on-line appointment booking.	Digital and IT	Service capacity to implement	Primary Care Project Board monitoring progress.	On-Line GP Patient Repeat Prescriptions and Appointment booking in place	Primary Car e / GP Information Systems
Green	GP Information Systems	System Cohort selection and implementation	2021/22 Q4	Migration to new national contract for GP systems is still in planning due to COVID-19 delays. An NHS Lothian Cohort Decision Group continues to meet to progress GP IT Reprovision activities, and GP system suppliers continue to present updates on their plans to deliver the required functionality to all Health Boards/NSS	Digital and IT	Service capacity to agree one cohort system and implement	Primary Care Project Board monitoring progress.	One Cohort system implemented under new GMS contract	Primary Care / GP Information Systems
Green	NearMe	Continuing to embed the use of NearMe in revised Clinic appointments and GP consultations – Redefining clinic and GP attendances	2021/22 Q4	Current NearMe usage has dropped 15% since peaking earlier in Late 2021, as some services have returned to face to face / telephone clinics, NearMe still averages 700pm GP attendances and 6000pm OP clinic attendances and will be reviews as part of ongoing service redesign for GP / OP services, To support these, we have deployed Integrated monitors (camera, mic and speakers) or separate cameras / headsets dependant on privacy arrangements in clinics, together with comprehensive training and support for service users	Digital and IT, GP and OP services	Telephone appointments maybe easier for many specialties. Awaiting National updates for Group calls and Patient outcomes (experience) in Nearme reporting (only available on request for specific clinics)	Primary Care and OP Modernisation Project Boards	Balanced activity (Face to face, telephone and Nearme) from service redesign in GP / OP services	Primary Care/ OP Services

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Green	Healthshare (East Region) Clinical Portal	Expand use of Clinical Viewed (East Region Clinical Portal) based on Intersystems Healthshare – added approx. 600 accounts and supported approx. 130,000 accesses during last 12 months	2021/22 Q4	Provides summary (portal) access to Trakcare patient information from one or more health boards, and from Local GP Systems (Vision / EMIS) –95 out of 120 practices are using CV, currently we are extending CV functionality to support Optometrist access to agreed summary clinical information to assist with referrals and to provide access to National Patient vaccination records	Digital and IT	East Coast (HealthShare) and West Coast (Orion) Clinical Portals need to inter-operate	Project Board monitoring progress.	All HBs, Lothian GPs and other approved contractors having cross board access to summary Patient Trakcare and National Vaccination status	Clinical Portal
Green	GP Information Systems	GP Infrastructure upgrades	2021/22 Q3	GP infrastructure replacements/upgrades to Server 2016 and upgrading their PCs to Win 10. We will be deploying one practice per week which takes us to Dec 21 to complete. Completed deployment of GP Laptops for GP homeworking and deployment of Integrated Video monitors. rollout of earlier model practice setup.	Digital and IT	Need new GMS Contract / Cohort to be agreed - may need to revisit some practices not on agreed systems	Primary Care Project Board monitoring progress	All GP Practice infrastructure at an acceptable level.	GP Information Systems
Green	Remote access	Support for Home Based Staff. Increased Firewall and Internet Bandwidth deployed to support remote access; the Wide area Network (WAN) links at SJH & WGH were each increased to 10Gb	2021/22 Q4	Current Pre-COVID-19 NHS Lothian capability for supporting up to 1,500 home based staff was rapidly increased to support 12,000 home based staff, and rapid creation and allocation of Remote Access Software and accounts - 250 new shared mailboxes (100 new from Aug 2020 to date) 500 ECS accounts for community pharmacy and opticians 3500 additional user account change requests above "normal" level. Increased Internet Bandwidth, Virtual Private Network (VPN) capacity increased from 1000 (Pre-COVID-19) to over 8000 currently, deployed over 3,000 laptops across the organisation now in the past 15 months.	Digital and IT	Further Increasing remote access of home or changing sites where services are delivered require increased internet bandwidth	Digital Oversight Board	Availability and Performance of systems for home based staff	Remote access / Home Working
Green	Trakcare Electronic Patient Record (EPR) updates	Enhanced TRAK EPR	2021/22 Q4	Continued prioritised TRAK Change Requests in next 6 months – OP Labs and Xray results review, Mental Health EPR, Patient Care Plans, NeuroSurgery eReferrals, Maternity updates, replace deprecated functionality (order entry / consultation), implement Ward Contingency application. Upgrades to Trak Mobile Enabled User Interface (MEUI) and to the Business Intelligence platform upgrades and Shadow Trak support for Dataloch Analytics	Digital and IT	Service capacity to review requirements and implement	Trak Project Board	Enhanced functionality delivered, tested, trained and Live	Electronic Patient Record (EPR) updates
Green	Trakcare Theatre Information Systems	Document requirements and implement core Theatre functionality within Trak	2021/22 Q4	Trak Theatres will replace an unsupported existing theatre system from the start of 2022, and deploying at WGH, SJH, RIE and PAEP through 2022, streamlining the scheduling of Theatre Booking, Instrument Tracking, Visibility of Theatre activity / EPR on a real time basis	Digital and IT	Expanding scope, impacting core theatre system functionality delivery	Trak Theatres Project Board	Trak Theatres functionality delivered, tested, trained and Live	Theatre Information Systems

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Green	Digital and IT Service Desk	Implement regional Service desk solution	2021/22 Q3	Continued Regional rollout of Digital and IT Service Now Service desk fully implemented in NHS Lothian, to NHS Fife and Borders - NHS Fife go live Aug 21, NHS Borders in November 21	Digital and IT	Cost of service may preclude some boards participating	Infrastructure Project Board	All Digital and IT Service requests routed through the new service desk	Digital and IT Service Desk
Green	National Office 365 / MS Teams deployment	Ongoing migration of existing on-premise MS exchange email to cloud based O365, and deployment of MS Teams	2021/22 Q4	NHS Mail Migration to Office365 for NHS Lothian NHS.NET Users in August 2020. This requires onboarding NHS Lothian accounts into Office365 during 2021/22, implementing JLM processes, implementing inTune MDM for mobile devices, MS Teams, onedrive/sharepoint deployment, and VDI configuration	Digital and IT	Costs of Licences for full-Client , where applications require this (only web deployment for most PC users, except laptops) Insecure tenancy configuration for hosting Health Board patient or staff details	Infrastructure Project Board	Full migration of Office 365 and MS Teams during 2022 and revised scot.nhs domain activated for nhslothian users	National MS Office 365 / MS Teams deployment in National tenancy
Green	Unified Communications deployment	Unified Communications Deployment (Handsets, Mobiles, PDA's, Switchboards and associated Infrastructure upgrades – inc POE switches)	2021/22 Q4	Unified Communications Deployment for SJH, REH, and a number of smaller locations - We have now deployed 10,000 handsets across 27 sites. Planned completion in September 21. In addition, this replaces existing Hospital Switch boards with resilient platforms / enhanced facilities. Deploy Ascom devices from Pager replacements and handheld data capture, and clinician alerting (eg new Referrals)	Digital and IT	Additional infrastructure upgrades required to assure digital coverage in Clinical areas	Infrastructure Project Board	New handsets, digital infrastructure, mobiles, Ascom PDAs and switchboard consoles implemented and live and in use Sept 21	Unified Communications
Green	Digital and IT Infrastructure Upgrades	Undertake infrastructure upgrades and Laptop deployments	2021/22 Q4	Over the next 6-12 month we will be replacing outdated servers, upgrading storage, supporting NIS security Audits, HEPMA, Unified Comms, and Office 365. Windows 10 deployment. The accelerated funding for 7,000 desktops (virtual and physical) should allow us to get to 96% completion during 2021/22, forecasted deployment of an additional 1,500 laptops across the organisation	Digital and IT	Potential supply issues / increasing costs if scarce supply and changing priorities impacting scheduled work	Infrastructure Project Board	Upgrades and deployments completed	Digital and IT Infrastructure Upgrades Associated programmes dependent on this infrastructure
Green	ICU System procurement and implementation	Complete procurement and Implementation	2022/23 Q2	Complete procurement of new intensive care unit (ICU) system - implemented as a national framework led by NHS Lothian, during 2021 and award of contract – system deployment and Trak integration during 2022.	Digital and IT Critical care	Additional Covid, ICU activity pressures or Staff Shortages precludes planned implementation	ICU Project Board	ICU system procured, system implementation, integration completed, trained and Live	ICU system
Green	Hospital Electronic Prescribing and Medicines Administration (HEPMA)	Complete HEPMA Deployment	2022/23 Q4	CMM (Wellsky) HEPMA deployment across all hospital locations, REH, WGH, and SJH live, RIE and TSH in config during the remainder of 2021/22 and smaller sites / wrap up during 2022/23, Upgrades for TSH security 2021/22 Q3 and Substance Misuse and MedRec functionality being added with V9 Mid 2022	Digital and IT Clinical Services Pharmacy Teams	Additional Covid, service or pharmacy activity pressures or staff shortages precludes	HEPMA Project Board	HEPM Live at all hospital sites in Lothian / The State Hospital (TSH)	HEPMA System

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						planned implementation			
Green	National CHI and SCPHWS system deployment	Deployment of CHI Broadcasts and SCPHWS (Rio) Child Health Systems)	2022/23 Q2	National CHI Broadcasts being replaced in Lothian Autumn 2021 (Group 3), SCPHWS Rio Child health systems (CHSP/ SIRS replacement) in config / testing with Go Live planned mid 2022	Digital and IT, Woman's and Children Services, Child Health Admin Team	National programme delays / supplier delivery failure of acceptable functionality Additional NHS Lothian Integration needs	National Board Lead Officers (BLO) meetings, National CHI / SCPHWS Project Board	New CHI and Child Health (SCPHWS) systems deployed	National CHI and SCPHWS Systems
Green	Trakcare Patient Outcomes / Model Ward	Deployment of Ward Based Patient Outcomes, Care Plans, Risk Assessments and monitoring Charts	2021/22 Q4	Patient Centred Care plans, risk assessments, NEWS charts, escalations, Observation measurements (Model Ward) / Mobile apps (TCUI and MEUI) including Acsom mobile PDA deployment for patient data collection.	Digital and IT Clinical Services	Additional Covid, or service activity pressures or staff shortages precludes planned implementation	Trak Project Board	Ward Outcomes, Care-plans, Risk assessments live and rolled out to all hospitals / wards / clinical services	Patient Outcomes / Model Ward
Green	East Region Recruitment Systems and Infrastructure support	Provide Digital and IT support for Regional Recruitment HR function	2021/22 Q3	Support East region HR Recruitment services being run by Lothian for associated territorial and special Health Boards – including Call centre setup and Remote user access / Office 365 upgrades, regional access to HR systems Jobtrain/eESS etc and shared files / mailboxes to support go Live Q3 2021	Digital and IT HR Recruitment	Individual Boards (Territorial and special) do not fund their part in Central call centre costs	HR Regional Recruitment Project Board	HR Regional Service Live for Lothian, Fife, Borders, NES/NSS and SAS	East Region Recruitment Systems
Green	Ophthalmology Information Systems	Support the implementation of OpenEyes EPR and provide access to Clinical viewer (CV) for referrals	2022/23 Q2	Support National initiative for OpenEyes Ophthalmology EPR deployment at PAEP and associated OP sites during 2022. Provide Cross Board Regional access to Clinical Viewer (CV) to support Ophthalmology referrals	Digital and IT Ophthalmology Service and Optometrists	Lack of National funding for OpenEyes implementation and Service funding of Clinical Viewer licences	Ophthalmology Project Board	OpenEyes EPR integrated into NHS Lothian systems, and CV access to Regional Optometrists	Ophthalmology Information Systems
Green	Neonatal and Maternity Systems	Deploy Badgernet Neonatal system Interfacing and K2 CTG rollout and procurement of EFREC system	2021/22 Q4	Complete deployment of Badgernet Neonatal (including Trak and neonatal monitor integration < and K2 CTG maternity monitoring systems, and review of future Badgernet Maternity options and procurement / implementation of and NHS lothian Fertility system (EFREC)	Digital and IT Neonatal Maternity Clinical Services	Neonatal and Maternity monitor replacement may implement implementation	Woman's and Children's Project Board	Neonatal and K2 CTG systems implemented and Fertility system procurement / implementation	Neonatal and Maternity Systems
Green	Interagency Information Exchange (IIE)	Updates to IIE and eIRD to support HSP, NHS, Local Authorities and other agency communication	2021/22 Q4	Updates to Interagency Information Exchange (IIE) to take account updates to Social Work systems in East and Mid (Mosaic) and CEC and WLC (Swift) for shared Health and Social care requests for service and service response information, Updates for Integrated Initial Referral Discussion (eIRD) child protection system to operate cross-board	Digital and IT Local Authorities and other agencies	Agreeing Local Authorities plans and resources to commit to a defined implementation plan	Interagency Systems Project Board	IIE updates implemented to support Local Authority system upgrades, and wider rollout of eIRD	Interagency Information Exchange (IIE)

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Green	Scottish Hospitals Inquiry (SHI) NHS Lothian	Initial Upload of all content to the Lothian Review platform, and publishing as appropriate to SG	2021/22 Q3	Support for the Scottish Hospitals Inquiry (SHI) requiring access to extensive (1.6Tb) of information from NHS Lothian regarding the construction of RHCYP/DCN building (email accounts and file system content) for input to local (OpenText) review and submissions to National review platforms	Digital and IT SHI / SG Project teams, CLO	Resource available to review over 1.6Tb of emails and file system content	SHI Project Board	All information published to Opentext System platform for SHI Review ongoing over the next 2-3 years	Scottish Hospitals Inquiry (SHI) NHS Lothian

NHS Lothian – *Public Health and Health Policy* - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Grey - Proposal – New Proposal/no funding yet agreed
Red - Unlikely to complete on time/meet target
Amber - At risk - requires action
Green - On Track
Blue - Complete/ Target met

RAG Status (mandatory)	**Deliverables (mandatory)** *these can be qualitative or quantitative*	**Lead Delivery Body**	**Risks (mandatory)** *list key risks to delivery and the required controls/mitigating actions*	**Outcomes (optional)** *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	**Strategies, plans & programmes** *repeat for each applicable deliverable/add multiple programmes if required*

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
	The Directorate will complete a review of workforce and transition to a new structure which will deliver on remobilisation and pandemic response.	The Public Health department is organised into four teams; Business and Administration, Population Health, Health Protection and Health Care Public Health	Job matching and assignment of existing staff to roles in new structure Advertisement and recruitment for new roles and also unfilled posts in structure	Job matching should be complete by end Sep 21. Recruitment to unfilled posts will then commence	Public Health	Staff recruitment and retention	Staff support and mentoring. Widespread advertising for new roles		Service Remobilisation Public Health Departmet re-structure
	Deliver the Health Protection response to the pandemic including the management of outbreaks and the Test and Protect Contact Tracing service	Recruitment of new staff to provide capacity including Consultants and new nurses	Contribute to the Regional review of health protection Review and revise Lothian's health protection operating model in line with best practice and the changing needs of the pandemic Embed the Test and Protect service within the health protection model	Lead Consultant for Health Protection appointed and new Consultant in post along with Consultant for Testing. Additional Band 6 nurses appointed. HPT now co-ordinating Community Testing and Test and Protect	Public Health	Staff retention and recruitment Jobs matching for new role (Nurse Consultant) so far unsuccessful VOCs change nature of pandemic and more staff required.	Staff support and mentoring Continued engagement with Workforce Organisational Change and Human Resources		Public Health Department re-structure
	Deliver the Health Protection response to the pandemic including the management of outbreaks and the Test and Protect Contact Tracing service	Test and Protect in NHS Lothian has scaled up the service rapidly from its original Tier 2 staffing requirements to achieve the current complement to support the service.	Scottish Government target set for NHS Lothian of 80 wte contact tracers on duty daily, 8-8 on 7 days per week plus Team Leads. Approximately 140 wte contact tracers and 35 wte Team Leads employed on 12 month contracts (to November 2021).	Workforce numbers are roughly the same but at 30 wte team leads most of the time. An almost continuous programme of recruitment is required to maintain target numbers. All contracts now confirmed until March 31st 2022 and surge capacity is now provided centrally. National contact tracing Tactical Operating Group (TOG) has been established. The TOG is accountable to DsPH, and has system wide oversight and a decision making remit on changes to contact tracing practice nationally to manage changing demand and competing priorities and ensure the system is working effectively across Scotland. NHS Lothian contact tracing clinical lead is one of the East region representatives on this group.. Digital solutions are	Public Health	Staff retention and recruitment VOCs change nature of pandemic and more staff required.	Staff support and mentoring		Public Health Department re-structure

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
				also being explored nationally as additional for surge situations in future.					
	COVID Vaccination/ Vaccination Transformation Programme	Review public health governance requirements for immunisation programmes	Review complete by August 2021	New governance arrangements in place	Public Health	n/a	n/a	Completed	
	Develop strategies to mitigate the wider harms associated with the COVID 19 Pandemic	Establish NHS Lothian public health COVID recovery priorities to inform work with local partnerships Develop Public Health action plans with HSCPs and CPP in each of the four partnership areas.	Priorities and workplan completed by September 2021	PH local partnership teams should be established by end September 2021 PH partnership team priorities and action plans delayed until end Deecember 2021	Public Health	Job matching and new staff teams delayed by PH re-structure	Ongoing dialogue with Workforce Organisational Change		Public Health Department re-structure
	Development of NHS Lothian's role as an anchor institution to support the Edinburgh Poverty commission aims and poverty prevention work across all community planning partnerships	Develop the NHS Lothian approach that will integrate our response to the Edinburgh Poverty Commission with the ambitions of an anchor institution and the requirements of the Fairer Scotland Duty Establish and lead work to develop NHS Lothian's anti-poverty plans Develop NHS Lothian anchor mission	Establish short-term NHS Lothian group to work on antipoverty by June 2021 Develop NHSL framework to integrate Fairer Scotland and anti-poverty work: by December 2021 Develop NHS Lothian anti-poverty Approach by September 2021	Anchor institution Programme Board established. Process agreed for Board level workplan which will include Fairer Scotland Duty Ongoing work within partnerships to develop local anti-poverty plans	Public Health	Job matching and new staff teams delayed by PH re-structure	Ongoing dialogue with Workforce Organisational Change but short-term arrangements to deliver Local Child Poverty Action Reports with partners		Local Child Poverty Action Reports
	Screening programmes	Oversee the remobilisation of the screening programmes (Breast cancer, Bowel cancer, Cervical cancer, Diabetic eye screening, Abdominal Aortic Aneurysm) focusing on the backlog of appointments that were missed due to the pandemic and then expanding services as capacity permits.	March 2022	**<u>Cervical screening:</u>** **Primary care:-** Funding delivered from SG to support additional capacity in the short term. Capacity remains lower but improved and sample numbers reaching the lab are in line with the business case re implementation of the HPV pathway. Cervical-primary care recovering well. Colposcopy - waiting times are beyond targets. Progress made with additional staff/re allocation however this is due to end and further increase in waits anticipated without additional staff. Funding requested for staffing (int (Bd)and ext-SG)-outcome awaited. As above pathology services under strain – being explored locally **Colposcopy:-** waiting times are beyond targets. Progress made with additional staff/re allocation however this is due to end and further increase in waits anticipated without additional staff. Funding requested for staffing (int (Bd)and ext-SG)-outcome awaited. As above pathology services under strain – being explored locally.	Public Health	Staffing funding, recruitment and retention	Successful SG funding requests. Service reviews to optimise resources		Service Remobilisation

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				<u>Breast screening:</u> Scotland level data demonstrates attendance remains high. Temporary 6th mobile in South East now up and running with staff etc and additional sessions are being held. This is helping to reduce the backlog towards the 3 year cycle length; however this will take an extended period of time (estimated over several years). 6th mobile allocated by NSD for 12 months to Jan 2022. Estimate a further 6-9 months would be required to recover pre-covid position (which was already running at 3 years 4 months cycle). Recovery to date has seen a 3yr 9month position in August 2020 improved to 3yr 6 month position by July 2021. National Breast screening review has been released in draft and awaiting final recommendations - Supporting pathology service lacks capacity – being explored through pathology **<u>Bowel screening:</u>** Referrals with positive results peaked in March following increase in invitation numbers to accommodate elements of Covid pause. Referrals appear to be reducing to pre Covid levels. Service managing demand via coordinated approach across other USOC services but remains a challenge to meet 31 days target. Pathology services under strain – being explored locally. **<u>AAA</u>**: backlog of screening but anticipate working through this within resources and timescale. **<u>DES</u>**: backlog is increasing. Requires Board funding and additional fixed term staff (2 years)/equipment. Even with additional resources will take more than a year to relieve backlog.					

NHS Lothian - Integrated Planned Care Mapping - Programmes, Priorities and Innovation Timeline

NHS Lothian / CfSD

IPC - Patient Pathway

Proactive avoidance

Patient identifies symptoms

Local DCE Campaign

Attends GP/CN

<OP 0 RS Pathway

>CR 0 Referral guidelines for suspected cancer

Assess and treat

Test and refer

<OP 830 NESGAT

>proc 0 qFIT

Early cancer diagnostic centres

Triage

<OP 1646 ACRT* - Top 9...

<OP 320 ACRT* - T & O

<OP 660 EQuIP

>proc 0 Cancer Regrading Policy

Initial diagnosis

>proc 664 Cytosponge

CCE

>cap 307 Digital Dermatology Assessment

>cap 0 Pre-sssessment Pathway

>proc 290 ADEPt

<TtD 0 Optimal cancer pathways

Assess

<OP 0 Coeliac Disease Pathway

Treat

<beds 1079 ERAS - non Ortho

<beds 0 ERAS - Ortho

<beds 761 Day Surgery

>proc 230 Cataract - additional procedures

CWT 0 Effective cancer management framework

Post treatment

Discharge

<OP 2052 PIR* - Top 9 specialties

<OP 545 PIR* - T & O

<OP 0 Heart Failure RHP

<beds 166 COPD RHP

Community follow up

<OP 0 IBD Community Nurse Follow Up

Review

>proc 0 Imaging Hubs (Opthalmology)

Outer - DEPLOYMENT- Low
Outer - DEPLOYMENT- Medium
Outer - DEPLOYMENT- High
Middle - IMPACT - Limited
Middle - IMPACT - Moderate
Middle - IMPACT - Significant
Centre - READINESS - initial concept
Centre - READINESS - early testing
Centre - READINESS - advanced testing
Centre - READINESS - ready for deployment
Centre - no work in this area
Currency
figure

Indicator	Definitions
A&E Attendances	Definitions as per Core Sites, unplanned attendances only
A&E 4-Hour Performance (%)	Definitions as per Core Sites, unplanned attendances only
Total Emergency Admissions	Definitions as per RAPID Datamart used in System Watch
Total Emergency Admission Mean Length of Stay	Definition as per Discovery indicator, see tab Definition Mean Hospital Stay for example and definitions.
31 Day Cancer – Decision to treat to first treatment	Definitions as per published statistics
62 Day Cancer - Referral to First treatment	Definitions as per published statistics
CAMHS - First Treatment Appointments (patients treated within 52 weeks of referral)	Definitions as per published statistics
CAMHS - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable)	Definitions as per published statistics
CAMHS - Performance against the 18 week standard (%)	Definitions as per published statistics
Psychological Therapies - First Treatment Appointments (patients treated within 52 weeks of referral)	Definitions as per published statistics
Psychological Therapies - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable)	Definitions as per published statistics
Psychological Therapies - Performance against the 18 week standard (%)	Definitions as per published statistics
Delayed Discharges at Month End (Total Delayed Discharges of Any Reason or Duration.	Definitions as per published statistics - The data required is the estimated number of people delayed at each census point (the snapshot figure). Baseline figures used are the census point figures as at the end of each month; https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/delayed-discharges/delayed-discharges-in-nhsscotland-monthly/

Projections (Refer to Definitions datasheet)	Quarter ending 30/06/2021	Quarter ending 30/09/2021	Quarter ending 31/12/2021	Quarter ending 31/03/2022
A&E Attendances (Definitions as per Core Sites, unplanned attendances only)	67,116	69,155	71,181	71,125
A&E 4-Hour Performance (%) (Definitions as per Core Sites, unplanned attendances only)	82.8	76.4	74.2	74
Total Emergency Admissions (Definitions as per RAPID Datamart used in System Watch)	24,377	23,798	24,164	24,530
Total Emergency Admission Mean Length of Stay (Definitions as per Discovery indicator attached)	6.5	6.2	6.1	6.0
31 Day Cancer – Decision to treat to first treatment (Definitions as per published statistics)	98.50%	92.70%	90%	89.60%
62 Day Cancer - Referral to First treatment (Definitions as per published statistics)	88.20%	83.90%	83.70%	83.30%
CAMHS - First Treatment Appointments (patients treated within 52 weeks of referral)(Definitions as per published statistics)	660	549	582	593
CAMHS - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	172	154	155	158
CAMHS - Performance against the 18 week standard (%) (Definitions as per published statistics)	63.20%	61%	61%	61%
Psychological Therapies - First Treatment Appointments (patients treated within 52 weeks of referral) (Definitions as per published statistics)	3,523	3,285	3,232	3,292
Psychological Therapies - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	474	320	359	366
Psychological Therapies - Performance against the 18 week standard (%) (Definitions as per published statistics)	76.90%	78.50%	78.50%	78.50%
	Month ending 30/06/2021	**Month ending 30/09/2021**	**Month ending 31/12/2021**	**Month ending 31/03/2022**
Delayed Discharges at Month End (Total Delayed Discharges of Any Reason or Duration, per the Definition for Published Statistics)	217	261	263	228

Non Elective Hospital Spell Activity Example from Discovery

Date Range: Hospital Spell Discharge Date between April 2019 and March 2021

Data Source: SMR01 and SMR01-01E (GLS)

Date Data Extracted: 22/06/2021

Definitions

Hospital Spells have been calculated as an unbroken period of time that a patient spends within a Hospital. A patient may change specialty, consultant or significant facility during a hospital spell. A change in hospital location would create a new hospital spell.
Admission Type: is based on the Admission Type recorded on the admitting episode of the Hospital Spell.
Non Elective Activity excludes Elective Admission Types 10, 11, 12 and 19.

SMR Data Completeness Estimates as at 12th May 2021

Please click for PHS Data Completeness Information

Quarters

NHS Board	SMR01						SMR01 GLS[1]			
	Oct'19-Dec'19	Jan'20-Mar'20	Apr'20-Jun'20	Jul'20-Sep'20	Oct'20-Dec'20	Jan'21-Mar'21	Apr'20-Jun'20	Jul'20-Sep'20	Oct'20-Dec'20	Jan'21-Mar'21
Ayrshire & Arran	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Borders	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
State Hospital										
Golden Jubilee	100%	100%	100%	100%	99%	96%				
Fife	99%	99%	98%	98%	98%	92%	98%	98%	96%	81%
Greater Glasgow & Clyde	100%	99%	99%	99%	99%	96%	100%	100%	85%	66%
Highland	99%	99%	99%	99%	99%	96%				
Lanarkshire	100%	100%	99%	99%	99%	96%	99%	100%	99%	99%
Grampian	98%	98%	97%	98%	97%	96%				
Orkney	100%	100%	100%	100%	100%	99%				
Lothian	98%	98%	99%	99%	97%	98%	98%	91%	94%	89%
Tayside	100%	100%	100%	99%	99%	98%				
Forth Valley	98%	97%	98%	97%	96%	72%	100%	100%	100%	100%
Western Isles	100%	100%	100%	100%	100%	100%				
Dumfries & Galloway	100%	100%	100%	99%	98%	96%				
Shetland	99%	99%	99%	99%	99%	84%				
All NHS Boards	**99%**	**99%**	**99%**	**99%**	**98%**	**95%**	**99%**	**98%**	**95%**	**89%**

Note: (1) GLS - Geriatric Long Stay

Public Health Scotland's Discovery Tool

A Hospital Spell Activity Dashboard is available within the PHS Discovery Tool that all Health Board Staff can request access to.
Health Boards have more detailed access to Hospital Spells within the Discovery Tool and can analyse information by Hospital, Discharging Specialty, Discharging Significant Facility, Discharging Diagnosis among other dimensions.

Direct Link to Discovery Hospital Spell Analysis Dashboard Treatment (authorisation required)
Link to Discovery Hospital Spell Analysis Dashboard Guidance Document

Link to Discovery Website
Link to Requesting Discovery Access Guide

Non Elective Hospital Spell Activity Example from Discovery

Date Range: Hospital Spell Discharge Date between April 2019 and March 2021

Data Source: SMR01 and SMR01-01E (GLS)

Date Data Extracted: 22/06/2021

Definitions

Hospital Spells have been calculated as an unbroken period of time that a patient spends within a Hospital. A patient may change specialty, consultant or significant facility during a hospital spell. A change in hospital location would create a new hospital spell.

Admission Type: is based on the Admission Type recorded on the admitting episode of the Hospital Spell. Non Elective Activity excludes Elective Admission Types 10, 11, 12 and 19.

		2019	2019	2019	2020	2020	2020	2020	2021	
Health Board	Indicator	Q2: Apr - Jun	Q3: Jul - Sep	Q4: Oct - Dec	Q1: Jan - Mar	Q2: Apr - Jun	Q3: Jul - Sep	Q4: Oct - Dec	Q1: Jan - Mar	Total
Golden Jubilee	Bed Days	3,838	3,514	3,692	3,489	3,998	4,217	3,645	3,861	30,254
Golden Jubilee	Hospital Spells	872	803	805	792	824	853	773	779	6,501
Golden Jubilee	Mean Hospital LOS	4.4	4.4	4.6	4.4	4.9	4.9	4.7	5.0	4.7
NHS Ayrshire & Arran	Bed Days	86,390	85,350	87,118	91,256	64,814	74,621	84,425	83,353	657,327
NHS Ayrshire & Arran	Hospital Spells	14,644	14,219	14,570	12,853	10,121	12,746	11,887	11,098	102,138
NHS Ayrshire & Arran	Mean Hospital LOS	5.9	6.0	6.0	7.1	6.4	5.9	7.1	7.5	6.4
NHS Borders	Bed Days	23,278	25,831	23,129	23,647	17,514	18,876	21,446	23,434	177,155
NHS Borders	Hospital Spells	3,175	3,289	3,426	3,003	2,358	2,656	2,626	2,562	23,095
NHS Borders	Mean Hospital LOS	7.3	7.9	6.8	7.9	7.4	7.1	8.2	9.1	7.7
NHS Dumfries & Galloway	Bed Days	35,298	35,449	37,423	40,124	22,018	27,514	27,823	27,522	253,171
NHS Dumfries & Galloway	Hospital Spells	4,984	4,720	5,206	4,878	3,398	4,300	4,210	4,081	35,777
NHS Dumfries & Galloway	Mean Hospital LOS	7.1	7.5	7.2	8.2	6.5	6.4	6.6	6.7	7.1
NHS Fife	Bed Days	61,966	62,865	63,804	67,287	42,387	53,397	53,863	52,425	457,994
NHS Fife	Hospital Spells	10,520	10,630	11,165	10,081	7,565	9,413	9,262	8,857	77,493
NHS Fife	Mean Hospital LOS	5.9	5.9	5.7	6.7	5.6	5.7	5.8	5.9	5.9
NHS Forth Valley	Bed Days	59,831	60,645	61,993	62,767	42,489	47,259	50,232	55,093	440,309
NHS Forth Valley	Hospital Spells	9,476	10,154	10,413	9,387	7,174	8,751	8,859	8,432	72,646
NHS Forth Valley	Mean Hospital LOS	6.3	6.0	6.0	6.7	5.9	5.4	5.7	6.5	6.1
NHS Grampian	Bed Days	88,452	89,879	100,268	101,608	64,992	68,733	73,604	77,374	664,910
NHS Grampian	Hospital Spells	13,735	13,884	14,559	13,729	11,837	12,626	12,084	11,835	104,289
NHS Grampian	Mean Hospital LOS	6.4	6.5	6.9	7.4	5.5	5.4	6.1	6.5	6.4
NHS Greater Glasgow & Clyde	Bed Days	283,855	279,922	295,816	300,019	207,899	247,008	265,844	265,957	#########
NHS Greater Glasgow & Clyde	Hospital Spells	40,988	40,968	42,971	38,869	28,973	35,924	34,209	33,056	295,958
NHS Greater Glasgow & Clyde	Mean Hospital LOS	6.9	6.8	6.9	7.7	7.2	6.9	7.8	8.0	7.3
NHS Highland	Bed Days	53,594	57,185	53,774	61,948	39,780	44,667	47,431	51,658	410,037
NHS Highland	Hospital Spells	8,535	8,382	8,732	8,081	6,025	7,630	7,484	7,073	61,942
NHS Highland	Mean Hospital LOS	6.3	6.8	6.2	7.7	6.6	5.9	6.3	7.3	6.6
NHS Lanarkshire	Bed Days	110,829	116,657	118,380	122,530	78,114	94,852	104,665	104,759	850,786
NHS Lanarkshire	Hospital Spells	20,956	21,047	21,906	19,594	14,924	18,040	17,065	16,934	150,466
NHS Lanarkshire	Mean Hospital LOS	5.3	5.5	5.4	6.3	5.2	5.3	6.1	6.2	5.7
NHS Lothian	Bed Days	164,778	158,772	168,826	178,167	119,385	143,882	146,816	149,679	#########
NHS Lothian	Hospital Spells	23,707	25,087	25,696	23,309	18,426	22,808	21,299	21,117	181,449
NHS Lothian	Mean Hospital LOS	7.0	6.3	6.6	7.6	6.5	6.3	6.9	7.1	6.8
NHS Orkney	Bed Days	3,168	2,521	2,720	3,081	2,402	2,350	2,901	2,349	21,492
NHS Orkney	Hospital Spells	478	441	453	430	338	443	453	467	3,503
NHS Orkney	Mean Hospital LOS	6.6	5.7	6.0	7.2	7.1	5.3	6.4	5.0	6.1
NHS Shetland	Bed Days	2,209	2,423	2,391	2,448	1,341	1,918	1,868	1,865	16,463
NHS Shetland	Hospital Spells	470	462	456	447	328	453	444	397	3,457
NHS Shetland	Mean Hospital LOS	4.7	5.2	5.2	5.5	4.1	4.2	4.2	4.7	4.8
NHS Tayside	Bed Days	73,601	74,565	78,755	78,631	49,777	62,330	64,746	65,769	548,174
NHS Tayside	Hospital Spells	13,052	12,846	13,895	12,750	10,034	12,179	11,789	11,156	97,701
NHS Tayside	Mean Hospital LOS	5.6	5.8	5.7	6.2	5.0	5.1	5.5	5.9	5.6
NHS Western Isles	Bed Days	5,902	6,669	5,657	6,614	2,691	3,477	3,954	4,573	39,537
NHS Western Isles	Hospital Spells	864	908	878	795	571	671	800	672	6,159
NHS Western Isles	Mean Hospital LOS	6.8	7.3	6.4	8.3	4.7	5.2	4.9	6.8	6.4
Scotland	Bed Days	1,056,989	1,062,247	1,103,746	1,143,616	759,601	895,101	953,263	969,671	#########
Scotland	Hospital Spells	166,456	167,840	175,131	158,998	122,896	149,493	143,244	138,516	#########
Scotland	Mean Hospital LOS	6.3	6.3	6.3	7.2	6.2	6.0	6.7	7.0	6.5

Indicator

8 Key Diagnostic Tests (new patients only, excludes planned repeats)

New Outpatient Activity Projections

TTG Activity Projections

Definitions

Definitions as per Scottish Government weekly diagnostic Management Information. Only include activity which corresponds to a new diagnostic waiting list entry. Patients who are undergoing regular planned tests should be excluded. The following types of activity should also be excluded: planned repeat/follow up/return; emergency; tests as part of inpatient treatment.

New Outpatient activity should only include activity that is measured against the 12 Week New Outpatient Standard. For example, the eight key diagnostic tests should be excluded. All definitions and methodology should the the same as the Public Health Scotland waiting times datamart.

TTG activity should only include activity that is measured against the 12 Week Treatment Time Guarantee. All definitions and methodology should the the same as the Public Health Scotland waiting times datamart. Boards are required to submit total TTG activity projections in the “All Urgencies” rows. Where possible and not timely to produce, Boards should provide a priority breakdown.

Activity Projections		31-Oct-21			
New Elective Diagnostic Test	**Urgency**	**October 2021 Planned**	**October 2021 Actual**	**October 2021 Variance**	**November 2021 Planned**
All Endoscopy	All Urgencies	1410	0	-1410	1600
All Endoscopy	Routine	0	0	0	0
All Endoscopy	Urgent	0	0	0	0
All Endoscopy	Urgent Suspicion Cancer	0	0	0	0
All Endoscopy	Bowel Screening	0	0	0	0
Upper Endoscopy	All Urgencies	480	0	-480	550
Upper Endoscopy	Routine			0	
Upper Endoscopy	Urgent			0	
Upper Endoscopy	Urgent Suspicion Cancer			0	
Lower Endoscopy (other than colonoscopy)	All Urgencies	100	0	-100	120
Lower Endoscopy (other than colonoscopy)	Routine			0	
Lower Endoscopy (other than colonoscopy)	Urgent			0	
Lower Endoscopy (other than colonoscopy)	Urgent Suspicion Cancer			0	
Colonoscopy	All Urgencies	580	0	-580	630
Colonoscopy	Routine			0	
Colonoscopy	Urgent			0	
Colonoscopy	Urgent Suspicion Cancer			0	
Colonoscopy	Bowel Screening			0	
Cystoscopy	All Urgencies	250	0	-250	300
Cystoscopy	Routine			0	
Cystoscopy	Urgent			0	
Cystoscopy	Urgent Suspicion Cancer			0	
All Radiology	All Urgencies	8632	0	-8632	6904
All Radiology	Routine	0	0	0	0
All Radiology	Urgent	0	0	0	0
All Radiology	Urgent Suspicion Cancer	0	0	0	0
Magnetic Resonance Imaging	All Urgencies	1904	0	-1904	1523
Magnetic Resonance Imaging	Routine			0	
Magnetic Resonance Imaging	Urgent			0	
Magnetic Resonance Imaging	Urgent Suspicion Cancer			0	
Computer Tomography	All Urgencies	2515	0	-2515	2012
Computer Tomography	Routine			0	
Computer Tomography	Urgent			0	
Computer Tomography	Urgent Suspicion Cancer			0	
Non-obstetric ultrasound	All Urgencies	4126	0	-4126	3300
Non-obstetric ultrasound	Routine			0	
Non-obstetric ultrasound	Urgent			0	
Non-obstetric ultrasound	Urgent Suspicion Cancer			0	
Barium Studies	All Urgencies	87	0	-87	69
Barium Studies	Routine			0	
Barium Studies	Urgent			0	
Barium Studies	Urgent Suspicion Cancer			0	

30-Nov-21	
November 2021 Actual	**November 2021 Variance**
0	-1600
0	0
0	0
0	0
0	0
0	-550
	0
	0
	0
0	-120
	0
	0
	0
0	-630
	0
	0
	0
	0
0	-300
	0
	0
	0
0	-6904
0	0
0	0
0	0
0	-1523
	0
	0
	0
0	-2012
	0
	0
	0
0	-3300
	0
	0
	0
0	-69
	0
	0
	0

Month Ends								
31-Dec-21			31-Jan-22			28-Feb-22		
December 2021 Planned	December 2021 Actual	December 2021 Variance	January 2021 Planned	January 2021 Actual	January 2021 Variance	February 2021 Planned	February 2021 Actual	February 2021 Variance
1360	0	-1360	1410	0	-1410	1550	0	-1550
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
480	0	-480	480	0	-480	550	0	-550
		0			0			0
		0			0			0
		0			0			0
100	0	-100	100	0	-100	120	0	-120
		0			0			0
		0			0			0
		0			0			0
580	0	-580	580	0	-580	630	0	-630
		0			0			0
		0			0			0
		0			0			0
		0			0			0
200	0	-200	250	0	-250	250	0	-250
		0			0			0
		0			0			0
		0			0			0
6904	0	-6904	8632	0	-8632	6904	0	-6904
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
1523	0	-1523	1904	0	-1904	1523	0	-1523
		0			0			0
		0			0			0
		0			0			0
2012	0	-2012	2515	0	-2515	2012	0	-2012
		0			0			0
		0			0			0
		0			0			0
3300	0	-3300	4126	0	-4126	3300	0	-3300
		0			0			0
		0			0			0
		0			0			0
69	0	-69	87	0	-87	69	0	-69
		0			0			0
		0			0			0
		0			0			0

31-Mar-22		
March 2021 Planned	**March 2021 Actual**	**March 2021 Variance**
1600	0	-1600
0	0	0
0	0	0
0	0	0
0	0	0
550	0	-550
		0
		0
		0
120	0	-120
		0
		0
		0
630	0	-630
		0
		0
		0
		0
300	0	-300
		0
		0
		0
6904	0	-6904
0	0	0
0	0	0
0	0	0
1523	0	-1523
		0
		0
		0
2012	0	-2012
		0
		0
		0
3300	0	-3300
		0
		0
		0
69	0	-69
		0
		0
		0

New Outpatient (12 Week Standard) Activity Projections		31-Oct-21		
Specialty	Urgency	October 2021 Planned	October 2021 Actual	October 2021 Variance
All Specialties	All Urgencies	18523		
All Specialties	Routine			
All Specialties	Urgent			
Anaesthetics	All Urgencies	142		
Anaesthetics	Routine			
Anaesthetics	Urgent			
Cardiology	All Urgencies	410		
Cardiology	Routine			
Cardiology	Urgent			
Dermatology	All Urgencies	1339		
Dermatology	Routine			
Dermatology	Urgent			
Diabetes/Endocrinology	All Urgencies	266		
Diabetes/Endocrinology	Routine			
Diabetes/Endocrinology	Urgent			
ENT	All Urgencies	769		
ENT	Routine			
ENT	Urgent			
Gastroenterology	All Urgencies	425		
Gastroenterology	Routine			
Gastroenterology	Urgent			
General Medicine	All Urgencies	900		
General Medicine	Routine			
General Medicine	Urgent			
General Surgery (inc Vascular)	All Urgencies	1563		
General Surgery (inc Vascular)	Routine			
General Surgery (inc Vascular)	Urgent			
Gynaecology	All Urgencies	2192		
Gynaecology	Routine			
Gynaecology	Urgent			
Neurology	All Urgencies	538		
Neurology	Routine			
Neurology	Urgent			
Neurosurgery	All Urgencies	185		
Neurosurgery	Routine			
Neurosurgery	Urgent			
Ophthalmology	All Urgencies	2557		
Ophthalmology	Routine			
Ophthalmology	Urgent			
Oral & Maxillofacial Surgery	All Urgencies	149		
Oral & Maxillofacial Surgery	Routine			
Oral & Maxillofacial Surgery	Urgent			
Oral Surgery	All Urgencies	575		
Oral Surgery	Routine			
Oral Surgery	Urgent			
Orthodontics	All Urgencies	76		
Orthodontics	Routine			
Orthodontics	Urgent			

Month Ends									
30-Nov-21			31-Dec-21			31-Jan-22			
November 2021 Planned	November 2021 Actual	November 2021 Variance	December 2021 Planned	December 2021 Actual	December 2021 Variance	January 2021 Planned	January 2021 Actual	January 2021 Variance	February 2021 Planned
18797			18608			18764			18851
142			142			142			142
410			410			410			410
1539			1539			1645			1658
265			260			286			295
769			769			769			769
425			357			357			357
900			892			896			896
1563			1563			1568			1568
2192			2192			2192			2192
538			538			538			538
185			176			176			185
2557			2557			2533			2533
149			149			149			149
575			575			575			575
76			76			76			76

28-Feb-22		31-Mar-22		
February 2021 Actual	February 2021 Variance	March 2021 Planned	March 2021 Actual	March 2021 Variance
		18995		
		142		
		410		
		1658		
		312		
		769		
		461		
		900		
		1568		
		2192		
		538		
		185		
		2533		
		149		
		575		
		76		

TTG Activity Projections		31-Oct-21		
Specialty	Urgency	October 2021 Planned	October 2021 Actual	October 2021 Variance
All Specialties	All Urgencies	2829		
All Specialties	Routine			
All Specialties	Urgent			
ENT	All Urgencies	137		
ENT	Routine			
ENT	Urgent			
Gastroenterology	All Urgencies	11		
Gastroenterology	Routine			
Gastroenterology	Urgent			
General Surgery (inc Vascular)	All Urgencies	530		
General Surgery (inc Vascular)	Routine			
General Surgery (inc Vascular)	Urgent			
Gynaecology	All Urgencies	313		
Gynaecology	Routine			
Gynaecology	Urgent			
Neurology	All Urgencies	2		
Neurology	Routine			
Neurology	Urgent			
Ophthalmology	All Urgencies	314		
Ophthalmology	Routine			
Ophthalmology	Urgent			
Oral & Maxillofacial Surgery	All Urgencies	65		
Oral & Maxillofacial Surgery	Routine			
Oral & Maxillofacial Surgery	Urgent			
Oral Surgery	All Urgencies	10		
Oral Surgery	Routine			
Oral Surgery	Urgent			
Orthodontics	All Urgencies			
Orthodontics	Routine			
Orthodontics	Urgent			

Month Ends										
30-Nov-21			31-Dec-21			31-Jan-22			28-Feb-22	
November 2021 Planned	November 2021 Actual	November 2021 Variance	December 2021 Planned	December 2021 Actual	December 2021 Variance	January 2021 Planned	January 2021 Actual	January 2021 Variance	February 2021 Planned	February 2021 Actual
2842			2821			2827			2853	
137			137			137			137	
11			11			11			11	
530			514			514			546	
313			313			313			313	
2			2			2			2	
314			314			314			314	
65			65			65			65	
10			10			10			10	

February 2021 Variance

31-Mar-22		
March 2021 Planned	March 2021 Actual	March 2021 Variance
2857		
137		
11		
530		
313		
2		
314		
65		
10		

Trajectories (Patients Waiting > 12 Weeks (OP/TTG) & > 6 Weeks (Diagnostics))

New Outpatients		Month end trajectory numbers waiting over 12 weeks					
Key Specialties *(include any additional at risk specialties)*	**Start position - numbers > 12 weeks**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
All Specialties	41675	42,108	42,522	42,861	43,309	43,723	44,353
Trauma & Orthopaedics	2317	2,150	2,049	1,969	1,867	1,787	1,705
Dermatology	9274	9,729	10,108	10,412	10,791	11,094	11,397
ENT	4106	4,149	4,184	4,211	4,246	4,273	4,301
Ophthalmology	7404	7,566	7,702	7,810	7,945	8,053	8,162
General Surgery (inc Vascular)	4575	4,876	5,125	5,326	5,576	5,775	5,976
Neurology	49	36	25	16	6	2	0
Urology	995	1,003	1,010	1,018	1,029	1,037	1,045
Gastroenterology	973	925	884	852	811	780	747
Gynaecology	3215	3,499	3,735	3,924	4,160	4,349	4,538
Pain Management							
Anaesthetics	8	4	4	4	4	5	5

Inpatients & Daycase		Month end trajectory numbers waiting over 12 weeks					
Key Specialties *(include any additional at risk specialties)*	**Start position - numbers > 12 weeks**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
All Specialties	10,999	12131	13071	13826	14762	15516	16271
Trauma & Orthopaedics	3,168	3492	3751	3961	4220	4429	4638
General Surgery (inc Vascular)	2,232	2311	2385	2438	2500	2555	2607
Ophthalmology	159	185	210	230	255	274	294
Urology	1,367	1525	1657	1763	1895	2001	2106
ENT	830	930	1011	1076	1159	1224	1291
Gynaecology	851	912	963	1004	1055	1096	1137
Oral & Maxillofacial Surgery	148	166	189	207	230	248	266
Plastic Surgery	1,203	1405	1562	1687	1844	1968	2094

Diagnostics		Month end trajectory numbers waiting over 6 weeks					
Scope/ Radiology	**Start position - numbers > 6 weeks**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
All Radiology	2574	2559	2581	2738	2586	2501	2633
Computer Tomography	249	182	135	75	28	0	0
Magnetic Resonance Imaging	261	222	217	344	166	36	76
Barium Studies	10	10	10	9	9	9	9
Non-obstetric ultrasound	2054	2145	2219	2310	2383	2456	2548
All Endoscopy	4657	4526	4348	4288	4171	4029	3887
Upper Endoscopy	2005	1958	1911	1874	1827	1790	1753
Lower Endoscopy (other than colonoscopy)	715	719	675	722	740	705	669
Colonoscopy	993	908	823	755	670	602	535
Cystoscopy	944	941	939	937	934	932	930

Previously >12 was predicted as the Additions-Removals gap, where a deficit would result in a breach at a point soon. There is no recognised methodology for predicting >52.
The current unstable position means a changing urgency profile (with a greater proportion of removals from the front of the list) and fewer removals are from the end of the list (as capacity is limited for routine long waits). One would require an understanding of where on a list the removals were to be removed from, what priority upgrades would occur for long waits (meaning these would be removed from the middle rather than the end of the list), and modelling forward the profiles of waiting list to that would tip into the 12 and 52 weeks in future if not ren
As such, statistical forecasting has been used to calculate the >12 and >52. Exponential Smoothing assigns the highest weight to the most recent observation, and weights decrease exponentially as observations come from further in the past.

noved.

Trajectories (Patients Waiting > 52 Weeks (OP/TTG) & > 52 Weeks (Diagnostics))

New Outpatients		Month end trajectory numbers waiting over 52 weeks					
Key Specialties *(include any additional at risk specialties)*	**Start position - numbers > 52 weeks**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
All Specialties	7082	7391	7762	8058	8433	8733	9030
Trauma & Orthopaedics	23	8	6	5	5	5	6
Dermatology	4118	4410	4654	4848	5092	5286	5481
ENT	550	580	605	625	651	671	691
Ophthalmology	684	652	626	605	579	558	536
General Surgery (inc Vascular)	674	714	749	777	811	840	867
Neurology	4	1	1	2	2	1	1
Urology	92	95	98	101	104	106	108
Gastroenterology	8	3	2	1	0	0	0
Gynaecology	204	122	130	136	144	151	157
Pain Management							
Anaesthetics	0	0	0	0	0	0	0

Inpatients & Daycase		Month end trajectory numbers waiting over 52 weeks					
Key Specialties *(include any additional at risk specialties)*	**Start position - numbers > 52 weeks**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
All Specialties	3198	3489	3738	3938	4184	4386	4579
Trauma & Orthopaedics	610	668	718	757	808	849	888
General Surgery (inc Vascular)	1079	1177	1264	1331	1412	1480	1547
Ophthalmology	22	23	23	24	24	25	25
Urology	555	599	636	666	703	732	762
ENT	265	282	297	309	324	336	348
Gynaecology	154	167	178	187	198	206	215
Oral & Maxillofacial Surgery	31	35	39	42	45	48	51
Plastic Surgery	225	254	278	297	321	340	358

Diagnostics		Month end trajectory numbers waiting over 52 weeks					
Scope/ Radiology	**Start position - numbers > 52 weeks**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
All Radiology	0	0	0	0	0	0	0
Computer Tomography	0	0	0	0	0	0	0
Magnetic Resonance Imaging	0	0	0	0	0	0	0
Barium Studies	0	0	0	0	0	0	0
Non-obstetric ultrasound	0	0	0	0	0	0	0
All Endoscopy	721	719	726	732	741	746	752
Upper Endoscopy	125	105	95	87	78	70	62
Lower Endoscopy (other than colonoscopy)	200	223	246	264	287	305	323
Colonoscopy	167	172	177	181	186	190	194
Cystoscopy	229	219	208	200	190	181	173

Previously >12 was predicted as the Additions-Removals gap, where a deficit would result in a breach at a point soon. There is no recognised methodology for predicting >52.
The current unstable position means a changing urgency profile (with a greater proportion of removals from the front of the list) and fewer removals are from the end of the list (as capacity is limited for routine long waits). One would require an understanding of where on a list the removals were to be removed from, what priority upgrades would occur for long waits (meaning these would be removed from the middle rather than the end of the list), and modelling forward the profiles of waiting list to that would tip into the 12 and 52 weeks in future if not remc
As such, statistical forecasting has been used to calculate the >12 and >52. Exponential Smoothing assigns the highest weight to the most recent observation, and weights decrease exponentially as observations come from further in the past.

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NHSScotland Chief Operating Officer

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19 November 2021

By email

Dear Calum,

RMP4 – Updated Remobilisation Plan for 2021/22

Thank you for submitting the latest iteration of your Remobilisation Plan. As we head into the second winter of the Covid-19 pandemic, I would like to take this opportunity to thank you and your teams for your dedication and hard work in delivering healthcare for our communities, in the face of considerable challenges.

I would also like to acknowledge the work that has gone into the development of this latest Plan, and in particular the input and support in developing and using the new format we trialled for RMP4. I would be grateful if you could pass on my thanks to all involved. I am very conscious of the extremely difficult, and rapidly changing, context in which your Plan was developed. I recognise that these plans will evolve over time in response to changing circumstances, and we are keen to continue to work with you in the coming months to understand the implications and to provide support accordingly.

Indeed, the process of planning for delivery becomes more, not less, important during a time of high pressure, uncertainty and changeability. These plans provide not only a foundation for us to agree what we aim to deliver over this next period, but also a basis for discussion about the risks which could impact on our ability to deliver, and how we can work together to mitigate these. The new format used this time round also allows us to build a more comprehensive picture of both aspiration and risk across all Health Boards, and will hopefully support collaboration between Boards in developing their plans.

The updated plans will continue to inform the regular engagement which already takes place between SG Policy Teams and relevant service leads within your teams, providing a direct feedback route to pick up any ongoing queries regarding your proposals. While we do not expect plans to be resubmitted, this feedback should be fed into future progress updates.

Finance

Following our Quarter One review, we wrote to confirm to NHS Boards on 26 October that funding will be provided for full Covid-19 and remobilisation costs on a non-repayable basis. This includes anticipated underachievement of savings in year,

with an expectation however that Boards continue to take appropriate measures to reduce this funding requirement. This letter also set out expected actions for the remainder of the year and in advance of the 2022-23 financial year.

We have received your Quarter Two financial return and are working through the detail included. Where further clarification is required we will follow up with your Director of Finance.

Costs in relation to remobilisation should continue to be reported through quarterly finance returns. You must ensure that any recurring impact from these actions is clearly reported, as this is a key focus of our review in advance of the draft Scottish Budget on 9 December.

Winter Planning

Helen Maitland, my National Director for Unscheduled Care, wrote to you previously on 2 November confirming the Winter funding available to your Board, and confirming that this should be targeted to deliver the key priorities noted in the Remobilisation Plan guidance, and as reflected in the Winter related elements of your Plan. I recognise how challenging the forthcoming Winter is likely to be for the entire health and care service and Helen's team stand ready to support you wherever possible to meet those challenges.

Planned Care

We will also be in touch subsequent to this letter to confirm your remaining allocation of Waiting Times Funding for this financial year.

Next Steps

Bearing the above comments in mind, I am content that you now take your updated Plan for the second half of 2021/22 through your own governance processes and would ask that you then make it available on your website.

In order to monitor progress on the delivery of your RMP4 going forward, we are putting in place arrangements to request quarterly progress updates against the key deliverables that you have identified. Updates should be submitted at the end of January 2022, covering Quarter Three, and the end of April 2022, for Quarter Four. These updates should include any changes to your plans for the following quarters. Details on the specific requirements for these updates will be issued in due course.

Three Year Operational Recovery Plans 2022-25

As you know, we are proposing to move to a slightly longer-term period of three years, for future Operational Plans. This will enable a more strategic approach to planning and support programmes of service transformation, aligned with the NHS Recovery Plan and the Care and Wellbeing Portfolio.

These three-year plans will take the form of a Recovery Plan for the period of 2022-25 for your Board. They will encompass a relatively high level narrative setting out

your key priorities for recovery and transformation within this period, and how these contribute to our national priorities, underpinned by a spreadsheet-based Annual Delivery Plan (ADP). This latter element, which will build on the format and content of the delivery planning template used for RMP4, will continue to form the basis for ongoing engagement as well as regular quarterly progress reports to Scottish Government, recognising the continuing fluidity in our operating context and supporting responsive changes to plans in-year.

In recognition of the pressures that you are currently working under, and the high level of uncertainty and volatility that remains in the system, these three year plans will be scheduled for submission at the end of July 2022. We intend that that this will allow sufficient time for you to take stock of your position as we move out of Winter, to consider your priorities, engage meaningfully with your staff, partners, communities and stakeholders on their desired outcomes, and to develop greater integration between your service, finance and workforce plans. In order to ensure that there is no gap in oversight during this period, it is important that you ensure that your Delivery Plans are kept updated as set out above.

We are also moving back to three year financial planning, and whilst we anticipate requiring some detail of plans in advance of the start of the financial year, we will use the Quarter One review in 2022-23 as an opportunity for Boards to refresh their financial plans to align with the three-year operational plans. Further detail will provided on this process in due course.

In the meantime, we have established a Short Life Working Group with a small group of Planning Leads from across the NHS Territorial and National Boards and SG officials. This team will be working closely together to produce guidance for the 2022-25 Recovery Plans and will remain in close contact with the wider Planning Collaborative Group.

Thank you again to you and your teams for all the hard work they have put in to developing this plan, and I look forward to working in partnership with you as we develop our vision for delivery in the NHS over the next three years.

Yours sincerely

JOHN G BURNS
NHSScotland Chief Operating Officer

Meeting Name: Board **Meeting date: 1 December 2021**

Title: NHS Lothian Pharmaceutical Care Service Plan

Purpose and Key Issues of the Report:					
DISCUSSION		DECISION	X	AWARENESS	

The NHS Lothian Pharmaceutical Care Services Plan delivered by Community Pharmacy 2021 represents a major revision of the plan and aligns with the local and national post COVID recovery and redesign plans.

The following have been consulted in the development of this plan: Lothian Area Pharmaceutical Committee, Community Pharmacy Lothian, HSCPs, Primary Care Joint Management Group, Pharmacy Practices Committee (PPC) and Primary Care Contractor organisation (PCCO).

The plan provides a comprehensive overview of the pharmaceutical care provided by community pharmacy. There are seventeen recommendations which reflect potential gaps and pharmaceutical care needs across NHS Lothian. Three are identified as priorities.

While the plan is reviewed and updated annually, it should be viewed in the context of a 3-5 year strategic planning cycle in terms of the delivery of recommendations.

Key risk is failure to comply with the requirement for Boards to publish a Pharmaceutical Care Service Plan annually.

Recommendations:

The Board are recommended to:

- Agree to the plan being published on The Community Pharmacy Lothian website and NHS Lothian internet site.
- Agree to the plan being reviewed annually and brought to the NHS Lothian Board every three years.

Author: Maureen M Reid **Date:** 22/11/21	**Director:** Dona Milne **Date:** 22/11/21

Community Pharmacy Pharmaceutical Care Services Plan 2021

EXECUTIVE SUMMARY

The Community Pharmacy Pharmaceutical Care Services Plan (PCSP) 2021 describes current community pharmacy pharmaceutical services across NHS Lothian, and where possible identifies unmet need and provides recommendations for how these needs might be addressed.

NHS boards are obliged to publish and monitor their pharmaceutical care service plan annually as set out in the NHS (Pharmaceutical Services) (Scotland) Amendment regulations 2011 (SSI 2011/32).

This 2021 update to the plan is aligned to both local and national NHS recovery and redesign plans which cover the time frame of 2021-2026. The PCSP is updated annually but the recommendations should be considered in the three to five year strategic planning time frame.

There is good core provision of pharmaceutical services across NHS Lothian with approximately one community pharmacy per 5,000 population. No unmet need is identified with respect to the four core pharmaceutical services which are delivered from 182 pharmacies across NHS Lothian. However, this will continue to be monitored closely at neighbourhood level with new housing developments in several areas.

In addition to the nationally negotiated core pharmaceutical services, there are several additional services that are commissioned to meet specific needs. These are locally negotiated services and not part of the core provision of service and therefore not all pharmacies will provide all additional services, and neither are they obliged to. There may be unmet need with respect to the provision of these services in a particular population or geographical area.

There are seventeen recommendations for the development of pharmaceutical care services included in the plan.

Three priority areas under the recovery and redesign plans are:

a. **Medication Care and Review service serial prescribing**. All GP practices and community pharmacies are enabled to provide this service. Increasing the use of serial prescribing is likely to reduce medicine waste and time spent on repeat prescribing in general practice.

b. **Implementation of the local Care Home Community Pharmacy Service.** This will increase pharmaceutical care provided to care homes and reduce medicine waste.

c. **Pharmacy First and Pharmacist independent prescribers to support out of hours services and unscheduled care**. This may be impacted by the location and number of pharmacies operating at weekends and extended hours in each HSCP. This is often less of an issue for urban areas as there are more pharmacies located in the city but still may necessitate travel at certain times to receive pharmaceutical care at a pharmacy.

Recommendations Summary

Pharmacy Provision

1 Opening hours out with core hours are likely to remain fluid and a local process for agreement of any opening hour changes should be retained involving local pharmaceutical (LAPC) and general practice (LMC) committees.

2 Premises facilities information should be gathered to provide an accurate level of current provision and determination of improvements required to achieve 100% of pharmacies with private consulting area, wheelchair accessibility and an induction hearing loop by 2025

3 20 minute neighbourhoods, Scottish Government and NHS Lothian sustainability objectives should be considered as part of the process in determining where community pharmacies are sited in the future.

Essential Core Services

4 Based on the number and distribution of pharmacy contracts across each HSCP there should be capacity to meet needs for the acute medication service but further effort is needed to actively progress the Medicine Care and Review service by increasing the number of active GP practices and community pharmacies engaged.

5 As all patients registered with a GP or living in Scotland can access the NHS Scotland Pharmacy First service there is no unmet need in the provision of treatment for common clinical conditions from a community pharmacy as an alternative to a GP practice appointment.

6 However unmet need will arise in urgent care provision where pharmacy opening hours do not offer full week end and extended opening hours in a local area. Local mitigations should be considered by the multidisciplinary teams.

7 Support public awareness of access to Pharmacy First as part of the provision of urgent care through use of national promotional materials for pharmacy first.

8 Support the planned opportunities for the community pharmacy smoking cessation service to work closely with specialist Quit Your Way services and pharmacy champions to achieve improved quit rates.

9 Support opportunities and new models of delivering additional sexual health services in community pharmacy as detailed in the Scottish Government Sexual Health and Blood Borne Virus Recovery Plan and the NHS Recovery Plan 2021-2026.

10 Undertake local assessment of need and potential mitigations where there are limited numbers of pharmacies open late, full and half day Saturday and Sunday opening. This may lead to unmet need in some HSCP localities when NHS Lothians GP Out-of-Hours Service (LUCS) recommend care which is provided by Community Pharmacy

11 Community pharmacy to have access to clinical records to help improve patient care when GP practice is closed and to support pharmacotherapy service element of Medicine Care and Review.

Additional Services

Substance Misuse

12 Key areas to be developed are increasing availability of take-home naloxone from community pharmacy and a test of change of Buvidal® administration from community pharmacy. Both are desirable to support reducing drug related deaths.

13 Undertake local reviews of injecting equipment and naloxone provision to ensure local needs are being met effectively post pandemic.

14 Injecting equipment provision is not a specific pharmacy only scheme. As pharmacies can often offer longer opening hours than drop in centres pharmacy-delivered needle exchange adds capacity to the harm reduction team.

Palliative Care Services

15 The Palliative Care Service is annually reviewed to ensure best coverage for the population of NHS Lothian by a small number of local experts for provision of palliative care medicines and advice both in and out of hours.

Pharmaceutical Advice to Care Homes

16 Progress implementation of the locally agreed Community Pharmacy Care Home service to increase pharmaceutical care provision and reduce medicine wastage across Health and Social Care Partnerships and NHS Lothian to meet the sustainability action plan

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Immunisation

17 As part of the Vaccine Transformation Programme Community Pharmacy should be considered in the future development of a range of NHS vaccination services by HSCPs to maintain and improve uptake of vaccinations including.

- COVID vaccination
- Flu vaccination
- Pneumococcal vaccination
- Shingles vaccination
- Travel vaccination

Plan for Pharmaceutical Care Services Delivered by Community Pharmacy 2021

1. Introduction

1.1 Background
1.2 Aim
1.3 Pharmacy Practice Committee
1.4 NHS COVID Recovery and Redesign Plans
1.5 NHS Lothian Sustainability Framework and Action Plan
1.6 Health and Social Care Partnerships
2. NHS Lothian Population
2.1 Age and Population
2.2 Ethnicity
3 Community Pharmacy services
3.1 Background
3.2 Summary of Pharmaceutical Care Services in NHS Lothian
3.3 Essential (Core) Services for Community Pharmacy
3.4 Additional Services
4 Non NHS commissioned services
5 Recommendations Summary
6 Appendices
Appendix 1 - HSCP Community Pharmacy Maps
Appendix 2 – HSCP Pharmacy Contractor List

Introduction

1.1 Background

The NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011/32) amended regulations so that NHS Boards are obliged to publish Pharmaceutical Care Services Plans and monitor their plan annually to reflect changes in service provision or service need. A pharmaceutical care services plan will give a summary of pharmaceutical services provided in the area of the Board together with an analysis of where it believes there is a lack of adequate provision or unmet need. While this plan is reviewed and published annually the delivery of recommendations will form part of the longer term strategic plans for delivery of community pharmacy services under Integrated Joint Board scheme of delegation and Health and Social Care Partnership strategic plans.

1.2 Aim

The primary function of this Pharmaceutical Care Services plan is to describe the pharmaceutical services provided by community pharmacy within Lothian Health Board for their population and where possible identify the unmet need for these pharmaceutical services with recommendations to the Health Board as to how these needs should be met. A secondary function of the plan is to inform and engage members of the public, health professionals and planners in respect of the planning and delivery of pharmaceutical services.

1.3 Pharmacy Practices Committee

The Pharmacy Practices Committee (PPC) considers all applications for new Community Pharmacies to open in NHS Lothian.

Regulations set out the procedures which must be followed by applicants who seek to open new Community Pharmacies in Scotland. The regulations (schedules 3 and 4) set out the statutory arrangements which Health Boards must put in place to receive and respond to such applications for a new community pharmacy. NHS Lothian is required to establish a PPC with representation by professional pharmacists and lay members, chaired by an NHS Board member. The PPC must, first, determine the boundaries of the neighbourhood in which the proposed pharmacy would be located; second, determine whether existing pharmaceutical services in or into that neighbourhood or adequate; and thirdly - only if the existing services are deemed inadequate - determine whether it is necessary or desirable to approve the application to establish a new pharmacy. PPCs should have reference to its Board's Pharmaceutical Care Services Plan when considering need for pharmaceutical services within the proposed area. The Pharmaceutical Care Services plan is one of a range of data sources that are available to the PPC to use in assessing need when considering applications to the Pharmaceutical List. The NHS needs of the local community are to be the main determinant of whether an additional community pharmacy or relocation is to be approved.

1.4 NHS Recovery and Redesign Plans

Since the previous NHS Lothian Pharmaceutical Care Service Plan was published the Scottish Government have published the NHS Recovery Plan

The recovery plan acknowledges that primary and community care services, such as general practice, pharmacy, dentistry and eye care, have been greatly impacted and are under significant pressure due to the COVID pandemic and lockdowns. It also proposes development of new services and roles for community pharmacy as national services to be provided from all pharmacies.

Community pharmacies, acting as the first port of call through the Pharmacy First Service, will be a key provider in unscheduled care, supporting the recovery of the NHS.

Future community pharmacy public health service plans include the introduction of a new pharmacy woman's health and wellbeing service. This new service will provide greater access to advice, guidance and if appropriate treatments in areas such conception, contraception and menopause. In the second year of this plan a community pharmacy hospital discharge and medicines reconciliation service to help speed up the process for people being discharged from hospital will be developed. Developing new digital solutions such as ePrescribing and eDispensing will help to make the prescribing process paperless, which will free up capacity for healthcare professionals so that they can see more patients. It will also make it easier for patients to access their medicines quickly and safely.

The NHS Lothian Primary Care Remobilisation plans also mirror this with community pharmacy services a key part of access to urgent care via Pharmacy First and Pharmacy First Plus. Key local remobilisation priorities for Community Pharmacy also include serial prescribing expansion, contributing to the vaccination transformation programme and implementation of an NHS Lothian care home service level agreement for community pharmacy to include additional pharmaceutical care provision.

Community Pharmacy are also identified for roles in provision of systemic anticancer therapy in the Recovery and Redesign of Cancer Services Action Plan published in December 2020.

Roles for Community Pharmacy are also included in the Reset and Rebuild: A Recovery Plan for Sexual Health and Blood Borne Virus Services document published in August 2021.

The Medication Assisted Treatment Standards: access, support and choice published in May 2021 in response to rises in drug related deaths support the role of community pharmacy as part of the multiagency and multiprofessional response.

1.5 Sustainability Framework and Action Plan

NHS Lothian has published its Sustainable Development Framework and Action Plan. Which states

Our vision is to be a lead organisation in sustainable health care with all our staff empowered to put sustainable healthcare at the heart of their practice. We will work with our partners and the communities we serve to put in place work practices, procurement systems and preventative interventions to minimise our environmental impact, protect the natural environment and enhance social value so that we are a sustainable service promoting good health and enhancing quality of life.

Pharmaceuticals and medical equipment together comprise half of all procurement emissions for NHS Scotland. Levels of pharmaceuticals can be found in soil and groundwater. Reducing the impact from pharmaceuticals in the environment centers on reducing pharmaceutical waste through regular medication review and improved adherence to prescribed medication putting evidence on environmental sustainability at the heart of the management of pharmaceuticals and prescribing in primary care. Community pharmacy Medicine Care and Review service along with development of the local care home service with increased pharmaceutical care provide examples which support the framework and action plan to reduce pharmaceutical waste.

1.6 Health and Social Care Partnerships

NHS Lothian is made up of four Health and Social Care Partnerships and the associated Integration Joint Boards (IJBs). They each have unique profiles based on geography, demographics and disease prevalence. Identifying unmet needs of communities is complex and should be based on evidence from: Health and Social Care Strategic Plans; Health and Social Care joint strategic needs assessment and integrated impact assessments; Public Health Annual Report; National Clinical strategies. Close working with a range of disciplines and patients within the Health and Social Care

Partnership and across the wider health system is required. Local knowledge and multidisciplinary expertise will be key to help Health and Social Care Partnerships identify unmet needs which are specific to a particular locality or population as part of their strategic planning process.

The Independent Review of Adult Social Care published in 2021 recommends development of a National Care Service. Local planning and delivery of support and services will continue. Under this review, and as part of any development of a national care service, Integration Joint Boards will be reformed to take more responsibility for the planning and delivery of adult social care support.

Inequalities are the unfair and avoidable differences in people's health and wellbeing and is a crosscutting theme for all Health and Social Care Partnership service areas including access to health services. The location of community pharmacies in all communities can support reduction of inequalities by providing access to the health services they provide for all.

1.6.1 City of Edinburgh

Community Pharmacies	107	Population	527,620
GP Practices	73	Life expectancy Most deprived	Male 71.3
Acute Hospitals	2		Female 77.2
Care Homes	82		Scotland 71.3 76.9

1.6.2 West Lothian

Community Pharmacies	33	Population	183,820
GP Practices	23	Life expectancy Most deprived	Male 74.5
Acute Hospitals	1		Female 78.4
Care Homes	29		Scotland 71.3 76.9

1.6.3 Midlothian

Community Pharmacies	19	Population	93,150
GP Practices	13	Life expectancy Most deprived	Male 74.5
Community Hospital	1		Female 79.7
Care Homes	12		Scotland 71.3 76.9

1.6.4 East Lothian

Community Pharmacies	23	Population	107,900
GP Practices	15	Life expectancy Most deprived	Male 75.0
Community Hospital	3		Female 80.6
Care Homes	19		Scotland 71.3 76.9

2 NHS Lothian Population

To put the pharmaceutical care service in context a brief description of the NHS Lothian population is a useful starting place

2.1 Age and Population

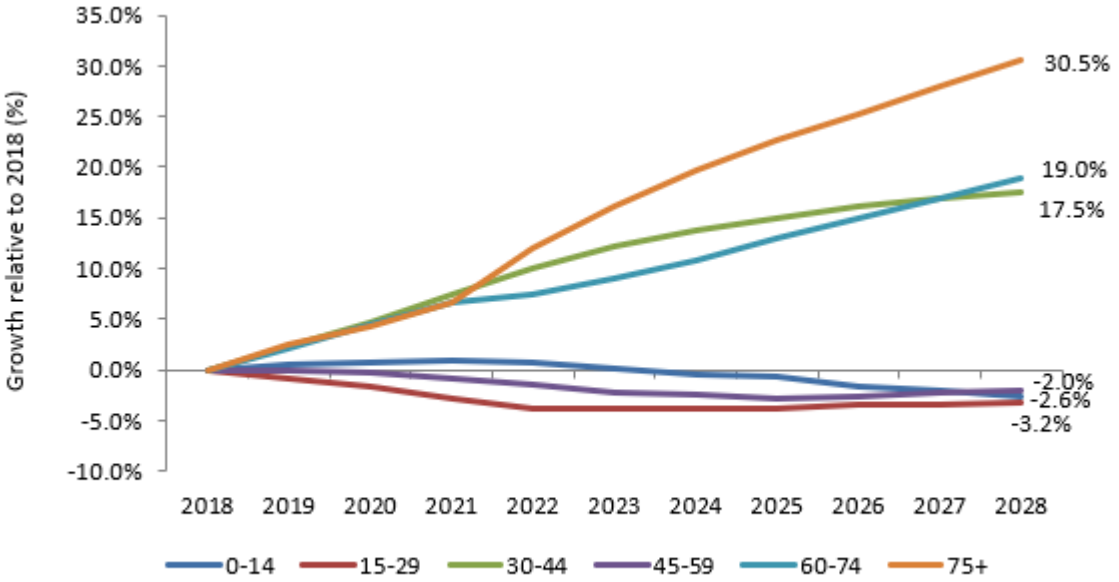
The spread of the population by age is important for pharmaceutical care services as patients tend to require more medication as they get older. Mothers and babies also tend to have particular needs from the pharmacy ranging from advice to treatment of minor ailments. Lothian Health Board's population will continue to grow. The table 1 shows the change projected in the population of Lothian from 2018 to 2028 in total and by age group.
Figures 1a and 1b illustrate the projected population growth by age group from 2018-2028 across Lothian and by local authority areas, respectively.

Table 1: Projected population of Lothian by age (2018-2028)

	2018		2028	
Age	**Population**	**%**	**Population**	**%**
0-14	142,831	15.9%	139,138	14.5%
15-29	188,121	21.0%	182,163	18.9%
30-44	192,934	21.5%	226,721	23.5%
45-59	179,456	20.0%	175,896	18.3%
60-74	129,505	14.4%	154,108	16.0%
75+	64,923	7.2%	84,719	8.8%
All ages	897,770	100%	962,745	100%

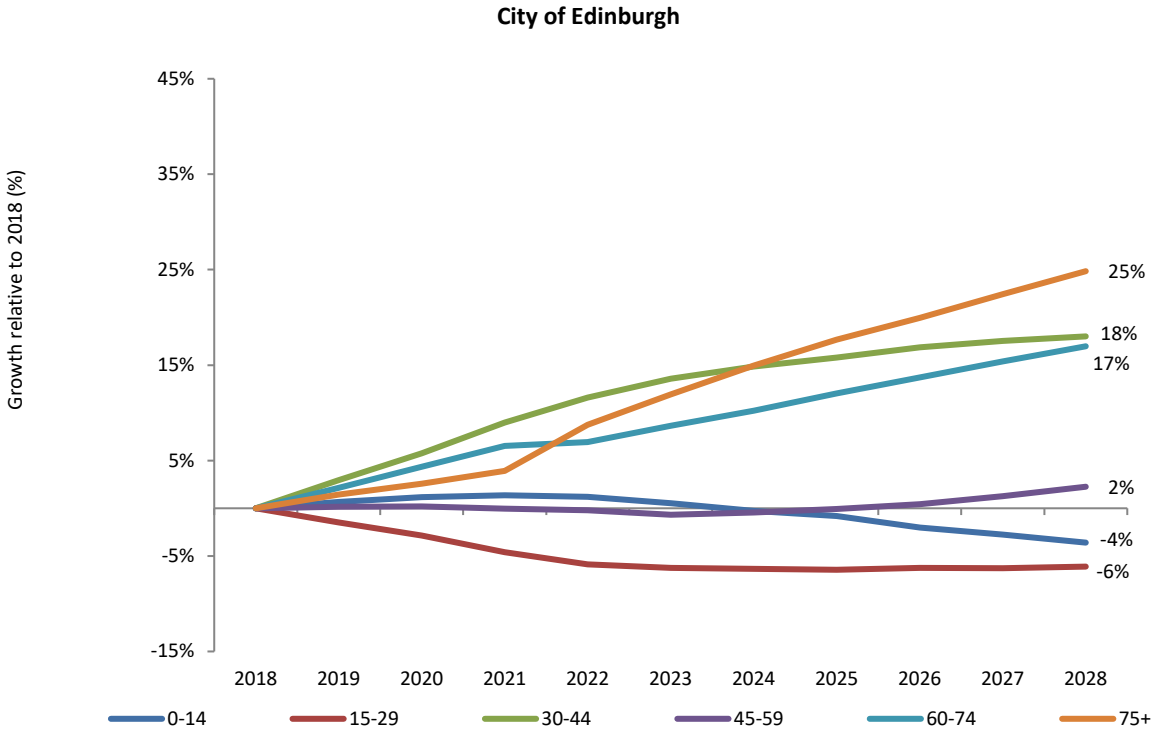
Source: National Records of Scotland (2021) Sub-National Population Projections

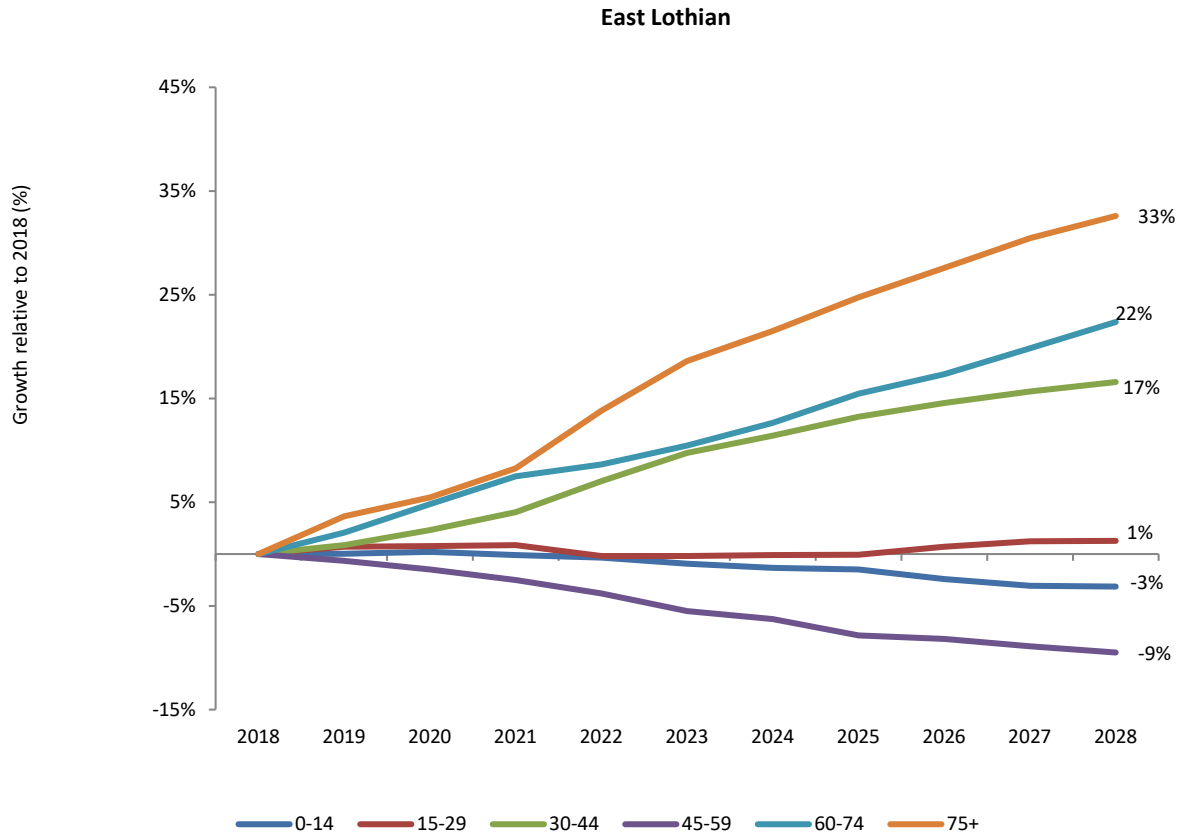
Figure 1a: Projected population growth of Lothian by age (2018-2028)



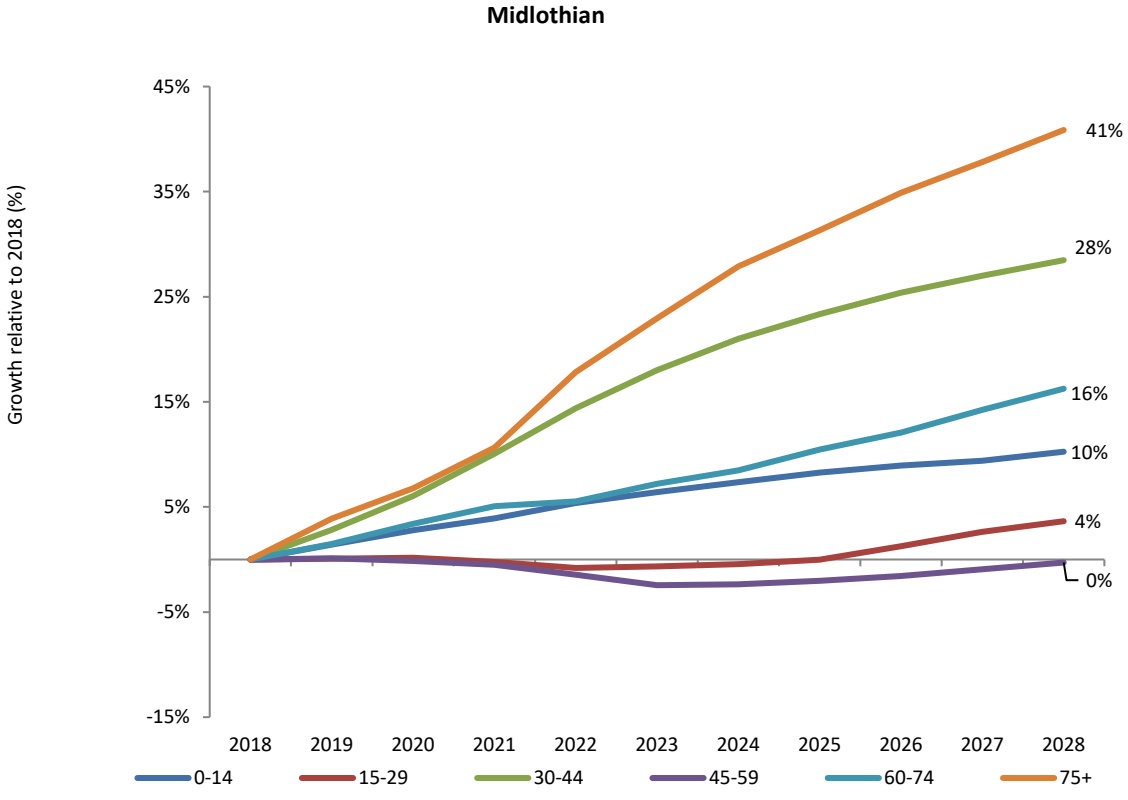
Source: National Records of Scotland (2021) Sub-National Population Projections, 2018-based

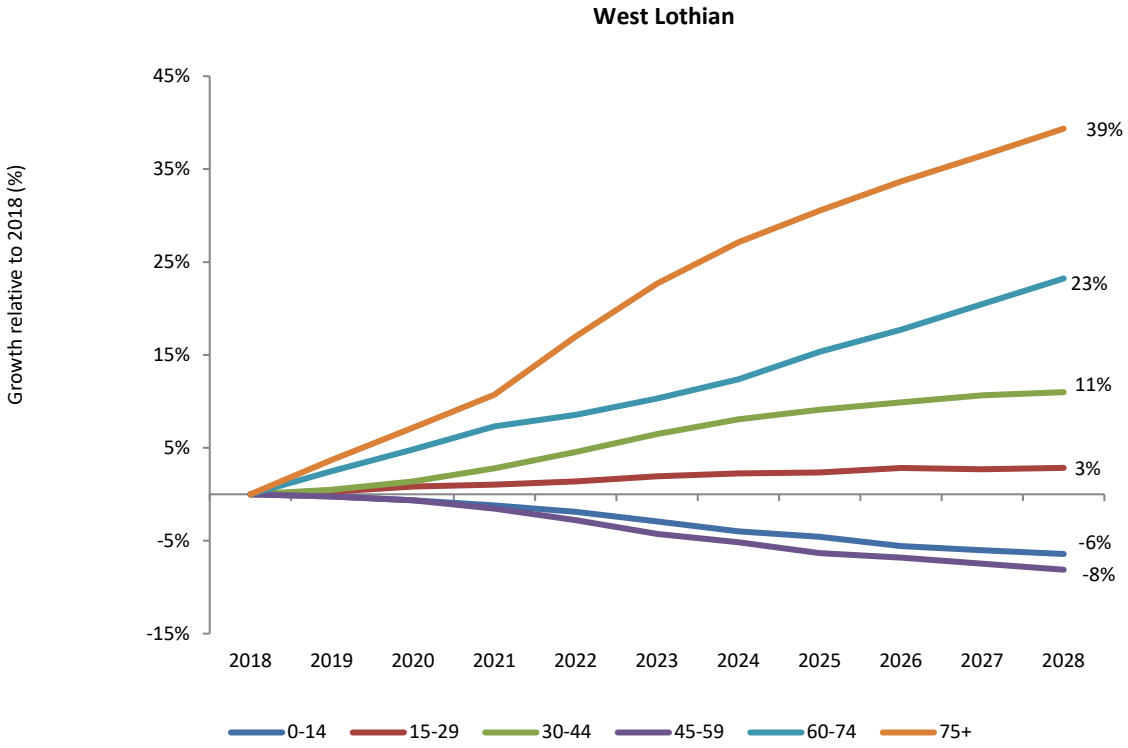
Figure 1b: Projected population growth of local authorities by age (2018-2028)





Source: National Records of Scotland (2021) Sub-National Population Projections, 2018-based



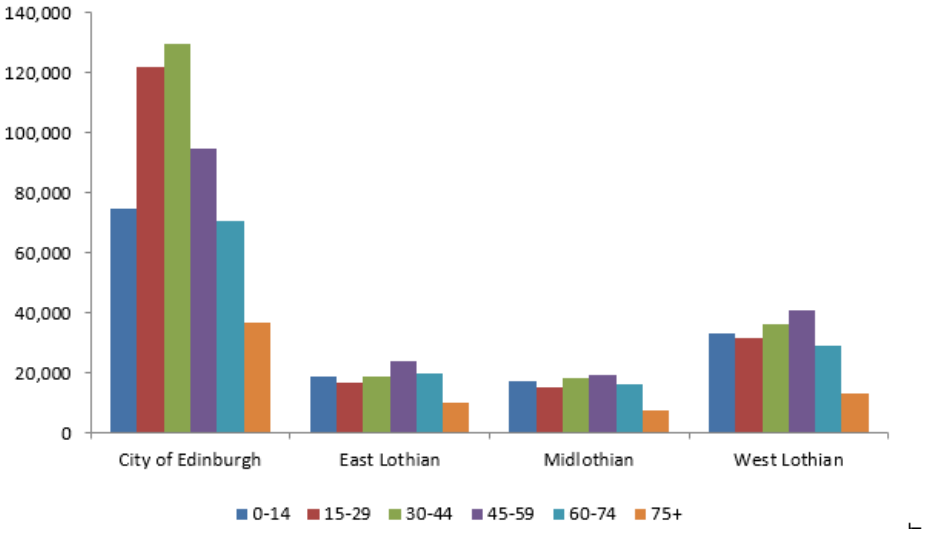


Source: National Records of Scotland (2021) Sub-National Population Projections, 2018-based

Large new housing developments in all areas will require establishment of new primary care services and associated facilities across Lothian. The projected growth in older adults, including particularly strong growth among adults aged 75 and over, will increase the demand for access to primary care services. This older population with multiple conditions will also require increasingly complex support at home from multidisciplinary services. The majority of people over 75 will be on at least one medication and as people get older, they are more at risk from adverse effects of medicines and likely to be on multiple medicines.

Figure 2 gives a view of comparative populations in the council areas relating to Health and Social Care Partnerships in NHS Lothian. Edinburgh has the largest population of the four areas.

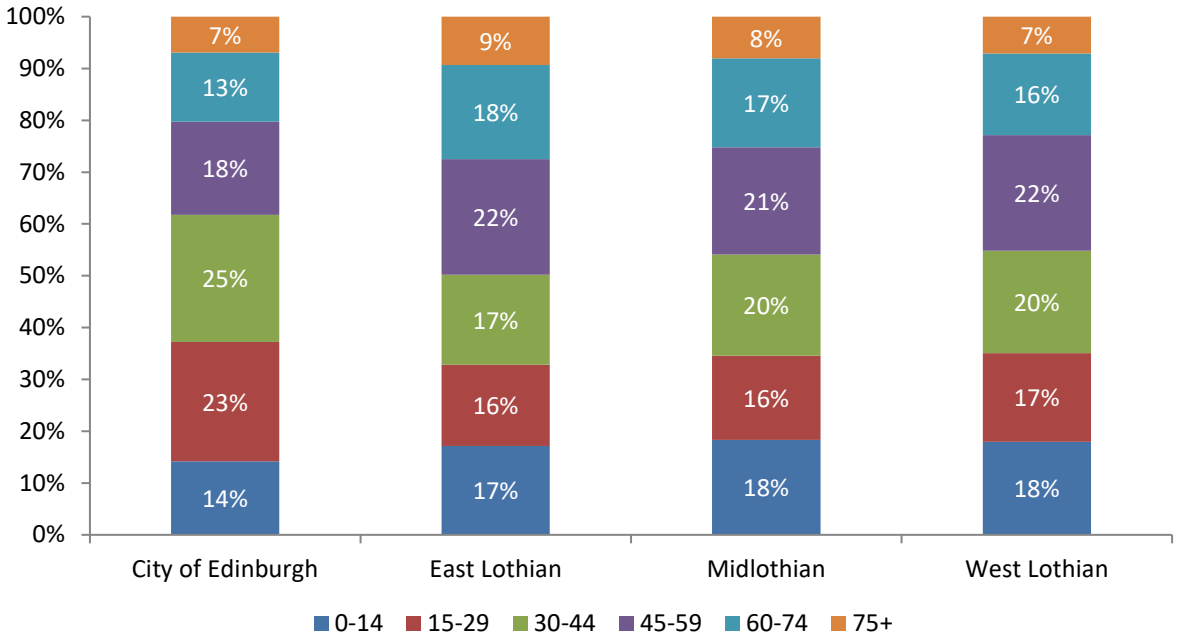
Figure 2: Estimated population by age and local authority (mid-2020)



Source: National Records of Scotland (2021) Mid-2020 Population Estimates

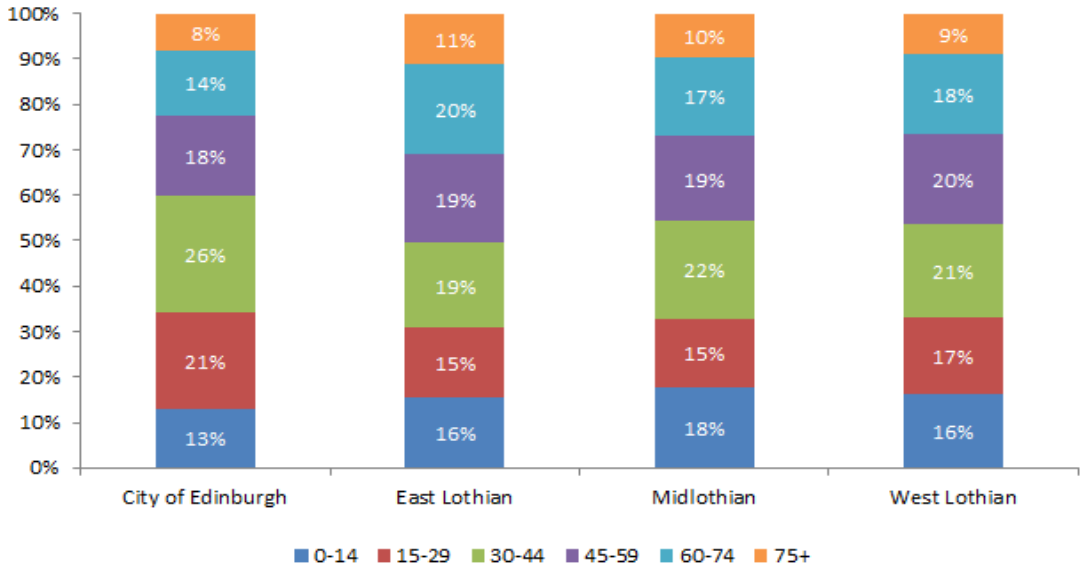
To get a better view of the age breakdown of the NHS Lothian population Figures 3a and 3b looks at the age groups in terms of percentage of the population in mid 2020 and projection to 2028. When age is considered in these terms there are not particularly wide differences in the extremes of age between the four Health and Social Care Partnership areas at present. In general, the extremes of age may have need of additional pharmaceutical care input. Edinburgh whilst having the largest population has a larger proportion in the younger groups than the other Health and Social Care Partnership areas; by 2028 it is projected that Edinburgh will have 21% of its population in the youngest and oldest categories, compared to 28% in Midlothian. It is therefore reasonable to expect broadly similar pharmaceutical needs in terms of age across NHS Lothian.

Figure 3a: Estimated population percentages by age and local authority (mid-2020)



Source: National Records of Scotland (2021) Mid-2020 Population Estimates

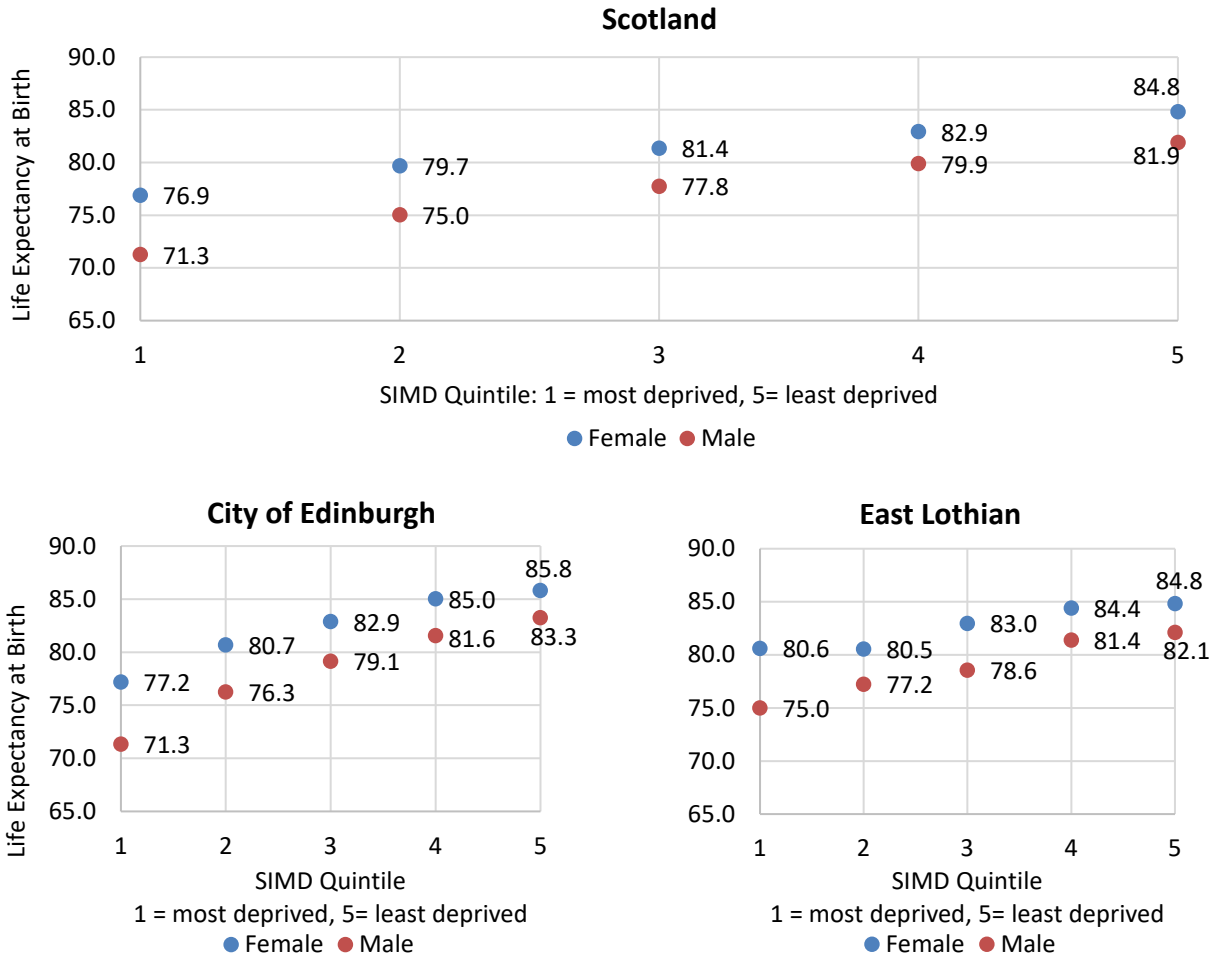
Figure 3b: Estimated population percentages by age and local authority (2028)

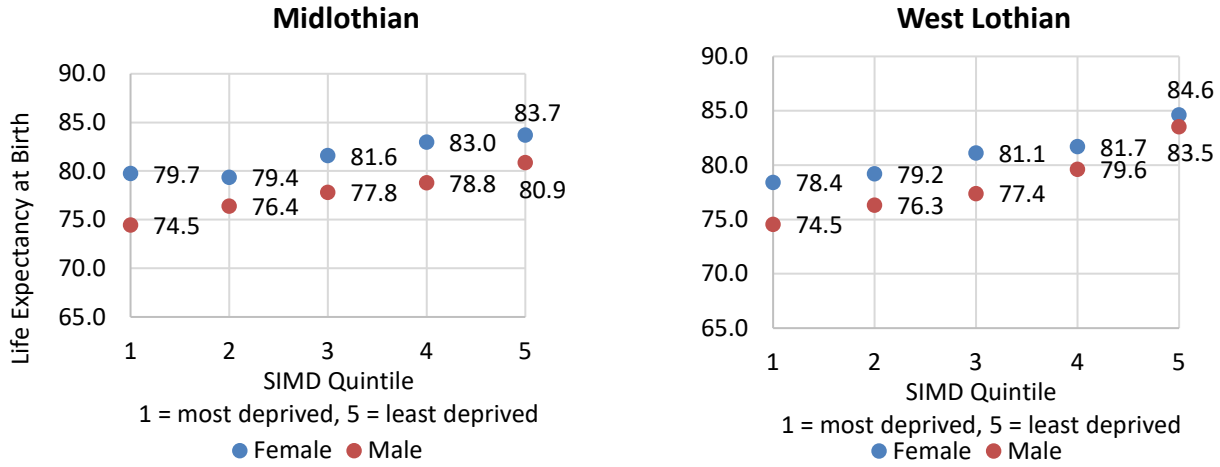


Source: National Records of Scotland (2021) Sub-National Population Projections, 2018-based

Social determinants of health will be a factor in the pharmaceutical needs of the population. Multimorbidity increases with age and for those living in areas of multiple deprivation. This occurs 10-15 years earlier when compared to areas with lower levels of multiple deprivation. People also experience disadvantage through gender, social position, ethnic origin, geography, age and disability. Figure 4 illustrates that, within each local authority area, there are considerable inequalities in life expectancy across Scottish Index of Multiple Deprivation (SIMD) quintiles. This is particularly pronounced in the City of Edinburgh, where men living in the most deprived communities live 12 years less, on average, than their counterparts in the least deprived areas. Those health inequalities exist for almost all health indicators.

Figure 4: Life expectancy at birth by sex and deprivation in Scotland and by local authority (2015-2019)





2.2 Ethnicity

Table 2 shows that 84% of Scottish residents identified themselves as White Scottish in response to the 2011 Census. In East Lothian, Midlothian, and West Lothian, the percentage of residents who identify as White Scottish is comparable with, or marginally higher than, the Scottish average (ranging from 86% - 90%), while the percentage of residents who identify as belonging to ethnic minority groups is comparable to, or lower than, the Scottish average. Conversely, in the City of Edinburgh a smaller percentage of residents identify as White Scottish (70%), while more individuals identify as belonging to other ethnic groups. In particular, 2.7% identify as White Polish, compared to the Scottish average of 1.2%, and 5.5% identify as Asian, Asian Scottish or Asian British, compared with 2.7% in Scotland as a whole.

Community pharmacy can access NHS Lothian translation services to support patients where English is not the first language. Where there is low health literacy a range of techniques can be adopted to support patients understand their medicine.

Table 2: Ethnicity of the population in Scotland and by local authority (Census 2011)

Ethnicity	Scotland	City of Edinburgh	East Lothian	Midlothian	West Lothian
White	96.0%	91.7%	98.3%	98.2%	97.6%
White: Scottish	84.0%	70.3%	85.6%	90.0%	87.8%
White: Other British	7.9%	11.8%	9.3%	5.8%	5.8%
White: Polish	1.2%	2.7%	0.8%	0.5%	1.9%
White: Irish	1.0%	1.8%	0.9%	0.6%	0.7%
White: Gypsy/Traveller	0.1%	0.1%	0.0%	0.1%	0.0%
White: Other White	1.9%	5.1%	1.7%	1.3%	1.3%
Asian, Asian Scottish or Asian British	2.7%	5.5%	1.0%	1.1%	1.7%
African	0.6%	0.9%	0.2%	0.2%	0.3%
Mixed or multiple ethnic groups	0.4%	0.9%	0.4%	0.3%	0.3%
Caribbean or Black	0.1%	0.2%	0.1%	0.1%	0.1%
Other ethnic groups	0.3%	0.8%	0.1%	0.1%	0.1%

Source: Scotland's Census (2011) Scottish Council Area 2011 by Ethnicity (Flat) by Term-time Address

3 Description of Pharmaceutical Services in NHS Lothian

3.1 Background

Pharmacists graduate at a Masters level of degree education. Pharmacists can also undertake further additional training to become independent prescribers. This education together with expertise in clinical practice offers the potential for the neighbourhood pharmacist to play a significant role in the assessment and delivery of care. Pharmacy technicians are also a trained and registered workforce within pharmacy. This highly trained workforce should enable the locations and facilities of pharmacies to be better utilised to meet the needs of patients and improve access to health services so as to reduce inequalities and improve citizens access to health services.

All pharmacies are required to provide all 4 core pharmaceutical care services

- Medication Care and Review
- Acute Medication Service
- Pharmacy First
- Public Health Services.

These services are described in more detail in this document.

There are also locally negotiated service contracts for services that are required in addition to the core services. These may not be available in all community pharmacies as there is no requirement for pharmacies to agree to provide enhanced services.

Integration Joint Boards and Health and Social Care Partnerships can agree which locally negotiated services are required to meet the needs of their populations and how these are delivered as part of the strategic planning process. Consultation and engagement with Community Pharmacy Lothian and the multidisciplinary primary care team will be required in the process to agree provision of appropriate locally negotiated services.

Pharmacies may also provide services which are non NHS commissioned. Not all pharmacies will provide the same non commissioned services. Non commissioned services are offered at the discretion of the contractor and are not funded by either NHS Lothian or remunerated as part of Scottish Government arrangements with community pharmacy.

3.2 Summary of Pharmacy Provision in NHS Lothian

Table 3: Community Pharmacies NHS Lothian

Location	Number of community pharmacies	Population (NRS mid 2020 estimates for council areas)	Population per community pharmacy
NHS Lothian	**182**	**912,620**	**5014**
East Lothian	23	107,900	4691
Edinburgh	107	527,620	4931
Midlothian	19	93,150	4902
West Lothian	33	183,820	5570

There is no standard as to the number of population that should be served by a pharmacy. Table 3 shows that there is some difference in the average population served by each pharmacy between the four Health and Social Care Partnerships areas. The Scottish average population served by a

community pharmacy is around 4530. Across Lothian the average population per pharmacy is 10% above the Scottish average. The highest population per pharmacy is seen in West Lothian.

Pharmacy Provision Across Lothian

Maps found in the appendices show pharmacies in relation to population density within each Health and Social Care Partnership area. These illustrate that typically pharmacies are located in the areas of the most dense population and the more dense the population the higher number of pharmacies there are. Pharmacies also tend to be nearby local and main routes of access, and this can be seen particularly in the more rural areas of Lothian. They are spread across the geographical area, with the preponderance of built-up areas having a pharmacy. This plan uses the 2019 small area population data. When updated in the future in light of the 2022 national census the information will show a change in population density due to the creation and occupation of new housing developments and will assist in the identification of areas where growth in population may have generated of unmet needs.

There can be diverse reasons for a community pharmacy location and the current data identify that a variety of local community pharmacies would appear to exist within NHS Lothian.

3.2.1 Ours of service

Normal hours of service for pharmacies are laid out in the NHS Lothian Hours of Service Scheme under Regulation 11(1) of the National Health Service (Pharmaceutical Services) (Scotland) Regulations as:

All places of business on the Pharmaceutical List shall be open for the supply of drugs and prescribed appliances (as the case may be), on the days and at the hours following:

On five full weekdays in the week (less any public holidays in the week).	9am to 6pm (during which time they may be closed for a maximum of one hour in the middle of the day).
On one half weekday (the Early Closing Day as defined in the Shops Act 1950-65).	9am to 1pm.

Additionally at any other time when a pharmacist's place of business is open for the purpose of supplying drugs or appliances, he shall supply drugs or prescribed appliances which are ordered under the regulations.

As a minimum each contracted pharmacy must open between 9am and 6pm on five and a half days per week. There are some variations to these hours depending upon individual circumstances and applications for shorter or longer hours have been made at various times to suit the local situation. Longer hours are at the discretion of the individual pharmacy and not enforceable through regulations. Changes to extended hours provision may impact on provision and availability of additional local services. If pharmaceutical provision is not met within the core hours mechanisms exist to facilitate provision of pharmaceutical services out with core hours, such as pharmaceutical service rotas, if this is identified as required to meet the need for pharmaceutical services. Additional funding may be required to support such extended service provision.

Table 4: Community Pharmacy Opening Hours in NHS Lothian (December 2019)

Location	NHS Lothian	East Lothian	Edinburgh	Midlothian	West Lothian
Number of community pharmacies	182	23	107	19	33
Number of pharmacies open until 6pm	97	11	52	12	22
Number open between 6pm and 10pm weekdays	23	0	17	2	4
Number open on Saturday morning only	88	10	56	9	13
Number open all day Saturday	64	13	24	10	17
Number open Sunday	18	0	13	1	4

Recommendation:
Opening hours out with core hours are likely to remain fluid and a local process for agreement of any opening hour changes should be retained involving local pharmaceutical (LAPC) and general practice (LMC) committees.

3.2.1.1 Facilities

Most community pharmacies now provide private areas which can be utilised for the provision of services, counselling and advice. These enable patients to have private conversations and to enable confidential services. These areas can be either fully or partially enclosed, reflecting the needs of different patients - for example if they do not like enclosed spaces. In NHS Lothian 90% of pharmacies currently have either a private area or room where patient confidentiality can be maintained. The majority also have induction loop facility and wheelchair access.

Premises facilities information should be gathered to an accurate level of provision and it is the aspiration of NHS Lothian that all community pharmacies should have a private consulting area, wheelchair accessibility and an induction hearing loop by 2025.

Recommendation:
Premises facilities information should be gathered annually to provide an accurate level of current provision and determination of improvements required to achieve 100% compliance of pharmacies with private consulting area, wheelchair accessibility and an induction hearing loop by 2025.

Table 5 Premises Facilities in NHS Lothian. Numbers of pharmacies with each facility and as a percentage of total pharmacies in the area (December 2019)

Area	FACILITY INDUCTION LOOP	FACILITY WHEELCHAIR ACCESS	FACILITY PRIVATE CONSULTING AREA/ROOM
NHS Lothian	**146 (81%)**	**165 (91%)**	**165(91%)**
East Lothian	20 (87%)	21 (91%)	20 (87%)
Midlothian	16 (84%)	17 (89%)	19 (100%)
Edinburgh	85 (79%)	96 (90%)	98(92%)
West Lothian	25 (78%)	30 (94%)	28 (88%)

3.2.2 Travel time / 20 minute Neighbourhoods

Neighbourhoods are defined by the communities who live there, and each will have unique expectations of the services and facilities they need. This will also vary depending on the wider area, including topography and landscape, population density, economic status. An important objective of the 20-minute neighbourhood concept is to better align spatial planning (i.e., what is in an area) with transport planning (transport infrastructure), to make it easier for people to walk, cycle and use public transport. This approach needs to be underpinned by ensuring 20-minute neighbourhoods are designed to be inclusive and equitable. Services and amenities may be shared between neighbourhoods, depending on the density of the area. 20-minute neighbourhoods may be difficult to implement in extremely rural villages and public transport options between these villages will be essential. Health services including pharmacy are considered an essential element for a 20 minute neighbourhood. 20-minute neighbourhoods are an opportunity for multi partnership involvement to support reductions in inequalities.

The travelling time of 20 minutes for driving, cycling and walking to a community pharmacy is shown on maps in the appendices for each Health and Social Care Partnership. It can be clearly seen that most city centre pharmacies are within 20 minutes' walk for most of the population and the population in many rural areas are within 20 minutes' drive from their nearest pharmacy. Travel times by public transport can be longer.

Public Transport infrastructure is critical to 20 minute neighbourhoods. Travel times by public transport across NHS Lothian are complex, particularly in rural areas and have not been mapped for this plan. The NHS Lothian area is serviced by a wide bus network and has some rail connections. The positioning of pharmacies on main routes aids accessibility.

In 2021 the Scottish Government undertook consultation on the Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development and identified the need for action on patient travel. It requires all NHS Scotland bodies to take action to reduce the carbon emissions resulting from travel associated with their activities, including staff and patient travel. Efforts should include actions to reduce the need for travel; actions to increase "active travel"; actions to increase the use of public or community transport to access services.

NHS Lothian supports these aspirations and is developing a Strategic Active and Sustainable Travel Plan Framework consistent with the Scottish Government policy. Decisions on location and provision of pharmacy services should have regard to the Government's and Health Board policies on sustainable development.

Recommendation:
20-minute neighbourhoods and sustainability objectives should be considered as part of the process in determining where community pharmacies are sited in the future.

3.3 Essential (Core) Services for Community Pharmacy

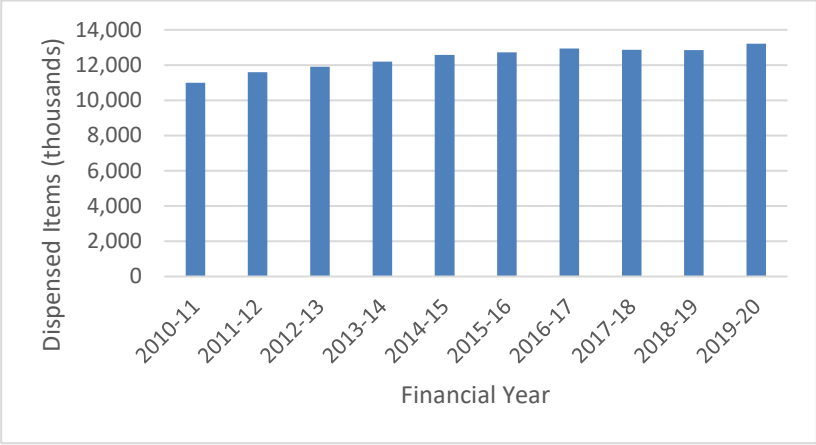
All Scottish community pharmacies offer the core NHS services and these are often complemented by local services which address more specific issues in each Health and Social Care Partnership. Being situated in the heart of local communities, community pharmacists are the most accessible healthcare professionals, making a difference to people's quality of life.

3.3.1 Acute Medication Service

The Acute Medication Service represents the provision of pharmaceutical care services for acute episodes of care and supports the dispensing of prescriptions and any associated counselling and advice.

Prescribing volumes have increased over the last 10 years, with an overall increase of 20% from 11.0 million items in 2010/11 to 13.2 million items in 2019/20. Figure 5 below shows a year on year increase in the number of prescriptions requiring to be dispensed in NHS Lothian with some stabilisation in 2018/19 followed by a rise in 2019/20. Population growth in Lothian, increasing multimorbidity, treatability of disease and polypharmacy defined in the 2018 Polypharmacy Guidance as two or more medicines along with an ageing population and more people living with long-term conditions are responsible for the increase in prescriptions. The projection of a growing and ageing population in Lothian and the aspiration for community pharmacies to be a first port of call for many service users suggest that further growth in volumes will occur in future years.

Figure 5 Dispensed Items in NHS Lothian 2010/11 to 2019/20



3.3.2 Medication Care and Review (MCR) / Serial Prescribing

The Medication Care and Review Service is the continuity of pharmaceutical care of patients with long term medical conditions.

The service provides personalised pharmaceutical care by a pharmacist to patients with long term conditions. It is underpinned by a systematic approach to pharmaceutical care in order to improve a patient's understanding of their medicines and to work with the patient to maximise the clinical outcomes from the therapy.

There are three stages to the Medication Care and Review Service:

- **Stage 1** - A patient with a long term condition registers with a pharmacy of their choice.
- **Stage 2** - Pharmacist assessment to identify and prioritise individuals or groups of patients' unmet pharmaceutical care needs'
- **Stage 3** – Serial dispensing for "suitable" patients in partnership with GP practice

Figures 6a and 6b demonstrate the progress being made to increase use of this service. All GPs and community pharmacies are IT enabled for this service with an increase in those active over the last eighteen months. The average number of dispensed items each month has increased from 7022 items in 2020 to 9616 items in the first six months of 2021.

Overall the current uptake of the serial prescribing and dispensing element of the MCR service remains low in relation to the total number of GP Practices and Community Pharmacies across Lothian. The Primary Care Pharmacy team are undertaking a quality improvement project aimed at increasing the use of serial prescribing for suitable patients as part of the pharmacotherapy service and COVID 19 response. The available local evidence supports that greater use of this service reduces workload and number of repeat prescriptions required from General Practice.

Active General Practices are defined as those where a chronic medication prescription has been issued. An active community pharmacy is defined as those having made a chronic medication service payment claim.

Active patients represents the number of patients who have had a chronic medication prescription issued (GP) and dispensed (CP).

New registrations are the number of new registrations started.

Figure 6a – Medication Care and Review Active General Practices and Community Pharmacies

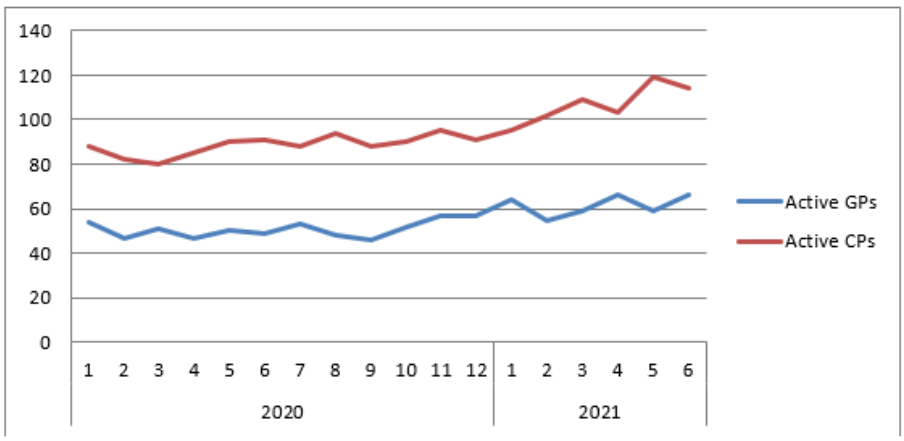
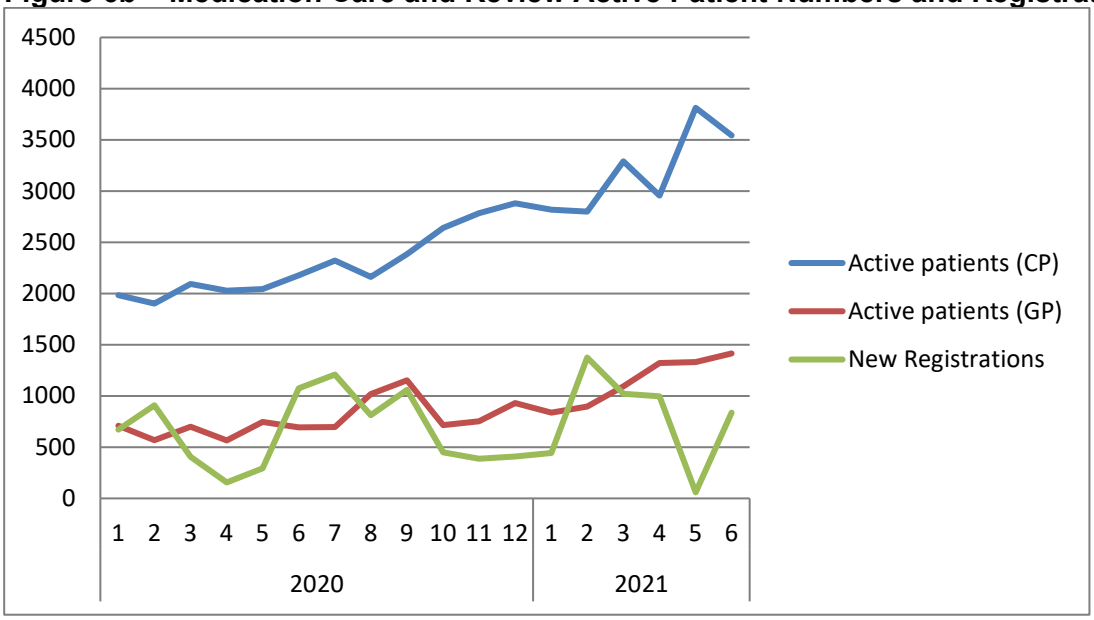


Figure 6b – Medication Care and Review Active Patient Numbers and Registrations



Recommendation:
Based on the number and distribution of pharmacy contracts across each HSCP there should be capacity to meet needs for the acute medication service, but further effort is needed to progress the Medicine Care and Review service by increasing the number of active GP practices and community pharmacies engaged.

3.3.3 NHS Pharmacy First Service

Provision of the Pharmacy First Service is important to the NHS Recovery Plan 2021-2026. The Pharmacy First Service launched in July 2020. It aims to support the provision of direct pharmaceutical care for common clinical conditions within the NHS by community pharmacists. The service is available to all individuals who are registered with a GP practice in Scotland or who live in Scotland (there are some exceptions for visitors to Scotland). The Pharmacy First service seeks to encourage people to go to their local community pharmacy for support with minor and acute health conditions thereby and importantly avoiding unnecessary GP and out of hours appointments. Lothian Unscheduled Care Service can direct people to seek treatment from a community pharmacy as an alternative to a GP assessments or attendances at Emergency Department.

Under the service pharmacy teams provide an NHS Pharmacy First Scotland consultation with one of three outcomes- Advice, Treatment or Referral to another healthcare professional if appropriate according to the needs of the individual.

The Pharmacy First Service in Lothian also provides consultation for the following additional common clinical conditions; uncomplicated urinary tract infections in women and impetigo with the addition in 2021 of soft tissue skin infections and shingles. Figures 7a and 7b show outcomes of treatment for minor conditions from August 2020 to May 2021. The average number of episodes of care for all Pharmacy First is 24,563 per month. Figure 7b shows urinary tract infection was the most frequent additional condition for which treatment was provided in the pharmacy and the most frequent condition resulting in GP referral. Additional common clinical conditions will be identified for future inclusion under the Pharmacy First Service for 2022/23.

Figure 7a: Pharmacy First (PF) Outcomes August 2020- May 2021

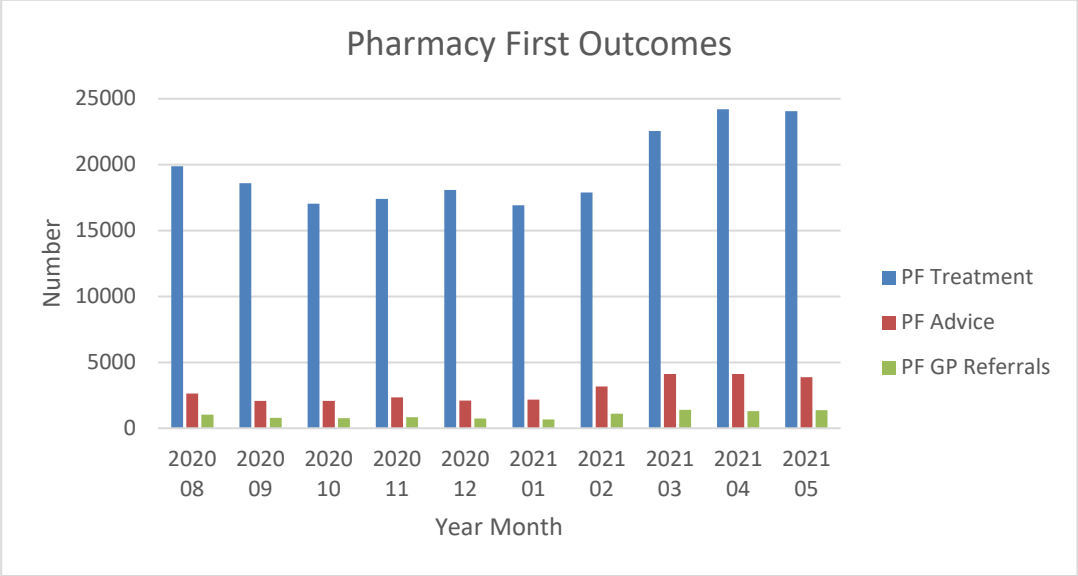
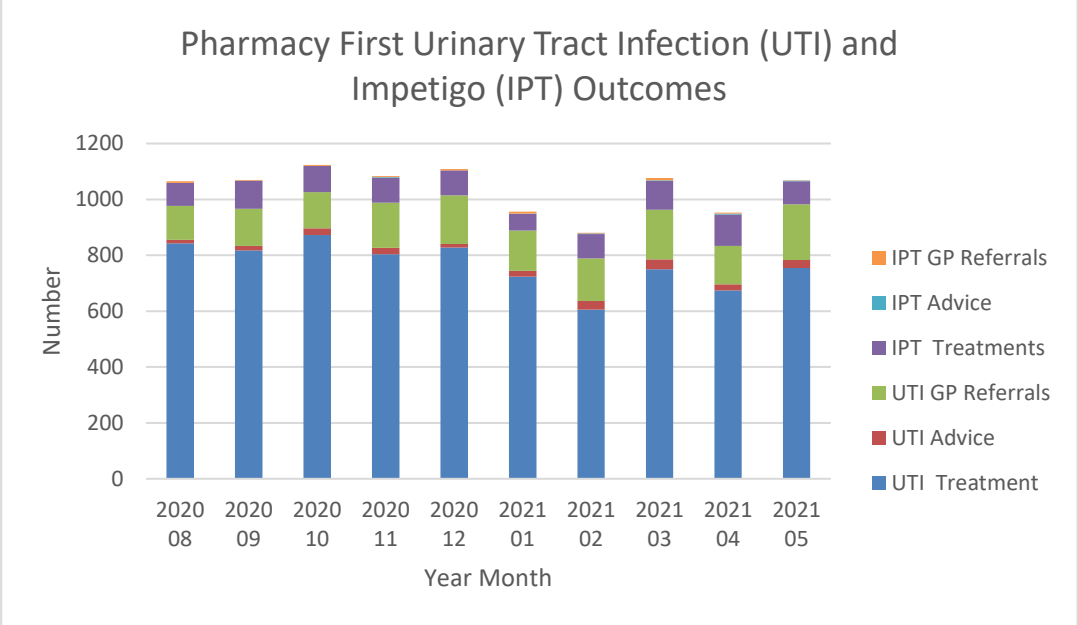


Figure 7b: Pharmacy First Outcomes for UTI and impetigo August 2020- May 2021



Recommendation:
Based on the number and distribution of pharmacy contracts across each HSCP there should be capacity to meet needs for the acute medication service but further effort is needed to actively progress the Medicine Care and Review service by increasing the number of active GP practices and community pharmacies engaged.

As all patients registered with a GP or living in Scotland can access the NHS Scotland Pharmacy First service there is no unmet need in the provision of treatment for common clinical conditions from a community pharmacy as an alternative to a GP practice appointment.

Unmet need will arise in unscheduled care where pharmacy opening hours do not offer full weekend and extended opening hours in a local area. Local mitigations should be considered by the multidisciplinary teams.

Support unscheduled care through use of national promotional materials for pharmacy first

3.3.4 Pharmacy First Plus Service

This new service allows provision of prescription only medicines and alternative products as determined by individual patient need assessed by an independent pharmacist prescriber.
PCA (P)(2020)16 available here outlines the terms for a Pharmacist Independent Prescriber-led common clinical conditions service to be known as NHS Pharmacy First Plus for which funding has been made available to support appropriately qualified Pharmacist Independent prescribers from September 2020. The service will be based on the community pharmacy contractor providing a Pharmacist Independent Prescriber –led service for patients presenting in the community pharmacy with a common clinical condition which is beyond the scope of the standard NHS Pharmacy First Scotland service and would otherwise require onward referral to another healthcare professional. Patient eligibility will mirror the eligibility for the NHS Pharmacy First Scotland service. NHS Lothian is keen to see the expansion of the number of qualified Pharmacist Independent Prescribers.

3.3.5 Public Health Service

Community pharmacists are highly accessible primary care practitioners in terms of location and opening hours including weekend and extended hours in some pharmacies. An appointment is not normally necessary to access services within a pharmacy setting.

The Public Health Service element of the contract has made a significant contribution to areas such as smoking cessation and access to emergency hormonal contraception in addition to health and wellbeing through the national community pharmacy public health poster campaigns.

3.3.5.1 Smoking Cessation Services

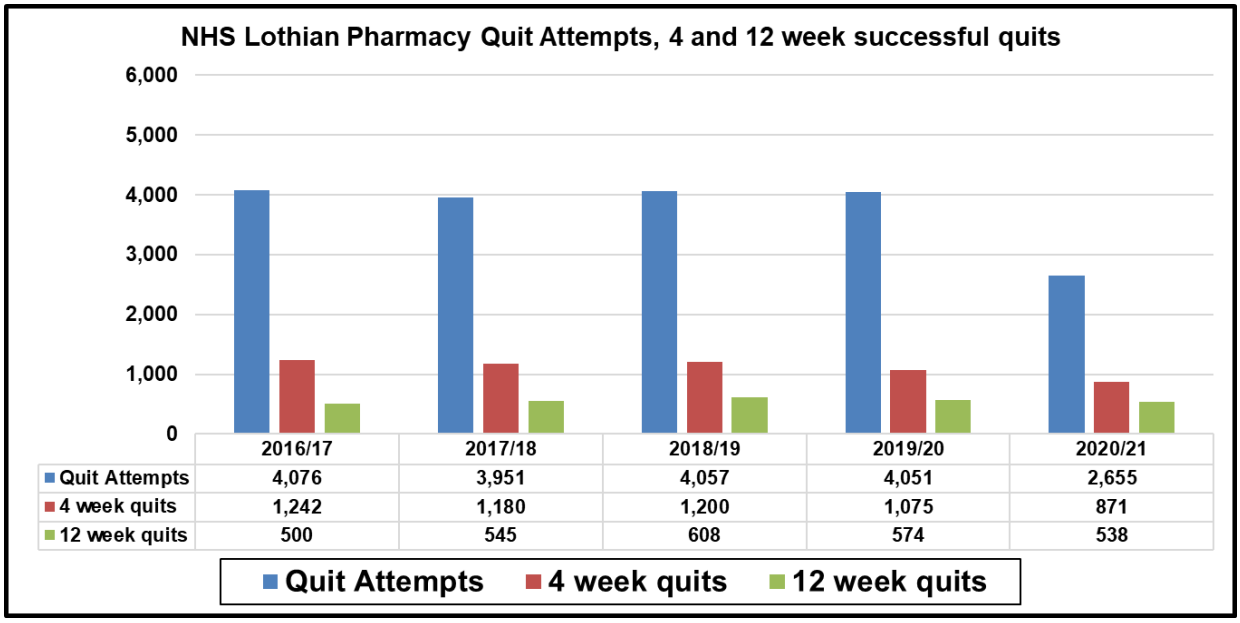
Tobacco smoking is the main risk factor for lung cancer, accounting for an estimated 80-90% of cases in developed countries and is linked to other cancers and Chronic Obstructive Pulmonary Disease (COPD).

This pharmacy service consists of the provision of a smoking cessation service comprising advice, support and supply of either nicotine replacement therapy (NRT) or varenicline over a period of up to 12 weeks, in order to help smokers successfully stop smoking. Varenicline is supplied using a patient group direction (PGD).

Community Pharmacy work with specialist Quit Your Way (QYW) services to supply nicotine replacement products to the specialist QYW service clients diverting this prescription workload away from general practice. Varenicline is provided to specialist QYW service clients on prescription from general practice.
More opportunities for joint working between the specialist QYW service and community pharmacy are in planning for the future to improve overall quit rates across NHS Lothian which support the local delivery plan target. This will ensure that the needs of individuals seeking help to quit smoking are being met and that community pharmacy in Lothian continue to contribute positively to the Scottish Government strategic goal to reduce smoking prevalence in Scotland to 5% by 2034.

The number of quit attempts recorded was falling as smoking prevalence reduced in response to the introduction of Smoke Free policies and the increase in use of e-cigarettes and vaping. This reduction is seen across both community pharmacy and specialist stop smoking services. The COVID 19 pandemic restrictions has led to a further fall in numbers accessing this service. Figure 8 shows a 40% drop in the number of quit attempts but a similar level of successful outcomes at 12 weeks.

Figure 8: Annual pharmacy quit attempts and 1 month and 3 month quit rates



	2016/17	2017/18	2018/19	2019/20	2020/21
Quit Attempts	4,076	3,951	4,057	4,051	2,655
4 week quits	1,242	1,180	1,200	1,075	871
12 week quits	500	545	608	574	538

The Public Health Service smoking cessation contributes to the Boards strategies to meet the Local Delivery Plan Smoking Cessation Standard (previously HEAT 6 target) to deliver successful smoking quits at 12 weeks post quit in our most deprived areas.

Recommendation:
Support the planned opportunities for the community pharmacy smoking cessation service to work closely with specialist QYW services and pharmacy champions to achieve improved quit rates.

3.3.5.2 Sexual Health Services

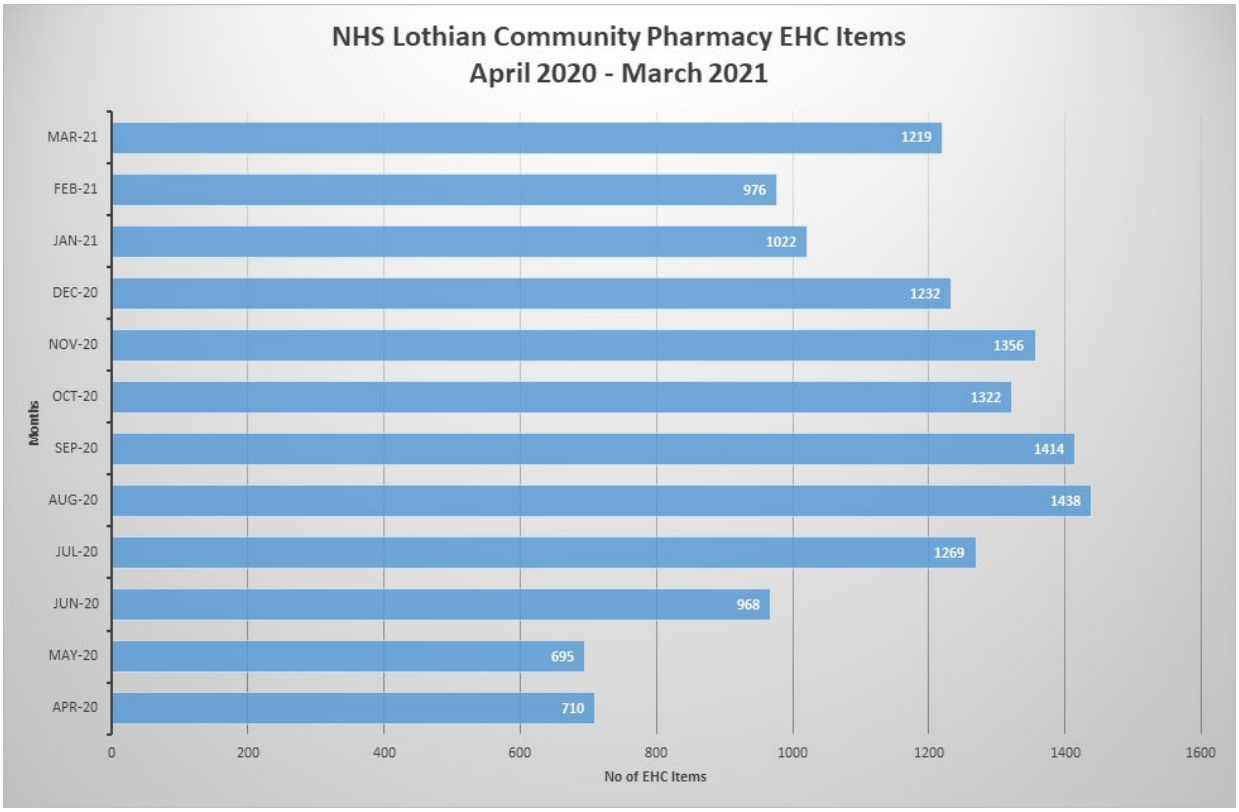
The Sexual Health Service involves consultation on, and supply of the emergency hormonal contraception to women 13 years and above. Community pharmacists provide emergency hormonal contraception to patients within local communities without the need for an appointment.

Where a pharmacy contractor decides not to supply emergency hormonal contraception, they should give notice in writing to the Health Board and advise the Agency of their decision and ensure prompt referral of patients to another provider who they have reason to believe provides that service. This is the only core service a contractor can opt out of.

In addition, regardless of the pharmacy policy, an individual pharmacist who chooses not to supply emergency hormonal contraceptive on the grounds of religious, moral or ethical reasons must treat the matter professionally, sensitively and advise the client on an alternative local source of supply (such as another pharmacy, GP or sexual health service). The majority of EHC is provided by community pharmacy.

Figure 9 shows that the provision for emergency hormonal contraception was impacted by the two COVID 19 lockdowns. Post lockdown the provision has risen back to a higher level closer to prepandemic provision. This demonstrates the continuing demand and need for this service. It is also known from pharmacy level data that there is capacity within the system to meet any increasing demand. The Lothian community pharmacy EHC service includes provision of free condoms provided by the C:Card service as part of every EHC consultation in every pharmacy.

Figure 9: Emergency Hormonal Contraception



The Scottish Government Sexual Health and Blood Borne Virus Recovery Plan includes future developments for sexual health services from community pharmacy such as the provision of three months of progesterone only contraception pills as “bridging contraception”. This will become part of

the EHC consultation. The proposed reclassification of some progesterone only contraceptive pills to a pharmacy medicine will support local and national development of accessible contraceptive services in community pharmacy. The NHS Recovery Plan 2021-2026 will also see the launch of new pharmacy woman's health and wellbeing service covering conception, contraception and menopause.

A locally negotiated service is available which enables community pharmacists to provide treatment of patients or partners of patients for chlamydia infection or pelvic inflammatory disease via community pharmacies in NHS Lothian. This service allows for men and women testing positive for chlamydia to take an electronic text 'voucher' to a participating pharmacy. They should be supplied (as per Lothian Formulary guidelines) with a 7 day course of doxycycline as per patient group direction.

Recommendation:
Support opportunities and new models of delivering additional sexual health services in community pharmacy as detailed in the Scottish Government Sexual Health and Blood Borne Virus Recovery Plan and the NHS Recovery Plan 2021-2026.

3.3.5.3 Prophylactic Antipyretic (Paracetamol)

Pharmacists provide prophylactic antipyretic (paracetamol) in advance of or following administration of childhood meningitis B vaccination and other childhood vaccinations as clinically appropriate in children under 12 months.

3.3.6 Urgent Care

Community pharmacy is an important access route for people requiring urgent care particularly over weekends and public holidays. One of the tools available to pharmacists is the National Patient Group Direction for the Urgent Supply of Repeat Medicines and Appliances. This allows the pharmacist to supply the patient with a medicine when their GP is unavailable should the patient have been receiving this medicine on repeat prescription from their GP. The pharmacist must be satisfied that the patient knows exactly which medicine they require and that they have received it previously. Certain medicines are excluded from the list of products that can be provided in this way. To support this pharmacist can now access the Emergency Care Summary for individual patients.

Community Pharmacies can also use Direct Referral to local GP Out of Hours services where the pharmacist feels that the patient does not have a medicines supply issue but requires input from another health professional.

Virtual consultations are also possible via telephone or the Near Me platform in Community Pharmacy.

Recommendation:

- Undertake local assessment of need and potential mitigations where there are limited numbers of pharmacies open late, full and half day Saturday and Sunday opening. This may lead to unmet need in some HSCP localities when NHS Lothian' GP Out-of-Hours Service (LUCS) recommend care which is provided by Community Pharmacy.
- Community pharmacy to have access to clinical records to help improve patient care when GP practice is closed and to support pharmacotherapy service element of Medicine Care and Review. National digital developments are needed to fully support this.

3.4 Additional Services

There are several additional services agreed within NHS Lothian. These are locally negotiated contracts and as such not all pharmacies participate. It is the responsibility of the NHS Board and Health and Social Care Partnerships to ensure that these additional services meet the needs of the population. This does not mean that the population requires these services equally across NHS Lothian or that it is necessary to provide them from every community pharmacy. The services might also be provided by other agencies and so provision must be looked at in the context of wider healthcare services.

3.4.1 Substance Misuse / Harm Reduction

These services are provided as part of the holistic support that the NHS, social services and third sector offer for people with substance use issues, which may include the use of opioids, stimulants, prescription medications, alcohol and more.

The core of these services is the provision of support to patients in recovery, along with dispensing and/or supervision of substitution therapies.

3.4.1.1 Supervised Self Administration of Methadone

Supervised self-administration of methadone has become a key component of any addiction treatment programme. Supervision can support high risk, chaotic patients as it ensures patients receive only the correct prescribed dose. Overdose from methadone is a real risk and often those receiving methadone continue to use street drugs on top. Supervision ensures that the patient takes the prescribed dose of methadone and it is not being shared, swapped or sold reducing risk to patient and public.

Supervision in community pharmacy allows patients to be treated in their own communities. All 182 pharmacies are available to dispense methadone however a supervised methadone service may not be available in all pharmacies at all times. This is likely in response to demand and not a pharmacy decision. The exact number of pharmacies delivering supervision of methadone is not captured in a formal return within NHS Lothian.

During the COVID pandemic lockdown periods and to support self isolation the clinical need and safety of reducing the need for supervised consumption was reviewed for individual patients. Delivery of prescribed methadone supply was also put in place with key support from local Drug and Alcohol Partnerships and third sector volunteers with experience of working with this population in collaboration with community pharmacies. Table 6 shows the growth in the number of methadone supervisions provided from community pharmacy prior to COVID 19. The impact of the COVID pandemic and lockdown restrictions can be seen in the reduced number of supervisions for 2020/21. In Lothian the Substance Misuse Service and GP prescribers clinically assessed and reduced supervisions and reduced pick up days in the majority of patients to help reduce contacts and maintain social distancing. Some supervisions were maintained for a small group of particularly high risk patients and for new patients.

Table 6 –Dispensing and supervision of methadone 2015/16 to 2020/21

Financial Year	Methadone Supervisions	Total Methadone Dispensings
2015/2016	268,851	750,176
2016/2017	325,521	832,966
2017/2018	331,197	863,406
2018/2019	367,772	899,114
2019/2020	400,930	929,230
2020/2021	171,403	730,078

3.4.1.2 Supervised self-administration of buprenorphine

Buprenorphine is also licensed for the treatment of opioid dependence although methadone remains the predominant treatment in Lothian. The use of either agent is dictated by clinical choice, the two drugs are not interchangeable.
Buprenorphine supervision may be requested by a prescriber in the same way as methadone for the same reasons. The exact number of pharmacies participating in buprenorphine supervision is not known and demand for the service is driven by prescribing practice. Table 7 shows the number of buprenorphine supervisions taking place across NHS Lothian. The impact of the COVID pandemic and lockdown restrictions can be seen in the reduced number of supervisions for 2020/21.

Table 7- Supervision of buprenorphine 2015/16 to 2020/21

Year	Total number of supervisions
2015/2016	40642
2016/2017	43844
2017/2018	57377
2018/2019	56140
2019/2020	60540
2020/2021	24377

Recommendation:

- Key areas to be developed are increasing availability of take-home naloxone from community pharmacy, a test of change of Buvidal® administration from community pharmacy and detection and treatment of hepatitis C in population who inject drugs. All are desirable to support reducing drug related deaths and harms.

- The services provided by pharmacies relating to substance misuse and harm reduction are part of an overall strategy led by the Alcohol and Drug Partnerships. It will be necessary to ensure that service need is addressed within that wider context and funding identified to support any increase in requirements to reflect local population unmet need.

3.4.1.3 Supervised self-administration of disulfiram

The purpose of this service is to increase the contribution that pharmacists make to the pharmaceutical care of patients with alcohol dependency, to help address service gaps, to allow for greater capacity in treatment services and to reduce health inequalities. The service makes an important contribution to the care of patients in maintaining abstinence from alcohol dependence. No information is available for the number of pharmacies offering supervision for disulfiram. Inequalities and gaps still remain in the disulfiram supervision service.

3.4.1.4 Injection Equipment Provision

A total of 19 out of the 182 pharmacies in Lothian (10 Edinburgh City; 4 East and Mid; 5 West Lothian to meet the needs of people who are current injectors and to protect individual and public health, in order to reduce the risks of harm associated with injecting practice and to prevent the spread of blood borne viruses. Ten Edinburgh City Pharmacies also provide naloxone in addition to injecting equipment. Injecting equipment and naloxone is also available in other community based settings such as mobile and pop-up clinics as determined by the respective Drug and Alcohol Partnerships.

The goals of this service are to:

- Provide free sterile injecting equipment and related paraphernalia as agreed locally
- Reduce the rate of sharing and other high risk injecting behaviours
- Provide a facility for safe disposal of used injecting equipment
- Provide information and advice on blood borne viruses, safer injecting, injecting technique, safer drug use
- Provide information on and to signpost and refer clients to drug treatment and other services for injecting drug users, including referral for testing and vaccination for blood borne viruses.

Recommendation:
Undertake local reviews of injecting equipment and naloxone provision to ensure local needs are being met effectively post pandemic.
Injecting equipment provision is not a specific pharmacy only scheme. As pharmacies can often offer longer opening hours than drop in centres pharmacy-delivered needle exchange adds capacity to the harm reduction team.

3.4.1.5 National and local drivers

In May 2021 the Scottish Government published standards for Medication Assisted Treatment (MAT) with multiagency and multiprofessional roles identified. Community pharmacies are identified as well placed to deliver scheduled or opportunistic care because they can have very frequent contact with people picking up prescriptions or attending for other reasons.

Areas for potential development working with other stakeholders include distribution of Take Home Naloxone to increase coverage and reduce the risks of drug related death and Dried Blood Spot Testing to increase access to testing for blood borne viruses such as hepatitis C and access to treatment.

Locality Drug and Alcohol Partnerships provide responses and plans for drug and alcohol issues working with their partners in the NHS, local authority and third sector.

The Alcohol and Drug Partnerships in Edinburgh City and West Lothian have funded projects working with community pharmacy to improve provision of naloxone from some pharmacies in key areas with high levels of drug related deaths and to implement provision of long acting Buvidal® from a community pharmacy as a test of change.

3.4.2 Pharmaceutical Advice to Care Homes

Community pharmacies may apply to NHS Lothian for inclusion in the existing care home scheme. The aim of this scheme is to ensure that all drugs and medicines supplied to the residents of a home are handled, stored and administered correctly.

Community pharmacists are the best placed healthcare professionals to offer this type of advice to homes. Any pharmacy on the scheme is responsible for providing pharmaceutical advice on the safe handling, storage and correct administration of any drugs and medicines that they supply to the residents of homes to which they are affiliated.

This service would not be expected to be geographically widespread across Lothian but instead correspond to the needs of care homes within their local area. It would not be necessary for a pharmacy providing this service to be located in the same Health and Social Care Partnership or health board as the care home.

There are 110 care homes located in NHS Lothian and of these 64 are currently affiliated with 32 pharmacies to receive pharmaceutical advice.

In reviewing this plan annually, it was identified that the existing service requires to be comprehensively reviewed to incorporate a greater clinical element as well as a focus on medicines waste. Work has been undertaken involving multidisciplinary input to develop a care home service level agreement for local negotiation.

Recommendation:
Progress implementation of the locally agreed Community Pharmacy Care Home Service to increase pharmaceutical care provision and reduce medicine wastage across Health and Social Care Partnerships and NHS Lothian to meet the sustainability action plan.

3.4.3 Palliative Care Network

The Palliative Care network was launched in November 2000 and was developed in response to concerns expressed in accessing palliative care drugs for patients being cared for at home, particularly out with normal working hours. The scheme follows the framework described in the Scottish Circular MEL (1999)78 for a Community Pharmacy Pharmaceutical Care Model Scheme for Palliative Care and is funded by this initiative. An on-call mechanism for access to palliative care drugs out of normal working hours is provided. Regular review taking into account the geographical spread confirms the utilisation of all pharmacies which are part of the Palliative Care network.
Patients or their carers are encouraged to continue to use their usual community pharmacy to obtain prescriptions. The community pharmacies participating in the scheme should only be accessed in the following situations:

- During normal working hours, when the patient's usual community pharmacy cannot supply the palliative care drug(s) within the timescale required.
- Out with normal working hours when the patient requires the palliative care drug(s) urgently.

There are now 22 pharmacies taking part in the palliative care network across NHS Lothian with 8 of these pharmacies providing an on-call service to maintain cover 24 hours a day. In order to ensure up to date knowledge relevant to providing pharmaceutical care for the palliative patient, the pharmacist's undertake relevant training and attend the three peer review sessions offered annually.

The aims of the network are to:

- Allow timely access to palliative care drugs for patients being cared for at home.
- Provide information regarding palliative care drugs to patients, carers and other health care professionals.
- Support and maintain the formation of a network of "palliative care" community pharmacies in NHS Lothian and liaise with other health care professionals on palliative care issues.

Achievement of these aims is demonstrated by the number of times the service is accessed urgently and out of hours to help people remain at home (Figure 10) and by the range of people who access the services (Figure 11). The service is responsive to changes in the provision actively recruiting replacements as needed. The figures for both 2019/20 and 2020/21 show a rise in demand compared to the preceding years and may reflect the impact of COVID restrictions.

Figure 10: Palliative Care Network workload

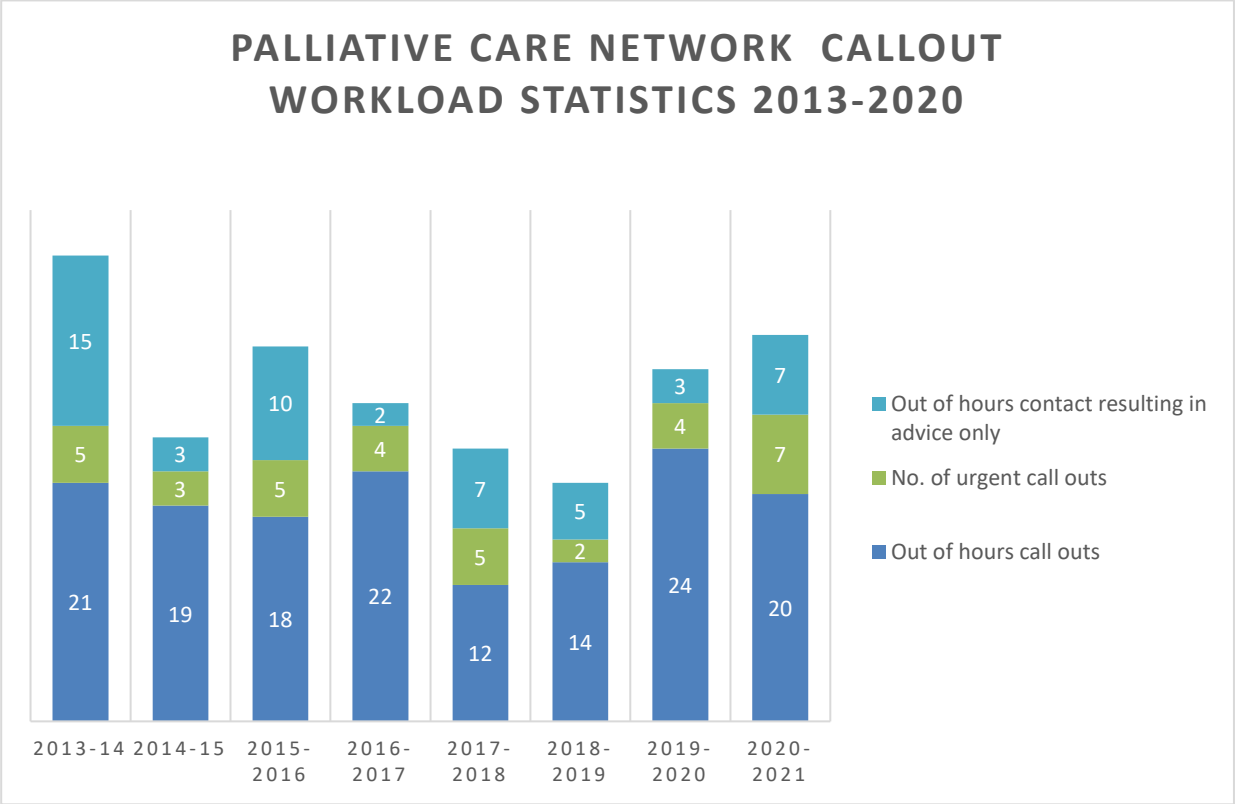
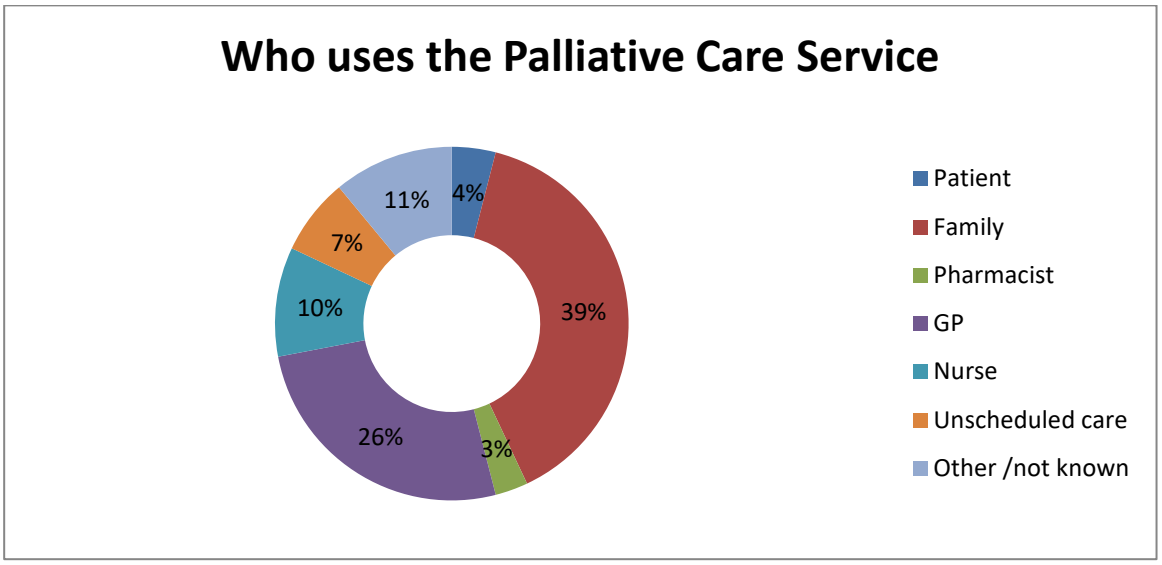


Figure 11: Users of the Palliative Care Network Service



Recommendation:
The Palliative Care Service is annually reviewed to ensure best coverage for the population of NHS Lothian by a small number of local experts for provision of palliative care medicines and advice both in and out of hours.

3.4.4 Tiered Services for medication prescribed by Secondary care

The aim of the service is to provide patients with access to medicines prescribed from the hospital service along with any associated pharmaceutical care support from a local community pharmacy contracted to provide NHS services. The tiers of service attract a fee which reflects the Pharmaceutical Care and any additional workload aspects which can be involved for the community pharmacy contractor when delivering these services.

Tier 1 – No additional Pharmaceutical Care required out with the normal dispensing and supply of a new drug to the patient

Tier 2–Those medicines and patients that require enhanced pharmaceutical care over and above that contracted for within the national arrangements.

Tier 3 – Those services that currently are provided for via homecare or might form part of a hospital at home solution where such services are being devised. Medicines and regimens in this tier would be those that require a significant level of pharmaceutical care beyond that traditionally provided by community pharmacy teams.

3.4.4.1 Systemic Anticancer Therapy (SACT)

Tier 1 services provided include enzalutamide and abiraterone for treatment of prostate cancer. Prescribing is initiated and monitored by the specialist team. For each patient receiving treatment under this service agreement, a contractor will receive an agreed annual payment.

3.4.4.2 Pharmaceutical Care of Patients Requiring Support with Adherence to Complex Medication Regimes- Hepatitis C

This tier 2 service provides antiviral treatment for hepatitis C.
The specific objectives of the service providing pharmaceutical care to patients receiving treatment for hepatitis C are:

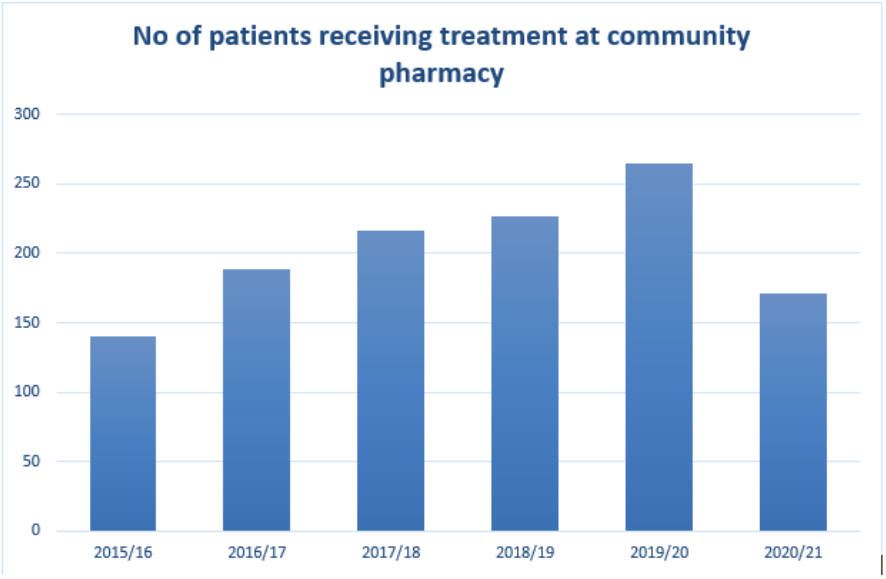
- To improve the clinical outcomes achieved by patients prescribed these medicines, especially preventing treatment defaults and poor adherence to treatment courses.
- to shorten the patient journey to one that can be accomplished by the majority of patients and avoid loss to follow-up
- to ensure close clinical monitoring for patients directly affected

Since June 2015 over 1000 patients have commenced treatment supplied through community pharmacy in NHS Lothian. To date >90% of patients have obtained a cure. This is clearly significant for the individual patient in terms of improving health outcomes but also contributes to reducing the burden of infection within local communities and contributes to the goal of elimination of HCV. Prescribing is initiated by the specialist team. The specialist clinical pharmacist will contact the community pharmacy nominated by the patient and will provide information and guidance to enable the community pharmacist to provide pharmaceutical care to the patient.
Contractors are required to complete a Service Level Agreement. Figure 24 shows the number of patients accessing treatment via community pharmacy. The impact of COVID 19 is seen from the decrease in number of patients being able to access this service due to a reduced capacity and reduced ability to test/identify patients as well as reduced capacity to see patients for treatment.

Patients have credited the pharmacy service with being key to the success of their treatment.

> Community Pharmacists comments on the service:
> *I find the Hep C service very satisfying to deliver - it makes use of community pharmacies position in people's communities. It also develops our relationship with a group of patients with multiple pharmaceutical care needs. It allows two sides of the pharmacy team to work in synergy - community and hospital. I find it very fulfilling to be involved in delivering this life changing treatment here in our pharmacy*

Figure 12: Hepatitis C service



3.4.5 Gluten Free Food Service

From August 2015 patients with a confirmed diagnosis of either Coeliac Disease or Dermatitis Herpetiformis have been able to self-manage their gluten free prescription with the help of community pharmacy and Dietetic Services. Gluten free foods are essential to these patients to avoid future complications of their disease. Patients on the Gluten Free Foods Service are provided with an allocation of gluten free units by their GP when they register for the pharmacy service. This system allows the patient more variation in their diet as the service allows them to make changes to their gluten-free order on a monthly basis. As part of the Gluten Free Food Service, community pharmacists are also required to undertake and record a Pharmacy Annual Health Check with adult patients receiving this service to discuss the patients concerns and refer to an appropriate healthcare professional if needed. Patients may opt out of the health check. The Community Pharmacy Gluten-Free Food Service forms part of the wider Modernising Patient Pathways for Coeliac Disease Test of Change.

3.4.6 Medicine Administration Record Charts

Community pharmacists in Edinburgh and Midlothian HSCPs support Health and Social Care Partnership care workers by providing medicines administration record charts for service users assessed at level 3; unable to administer prescribed medicines themselves with or without prompt. Care workers document on the medicines administration record chart the administration of prescribed medicines to the service user. This service supports people to live in their own homes for as long as possible and protects the safety and wellbeing of service users while safeguarding care workers in Health and Social Care Partnership. More than 400 service users are assessed at level 3 within Edinburgh Health and Social Care Partnership. The community pharmacies involved provide the medicines administration record chart as an additional service under contract with the Health and Social Care Partnership.

3.4.7 Quality Improvement

Circular PCA(P) (2016)15, issued in September 2016, first introduced Quality Improvement as a key focus of the Community Pharmacy Funding Arrangement . Circular PCA (P) (2018) 2 issued in March 2018 advised community pharmacy contractors and NHS Boards of initiatives to continue to strengthen and raise the profile of Quality Improvement activity within community pharmacy. The QI component of the Community Pharmacy Funding Arrangement continues as outlined in PCA (P) (2021)5 from April to August 2021 will support the implementation and training requirements for additional clinical conditions added to the NHS Pharmacy First Scotland service and Public Health Service – Bridging Contraception and from September 2021 activities will support the refresh work on Medicines: Care and Review. This will be subject to any changes in policy priorities.

3.4.8 Sharps and Medicines Waste

There is a Service Level Agreement (SLA) which acts as a contract between NHS Lothian and the community pharmacy contractor and commits the contractor to provide the services as defined by a Prescribed Medicines and Sharps Waste Disposal Service to patients in Lothian. This has been agreed on an annual basis subject to negotiation with Community Pharmacy Lothian. Participating pharmacy contractors are required to accept medicine and sharps waste in appropriate bins from patients being treated at or in a homely setting for uplift and disposal by NHS Lothian if they have signed the SLA.

3.4.9 Vaccination Services

Community pharmacies across the four health and care partnerships took part in two successful NHS influenza vaccination service pilots: 2019/20 and 2020/21 flu seasons. Patient feedback from the first pilot showed participating pharmacies had a very high satisfaction rating from patients using the service. During the 2020/21 pilot more than 20,000 NHS flu vaccinations were delivered by community pharmacy in Lothian. This will be built on for the 2021/22 flu season with pharmacies offering 50,000 NHS flu vaccination to those unable to easily access other clinic sites.

As part of the Inclusive COVID 19 Vaccination work stream four pharmacies were selected as a test of change demonstration. Selection was based on unvaccinated substance misuse client numbers and low local provision for people who had missed or been unable to take the opportunity to be vaccinated at other vaccination sites.

Recommendation:

As part of the Vaccine Transformation Programme Community Pharmacy should be considered in the future development of a range of NHS vaccination services by HSCPs to maintain and improve uptake of immunisation including.

- COVID vaccination
- Flu vaccination
- Pneumococcal vaccination
- Shingles vaccination
- Travel vaccination

4 Non Commissioned Services

Non-commissioned services are services that are not funded by the NHS, being neither part of the core pharmacy contract or part of the additional services agreement. They are out with the control of the Board and the decision to provide these services lies directly with community pharmacy

contractors. Some of these services will be provided free of charge to patients, while others will have a cost associated with them.

4.1 Collection and delivery service

Pharmacies can provide a collection service for prescriptions from GP Practices and many provide a delivery service, delivering medication to patients. In some cases delivery is limited to a specific distance from the pharmacy or to certain days of the week. Those pharmacies who do not offer an official delivery service do often deliver medication to their regular patients when requested to do so in an emergency. Pharmacies may charge patients for this service. A time limited funded COVID 19 Community Pharmacy medicine delivery service for those most at risk was put in place in 2021 as described in PCA(P) 2021(1). This was continued until 30th April 2021 after which normal arrangements for this service resumed.

4.2 Dementia Friendly Services

With a growing number of older people with memory problems one Lothian Pharmacy has developed a dementia friendly toolkit and established themselves as a Dementia Friendly Pharmacy offering their services tailored to meet the needs of dementia patients, their family and carers. They provide access to a resource folder with details of local services such as a Dementia Cafe.
A patient focused approach shapes the patient journey.

An example of how the patient's journey may now look:
A woman who presents in the pharmacy regularly and is the main carer for her disabled husband appeared to be getting more confused about her medicines. She was often in the pharmacy two to three times a day. We arrange for her to be assessed for a dosette box which has reduced the number of medicines in the house and gives her a set day to attend. The whole team know how to help her find what she is looking for in the pharmacy. Her condition has recently deteriorated, and we were able to phone her CPN to discuss this and through liaising with her family her care package has been increased. This lady is still able to live in her own home and remain in her community.

4.3 Continence Care

Community pharmacies across Lothian work with the Continence Care Service to dispense urinary continence supplies to patients. Pharmacies receive orders via a secure nhs. scot e-mail account from the Continence Care Service, order, dispense and supply the products to patients. There are over 2,500 patients registered on this service across Edinburgh, Midlothian and East Lothian. The West Lothian service has over 900 patients registered for the service.

4.4 Other Non-Commissioned Services offered throughout Lothian

Pharmacies throughout Lothian currently offer non-commissioned services such as those in the list below. Some offer a variety of services, others do not offer any of these services.

- Blood glucose checks
- Blood pressure checks
- Cholesterol checks
- Asthma management
- Weight management
- Private Flu vaccination
- Private Travel Clinics
- Stoma appliance supply
- Compliance aid

5 Recommendations Summary

Pharmacy Provision

1 Opening hours out with core hours are likely to remain fluid and a local process for agreement of any opening hour changes should be retained involving local pharmaceutical (LAPC) and general practice (LMC) committees.

2 Premises facilities information should be gathered to provide an accurate level of current provision and determination of improvements required to achieve 100% of pharmacies with private consulting area, wheelchair accessibility and an induction hearing loop by 2025

3 20 minute neighbourhoods, Scottish Government and NHS Lothian sustainability objectives should be considered as part of the process in determining where community pharmacies are sited in the future.

Essential Core Services

4 Based on the number and distribution of pharmacy contracts across each HSCP there should be capacity to meet needs for the acute medication service but further effort is needed to actively progress the Medicine Care and Review service by increasing the number of active GP practices and community pharmacies engaged.

5 As all patients registered with a GP or living in Scotland can access the NHS Scotland Pharmacy First service there is no unmet need in the provision of treatment for common clinical conditions from a community pharmacy as an alternative to a GP practice appointment.

6 However unmet need will arise in urgent care provision where pharmacy opening hours do not offer full weekend and extended opening hours in a local area. Local mitigations should be considered by the multidisciplinary teams.

7 Support public awareness of access to Pharmacy First as part of the provision of urgent care through use of national promotional materials for pharmacy first.

8 Support the planned opportunities for the community pharmacy smoking cessation service to work closely with specialist Quit Your Way services and pharmacy champions to achieve improved quit rates.

9 Support opportunities and new models of delivering additional sexual health services in community pharmacy as detailed in the Scottish Government Sexual Health and Blood Borne Virus Recovery Plan and the NHS Recovery Plan 2021-2026.

10 Undertake local assessment of need and potential mitigations where there are limited numbers of pharmacies open late, full and half day Saturday and Sunday opening. This may lead to unmet need in some HSCP localities when NHS Lothian;s GP Out-of-Hours Service (LUCS) recommend care which is provided by Community Pharmacy

11 Community pharmacy to have access to clinical records to help improve patient care when GP practice is closed and to support pharmacotherapy service element of Medicine Care and Review

Additional Services

Substance Misuse

12 Key areas to be developed are increasing availability of take-home naloxone from community pharmacy and a test of change of Buvidal® administration from community pharmacy. Both are desirable to support reducing drug related deaths.

13 Undertake local reviews of injecting equipment and naloxone provision to ensure local needs are being met effectively post pandemic.

14 Injecting equipment provision is not a specific pharmacy only scheme. As pharmacies can often offer longer opening hours than drop in centres pharmacy-delivered needle exchange adds capacity to the harm reduction team.

Palliative Care Services

15 The Palliative Care Service is annually reviewed to ensure best coverage for the population of NHS Lothian by a small number of local experts for provision of palliative care medicines and advice both in and out of hours.

Pharmaceutical Advice to Care Homes

16 Progress implementation of the locally agreed Community Pharmacy Care Home service to increase pharmaceutical care provision and reduce medicine wastage across Health and Social Care Partnerships and NHS Lothian to meet the sustainability action plan.

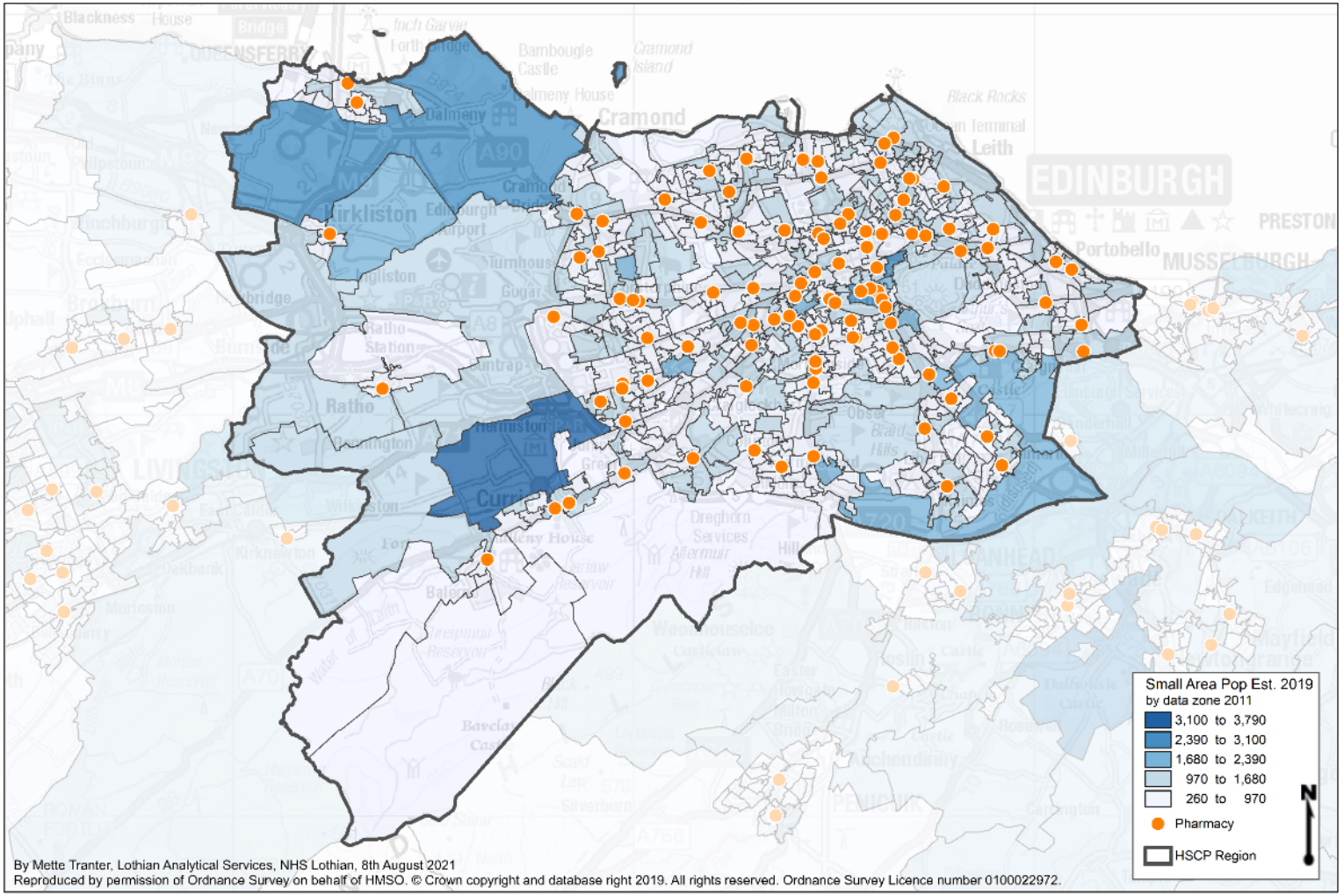
Immunisation

17 As part of the Vaccine Transformation Programme Community Pharmacy should be considered in the future development of a range of NHS vaccination services by HSCPs to maintain and improve uptake of vaccinations including.

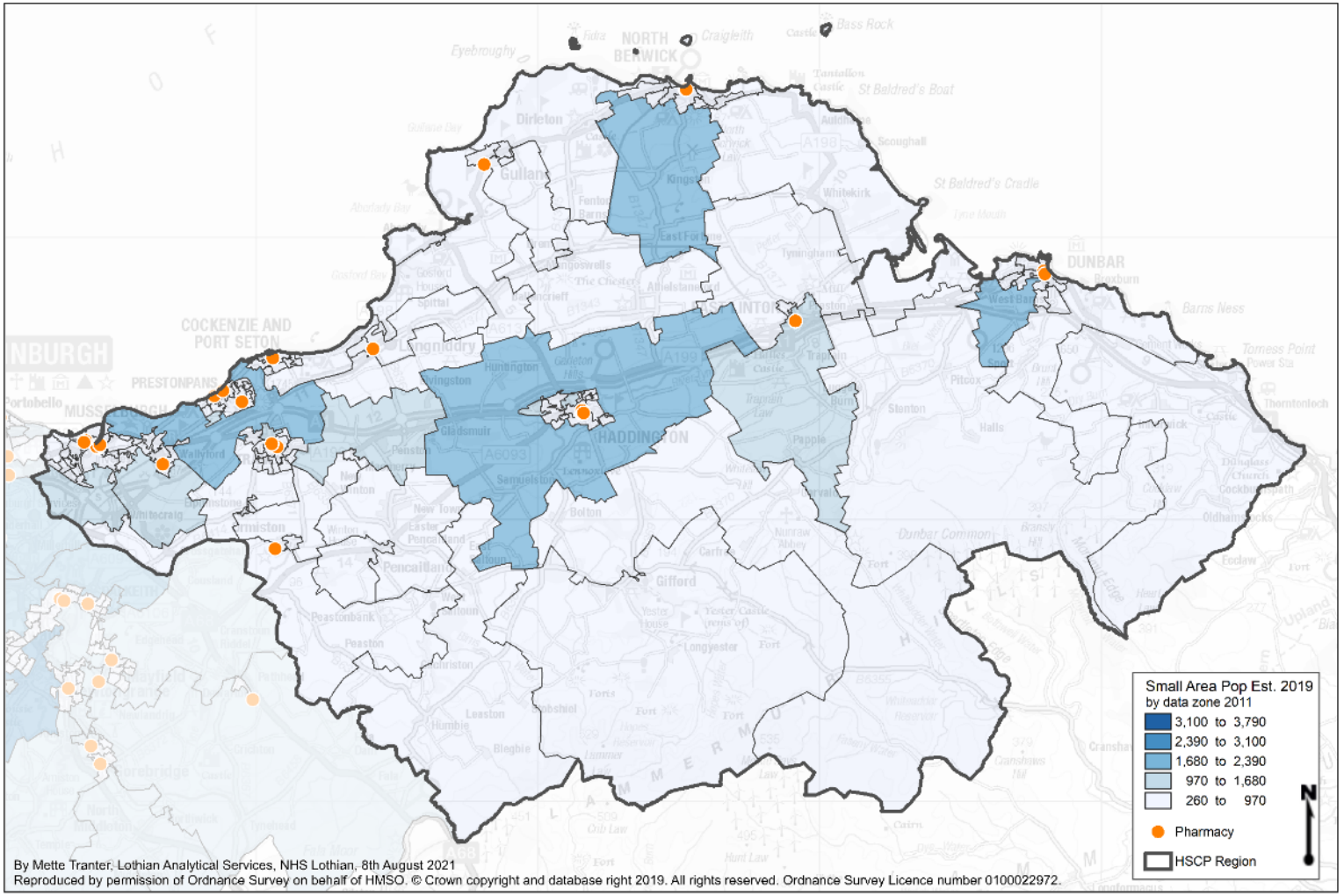
- COVID vaccination
- Flu vaccination
- Pneumococcal vaccination
- Shingles vaccination
- Travel vaccination

Appendix 1 Provision of NHS Lothian Community Pharmacy Services

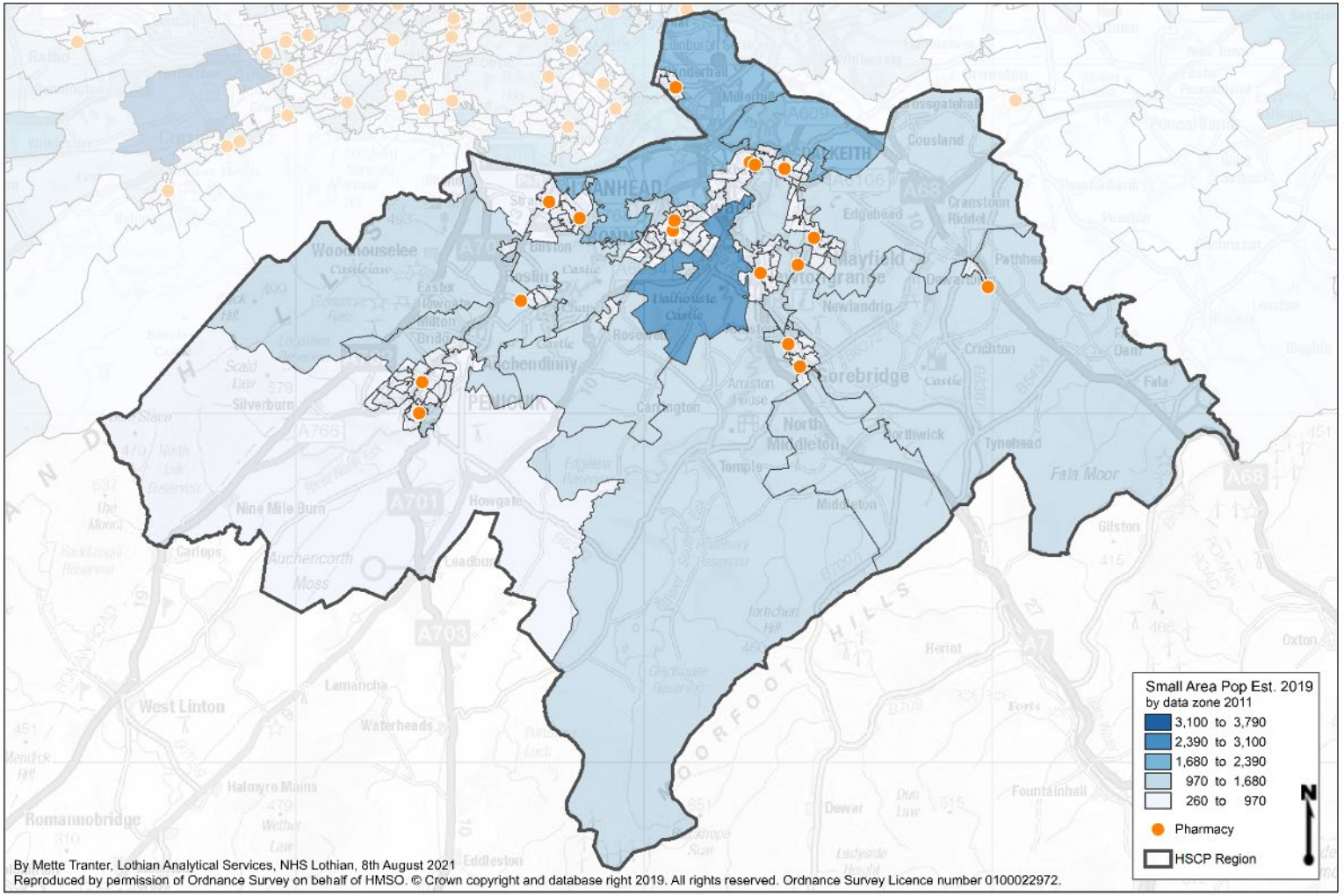
Map of Edinburgh HSCP showing Pharmacies and Small Area Pop. Estimates (2019)



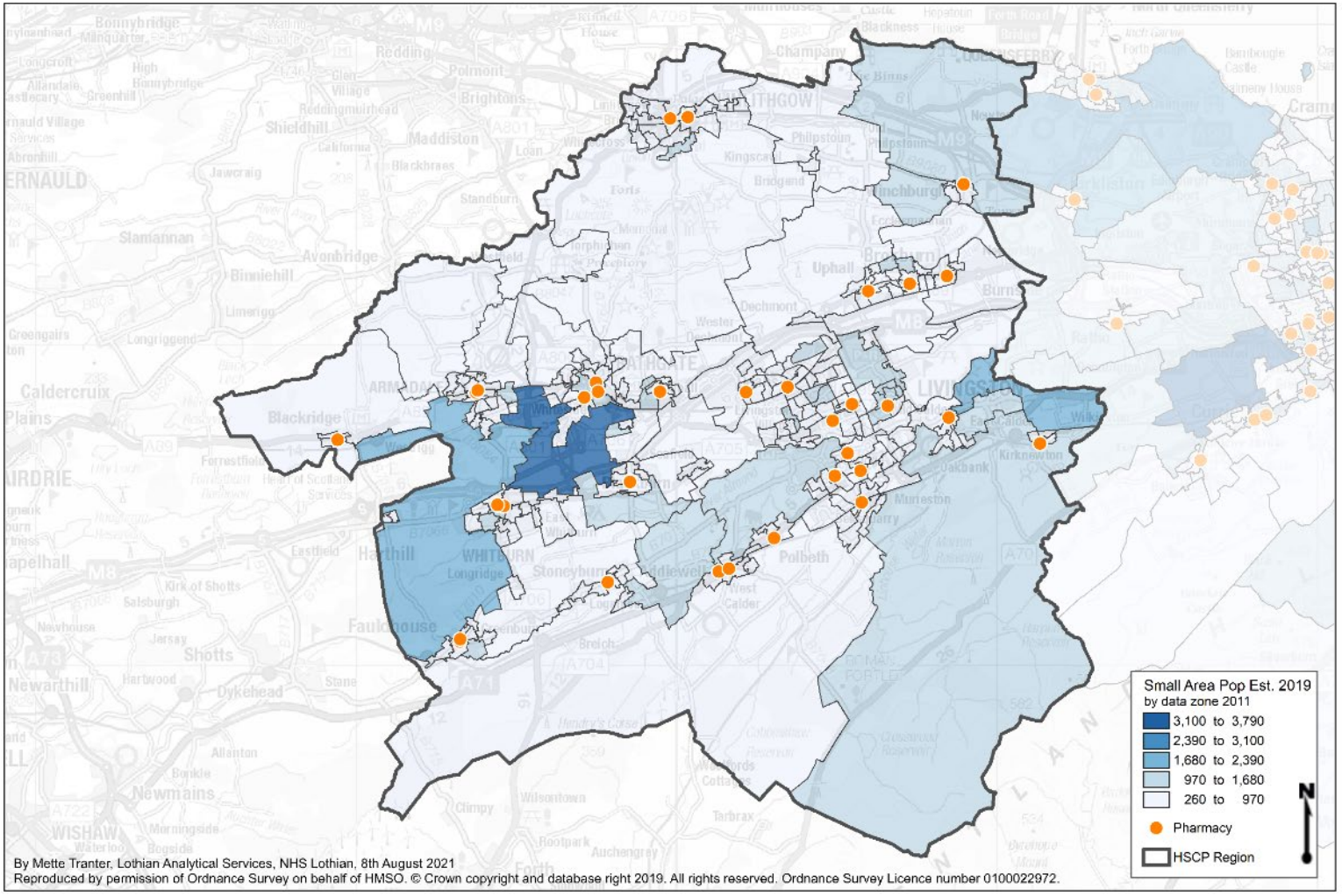
Map of East Lothian HSCP showing Pharmacies and Small Area Pop. Estimates (2019)



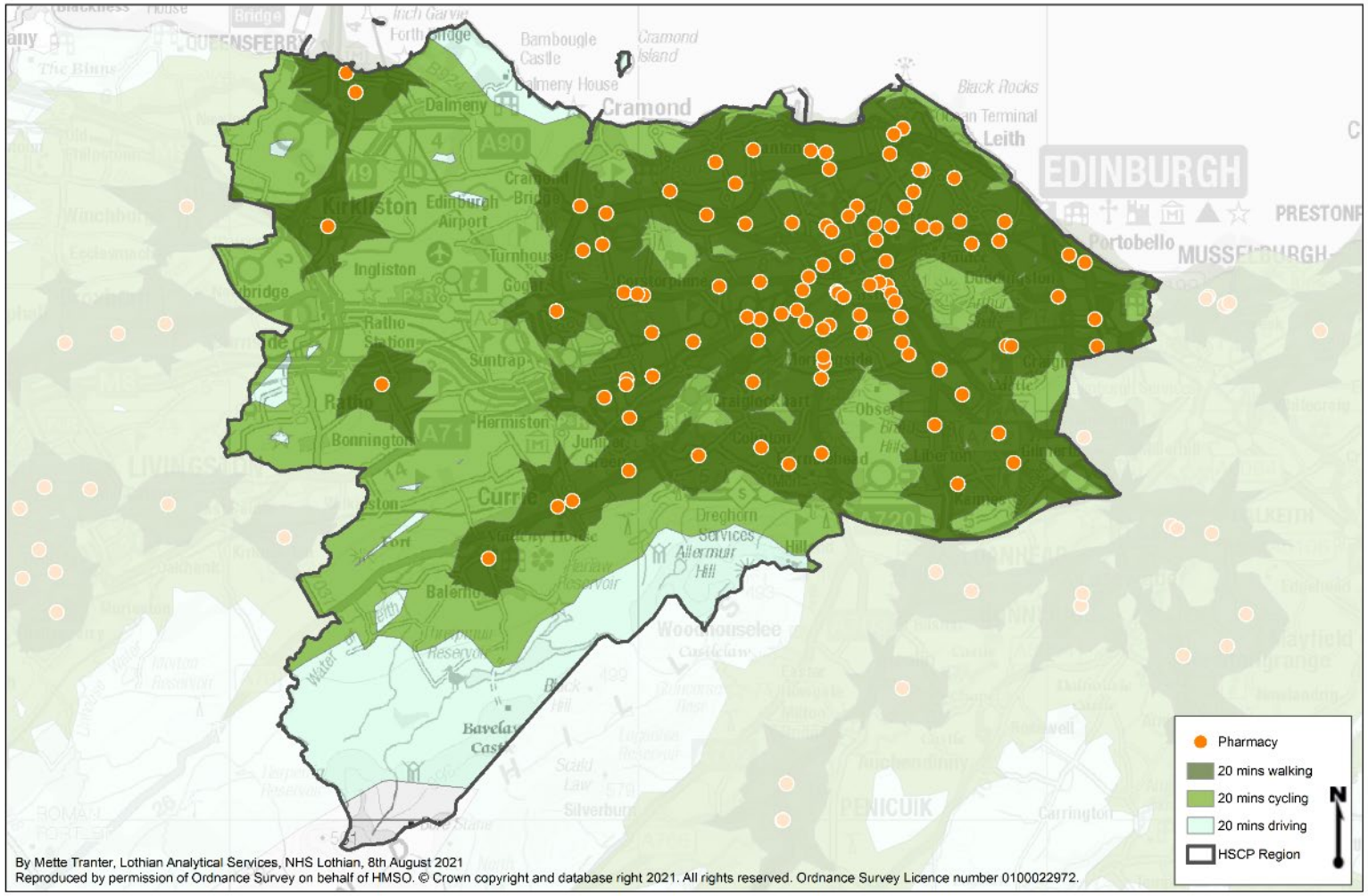
Map of Midlothian HSCP showing Pharmacies and Small Area Pop. Estimates (2019)



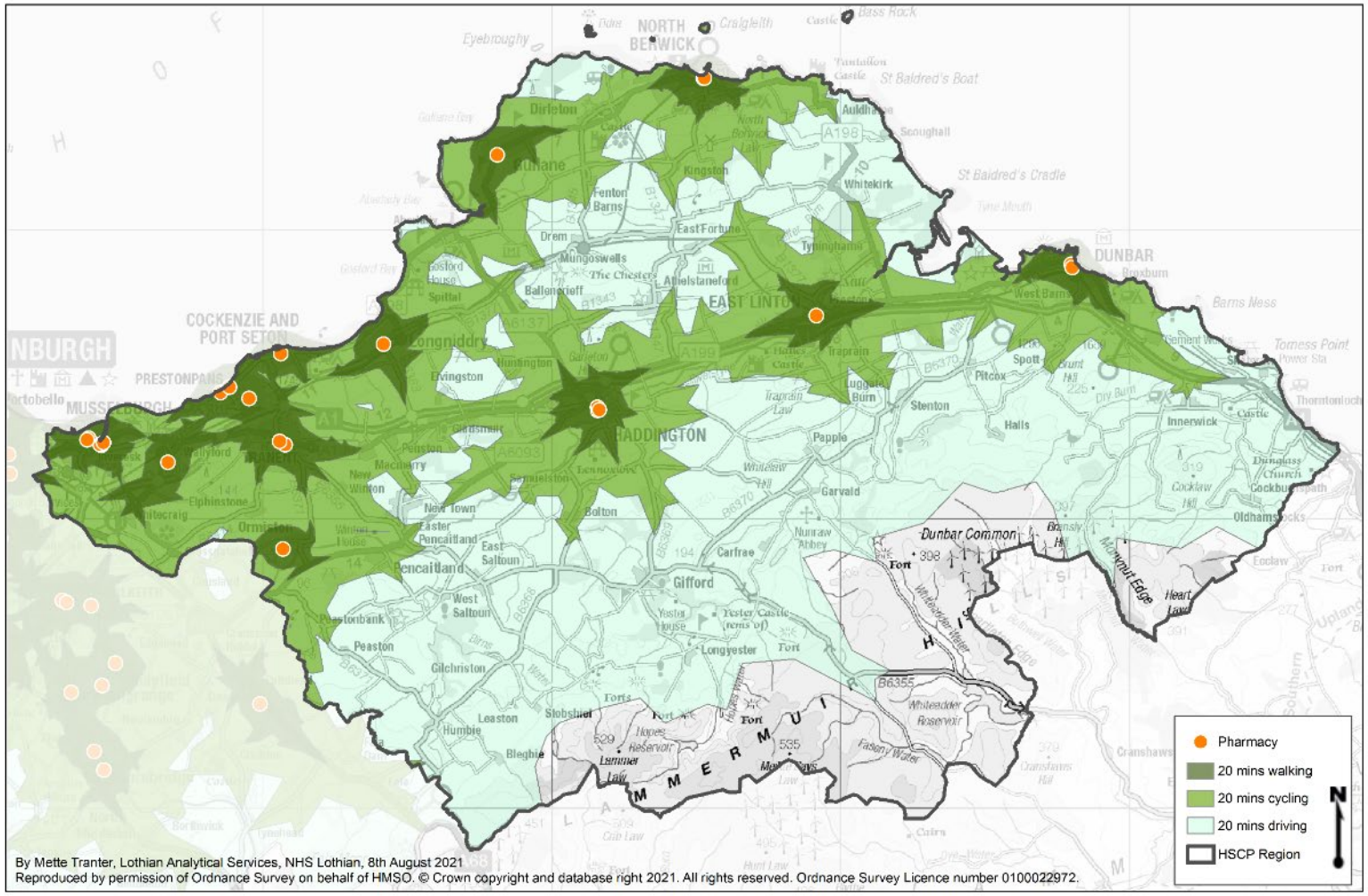
Map of West Lothian HSCP showing Pharmacies and Small Area Pop. Estimates (2019)



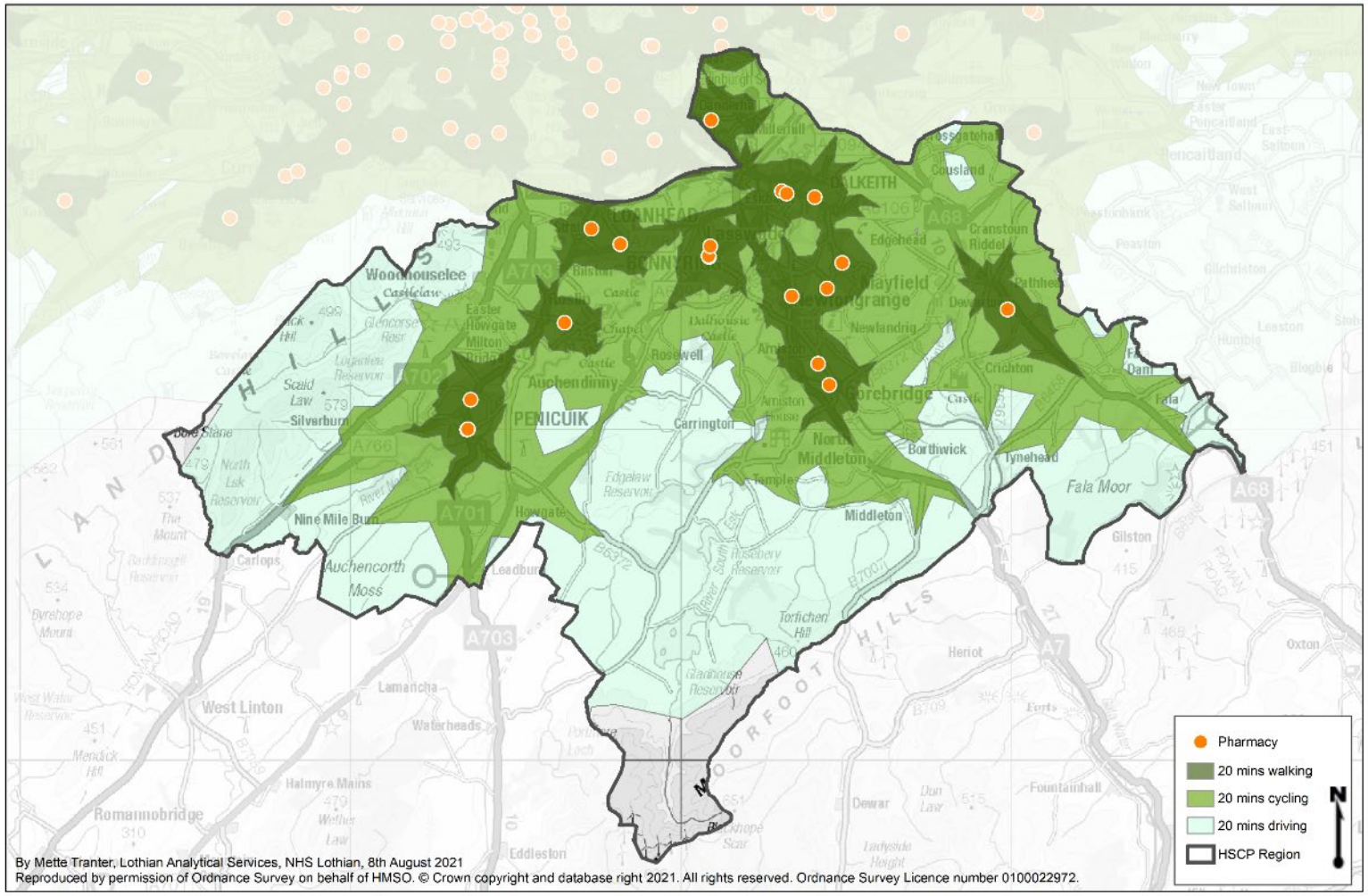
Map Showing Travel Time (isochrones) from Pharmacies in Edinburgh (HSCP) area



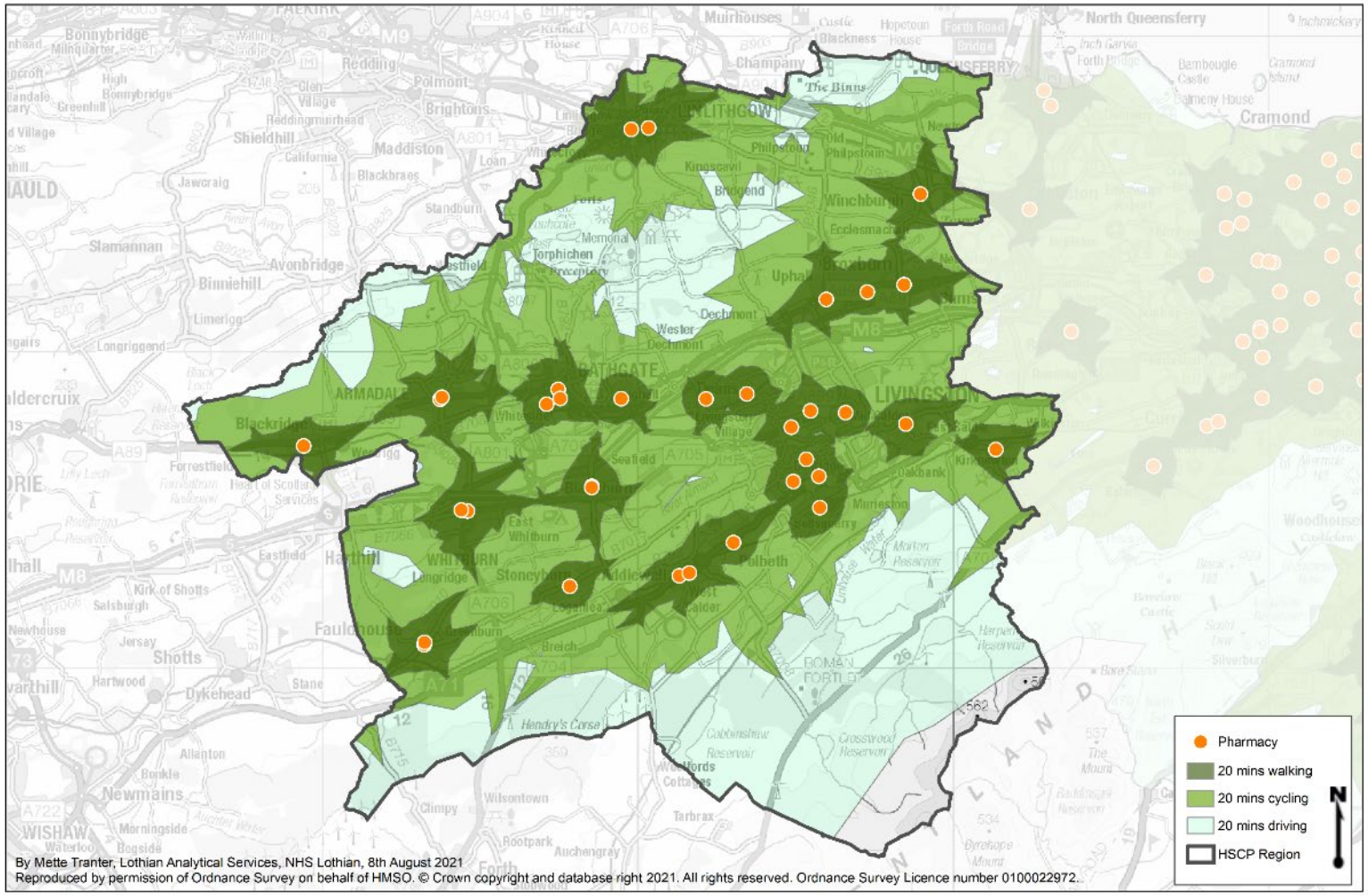
Map Showing Travel Time (isochrones) from Pharmacies in East Lothian (HSCP) area



Map Showing Travel Time (isochrones) from Pharmacies in Midlothian (HSCP) area



Map Showing Travel Time (isochrones) from Pharmacies in West Lothian (HSCP) area



Appendix 2 Provision of NHS Lothian Community Pharmacy Services

East Lothian								
Contractor code	**HSCP LOCALITY**	**PHARMACY NAME**	**ADDRESS**	**POSTCODE**	**SUNDAY HOURS**	**NEEDLE EXCHANGE (local service)**	**NURSING HOME ADVICE (local service)**	**PALLIATIVE CARE NETWORK (local service)**
2011	East Lothian E	AITKEN PHARMACY LTD	67 HIGH STREET DUNBAR EAST LOTHIAN	EH42 1EW		NO	NO	NO
2034	East Lothian E	BOOTS	36 HIGH STREET HADDINGTON EAST LOTHIAN	EH41 3EE		NO	NO	YES
2036	East Lothian W	BOOTS	164 HIGH STREET MUSSELBURGH EAST LOTHIAN	EH21 7DZ		NO	YES	NO
2037	East Lothian E	BOOTS	80 HIGH STREET NORTH BERWICK EAST LOTHIAN	EH39 4HF		NO	NO	NO
2067	East Lothian W	WELL	ORMISTON MEDICAL CENTRE TYNEMOUNT ROAD ORMISTON EAST LOTHIAN	EH35 5AB		NO	NO	NO

2069	East Lothian W	WELL	42 LINKS ROAD PORT SETON EAST LOTHIAN	EH32 0EA		NO	NO	NO

2070	East Lothian W	WELL	115 HIGH STREET TRANENT EAST LOTHIAN	EH33 1LW		NO	NO	YES
2170	East Lothian W	WELL	123 NORTH HIGH STREET MUSSELBURGH EAST LOTHIAN	EH21 6JE		YES	NO	NO
2369	East Lothian W	LLOYDS PHARMACY	49-51 HIGH STREET TRANENT EAST LOTHIAN	EH33 1LN		NO	NO	NO
2400	East Lothian W	BOOTS	106 NORTH HIGH STREET MUSSELBURGH EAST LOTHIAN	EH21 6AS		NO	NO	NO
2409	East Lothian W	WELL	176 HIGH STREET PRESTONPANS EAST LOTHIAN	EH32 9AZ		NO	NO	NO
2425	East Lothian E	LLOYDS PHARMACY	25 HIGH STREET DUNBAR EAST LOTHIAN	EH42 1EN		NO	NO	NO
2433	East Lothian W	PRESTONLINKS PHARMACY	65C HIGH STREET PRESTONPANS EAST LOTHIAN	EH32 9AF		NO	YES	NO
2479	East Lothian E	LINTON PHARMACY	1 THE SQUARE EAST LINTON EAST LOTHIAN	EH40 3AD		NO	NO	NO

2482	East Lothian E	MARKET STREET PHARMACY	22 MARKET STREET HADDINGTON EAST LOTHIAN	EH41 3JE		NO	YES	NO
2513	East Lothian W	BANKTON PHARMACY	HAWTHORN ROAD PRESTONPANS EAST LOTHIAN	EH32 9QW		YES	NO	NO
2518	East Lothian W	LONGNIDDRY PHARMACY	LINKS ROAD LONGNIDDRY EAST LOTHIAN	EH32 0NH		NO	NO	NO
2525	East Lothian E	RIGHT MEDICINE PHARMACY	20 HIGH STREET HADDINGTON EAST LOTHIAN	EH41 3ES		YES	NO	NO
2527	East Lothian W	GORDONS CHEMISTS	105 HIGH STEET MUSSELBURGH EAST LOTHIAN	EH21 7DA		NO	NO	NO
2529	East Lothian E	NORTH BERWICK PHARMACY	66 HIGH STREET NORTH BERWICK EAST LOTHIAN	EH39 4HF		NO	NO	NO
2540	East Lothian W	WALLYFORD PHARMACY	121 SALTER'S ROAD WALLYFORD	EH21 8AQ		NO	YES	NO
2541	East Lothian E	GULLANE PHARMACY	7 ROSEBERY PLACE GULLANE EAST LOTHIAN	EH31 2AN		NO	NO	NO

2563	East Lothian W	M&D GREEN - ESKSIDE PHARMACY	165 HIGH STREET MUSSELBURGH EAST LOTHIAN	EH21 7DE		NO	YES	NO

Midlothian								
Contractor code	**HSCP LOCALITY**	**PHARMACY NAME**	**ADDRESS**	**POSTCODE**	**SUNDAY HOURS**	**NEEDLE EXCHANGE (local service)**	**NURSING HOME ADVICE (local service)**	**PALLIATIVE CARE NETWORK (local service)**
2022	Midlothian E	BOOTS	17-19 HIGH STREET DALKEITH MIDLOTHIAN	EH22 1JB		NO	NO	NO
2226	Midlothian E	LINDSAY & GILMOUR CHEMIST	18/20 WOODBURN AVENUE DALKEITH MIDLOTHIAN	EH22 2BP		NO	NO	NO
2370	Midlothian W	LLOYDS PHARMACY	32-34 HIGH STREET BONNYRIGG MIDLOTHIAN	EH19 2AA		NO	YES	NO
2371	Midlothian E	LLOYDS PHARMACY	17 ESKDAILL COURT DALKEITH MIDLOTHIAN	EH22 1AG		NO	YES	NO

2372	Midlothian E	LLOYDS PHARMACY	105 HUNTERFIELD ROAD GOREBRIDGE MIDLOTHIAN	EH23 4TS		NO	NO	NO
2373	Midlothian E	LLOYDS PHARMACY	35 MAIN STREET GOREBRIDGE MIDLOTHIAN	EH23 4BX		NO	NO	NO
2374	Midlothian E	LLOYDS PHARMACY	123/125 MAIN STREET NEWTONGRANGE MIDLOTHIAN	EH22 4PS		NO	YES	NO
2375	Midlothian E	LLOYDS PHARMACY	2 BOGWOOD COURT MAYFIELD MIDLOTHIAN	EH22 5DG		NO	NO	NO
2376	Midlothian W	LLOYDS PHARMACY	44a JOHN STREET PENICUIK MIDLOTHIAN	EH26 8AB		NO	NO	NO
2426	Midlothian E	RIGHT MEDICINE PHARMACY	71 NEWTON CHURCH ROAD DANDERHALL MIDLOTHIAN	EH22 1LX		NO	NO	NO
2445	Midlothian W	ROWLANDS PHARMACY	48 HIGH STREET BONNYRIGG MIDLOTHIAN	EH19 2AB		NO	NO	NO
2447	Midlothian W	ROWLANDS PHARMACY	27 JOHN STREET PENICUIK MIDLOTHIAN	EH26 8HN		NO	NO	YES
2448	Midlothian W	ROWLANDS PHARMACY	22 EDINBURGH ROAD	EH26 8NW		NO	NO	NO

			PENICUIK MIDLOTHIAN					
2450	Midlothian W	ROWLANDS PHARMACY	55 CLERK STREET LOANHEAD MIDLOTHIAN	EH20 9RE		YES	NO	NO
2454	Midlothian E	LLOYDS PHARMACY	NEWBATTLE MEDICAL PRACTICE MAYFIELD DALKEITH	EH22 4AA		NO	NO	NO
2523	Midlothian E	PATHHEAD PHARMACY	210 MAIN STREET PATHHEAD	EH37 5PP		NO	NO	NO
2542	Midlothian W	COHEN CHEMIST	BONNYRIGG HEALTH CENTRE BONNYRIGG MIDLOTHIAN	EH19 2ET		NO	NO	NO
2554	Midlothian W	LLOYDS PHARMACY	STRAITON MAINS STRAITON MIDLOTHIAN	EH20 9PW	0800-1900	NO	NO	YES
2558	Midlothian W	ROSLIN PHARMACY	122 PENICUIK ROAD ROSLIN	EH25 9NT		NO	NO	NO

West Lothian								
Contractor code	**HSCP LOCALITY**	**PHARMACY NAME**	**ADDRESS**	**POSTCODE**	**SUNDAY HOURS**	**NEEDLE EXCHANGE (local service)**	**NURSING HOME ADVICE (local service)**	**PALLIATIVE CARE NETWORK (local service)**
2020	West Lothian W	BOOTS	26-30 GEORGE STREET BATHGATE WEST LOTHIAN	EH48 1PW		NO	YES	NO
2021	West Lothian E	BOOTS	Units 8-9 ARGYLE COURT 114 EAST MAIN STREET	EH52 5EQ		NO	NO	NO

			BROXBURN WEST LOTHIAN					
2035	West Lothian E	BOOTS	ALMONDVALE CENTRE LIVINGSTON WEST LOTHIAN	EH54 6HR	0930-1800	NO	YES	NO
2169	West Lothian W	WELL	2 MAIN STREET FAULDHOUSE WEST LOTHIAN	EH47 9JA		NO	NO	NO
2227	West Lothian E	LINDSAY & GILMOUR CHEMIST	173 MAIN STREET EAST CALDER WEST LOTHIAN	EH53 0EL		NO	NO	NO
2239	West Lothian W	LINDSAY & GILMOUR CHEMIST	HEALTH CENTRE BURNGRANGE WEST CALDER	EH55 8EJ		YES	YES	YES
2307	West Lothian W	BOOTS	7-9 SYCAMORE WALK BLACKBURN WEST LOTHIAN	EH47 7LQ		NO	NO	NO
2308	West Lothian E	BOOTS	12 THE MALL - CRAIGSHILL LIVINGSTON WEST LOTHIAN	EH54 5ED		NO	NO	NO
2309	West Lothian W	BOOTS	12 WEST MAIN STREET WHITBURN WEST LOTHIAN	EH47 0QZ		NO	NO	NO
2310	West Lothian W	BOOTS	WHITBURN HEALTH CENTRE	EH47 0SD		NO	NO	NO

			1 WEAVER'S LANE WHITBURN WEST LOTHIAN					
2351	West Lothian E	BOOTS	72-74 HIGH STREET LINLITHGOW WEST LOTHIAN	EH49 7AQ		NO	NO	NO
2377	West Lothian W	LLOYDS PHARMACY	BATHGATE PRIMARY CARE CENTRE BATHGATE WEST LOTHIAN	EH48 2SS		NO	NO	NO
2378	West Lothian W	LLOYDS PHARMACY	25 KING STREET BATHGATE WEST LOTHIAN	EH48 1AZ	1200-1600	NO	NO	NO
2394	West Lothian E	RIGHT MEDICINE PHARMACY	5 CANAL ROAD WINCHBURGH WEST LOTHIAN	EH52 6FD		NO	NO	NO
2429	West Lothian E	LLOYDS PHARMACY	STRATHBROCK CENTRE BROXBURN WEST LOTHIAN	EH52 5LH		NO	NO	NO
2430	West Lothian E	LLOYDS PHARMACY	157 NIGEL RISE - DEDRIDGE LIVINGSTON WEST LOTHIAN	EH54 6LX		YES	NO	NO
2431	West Lothian E	LLOYDS PHARMACY	286 HIGH STREET LINLITHGOW WEST LOTHIAN	EH49 7ER		YES	NO	YES

2432	West Lothian W	LLOYDS PHARMACY	21 WEST MAIN STREET ARMADALE WEST LOTHIAN	EH48 3PZ		NO	YES	NO
2436	West Lothian W	LINDSAY & GILMOUR CHEMIST	34 MAIN STREET WEST CALDER WEST LOTHIAN	EH55 8DR		NO	NO	NO
2452	West Lothian E	LLOYDS PHARMACY	MURIESTON MEDICAL PRACTICE HAMILTON SQUARE LIVINGSTON	EH54 9JZ		NO	YES	NO
2457	West Lothian E	OMNICARE PHARMACY	6 MAIN STREET DEANS LIVINGSTON	EH54 8DF		YES	YES	YES
2463	West Lothian E	MORRISONS PHARMACY	DEDRIDGE ROAD NORTH LIVINGSTON WEST LOTHIAN	EH54 6DB	1000-1800	NO	NO	YES
2464	West Lothian E	MORRISONS PHARMACY	CARMONDEAN CENTRE LIVINGSTON WEST LOTHIAN	EH54 8PT	1000-1700	NO	NO	NO
2484	West Lothian W	STONEYBURN PHARMACY	67 MAIN STREET STONEYBURN WEST LOTHIAN	EH47 8BY		NO	NO	NO
2491	West Lothian W	WELL	F'HOUSE P'SHIP CENTRE LANRIGG	EH47 9JD		NO	NO	YES

			ROAD FAULDHOUSE					
2498	West Lothian W	RIGHT MEDICINE PHARMACY	103 CHAPELTON DRIVE POLBETH	EH55 8SQ		NO	NO	NO
2501	West Lothian E	LLOYDS PHARMACY	HOWDEN HEALTH CENTRE LIVINGSTON WEST LOTHIAN	EH54 6TP		NO	NO	NO
2515	West Lothian W	DUNAMIS PHARMACY	27 ELIZABETH DRIVE BOGHALL WEST LOTHIAN	EH48 1SJ		YES	NO	NO
2519	West Lothian W	BLACKRIDGE PHARMACY	22 MAIN STREET BLACKRIDGE WEST LOTHIAN	EH48 3SH		NO	NO	NO
2520	West Lothian E	LADYWELL PHARMACY	45 FERNBANK LADYWELL LIVINGSTON WEST LOTHIAN	EH54 6DT		NO	NO	NO
2521	West Lothian E	OMNICARE PHARMACY	23 -25 WEST MAIN STREET UPHALL	EH52 5DN		NO	NO	NO
2524	West Lothian W	GORDONS CHEMISTS	7 NORTH STREET ARMADALE	EH48 3QB		NO	NO	YES
2543	West Lothian E	KIRKNEWTON PHARMACY	24 MAIN STREET KIRKNEWTON	EH27 8AH		NO		NO

2561	West Lothian W	BLACKBURN PHARMACY	2 SYCAMORE WALK BLACKBURN	EH47 7LH	0900-1600			

Edinburgh North								
Contractor code	**HSCP LOCALITY**	**PHARMACY NAME**	**ADDRESS**	**POSTCODE**	**SUNDAY HOURS**	**NEEDLE EXCHANGE (local service)**	**NURSING HOME ADVICE (local service)**	**PALLIATIVE CARE NETWORK (local service)**
2027	Edinburgh NE	BOOTS	42 NEW KIRKGATE EDINBURGH	EH6 6AA		NO	NO	NO
2028	Edinburgh NE	BOOTS	174 PORTOBELLO HIGH ST EDINBURGH	EH15 1EX		NO	NO	NO
2032	Edinburgh NW	BOOTS	129 ST JOHN'S ROAD EDINBURGH	EH12 7SB		NO	NO	NO
2175	Edinburgh NE	NUCHEM	173 PIERSFIELD TERRACE EDINBURGH	EH8 7BT		NO	YES	NO
2229	Edinburgh NW	LINDSAY & GILMOUR CHEMIST	228-230 CREWE ROAD NORTH EDINBURGH	EH5 2NS		YES	NO	NO

2231	Edinburgh NE	LINDSAY & GILMOUR CHEMIST	11 ELM ROW EDINBURGH	EH7 4AA		NO	NO	NO
2232	Edinburgh NE	LINDSAY & GILMOUR CHEMIST	257A LEITH WALK EDINBURGH	EH6 8NY		YES	NO	NO
2304	Edinburgh NE	LLOYDS PHARMACY	3-5 DUKE STREET EDINBURGH	EH6 6AE		NO	NO	NO
2320	Edinburgh NW	BOOTS	UNIT 10 GYLE SHOPPING CENTRE EDINBURGH	EH12 9JS	0900-1830	NO	NO	YES
2338	Edinburgh NE	TESCO INSTORE PHARMACY	7 BROUGHTON ROAD EDINBURGH	EH7 4EW	1000-1700	NO	NO	NO
2360	Edinburgh NW	LLOYDS PHARMACY	115 CORSTORPHINE ROAD EDINBURGH	EH12 5PZ		NO	NO	NO
2361	Edinburgh NE	LLOYDS PHARMACY	6-7 CRIGHTON PLACE EDINBURGH	EH7 4NZ		NO	NO	NO
2362	Edinburgh NW	LLOYDS PHARMACY	7-9 DEANHAUGH STREET EDINBURGH	EH4 1LU		NO	YES	NO
2365	Edinburgh NW	LLOYDS PHARMACY	6 MACMILLAN SQUARE EDINBURGH	EH4 4AB		NO	NO	NO

2379	Edinburgh NW	LLOYDS PHARMACY	UNIT 33 THE LOAN SOUTH QUEENSFERRY	EH30 9SD		NO	NO	NO
2380	Edinburgh NW	BOOTS	58-60 MAIN STREET DAVIDSON'S MAINS EDINBURGH	EH4 5AA		NO	NO	NO
2381	Edinburgh NW	BOOTS	151 COMELY BANK ROAD EDINBURGH	EH4 1BH		NO	YES	NO
2396	Edinburgh NE	BOOTS	UNIT 1 FORT RETAIL PARK NEWCRAIGHALL EDINBURGH	EH15 3HS	0900-1830	NO	NO	YES
2398	Edinburgh NW	LINDSAY & GILMOUR CHEMIST	22 HILLHOUSE ROAD BLACKHALL EDINBURGH	EH4 2AG		NO	NO	NO
2399	Edinburgh NE	BOOTS	123 FERRY ROAD EDINBURGH	EH6 4ET		NO	NO	NO
2413	Edinburgh NE	ASDA PHARMACY	100 THE JEWEL BRUNSTANE EDINBURGH	EH15 3AR	0900-1800	NO	NO	NO
2417	Edinburgh NW	ROWLANDS PHARMACY	5A FEATHERHALL AVENUE EDINBURGH	EH12 7TG		NO	NO	YES

2438	Edinburgh NW	BOOTS	24 SOUTH GROATHILL AVENUE CRAIGLEITH RETAIL PARK EDINBURGH	EH4 2LN	1000-1800	NO	NO	NO
2441	Edinburgh NW	LLOYDS PHARMACY	2 FERRYBURN SOUTH QUEENSFERRY EDINBURGH	EH30 9QS		NO	NO	NO
2444	Edinburgh NE	LINDSAY & GILMOUR CHEMIST	6 MILTON ROAD WEST EDINBURGH	EH15 1LF		NO	NO	NO
2455	Edinburgh NE	BOOTS	29-31 PARSON'S GREEN TERRACE	EH8 7AF		NO	NO	NO
2456	Edinburgh NW	WELL	38 MAIN STREET KIRKLISTON	EH29 9AA		NO	NO	NO
2458	Edinburgh NE	BOOTS	UNIT 22 OCEAN TERMINAL OCEAN DRIVE EDINBURGH	EH6 6JJ	1000-1800	NO	NO	YES
2465	Edinburgh NW	LLOYDS PHARMACY	BUGHTLIN MARKET EAST CRAIGS EDINBURGH	EH12 8XP		NO	NO	NO
2470	Edinburgh NE	WELL	1 RESTALRIG ROAD EDINBURGH	EH6 8BB		NO	NO	NO

2471	Edinburgh NE	WELL	100 CRAIGENTINNY ROAD EDINBURGH	EH7 6RN		NO	NO	NO
2472	Edinburgh NW	WELL	114-116 GRANTON ROAD EDINBURGH	EH5 3RE		NO	NO	NO
2473	Edinburgh NE	WELL	12A LOCHEND ROAD SOUTH EDINBURGH	EH7 6BP		NO	NO	NO
2499	Edinburgh NW	CARRICK KNOWE PHARMACY	146 SAUGHTON ROAD NORTH EDINBURGH	EH12 7DS		NO	NO	NO
2508	Edinburgh NW	OMNICARE PHARMACY	38 DUART CRESCENT EDINBURGH	EH4 7JP		NO	YES	NO
2510	Edinburgh NW	OMNICARE PHARMACY	Unit 4 527 QUEENSFERRY RD EDINBURGH	EH4 7QD		NO	YES	YES
2514	Edinburgh NW	RIGHT MEDICINE PHARMACY	9-11 ROSEBURN TERRACE EDINBURGH	EH12 5NG		NO	NO	NO
2516	Edinburgh NW	BARNTON PHARMACY	195 WHITEHOUSE ROAD EDINBURGH	EH4 6BU		NO	NO	

2517	Edinburgh NW	STOCKBRIDGE PHARMACY	35-37 NORTH WEST CIRCUS PLACE	EH3 6TW		NO	NO	NO
2528	Edinburgh NE	LEITH PHARMACY	7 GREAT JUNCTION STREET LEITH EDINBURGH	EH6 5HX		NO	NO	NO
2531	Edinburgh NW	DEARS PHARMACY	645 FERRY ROAD EDINBURGH	EH4 2TX		NO	NO	NO
2532	Edinburgh NE	DEARS PHARMACY	92-96 EASTER ROAD EDINBURGH	EH7 5RQ		NO	YES	NO
2538	Edinburgh NW	CORSTORPHINE PHARMACY	159 ST JOHN'S ROAD EDINBURGH	EH12 7SD		NO	NO	NO
2545	Edinburgh NW	RIGHTDOSE PHARMACY	6 EYRE PLACE EDINBURGH	EH3 5EP		NO	YES	NO
2550	Edinburgh NE	LINDSAY & GILMOUR CHEMIST	96 NIDDRIE MAINS RD EDINBURGH	EH16 4DT		NO	NO	YES
2551	Edinburgh NE	LINDSAY & GILMOUR CHEMIST	58-60 NIDDRIE MAINS ROAD EDINBURGH	EH16 4BG		YES	NO	NO
2553	Edinburgh NE	LLOYDS PHARMACY	MEADOWBANK RETAIL PARK MORAY PARK EDINBURGH	EH7 5TS	1000-1900	NO	NO	NO

2555	Edinburgh NW	L E HARTLEY CHEMIST	37 SOUTH TRINITY ROAD EDINBURGH	EH5 3PN		NO	NO	NO
2556	Edinburgh NW	EDINBURGH PHARMACY	5 MONTAGUE TERRACE	EH3 5QX		NO	NO	NO
2557	Edinburgh NE	LINDSAY & GILMOUR CHEMIST	332 PORTOBELLO HIGH ST EDINBURGH	EH15 2DA		NO	YES	NO
2560	Edinburgh NE	WOOTON PHARMACY	168 PORTOBELLO HIGH STREET EDINBURGH	EH15 1EX		NO	NO	NO
2562	Edinburgh NE	CLARK CHEMIST	1 LINDSAY ROAD EDINBURGH	EH6 4EP		NO	NO	NO
2550	Edinburgh NE	LINDSAY & GILMOUR CHEMIST	96 NIDDRIE MAINS RD EDINBURGH	EH16 4DT		NO	NO	YES

Edinburgh South								
Contractor code	**HSCP LOCALITY**	**PHARMACY NAME**	**ADDRESS**	**POSTCODE**	**SUNDAY HOURS**	**NEEDLE EXCHANGE (local service)**	**NURSING HOME ADVICE (local service)**	**PALLIATIVE CARE NETWORK (local service)**
2023	Edinburgh SE	BOOTS	14 CAMERON TOLL CENTRE 6 LADY ROAD EDINBURGH	EH16 5PB	0930-1730	NO	NO	NO
2026	Edinburgh SW	BOOTS	230-232 GORGIE ROAD EDINBURGH	EH11 2PN		NO	NO	NO
2029	Edinburgh SE	BOOTS	101-103 PRINCES STREET EDINBURGH	EH2 3AD	1000-1800	NO	NO	NO
2030	Edinburgh SE	BOOTS	46-48 SHANDWICK PLACE EDINBURGH	EH2 4SA	1030-1700	YES	NO	YES
2031	Edinburgh SE	BOOTS	121-127 St JAMES CRESCENT EDINBURGH	EH1 3AD	1000-1800	NO	NO	NO
2033	Edinburgh SE	BOOTS	16-20 EARL GREY STREET EDINBURGH	EH3 9BN		NO	NO	NO
2105	Edinburgh SE	SOUTHSIDE PHARMACY	79 NICOLSON STREET EDINBURGH	EH8 9BZ		NO	NO	NO
2186	Edinburgh SW	COLINTON PHARMACY	46A BRIDGE RD EDINBURGH	EH13 0LQ		NO	NO	NO
2225	Edinburgh SW	LINDSAY & GILMOUR CHEMIST	2 PENTLAND VIEW COURT	EH14 5NP		NO	NO	NO

			CURRIE EDINBURGH					
2243	Edinburgh SW	COLINTON MAINS PHARMACY	84 COLINTON MAINS DRIVE EDINBURGH	EH13 9BJ		NO	NO	YES
2247	Edinburgh SE	BRISTO SQUARE PHARMACY	UNIVERSITY OF ED'BURGH 6 BRISTO SQUARE EDINBURGH	EH8 9AL		NO	NO	NO
2254	Edinburgh SE	RIGHT MEDICINE PHARMACY	2 BEAUFORT ROAD EDINBURGH	EH9 1AG		NO	NO	NO
2268	Edinburgh SW	LINDSAY & GILMOUR CHEMIST	536 LANARK ROAD JUNIPER GREEN EDINBURGH	EH14 5DJ		NO	NO	NO
2283	Edinburgh SW	SIGHTHILL HEALTH CENTRE	SIGHTHILL HEALTH CENTRE CALDER ROAD EDINBURGH	EH11 4AU		NO	NO	NO
2313	Edinburgh SW	CALDER PHARMACY	18 CALDER PARK SIGHTHILL EDINBURGH	EH11 4JN		NO	NO	NO
2332	Edinburgh SE	BOOTS	28-30 NEWINGTON ROAD EDINBURGH	EH9 1QS		NO	NO	NO
2335	Edinburgh SW	BOOTS	10A BUCKSTONE TERRACE EDINBURGH	EH10 6PZ		NO	NO	NO
2339	Edinburgh SE	BOOTS	207-209 MORNINGSIDE ROAD EDINBURGH	EH10 4QT		NO	NO	NO
2343	Edinburgh SE	BOOTS	6 ST PATRICK STREET EDINBURGH	EH8 9HB		NO	NO	NO

2344	Edinburgh SE	LINDSAY & GILMOUR CHEMIST	18-20 COMISTON ROAD EDINBURGH	EH10 5QE		NO	YES	NO
2358	Edinburgh SE	LLOYDS PHARMACY	129 BRUNTSFIELD PLACE EDINBURGH	EH10 4EQ	1200-1600	NO	NO	NO
2363	Edinburgh SE	LLOYDS PHARMACY	2 FERNIEHILL ROAD EDINBURGH	EH17 7AB		YES	NO	NO
2368	Edinburgh SW	LLOYDS PHARMACY	26 WESTER HAILES CRESCENT SHOPPING CENTRE EDINBURGH	EH14 2SW		YES	NO	NO
2383	Edinburgh SE	BOOTS	32 WEST MAITLAND STREET EDINBURGH	EH12 5DX		NO	NO	NO
2395	Edinburgh SW	LINDSAY & GILMOUR CHEMIST	24 MAIN STREET BALERNO EDINBURGH	EH14 7EH		NO	NO	NO
2397	Edinburgh SW	POLWARTH PHARMACY	10 POLWARTH GARDENS EDINBURGH	EH11 1LW		NO	YES	NO
2405	Edinburgh SE	PATON & FINLAY	177 BRUNTSFIELD PLACE EDINBURGH	EH10 4DG		NO	NO	NO
2442	Edinburgh SE	OMNICARE PHARMACY	2 HOME STREET EDINBURGH	EH3 9LY		NO	YES	NO
2449	Edinburgh SE	LINDSAY & GILMOUR CHEMIST	37 MOREDUN PARK ROAD EDINBURGH	EH17 7ES		NO	NO	NO
2453	Edinburgh SE	RIGHT MEDICINE PHARMACY	45 FORREST ROAD EDINBURGH	EH1 2QP		NO	YES	NO

2475	Edinburgh SW	WELL	4 STENHOUSE CROSS EDINBURGH	EH11 3JY		NO	NO	NO
2476	Edinburgh SE	WELL	55A MAYFIELD ROAD EDINBURGH	EH9 3AA		NO	NO	NO
2478	Edinburgh SE	MORNINGSIDE PHARMACY	153 MORNINGSIDE ROAD EDINBURGH	EH10 4AX		NO	NO	NO
2480	Edinburgh SE	MARCHMONT PHARMACY	26 MARCHMONT ROAD EDINBURGH	EH9 1HZ		NO	YES	YES
2481	Edinburgh SE	WM KING & SON	142 MARCHMONT ROAD EDINBURGH	EH9 1AQ		NO	NO	NO
2490	Edinburgh SE	GORDONS CHEMISTS	1 GRACEMOUNT DRIVE EDINBURGH	EH16 6RR		NO	YES	YES
2495	Edinburgh SE	NEWINGTON PHARMACY	46-48 CLERK STREET EDINBURGH	EH8 9JB		YES	NO	YES
2496	Edinburgh SE	OMNICARE PHARMACY	160 CAUSEWAYSIDE EDINBURGH	EH9 1PR		NO	YES	NO
2497	Edinburgh SE	RIGHT MEDICINE PHARMACY	67 HIGH STREET EDINBURGH	EH1 1SR		NO	NO	NO
2500	Edinburgh SW	APPLE PHARMACY	65 DALRY ROAD EDINBURGH	EH11 2BZ		NO	YES	NO
2502	Edinburgh SW	LLOYDS PHARMACY	162 LANARK ROAD WEST CURRIE EDINBURGH	EH14 5NY		NO	NO	NO
2503	Edinburgh SW	LLOYDS PHARMACY	483A CALDER ROAD EDINBURGH	EH11 4AW		NO	NO	NO
2507	Edinburgh SE	OMNICARE PHARMACY	102 WALTER SCOTT AVENUE EDINBURGH	EH16 5RL		YES	YES	NO

2509	Edinburgh SW	OMNICARE PHARMACY	3 ARDMILLAN TERRACE EDINBURGH	EH11 2JN		YES	YES	NO
2511	Edinburgh SW	CRAIGLOCKHART PHARMACY	2 CRAIGLOCKHART RD N EDINBURGH	EH14 1BU		NO	NO	NO
2522	Edinburgh SW	LINDSAY & GILMOUR CHEMIST	107 SLATEFORD ROAD	EH11 1QY		NO	NO	NO
2526	Edinburgh SE	FLEMING CHEMIST	131 LIBERTON BRAE EDINBURGH	EH16 6LD		NO	NO	NO
2533	Edinburgh SW	DEARS PHARMACY	7 OXGANGS BROADWAY EDINBURGH	EH13 9LQ		NO	NO	NO
2534	Edinburgh SW	MACKINNON PHARMACY	291 CALDER ROAD EDINBURGH	EH11 4RH		YES	NO	NO
2539	Edinburgh SE	CLEAR PHARMACY	26 BROUGHAM PLACE EDINBURGH	EH3 9JU		NO	NO	NO
2549	Edinburgh SW	LLOYDS PHARMACY	SAINSBURYS,39 WESTFIELD ROAD,EDINBURGH,EH11 2QW	EH11 2NB	1000-1400	NO	NO	NO
2552	Edinburgh SW	RATHO PHARMACY	64 NORTH ST RATHO EDINBURGH	EH28 8RR		NO	NO	NO
2559	Edinburgh SW	FOUNTAINBRIDGE PHARMACY	179 DUNDEE STREET EDINBURGH	EH11 1BY		NO	NO	NO
2564	Edinburgh SE	BROUGHTON PHARMACY	105 BROUGHTON STREET EDINBURGH	EH1 3RZ		NO	YES	NO

Meeting Name: Board **Meeting date: 1 December 2021**

Title: SEPTEMBER 2021 FINANCIAL POSITION

Purpose and Key Issues of the Report:
Provides an update to the Board on the Period 6 financial position for NHS Lothian, including the impact of Covid and current core pressures.

DISCUSSION		DECISION		AWARENESS	X

This paper sets out the year-to-date financial position and year end forecast for NHS Lothian. The paper details the following key points:

- Lothian is currently £8.8m overspent year-to-date at Period 6;
- The year-end forecast for Lothian currently estimates an overspend of £6.8m;
- The Scottish Government have confirmed that, consistent with last year, all boards will be provided with non-recurrent financial support to deliver a balanced outturn;
- We are therefore able to provide **significant assurance** on the achievement of breakeven this year;
- Our Covid Costs will also be fully funded this year – Current estimate is for an additional spend of £130m by the year end, with £49m of cost incurred year to date;
- Expected Covid costs for 22/23 are £84m, with £62m of this recurringly in future years.

Recommendations:

The Board is asked to accept that, based on information available at this stage and assumptions around additional funding, NHS Lothian can provide **significant assurance** on its ability to deliver a breakeven position in 2021/22.

Author: Andrew McCreadie **Date:** 18 November 2021	**Director:** Susan Goldsmith **Date:** 18 November 2021

NHS LOTHIAN

Board Meeting
1st December 2021

Director of Finance

SEPTEMBER 2021 YTD FINANCIAL POSITION

1 Purpose of the Report

1.1 This paper provides an update to the Board on the financial position at Period 6 for NHS Lothian.

1.2 The paper sets out the financial impact from Covid-19 to September and provides an update on the main core pressures in year. It also sets out the estimated outturn at year end based on current information and assumptions.

1.3 Any member wishing additional information on the detail behind this paper should contact the Director of Finance prior to the meeting.

2 Recommendations

2.1 The Board is recommended to:

- **Accept** that, based on information available at this stage and assumptions around additional funding, NHS Lothian is able to provide **significant assurance** on its ability to deliver a breakeven position in 2021/22.

3 Discussion of Key Issues

Financial Position as at September 2021

3.1 The Finance and Resources Committee considered the Period 6 finance position and year end forecast at its meeting of the 17th November. The Committee accepted **significant assurance** that the statutory target of breakeven would be achieved this year on the basis of the information contained within the report, and shared with the Board in this paper.

3.2 At Period 6, NHS Lothian underspent by £139k bringing the year to date position to £8.8m overspend against the Revenue Resource Limit. A summary of the position is shown in Table 1 below with further detail in Appendix 1 and by operational unit in Appendix 2.

Table 1: Financial Position to 30th September 2021

	Mth 6 £k	YTD £k
Pay	4,695	1,869
Non Pays	(5,586)	(21,234)
Income	1,030	10,605
Total	**• 139**	**(8,759)**

3.3 The Financial Plan presented to the Board in April 2021 showed a projected deficit for the year ahead of £25m of core pressures (i.e. excluding Covid). As at quarter 1 that estimate was revised down to £22m.

3.4 Since that time, progress has been made on securing additional resources relating to the disposal of the RHSC and assumed funds relating to medical and dental uplift funding. As a result, the latest update as at month 6 is now estimating a £6.8m forecast overspend. Table 2 summarises the movement in the forecast position over the year.

Table 2: 21/22 Forecast Position

	21/22 Financial Plan £k	Q1 YE Forecast £k	Updated Forecast @ Mth 6 £k
Operational Position	(33,359)	(30,197)	(25,147)
Reserves/N/R Flexibility	12,662	12,662	18,015
FP Commitments	(4,623)	(4,623)	311
Total	**(25,320)**	**(22,158)**	**(6,821)**

3.5 Due to significant operational and financial challenges within the overall NHS system nationally, the SG formally communicated to Boards and Integration Authorities on the 26th October to confirm that additional financial support will be available to deliver breakeven on a non-repayable basis, providing appropriate review and control at a Board level. Based on this information, we are now able to move to a **significant assurance** level on the achievement of financial balance for this year.

Core Overspend at Period 6

3.6 As previously reported, the Core pressures are driven by Acute drugs and Medical and Dental spend, which were recognised as key contributors to the gap forecast in the Financial Plan.

3.7 Drugs are currently overspent year to date by £7.4m. This is mainly within Acute areas (WGH £3.9m; RIE £1.1m; St Johns £0.6m; and W&C £0.6m).

3.8 Medical and Dental pays are overspent by £4.7m year to date, again largely within Acute (£2.8m), REAS (£0.5m), East Lothian (£0.4m) and Edinburgh Partnership (£0.4m). £1.6m of this variance relates to Junior Medical pressures, specifically where costs are above training income received from NES.

Financial Impact of Covid-19 at Period 6

3.9 The latest review of Covid-19 costs up to the end of September 2021 shows that the board has incurred an estimated £49m of additional Covid related costs to date this year, which is largely funded from the initial allocation of Covid resource by the SG. Additional funding has now been released by the SG in November based on the information in the quarterly return submitted at the end of July. This allocation funds the costs incurred in the first quarter, plus 70% of estimated costs for the remainder of the year adjusted for any available IJB reserves. Further funding will be issued after the third quarter submission to the SG on Covid costs at the end of January.

3.10 The breakdown of Covid costs recorded to date is shown in Table 3. The largest element of Covid spend to date relates to the ongoing Covid Vaccine rollout at circa £23m.

Table 3: Covid Position YTD

SG Category	Total Covid Costs recorded to Date £k
Covid-19 Vaccination	£22,921
Other Additional Staff Costs	£10,173
Additional Bed Capacity/Change in Usage	£3,410
Loss of Income	£2,978
Other	£2,847
Contact Tracing	£2,666
Testing	£2,151
Additional FHS Prescribing	£1,647
Additional Community Hospital Bed Capacity	£1,008
Additional PPE	£773
Remobilisation -Digital & IT costs	£746
Scale up of Public Health Measures	£721
Reducing Delayed Discharge	£674
Community Hubs	£515
Additional Equipment and Maintenance	£366
Additional Infection Prevention and Control Co	£174
Additional FHS Contractor Costs	£161
Remobilisation -Primary Care	£26
Offsetting Cost Reductions	£(5,023)
Total Covid Costs to date	**£48,932**

Directorate	Total Covid Costs recorded to Date £k
Acute Services Division	£11,415
Corporate Services	£1,282
Directorate Of Primary Care	£22,010
East Lothian Partnership	£2,404
Edinburgh Partnership	£1,822
Facilities And Consort	£3,963
Inc + Assoc Hlthcare Purchases	£1,314
Midlothian Partnership	£2,395
Reas	£660
Service Improvement	£436
Strategic Services	£2
West Lothian Hsc Partnership	£1,230
Grand Total	**£48,932**

3.11 The second quarterly review at the end of October has now estimated £130.5m of Covid expenditure for the year and this value has been submitted to the SG as part of the reporting process. Table 4 below also shows a breakdown of this forecast.

Table 4: Updated Full Year Estimate of Covid Costs

SG Category	21/22 Estimated Covid Costs £k
Covid-19 Vaccination	£33,529
Testing (incl Community Testing Costs)	£21,283
Other Additional Staff Costs	£11,373
Additional Bed Capacity/Change in Usage	£8,683
Other (incl Drugs, Long Covid, Transport)	£7,802
Contact Tracing	£6,673
Loss of Income	£6,045
Additional Community Hospital Bed Capacity	£5,493
Remob -Primary Care	£4,500
Flu Vaccination	£3,437
Remob HSCP-Reducing Delayed Discharge	£3,339
Additional FHS Prescribing	£3,294
Scale up of Public Health Measures	£2,378
Additional FHS Contractor Costs	£2,366
Remob -Digital & IT costs	£2,213
Community Hubs	£1,389
Additional PPE	£1,383
Remob - Other	£1,176
Unachieved Savings	£4,220
Estimated CY Covid Costs	**£130,576**

Recurrency of Covid Commitments

3.12 As part of the Quarter 1 process, a review was undertaken to assess the recurring impact of Covid Services into 22/23 and beyond. Based on information currently available on ongoing Covid services and requirements, there is an estimated £84m of costs expected to be incurred in 22/23, including a continuation of the majority of the additional staff that are

currently employed to deliver Covid specific services. Further analysis shows an estimated £62m expenditure will be recurring with circa 800 wte additional staff required into future years beyond 22/23 with currently no agreed funding mechanism for these services. These figures have also now been incorporated within the latest SG return submitted in October. Table 5 gives a breakdown of these ongoing Covid costs.

Table 5: Recurring Covid Services Detail

Area	22/23 Estimated Cost £k	Estimated Recurring Cost £k
DATCC	£15,541	£11,935
Public Health	£14,983	£3,017
Director of Primary Care	£14,200	£14,200
East Lothian Partnership	£6,662	£6,662
Facilities	£5,650	£5,580
Edinburgh Partnership	£5,320	£5,320
Midlothian Partnership	£5,003	£5,003
West Lothian Partnership	£4,613	£4,613
WGH Site	£3,931	£2,633
Royal Infirmary Site	£2,698	£0
REAS	£1,689	£1,419
OAS	£1,505	£650
St John's Site	£996	£150
W&C	£896	£518
Oral Health	£345	£0
eHealth	£213	£213
Dermatology	£150	£0
Total	**£84,395**	**£61,913**

Main Recurring Covid Services	Recurring Pressure £k	Estimated Recurring WTE
Vaccination ongoing costs (Including Booster & Flu)	£14,200	250
Whole Genome Sequencing	£7,092	14
Partnership Delayed Discharge& Care Home Support	£6,959	155
PC Prescribing Pressures	£5,603	-
Other Covid Costs/Services	£5,553	55
Facilities covid pay costs	£4,305	137
ELCH Ward 5 & 6	£3,969	75
Extended Flu Costs	£3,437	-
Cancer & GI COVID Drugs Pressure	£2,581	-
Regional Hub Laboratory	£2,253	72
Public Health CAT	£1,989	13
Additional ward in MCH	£1,630	36
Increase Lab Activity	£675	11
OAS Clinics - Monitoring costs	£650	-
REAS - BRAIDS 6 COVID BEDS	£618	10
REAS - BUVIDAL drugs Pressure	£400	-
Total	**£61,913**	**828**

3.13 Further work is required to fully understand implications of potential Covid commitments into future years, not least in relation to the staffing implications. Dialogue with the SG about the continuation of some of these services as part of Covid management and recovery in future years of the whole system is ongoing. The levels of staffing required to maintain services is now a particular focus.

4 Risk Register

4.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

4.2 The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

5 Impact on Inequality, Including Health Inequalities

5.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

6.1 The implementation of the financial plan and the delivery of a breakeven outturn may require service changes. As this paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation.

Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

7 Resource Implications

7.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith
Director of Finance
18th November 2021
susan.goldsmith@nhslothian.scot.nhs.uk

Appendix 1 - NHS Lothian Income & Expenditure Summary to 30th September 2021
Appendix 2 - NHS Lothian Summary by Operational Unit to 30th September 2021

Appendix 1 – NHS Lothian Income & Expenditure Summary to 30th September 2021

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)
Medical & Dental	304,964	153,208	157,923	(4,715)
Nursing	526,331	265,111	259,099	6,012
Administrative Services	155,123	73,367	69,531	3,836
Allied Health Professionals	89,287	44,545	43,970	575
Health Science Services	48,557	24,715	23,999	715
Management	8,766	4,366	3,638	728
Support Services	83,433	41,529	44,055	(2,526)
Medical & Dental Support	14,418	7,126	7,406	(280)
Other Therapeutic	39,942	20,512	22,691	(2,179)
Personal & Social Care	3,479	1,742	1,698	43
Other Pay	(5,584)	(5,633)	(5,418)	(214)
Emergency Services	5	10	13	(3)
Vacancy Factor	(248)	(124)	0	(124)
Pay	**1,268,473**	**630,474**	**628,605**	**1,869**
Drugs	119,887	55,397	62,791	(7,394)
Medical Supplies	91,463	47,560	50,168	(2,608)
Maintenance Costs	8,453	5,864	4,111	1,754
Property Costs	41,951	14,366	14,390	(24)
Equipment Costs	31,088	9,539	14,473	(4,934)
Transport Costs	9,692	4,748	4,568	181
Administration Costs	198,183	24,788	26,271	(1,483)
Ancillary Costs	14,427	8,267	8,455	(188)
Other	(6,362)	(22,670)	(22,992)	322
Service Agreement Patient Serv	37,537	17,191	17,790	(598)
Savings Target Non-pay	(1,157)	(582)	0	(582)
Resource Trf + L/a Payments	109,360	37,708	39,114	(1,406)
Non-pay	**654,519**	**202,177**	**219,138**	**(16,961)**
Gms2 Expenditure	145,728	71,660	71,970	(310)
Ncl Expenditure	888	444	404	39
Other Primary Care Expenditure	87	44	39	5
Pharmaceuticals	155,658	75,937	77,713	(1,775)
Primary Care	**302,360**	**148,084**	**150,125**	**(2,041)**
Other	**(1,338)**	**(659)**	**(379)**	**(280)**
Income	**(303,534)**	**(170,781)**	**(181,386)**	**10,605**
Extraordinary Items	**0**	**0**	**1,952**	**(1,952)**
CORE POSITION	**1,920,480**	**809,295**	**818,054**	**(8,759)**
Additional Reserves Flexibility	0	0	0	0
TOTAL	**1,920,480**	**809,295**	**818,054**	**(8,759)**

Appendix 2 - NHS Lothian Summary by Operational Unit to 30th September 2021

Description	Acute Services Division (£k)	Reas (£k)	Directorate Of Primary Care (£k)	East Lothian Partnership (£k)	Edinburgh Partnership (£k)	Midlothian Partnership (£k)	West Lothian Hsc Partnership (£k)	Facilities And Consort (£k)	Corporate Services (£k)	Strategic Services (£k)	Service Improvement (£k)	Research + Teaching (£k)	Inc + Assoc Hlthcare Purchases (£k)	Reserves (£k)	Total (£k)
Annual Budget	**854,392**	**117,332**	**46,153**	**87,671**	**339,952**	**76,691**	**135,112**	**136,570**	**219,002**	**(19,406)**	**24,827**	**(10,462)**	**(140,798)**	**53,444**	**1,920,480**
Medical & Dental	(2,829)	(464)	(250)	(429)	(401)	(150)	(82)	0	(86)	(111)	112	(25)	0	0	**(4,715)**
Nursing	865	246	120	892	2,166	422	1,096	(22)	519	14	68	(373)	0	0	**6,012**
Administrative Services	645	51	(95)	(50)	136	(55)	49	(163)	3,770	(253)	(92)	(107)	(0)	0	**3,836**
Allied Health Professionals	(565)	(45)	(32)	79	815	2	359	(14)	(23)	0	0	(2)	0	0	**575**
Health Science Services	830	(0)	(15)	0	157	(3)	1	(5)	(283)	(2)	2	33	0	0	**715**
Management	(77)	5	56	3	272	7	26	(16)	342	82	0	29	0	0	**728**
Support Services	(93)	37	(227)	(13)	(52)	(12)	(1)	(2,135)	(29)	(6)	2	3	0	0	**(2,526)**
Medical & Dental Support	(438)	(0)	0	(74)	(6)	1	(1)	0	(17)	0	256	0	0	0	**(280)**
Other Therapeutic	(36)	496	(119)	(39)	(37)	139	30	0	(2,583)	(31)	(0)	0	0	0	**(2,179)**
Personal & Social Care	(14)	(3)	9	10	(15)	5	0	0	51	0	0	0	0	0	**43**
Other Pay	(55)	4	(173)	(6)	13	(5)	0	48	(41)	0	0	0	0	0	**(214)**
Emergency Services	0	0	0	0	0	0	0	(3)	0	0	0	0	0	0	**(3)**
Vacancy Factor	(87)	0	0	0	0	0	0	0	0	0	(37)	0	0	0	**(124)**
Pay	**(1,852)**	**327**	**(726)**	**372**	**3,049**	**351**	**1,476**	**(2,310)**	**1,619**	**(306)**	**311**	**(442)**	**(0)**	**0**	**1,869**
Drugs	(6,249)	10	47	(94)	(237)	(63)	(78)	(2)	(326)	(299)	(103)	0	0	0	**(7,394)**
Medical Supplies	(1,440)	(63)	(5)	(103)	(631)	(8)	13	(111)	(28)	(0)	(168)	(64)	0	0	**(2,608)**
Maintenance Costs	(338)	(69)	(93)	(25)	(87)	(11)	(65)	(575)	(91)	3,127	(18)	0	0	0	**1,754**
Property Costs	(14)	(39)	(709)	18	18	129	(19)	1,094	(4)	(499)	0	0	0	0	**(24)**
Equipment Costs	(2,766)	(170)	6	(203)	(220)	(135)	(96)	(110)	(1,185)	(8)	(43)	(5)	1	0	**(4,934)**
Transport Costs	14	66	(3)	(5)	12	2	42	(84)	89	11	41	(0)	(3)	0	**181**
Administration Costs	(351)	19	1,834	(11)	833	(7)	(33)	1,654	(1,869)	(3,574)	(2)	8	15	0	**(1,483)**
Ancillary Costs	(148)	27	58	(15)	(5)	14	(21)	23	(120)	(0)	(2)	(0)	0	0	**(188)**
Other	21	2	19	0	0	0	0	72	208	0	0	0	0	0	**322**
Service Agreement Patient Serv	(73)	344	(0)	21	(4)	4	(136)	(16)	76	(193)	(16)	(0)	(606)	0	**(598)**
Savings Target Non-pay	(379)	0	0	0	(211)	0	0	0	8	(0)	(0)	0	0	0	**(582)**
Resource Trf + L/a Payments	(174)	6	(165)	30	(924)	(50)	(5)	(27)	(96)	0	0	0	0	0	**(1,406)**
Non-pay	**(11,897)**	**135**	**987**	**(386)**	**(1,456)**	**(124)**	**(399)**	**1,918**	**(3,339)**	**(1,436)**	**(310)**	**(61)**	**(594)**	**0**	**(16,961)**
Gms2 Expenditure	(15)	6	(140)	(114)	(11)	(39)	45	(25)	(17)	0	(1)	0	0	0	**(310)**
Ncl Expenditure	0	0	39	0	0	0	0	0	0	0	0	0	0	0	**39**
Other Primary Care Expenditure	5	0	0	0	0	0	0	0	0	0	0	0	0	0	**5**
Pharmaceuticals	0	0	(104)	(305)	(482)	(302)	(584)	0	0	0	0	0	0	0	**(1,775)**
Primary Care	**(9)**	**6**	**(205)**	**(419)**	**(492)**	**(341)**	**(539)**	**(25)**	**(17)**	**0**	**(1)**	**0**	**0**	**0**	**(2,041)**
Other	**1**	**(0)**	**0**	**0**	**(10)**	**0**	**(18)**	**(0)**	**0**	**0**	**(0)**	**0**	**(253)**	**0**	**(280)**
Income	**1,570**	**44**	**(33)**	**(0)**	**60**	**(0)**	**27**	**427**	**91**	**2,016**	**(12)**	**170**	**6,244**	**0**	**10,605**
Extraordinary Items	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,952)**	**0**	**0**	**0**	**0**	**(1,952)**
CORE POSITION	**(12,188)**	**513**	**23**	**(433)**	**1,151**	**(113)**	**548**	**10**	**(1,646)**	**(1,678)**	**(12)**	**(332)**	**5,397**	**0**	**(8,759)**
Additional Reserves Flexibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
TOTAL	**(12,188)**	**513**	**23**	**(433)**	**1,151**	**(113)**	**548**	**10**	**(1,646)**	**(1,678)**	**(12)**	**(332)**	**5,397**	**0**	**(8,759)**

Meeting Name: Board **Meeting date: 1 December 2021**

Title: National Whistleblowing Standards – Quarter 2 Performance Report

Purpose and Key Issues of the Report:

DISCUSSION	X	DECISION		AWARENESS	

This is the second quarterly performance report present to the Board as required by the National Whistleblowing Standards.

The report provides information to the Board on the progress with the implementation of the Standards.

The attached performance report covers the key performance metrics on which Boards are required to report to the Scottish Public Services Ombudsman

To note that since the quarter 1 performance report two further stage two concern have been received.

To note that on average Stage 2 concerns have taken 24 working days to respond to in full against the 20 working days target.

Recommendations:

Note:

The content of the Quarter 2 Performance Report and the downward trend in number of concerns received against Quarter 1.

That from Quarter 4 onwards Performance Reports will include any data received from Primary Care Contractors.

That implementation of the Whistleblowing standards, links to the Corporate Objective – Improving Staff Experience (objective 10).

Author: Lynne Barclay **Date: 24/11/21**	**Director: Janis Buter** **Date: 24/11/21**

NHS LOTHIAN

Board
1 December 2021

**NATIONAL WHISTLEBLOWING STANDARDS –
QUARTER 2 PERFORMANCE REPORT**

1 Purpose of the Report

1.1 The purpose of this report is to present to the Board for discussion and noting the Quarter 2 Whistleblowing Performance report.

2 Recommendations

The Board is invited to:

2.1 Note the content of the attached Quarter 2 Performance Report and the downward trend in number of concerns received against Quarter 1.

2.2 Note that from Quarter 4 onwards Performance Reports will include any data received from Primary Care Contractors.

2.3 Note that implementation of the Whistleblowing standards, links to the Corporate Objective – Improving Staff Experience (objective 10).

3 Discussion of Key Issues

3.1 As required by The National Whistleblowing Standards the Board are asked to note the content of the Performance report as attached. And note that performance report has been discussed and noted by the Staff Governance Committee at its meeting on the 20 October 2021.

3.1 Since reporting to the Board in October, good progress has been made with regards to embedding the Standards within Primary Care and following discussion with the Director of Primary Care, performance figures will be collected and recorded from the 1 January 2022 and reported at Quarter 4.

3.2 In addition to the four Stage 2 concerns received during Quarter 1 a further two Stage 2 concerns were received during Quarter 2. The total number of concerns received under this measure is now six. During Quarter 2 no further Stage 1 concerns were recorded.

3.3 On average Stage 2 concerns have taken 24 working days against the 20 working days timescales stipulated under the Standards, in which to be responded to in full. However, Stage 2 concerns vary in complexity, with the most complex of the concerns received taking 63 days to conclude. In line with the Standards the Whistleblower was advised of the revised timescales and kept up to date with the progress of the investigation.

3.4 Details of all the performance measures associated with the National Whistleblowing Standards are contained within the attached Q2 Performance Report (Appendix 1).

3.5 Due to the low number of concerns received learning, changes or improvements to services are limited, and as there is a requirement in the Standards to maintain anonymity there is a real concern that those raising concerns may be identified. However, learning from concerns is being recorded and shared with relevant management teams and service areas. In general, the concerns received to date have been complex and have been overlayed by cultural issues. Following discussion at both the Shor Life Working group and the Staff Governance Committee focus will be on introducing a mechanism for appropriate system wide learning

3.6 All those who raise concerns are given the opportunity to feedback on their experience of using the Whistleblowing procedure in order that we can learn and make any improvements in our processes as appropriate. For those raising concerns at Stage 2 they are offered a follow up conversation with the Non-Executive Whistleblowing Champion, should they wish.

4 Key Risks

4.1 In respect of the implementation of the standards, there is a risk that if the new standards are not widely promoted across the organisation then staff will be unaware of how to raise a concern and consequently the organisation may lose the opportunity for improvement and learning. In order to mitigate this risk, there is ongoing communications and training.

5 Risk Register

5.1 There is no requirement for anything to be added to the Risk Register at this stage.

6 Impact on Inequality, Including Health Inequalities

6.1 At this stage there are no implications for health inequalities or general equality and diversity issues arising from this paper.

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

7.1 There is no requirement for engagement and consultation in relation to this paper.

8 Resource Implications

8.1 There are no specific resource implications associated with this paper.

Lynne Barclay
Whistleblowing Programme and Liaison Manager
11 November 2021
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Appendix 1: Quarter 2 Whistleblowing Performance Report

Whistleblowing Performance Report

Quarter 1 & 2 April to 30 September 2021

Lynne Barclay
Whistleblowing Programme and Liaison Manager

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Whistleblowing Concerns - Quarter 1 & 2 (April – September) 2021-22

Context

The new role of Independent National Whistleblowing Officer (INWO), which is to be undertaken by the Scottish Public Services Ombudsman came into effect on the 1 April 2021. This provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing concern. On the same date the National Whistleblowing Standards were formally published and the "Once for Scotland" Whistleblowing Policy went live.

The National Whistleblowing Standards set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in these services, whether they are directly employed by the NHS or a contracted organisation.

The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow. Health Boards have particular responsibilities regarding the implementation of the Standards:

- ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
- ensuring there are systems in place for primary care providers in their area to report performance data on handling concerns.
- working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

The Whistleblowing principles for the NHS as defined by the Standards is
'An effective procedure for raising concerns whistleblowing that is, open, focused on improvement, objective, impartial and fair, accessible, supportive to people who raise a concern and all people involved in the procedure, simple and timely, thorough, proportionate and consistent.'

A staged process has been developed by the Independent National Whistleblowing Officer (INWO). There are two stages of the process which are for NHS Lothian to deliver, and the INWO can act as a final, independent review stage, if required.

- Stage 1: Early resolution – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.
- Stage 2: Investigation – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

The standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements.

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns
- The experience of all those involved in the whistleblowing procedure
- Staff perceptions, awareness, and training

As reported at quarter 1 the learning, changes or improvements to services are limited by the low number of concerns which have been raised and as the requirements of the Standards are to maintain anonymity there is a real concern that those raising concerns may be identified however learning from concerns is being recorded and shared with relevant management teams and service areas. However, in general the concerns received to date have been complex and have been overlayed by cultural issues.

All those who raise concerns are given the opportunity to feedback on their experience of using the Whistleblowing procedure in order that we can learn and make any improvements in our processes as appropriate. For those raising concerns at Stage 2 they are offered a follow up conversation with the Non-Executive Whistleblowing Champion, should they wish.

It is difficult to quantify staff perceptions, however prior to implementation of the standards, lunch and learn sessions were established and attendance at these was good. Managers and staff guides have been produced and have been widely publicised. Softer skills and investigation training for those who may be involved in taking or investigating whistleblowing concerns have been or are being set up. We will continue to monitor uptake, effectiveness and appropriateness of training and will review and refine as required. Communications continue to promote raising concerns in NHS Lothian and how this can be done.

Quarter 1 & 2 Performance Information April 2021 – September 2021

Under the terms of the standards the quarterly performance report must contain information on:

- Total number of concerns received
- Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed
- Concerns upheld, partially upheld and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage
- The average time in working days for a full response to concerns at each stage of the whistleblowing procedure
- The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days
- The number of concerns at stage 1 where an extension was authorises as a percentage of all concerns at stage 1
- The number of concerns at stage 2 where an extension was authorises as a percentage of all concerns at stage 2

For reporting purposes, except for Charts 1 and 2, the figures and percentages are for the cumulative period (April to September 2021).

Total number of concerns, and concerns by Stage

Chart 1 details the overall number of concerns received each quarter since implementation in April 2021, with Chart 2 showing the breakdown between Stage 1 and Stage 2 concerns received over the same period.

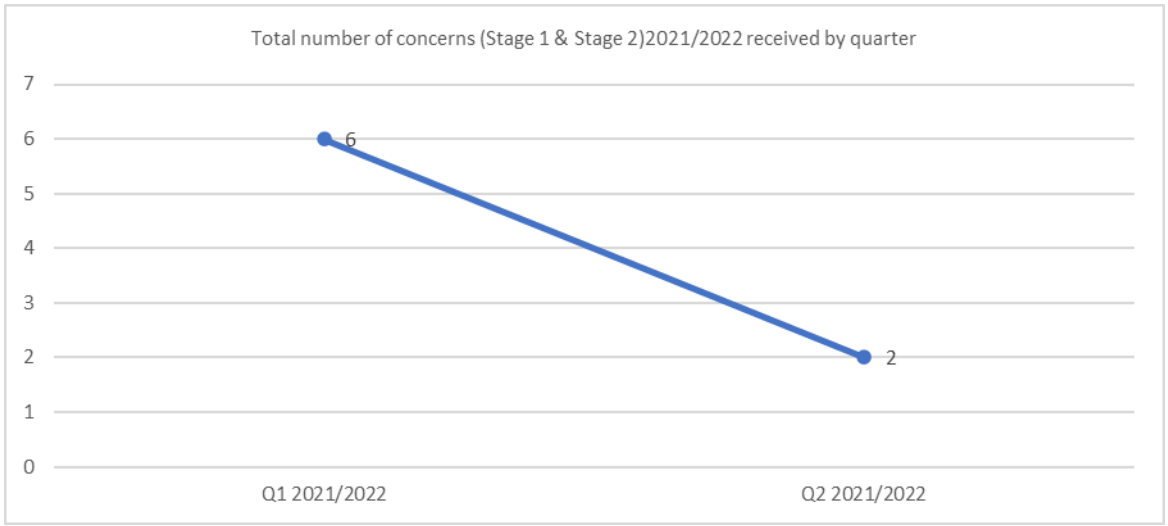

Chart 1

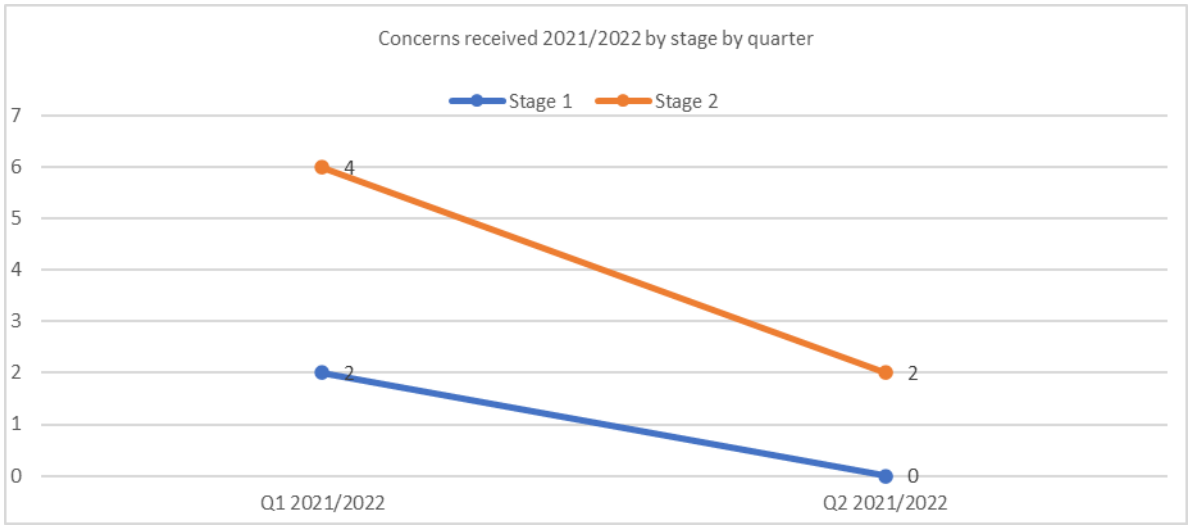

Chart 2

Concerns closed at Stage 1 and Stage 2 as a percentage of all concerns closed

Chart 3 below, identifies the number of concerns closed at each stage as a percentage of all concerns closed, the data reflects the cumulative position as at quarter 2. The orange line shows those stage 2 concerns which were closed as a percentage of all concerns. The blue line shows those stage 1 concerns that were closed as a percentage of all concerns received from 1 April 2021. As outlined in Chart 2 above there were no Stage 1 concerns received during quarter 2.

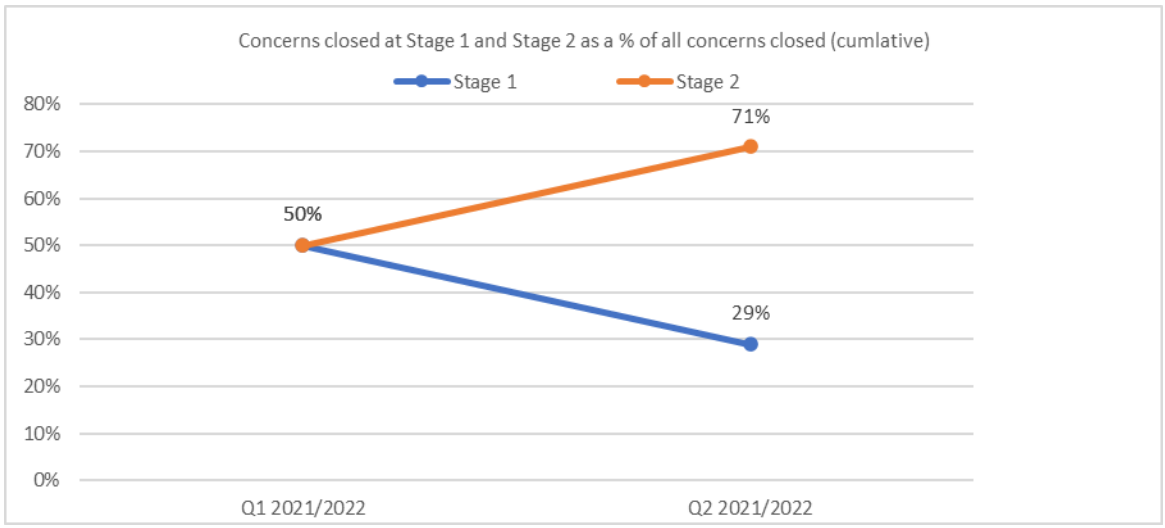

Chart 3

Concerns upheld, partially upheld and not upheld as a percentage of all concerns closed in full at each stage

As previously referenced, the definition of a Stage 1 concern - Early resolution is for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action, within 5 working days.

Chart 4 below details the outcome of the two Stage 1 concerns which have been received during quarter 1. As previously noted, there were no Stage 1 concerns received in quarter 2.

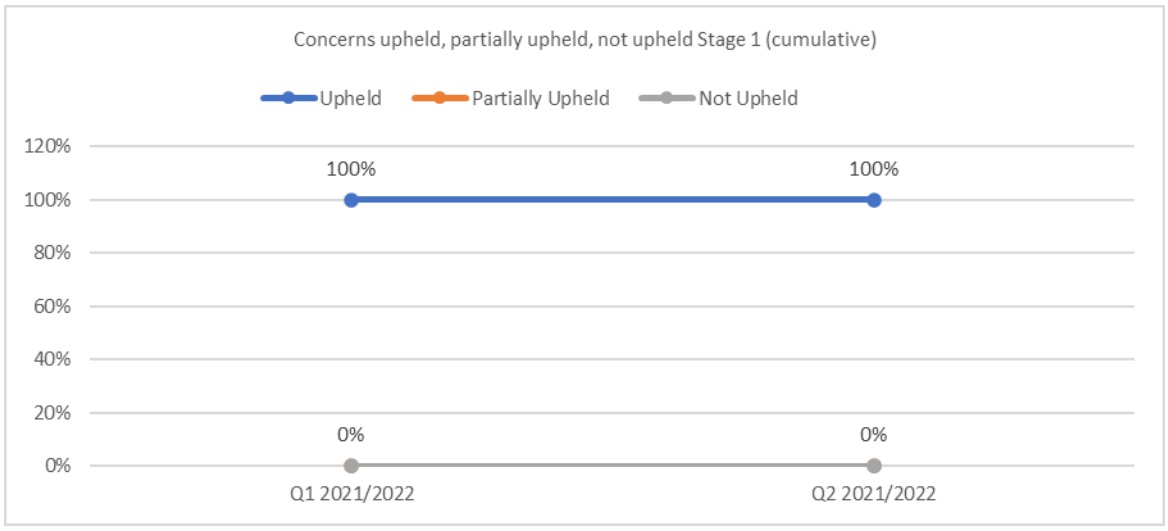

Chart 4

The definition of a stage 2 concern – are concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response within 20 working days. Chart 5 below details the outcome of the five Stage 2 concerns which have been closed at the end of quarter 2. One Stage 2 concern received during this quarter is still subject to an ongoing investigation.

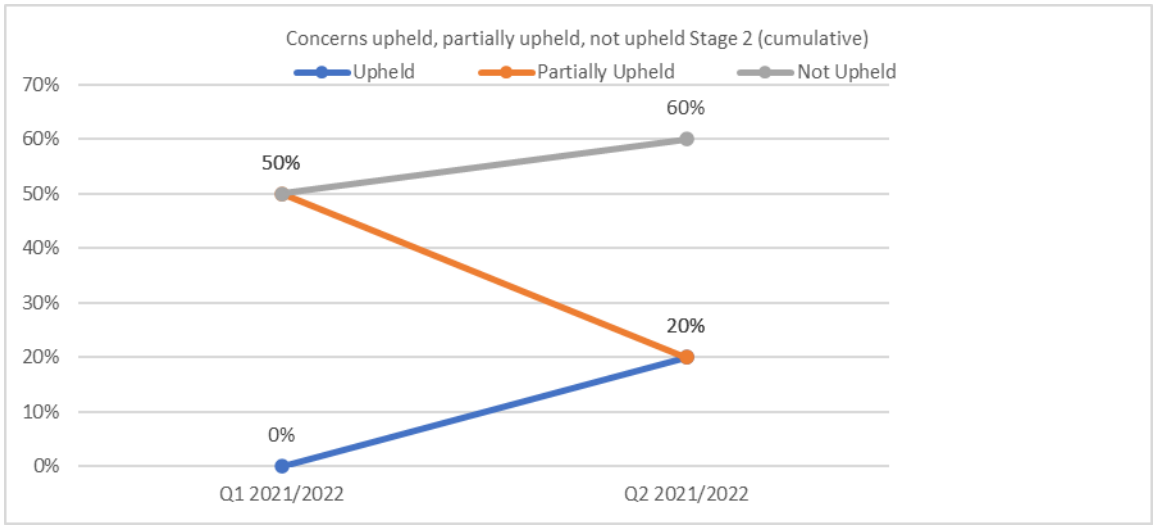

Chart 5

The average time in working days for a full response

Chart 6 below details the average number of working days to response to Stage 1 and Stage 2 concerns.

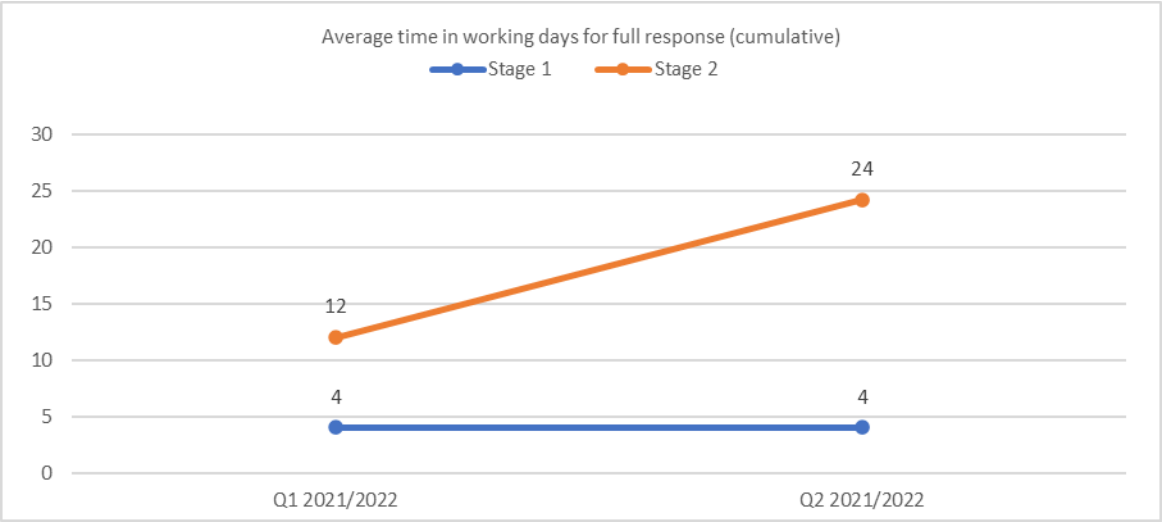

Chart 6

Number and percentage of concerns closed in full within set timescales

Charts 7 and 8 below detail the number and percentage of complaints that have been closed in full for Stage 1, and Stage 2.

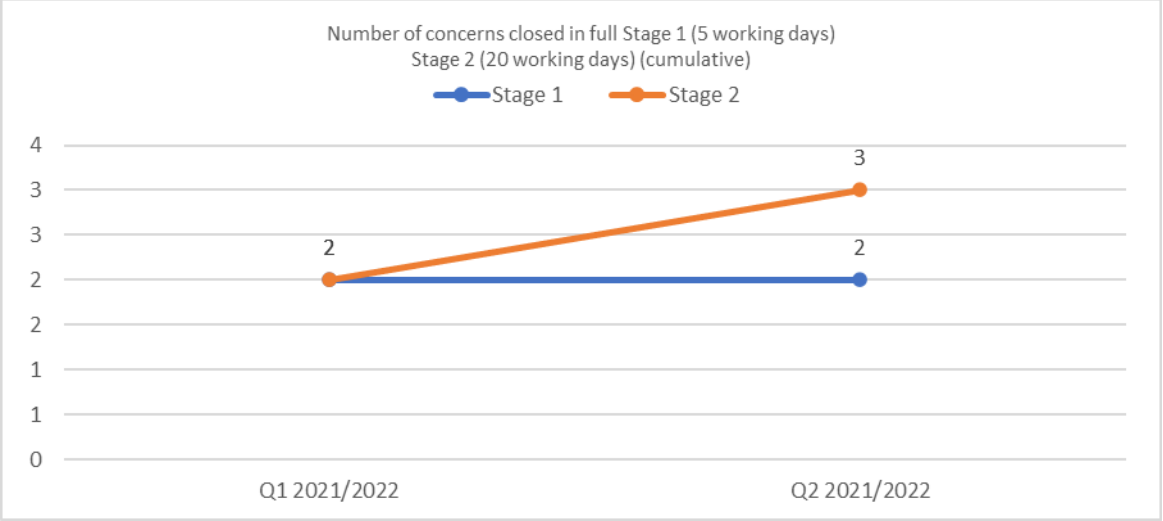

Chart 7

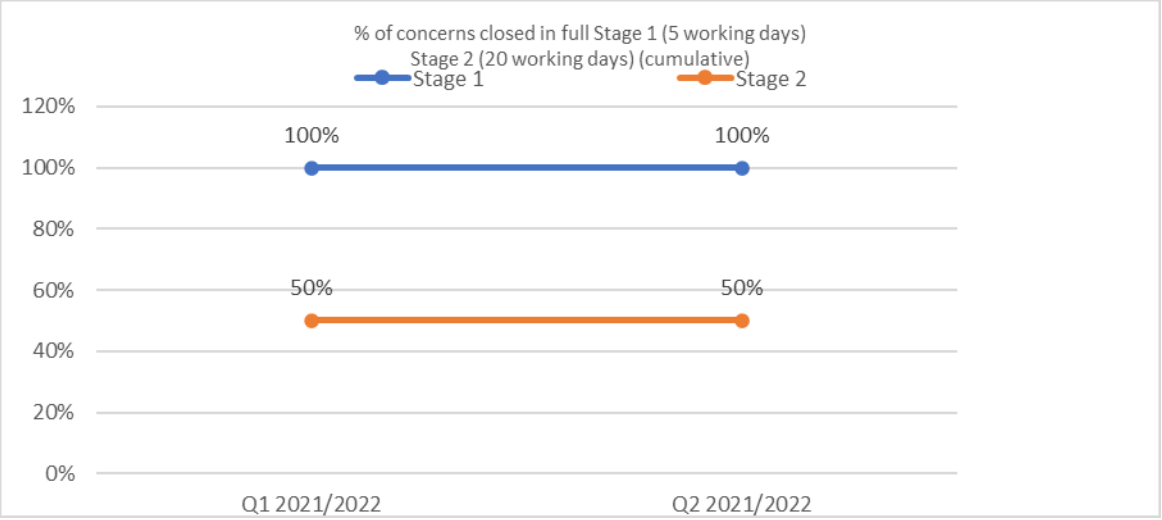

Chart 8

Concerns where an extension was authorised

Under the terms of the standards, for both Stage 1 and Stage 2 concerns there is the ability, in some instances, for example staff absence or difficulty in arranging meetings, to extend the timeframe in which a response is provided. The person raising the concern must be advised that additional time is required, when they can expect a response, and for Stage 2 concerns must provide an update on the progress of any investigation every 20 days, details are shown in Chart 9 below. To date no Stage 1 concerns have required an extension, however three of the six Stage 2 concerns received since April 2021 have had timescales extended.

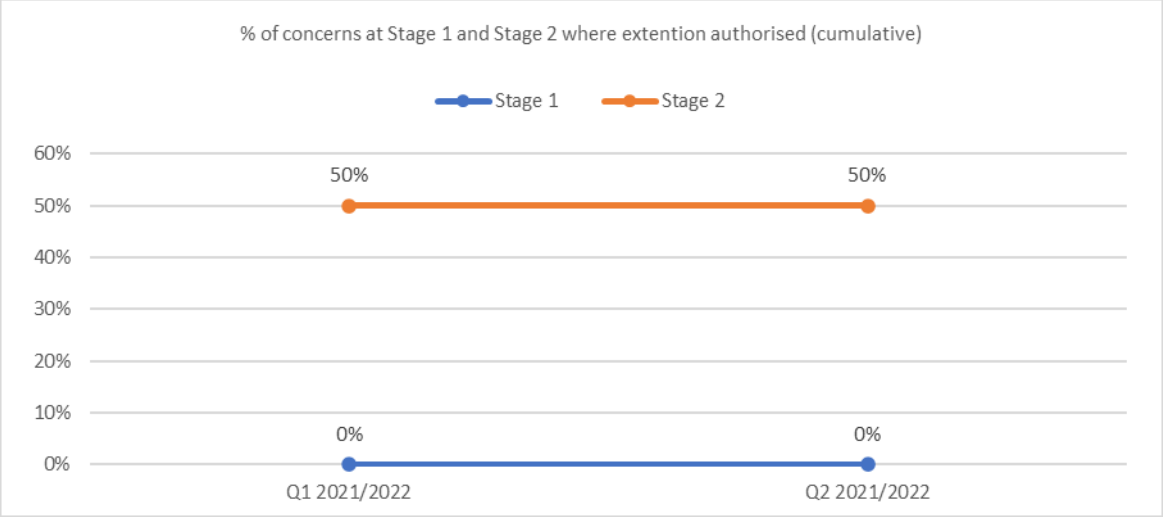

Chart 9

Anonymous Concerns

Concerns cannot be raised anonymously under the Standards, nor can they be considered by the INWO. However good practice is to follow the whistleblowing principals and investigate the concern in line with the Standards, as far as practicable. NHS Lothian has decided that anonymous concerns should be recorded for management information purposes. The definition of an anonymous concern is 'a concern which has been shared with the organisation in such a way that **nobody** knows who provided the information'.

We have to date received three anonymous concerns, two in quarter 1 and one in quarter 2.

Key Themes

Analysis of the concerns raised by key themes is provided below, with a comparison across the two quarters.

Theme*	Q1	Theme*	Q2
Poor Practice	5	Poor Practice	1
Patient Care /Patient Safety	2	Patient Care/Patient Safety	3
Unsafe working conditions	2	Unsafe working conditions	1
Breaking legal obligations	1	Abusing authority	1

*more than one theme may be applicable to a single Whistleblowing Concern

Concerns raised by Division

Division	Number
Edinburgh Health and Social Care Partnership	*
Acute Hospitals	*
Corporate Services	*
REAS	*

*to maintain anonymity actual case numbers have not been included.

Meeting Name: Board Meeting date: 1 December 2021

Title: NHS LOTHIAN CORPORATE RISK REGISTER

Purpose of the Report:

DISCUSSION		DECISION	✓	AWARENESS	

The reports sets out recommendations with respect to specific risks and new risk processes that require decisions by the Board.

Recommendations:

1.1 Review the updates provided by the executive leads on risk mitigation set out in the Assurance table in Appendix 1.

1.2 Note the outcome of the Executives/Committee Chairs Risk Assurance Session held in September 2021, as set out in Appendix 2.

1.3 Accept a standardised level of assurance for risk mitigation plans developed in response to actions agreed at the Executives/Committee Chairs session – see Appendix 3.

1.4 Accept a standardised Board committee paper to be used when submitting Board Committee papers related to specific risks on the CRR – see Appendix 4.

1.5 Approve the Corporate Management Team (CMT) recommendation to increase the grading of the timely discharge of inpatients risk to Very High due to significant pressure in the system.

1.6 Approve the CMT recommendation to remove the EU/Brexit risk from the CRR, as the potential risks have not materialised and will be kept under review nationally and locally.

Author: Jo Bennett **Date: 09/11/21**	**Director: Tracey Gillies** **Date: 09/11/21**

NHS LOTHIAN

Board
1 December 2021

Medical Director

CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to review NHS Lothian's Corporate Risk Register (CRR) and associated processes to ensure it remains fit for purpose.

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

2 Recommendations

The Board is recommended to:

2.1 Review the updates provided by the executive leads on risk mitigation set out in the Assurance table in Appendix 1.

2.2 Note the outcome of the Executives/Committee Chairs Risk Assurance Session held in September 2021, as set out in Appendix 2.

2.3 Accept a standardised level of assurance for risk mitigation plans developed in response to actions agreed at the Executives/Committee Chairs session – see Appendix 3.

2.4 Accept a standardised Board committee paper to be used when submitting Board Committee papers related to specific risks on the CRR – see Appendix 4.

2.5 Approve the Corporate Management Team (CMT) recommendation to increase the grading of the timely discharge of inpatients risk to Very High due to significant pressure in the system.

2.6 Approve the CMT recommendation to remove the EU/Brexit risk from the CRR, as the potential risks have not materialised and will be kept under review nationally and locally.

3 Discussion of Key Issues

3.1 Role of the Corporate Management Team

3.1.1 It was agreed at the February 2021 CMT that the CRR would be managed through the CMT and subject to review every two months, with the risk manager in attendance to ensure proactive management, including timely feedback from assurance committees and alignment of assurance levels and risk grading. A process has been established to meet executive leads prior to each CMT to inform the CMT risk paper. The October 2021 Executive Leads updates are summarised in the Assurance Table in Appendix 1.

3.1.2 The CMT then make recommendations to the Board with respect to new and/or amended risks, with a clear articulation of the risk that cannot be managed at an operational level, explicit plans to mitigate the risk along with associated measures to assess the impact of these plans. This collective oversight strengthens the NHSL risk management system including our assurance system.

3.1.3 The CMT considered in August 2021, the Very High and High Risk risks on the divisional risk registers, with an expectation that Directors will present to CMT their plans to mitigate these risks. Divisional risks that remain at a Very High and High level and that cannot be managed at a divisional level, will be considered for inclusion on the CRR.

3.2 Risk Assurance Session for Executives & Committee Chairs

3.2.1 The above session took place on 15th September 2021. The aims, objectives, and outputs of the session, are detailed in Appendix 2 and the agreed next steps are set out below:

Next steps agreed were:

- Develop a standardised risk management plan for managers to use when submitting risk papers to committees
- Develop standard assurance levels of risk management with a focus on risk mitigation plans
- Consider the work plans and agenda layout for committees to clearly identify papers relating to the CRR and other agenda items
- Consider mechanisms for engaging new and existing board/committee members around roles and responsibilities re risk management
- Develop a paper to clearly set out authors requirements re risk management assurance papers.

In response to the above, the following has been developed for testing:

- Standard assurance levels of risk management with a focus on risk mitigation plans to be used in Governance Committees
- Standard risk mitigation plan template to accompany all papers that address risks on the CRR
- Standard risk Board Governance Committee Paper for use by Executives when submitting papers to Governance committees and to be used in conjunction with the standard risk mitigation plan template.

4 Key Risks

4.1 The risk register process fails to identify, control, or escalate risks that could have a significant impact on NHS Lothian.

5 Risk Register

5.1 Will positively impact on the CRR and associated risk system

6 Impact on Inequality, Including Health Inequalities

6.1 Not applicable.

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

7.1 This paper does not consider developing, planning, designing services and/or policies and strategies.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

Jo Bennett
Associate Director for Quality Improvement & Safety
8 November 2021
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: CRR Risks Assurance Table
Appendix 2: Outcome of the Executives/Committee Chairs Risk Assurance Session
Appendix 3: Standard levels of assurance for risk mitigation plans
Appendix 4: Standardised Board Committee Paper

Risk Assurance Table – All risks revised in June 2021 and approved at June 2021 Board

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td rowspan="2">4984</td><td rowspan="2">Covid-19

There is a significant risk to the health of the population from the current Covid-19 outbreak and that NHS Lothian will not have sufficient capacity to respond because of the number of people requiring care, including critical care, reduced numbers of staff available to deliver care due to illness or isolation, timely availability of supplies leading to reduced quality and safety of patient care as well as physical and psychological pressure on staff. There will also be a significant impact on routine activity including waiting lists as resources are diverted to managing the impact of Covid-19.

New risk added June 2020.

Executive Lead: Jim Crombie</td><td colspan="2">Healthcare Governance & Risk Committee (HCG)

July 2020 - HCG accepted limited assurance on this risk overall. A standing item on the HCG Agenda.

Paper on Vaccines went to the June 2021 Board</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>
• Gold command re-convened due to significant rise in cases, impacting on availability of staff to deliver services due to infection and self-isolation. Remobilisation for plans in development.
• Remobilisation 3 plans in place. Remobilisation 4 plans due to be submitted to Scottish government September 2021
• Vaccine programme on course in line with government targets. No issues with delayed discharges in HSCPs except for Edinburgh.
• Continuous monitoring through ELT/CMT highlighting ongoing capacity issues re the acute and EHSCP

<u>October Update</u>
• Remobilisation for plan has been submitted to the Scottish Government and waiting response. Thereafter to be approved by the Board
• Continuous monitoring through ELT/CMT highlighting ongoing capacity issues in acute/social care (HSCP). Gold and Silver command re-established.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021
Very High 20</td><td>CMT/Board June 2021
Very High 20</td></tr>
<tr><td>3600</td><td>Finance

There is a risk that the Board is unable to respond to the service requirements arising from the population growth in all age groups across NHS Lothian. This is as a result of a combination of the level of resource available and uncertainty around future resource leading to inability to plan for, and deliver the additional capacity required.</td><td colspan="2">Finance & Resources Committee

November 2020 – F&R continued to accept limited assurance on the management of this risk.

March 2021- significant assurance accepted on the NHS Lothian ability to deliver a breakeven position in 2020/21 on the basis of the financial position as at 31 January 2021.

Limited assurance on delivering a balanced financial position in 21/22 based on NHS Lothian 5-year Financial Outlook and Outline Plan 21/22</td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	Executive Lead: Susan Goldsmith	Risk to be discussed at August 2021 F&R.	

		Outcome of Executive Lead Discussions
		• **This is a newly approved risk and plans to mitigate the risk are numerous and come from a range of sources such as programme boards (scheduled and unscheduled care) and specific workforce plans examples are:**
		  ○ **Elective Centre discussions**
		  ○ **Access support from the Independent sector**
		  ○ **COVID exit plan**
		  ○ **Efficiency programme**
		  ○ **Seeking SG recurrent funding to support CAMHS and PT recovery to improve access.**
		  ○ **There is a 5year financial plan in place, currently bringing a range of plans around improving capacity together to inform the 5-year plan, plus national regional and local discussions.**
		• **Efficiency programme has been reviewed and approved by the CMT to contribute to the management of this risk acknowledging underlying capacity shortfalls are significant and long standing.**
		• **Discussions around population health interventions, associated resources and impact require further consideration, as does how we measure the impact of additional funding allocations aimed at increasing capacity and improving access.**
		October Update
		• **Risk went to the August 2021 F&R and was discussed but not approved. The risk description to go back to the November 2021 F&R session for further discussion. The recovery plan version 4 is being used to bring together a capacity and resources plan (Nov/Dec 2021) this will form the basis of the risk mitigation plan acknowledging it only covers this year and next. A longer plan term capacity plan is required to inform the 5-year plan.**	

	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		Very High 20	Very High 20

Datix ID	Risk Title & Description	Committee Assurance Review Date	
5186	**4 Hours Emergency Access Target** There is a risk that NHS Lothian will fail to deliver safe and timely unscheduled care to patients presenting to EDs due to the volume and complexity of patients, challenges in managing flow through the department, especially when maintaining red and amber Covid streams, and availability of beds, leading to a delay in first assessment, diagnosis and subsequent treatment for patients and therefore increased likelihood of patient harm and poor experience of care. New risk created from previous risks 3203 & 4688. Approved by June 2021 Board. Executive Lead: Jim Crombie	<u>Healthcare Governance Committee</u> Newly revised risk November 2020 - HCG accepted moderate assurance on the Winter plan which includes 4 hour performance in RIE ED. Unscheduled Care Winter Plan, May 2021 HCG accepted Significant Assurance with respect to the 4-Hr Emergency Access Target to March 2021. June 2021 Board agreed downgrade of risk from Very High to High Considered at each Board through the Performance Report, no specific levels of assurance proposed or agreed. **<u>Outcome of Executive Lead Discussions</u>** • **Unscheduled care programme Board meeting regularly as are subgroups which are in place for each element.** • **Plans still in development. Implementation of Redesign of Urgent Care phase 1 is underway and phase 2 is in development. The newly appointed Director will take the development of the plans forward** • **RIE ED escalated for enhanced monitoring by the performance oversight Board and Gold command** **<u>October Update</u>** • **Improvement actions are to be agreed and submitted with performance indicators. This will come back to the Performance Oversight Group in November 2021 to discuss and potentially agree plan.** • **Considered at each Board meeting as part of the wider Performance report. No specific levels of assurance proposed or agreed.** • **RIE ED remains on escalation.**	
	Risk Grading:	**Jan-Mar 2021** Very High 20	**CMT/Board June 2021** High 16
3726	**Timely Discharge of Inpatients** There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care. Executive Lead: Jim Crombie	<u>Healthcare Governance Committee</u> September 2020 – delayed discharge was discussed as part of HSCP annual reports, with moderate assurance accepted. November 2020 - HCG accepted moderate assurance on the Winter plan, which includes timely discharge. Unscheduled Care Winter Plan, May 2021 HCG accepted Significant Assurance with respect to the Delayed Discharges to March 2021. June 2021 Board agreed to downgrade risk from Very High to High.	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		<u>Outcome of Executive Lead Discussions</u> • **Funding provided by HIS to accelerate provision of 'Hospital at Home'.** • **Unscheduled care programme plan still in process of being collated new Director of unscheduled Care appointed and will take forward.** • **Performance continues to be encouraging for all HSCPs, except for Edinburgh.** • **Considered at each Board meeting as part of wider performance report. No specific levels of assurance proposed or agreed.** • **Social Care capacity in Edinburgh now escalated for enhanced monitoring by the performance oversight Board and Gold Command** • **Under review** **<u>October Update</u>** • **Risk definition has been reframed and with Executive Lead for approval** • **Controls and grading to be reviewed following the reframing of the risk by the Chair of the Unscheduled Care Board, Director of Primary Care and Director of Acute Services (COO).** • **To recommend to the Dec 2021 Board to increase grading to very high due to significant system pressures.**	
	Risk Grading:	**Jan-Mar 2021** Very high 20	**CMT/Board June 2021** High 15
3829	**Sustainability of Model of General Practice** There is a risk that the Board will be unable to meets its duty to provide access to primary medical services in and out of hours for its population due to increasing population with multiple needs combined with difficulties in recruiting and retaining general practitioners, other staff and premises issues (e.g., leases or constraints on space), which will impact on patient care and experience and have a negative impact on other parts of the health and social care system. Executive Lead: Tracey Gillies	<u>Healthcare Governance Committee</u> July 2020 – HCG continued to accept limited assurance. Acknowledged that risk needs to be re-evaluated. Deferred from January 2021 agenda. Update paper went to HCG May 2021. No assurance level of assurance proposed or agreed as paper setting out the current position.	
		<u>Outcome of Executive Lead Discussions</u> **Risk revised to be approved at October 2021 Board.** **New Director in place and plans being drawn up to mitigate this risk for consideration by the August/September CMT** **<u>October Update</u>** • **Workshops have taken place with HSCPs and GP Sub colleagues during September 2021 and a plan informed by these workshops will be submitted to the CMT on 9th November 2021.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		Very High 20	Very High 20
5185	**Access to Treatment** There is a significant risk that NHS Lothian will not achieve waiting time standards for 2021/22 and that waits further increase for inpatient, day case procedures, Out-patients, diagnostic and cancer patients which has been compounded by COVID 19 cancellations with demand exceeding capacity. This will lead to delay in diagnosis and potential progression of disease and hence poorer experience and outcomes for patients. New risk created from previous risks 3211 & 4191. Approved by June 2021 Board. Executive Lead: Jim Crombie	Healthcare Governance Committee October 2020 - Board accepted limited assurance that Remobilisation plans will mitigate growing volumes of long wait patients for scheduled care/ cancer services, against rising Covid infections & Winter. November 2020 – HCG accepted moderate assurance on the Clinical prioritisation plan. December 2020 – the Board accepted limited assurance that Remobilisation will mitigate growing volumes of long wait patients for scheduled care/ cancer services, against rising Covid infections & Winter. January 2021 – HCG discussed recommendation of moderate assurance in relation to CAMHs, however deferred decision on assurance level with request to bring back further detail in 6 months. March 2021 – HCG accepted moderate assurance that lung cancer patients are being managed appropriately, despite challenges of Covid-19.	
		Outcome of Executive Lead Discussions • **Remobilisation 4 plans due to be submitted to Scottish government September 2021.** • **Remobilisation 3 plans in place.** • **Each of the 4 Recovery Boards have plans in place, which include at specialty level.** • **Monitored by the Performance Oversight Board, too early to see any measurable impact as yet and acknowledge there are longstanding capacity issues.** **October Update** • **Remobilisation 4 plans submitted, awaiting Scottish Government response. Thereafter, final draft will be taken to full Board for agreement.** • **Pressure continues across Acute services with significant disruption to scheduled care. Continued scrutiny with dynamic response required. Major incident response capability compromised.**	
	Risk Grading:	**Jan-Mar 2021** Very High 20	**CMT/Board June 2021** Very High 20
4693	**Brexit/EU exit** There is a risk that patient experience and outcome care may be compromised due to uncertainty relating to EU Exit. Executive Lead: Jim Crombie	Healthcare Governance Committee Agreement to keep under review pending discussions on trade agreements. October 2020 – Board agreed to reinstatement of this risk. January 2021 - HCG accepted limited assurance – **to be re-assessed July 2021.**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		April 2021 Board agreed to downgrade risk from Very High to Medium. July 2021 HCG – verbal update. Focus on Medicines Management, no significant issues being experienced at present.	
		<u>Outcome of Executive Lead Discussions</u> • **NHSL SEUMG was temporarily stood down as agreed by SMT Gold in March 2021 and will be reconvened if required.** • **Position reviewed by the Resilience Committee who agreed there are no specific issues relating to EU exit at present therefore specific plans not in place or required. General business continuity and emergency planning actions are captured as part of general resilience plans.** • **The position will be reviewed in September 2021 in light of the national position.** **<u>October Update</u>** • **Continue to have no specific issues relating to EU exit. Recommend to the CMT that this risk be removed and reinstated at a later date if required.** • **NHS Lothian has robust links with national groups through Pharmacy and Procurement which would give early warning of emerging risks.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		Very High 20	Medium 9
5187	**Access to Psychological Therapies** There is a risk that patients will wait longer than the national waiting times standards for Psychological Therapies which has been exacerbated by Covid 19 cancellations, impacting on patients/family experience and outcomes of care. <u>New risk approved by June 2021 Board.</u> Executive Lead: Alex McMahon	<u>Healthcare Governance Committee</u> New risk pertinent to HCG. Approved at June 2021 Board. Considered at each Board through the Performance Report, no specific levels of assurance proposed or agreed	
		<u>Outcome of Executive Lead Discussions</u> • **The Scottish Government has requested costed improvement plans to improve access to Psychological therapies.** • **Plans are in place to manage locally. However, additional finance required.** • **Additional funds required to achieve national standards which have been submitted to Scottish Government with the aim of achieving standards by March 2023. Await Scot Gov confirmation of funds. Early signs of improvement** **<u>October Update</u>** • **Recovery plan in place and funded on non-recurrent in year monies. Plan Submitted to Scottish Government awaiting feedback re-funding.**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		N/A	Very High 20
5188	**Access to CAMHS** There is a risk that patients will wait longer than the national waiting times standards for CAMHS which has been exacerbated by Covid 19 cancellations, impacting on patients/family experience and outcomes of care. <u>New risk approved by June 2021 Board</u> Executive Lead: Alex McMahon	<u>Healthcare Governance Committee</u> New risk pertinent to HCG. Approved at June 2021 June. July 2021 HCG accepted limited assurance with respect to plans in place to improve access, acknowledging significant work is taking place to rectify the current position. Considered at each Board through the Performance Report, no specific levels of assurance proposed or agreed	
		<u>Outcome of Executive Lead Discussions</u> • **CAMHS are in a better position than Psychological Therapies as they have non-recurrent funding in place to support achievement of the national standards.** • **Utilising non-recurrent funding and a range of actions to improve compliance with national standards.** • **Plans in place to mitigate the risk with a view to seeing improvement in performance from October 2021** **October Update** • **Recovery plan in place and funded on non-recurrent in year monies, with early signs of improvement being shown. Plan submitted to Scottish Government. Awaiting feedback re-funding.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		N/A	Very High 20
3828	**Nursing Workforce** There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and/or inability to recruit to specific posts. The subsequent high use of supplementary staffing to counteract shortfalls potentially leading to compromise of safe patient care impacting on length of stay and patient experience. Executive Lead: Alex McMahon	<u>Staff Governance Committee</u> July 2020 - increase in grading from 6 to 12 Significant assurance that there is a robust mobilisation plan and mechanism to co-ordinate the responses across the nursing and midwifery workforce. Limited assurance that there is sufficient capacity in the event the pandemic requires that the Board delivers a full surge plan in acute and community, including supporting the NHS Louisa Jordan October 2020 – verbal update provided no new level of assurance agreed.	

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="3">Committee Assurance Review Date</th></tr>
<tr><td></td><td></td><td colspan="3">December 2020 – increase in grading to very high agreed. Significant assurances accepted that robust corporate oversight to co-ordinate and prioritise responses across workforce. Limited assurance regarding capacity to respond to increased demand due to Covid activity and increase in staff absence due to Covid isolation.

May 2021 – Staff Governance accepted grading reduced from Very High to High.
• Paper went to Private Board August 2021 and agreed to increase grading from High to Very High. Follow up paper to go to September 2021 Board</td></tr>
<tr><td></td><td></td><td colspan="3"><u>Outcome of Executive Lead Discussions</u>
• Key issue with respect to this risk is the current impact on staffing as a result of staff required to isolate due to test and trace mechanisms.
• Plans are in place and reported through the management and governance structure.
• All the controls that are within the gift of the system are working well, however, the pandemic and staffing issues related to isolation continue are a significant risk and as such the grading will require constant review.

<u>October Update</u>
• Risk increased to high from moderate due to increasing pressures for a range of reasons
• Progressing international recruitment
• 493 of 582 additional staff in place
• Increased reporting of staffing pressures and managerial oversight and response including escalation and use of safety/quality information
• Change adequacy of control to Inadequate due in part to external factors.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021</td><td>CMT/Board June 2021</td><td>CMT/Board Aug 2021</td></tr>
<tr><td></td><td></td><td>Very High 20</td><td>High 16</td><td>Very High 20</td></tr>
<tr><td>5034</td><td>Care Homes

There is an ongoing risk to the health and well-being of care home residents and staff from Covid-19 outbreaks. This is as a result of the potential for community transmission to a vulnerable population and the enhanced requirements for infection prevention and control within non-clinical environments.

Health Boards have been given additional responsibilities for multi professional oversight in organisations that they have no formal jurisdiction</td><td colspan="3"><u>Healthcare Governance Committee</u>

September 2020 – moderate assurance accepted on oversight of quality in care homes by HSCPs as part of HSCP annual reports.
January 2021 – moderate assurance accepted that governance infrastructure in place to deliver the enhanced professional oversight.
Limited assurance in respect of the 4 aspects of care for which Exec nurse director given accountable.

June 2021 – went to HCG. Accepted moderate assurance for professional oversight and for the four aspects of care which the executive Nurse Director is accountable.</td></tr>
</table>

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="3">Committee Assurance Review Date</th></tr>
<tr><td></td><td>over. This presents potential reputational, political and legal risk to NHS Lothian.

New risk –approved by Board, 12 August 2020.

Executive Lead: Alex McMahon</td><td colspan="3"><u>Outcome of Executive Lead Discussions</u>
• Widening the support for care homes, particularly around falls and delirium.
• Clear oversight of quality within care homes. Infrastructure to support reliable quality of care in place. Clear visibility of issues around infection prevention and control demonstrated by flexible, timely response to limited Covid outbreaks.

<u>October Update</u>
• Recommendation to the October Board Approved to reduce the risk and rationale
• Reviewing the risk considering the implementation of Scottish Government, Terms of Reference- Clinical and Professional Oversight Group for Care Homes and Community Health.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021</td><td>CMT/Board June 2021</td><td>Board October 2021</td></tr>
<tr><td></td><td></td><td>High 12</td><td>High 12</td><td>Medium 9</td></tr>
<tr><td rowspan="2">5020</td><td rowspan="2">Water Safety and Quality

There is a risk that Legionella may be present in water supplies to healthcare premises due to reduced or no usage of water in some areas during Covid pandemic, seasonal increase in water temperature and incomplete implementation of existing plans to improve systems of control around water safety and provide assurance through documented evidence.
This may lead to harm to patients, staff and the general public, potential prosecution under H&S law. In addition, the ability to remobilise services following Covid-19 will be affected where we are not able to demonstrate safety of water systems.

New risk –approved by Board 12 August 2020.

Executive Lead: Tracey Gillies</td><td colspan="3"><u>Staff Governance Committee</u>

October 2020 – limited assurance accepted.

Limited assurance was agreed by the NHS Lothian H&S committee in May 2021.
A paper will be presented to the next Staff Governance Committee as the principle committee for assurance of this risk.</td></tr>
<tr><td colspan="3"><u>Outcome of Executive Lead Discussions</u>

• Main issue has been for community premises where water use has been reduced due to suspension of services through the pandemic.
• Water safety plans have been written for the majority of NHS Lothian community premises and are in the process of being written for all acute sites. Written schemes of control and Legionella risk assessments are in place for all sites with a reporting structure agreed.
• Local sub-groups have been established for all acute sites. REAS & HSCPs are not yet in place.
• It is anticipated that Water safety plans for all NHS Lothian and Third-Party providers with easy access to documentation and reports to be completed within the next 12 months
• Plans for all premises are not yet in place.

<u>October Update</u></td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		• **Medical Director has emailed duty holders in HSCPs advising of their obligations and need to assist Facilities in managing good water turnover in line with guidance. A mechanism to monitor this is being developed but is yet to be tested.** • **Progress in completion of Water Safety Action Plans continue to be monitored by the Water Safety Group.** • **Water quality remains in limits and is not showing substantial change from previous results.** • **Paper to be presented to Staff Governance Committee in October 2021.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		High 12	High 12
3454	**Timeliness and Learning from Complaints** There is a risk that the complaints management process does not meet national performance standards and cannot evidence actions from learning. Executive Lead: Alex McMahon	<u>Healthcare Governance Committee</u> November 2020 – Moderate assurance accepted. March 2021 – limited assurance accepted on the effectiveness of processes to collect feedback on complaints handling and performance in respect of stage 1 and 2 complaints. HCG May 2021 accepted Moderate Assurance re complaints management.	
		<u>Outcome of Executive Lead Discussions</u> • **Alignment of complaints officers to operational units is now in place to support performance improvement. Proposal going to CMT to close complaints which are part of a SAE process.** • **Additional controls have been put in place to enhance management oversight and accountability of complaints management at HSCP and Acute level, which is supported by weekly, monthly and quarterly reporting/data across the system, including CMT.** • **An initial improvement plan has been developed which went to HCG in May 2021 and a more robust plan will go to the August 2021 HCG for consideration.** • **Complaint's objectives being set for Acute and HSCPs and monitored through CMT.** • **Significant improvements in 20day target which will inform the grading when sustained.** **<u>October Update</u>** • **Recommendation to October Board to reduce grading and rationale** • **Improvements in performance sustained due to enhance management oversight** • **Improvement plan approved by August HCG, agreed to identify actions on the plan that attend to the risk and monitor via the programme board.** • **Process to close complaints related to an SAE approved by the CMT**	

Datix ID	Risk Title & Description	Committee Assurance Review Date		
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**	**Board October 2021**
		High 16	High 16	Medium 9
3189	**Facilities Fit for Purpose** There is a risk that NHS Lothian is unable to deliver an efficient healthcare service because of unsuitable accommodation and clinical environments leading to potential delays in patient care and threatening patient and staff safety. Executive Lead: Jim Crombie	Finance & Resources Committee June 2020 - Moderate assurance agreed, reduction in grading from High 16 to high 12 (impact changed from high to moderate) January 2021 – moderate assurance accepted further review July 2021. **Outcome of Executive Lead Discussions** • **Comprehensive, systematic plan in development informed by current survey of whole estate.** **October update** • **Further plans due in January 2022 based on full survey relating to backlog maintenance.** • **Capital investment plan also in place.** • **Paper to be presented to F&R in November 2021.** • **Risk to be reviewed in January 2022 when work to review the estate has been completed.**		
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**	
		High 12	High 12	
5189	**RIE Facilities** There is a risk that facilities in the RIE are not fit for purpose because of a failure to carry out required Life cycle Works and maintenance of the estate including: • Infrastructure (lifts, electrical systems, heating, ventilation, water, medical gases) • Water quality and management of water systems (flushing, temperature control, periodic testing) • Window safety and maintenance • Wire Safety	Finance & Resources Committee New risk approved by Board June 2021. **Outcome of Executive Lead Discussions** • **There has been an issue in gaining traction with contractors and dispute resolution process has been undertaken which has now re-set relationships with Consort.** • **Plans in place overseen by RIE estates and facilities improvement group, continuous development informed by results of site wide surveys.** • **A risk workshop is being undertaken with the technical team to look at patient safety, infection control and facilities to inform priorities and where escalation is required.**		

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td></td><td>Leading to interruption to services, potential harm to patients and staff and significant remedial costs.

<u>New risk approved by June 2021 Board</u>

Executive Lead: Jim Crombie</td><td colspan="2">• Some progress is now being made with lifecycles works. Plans not yet fully developed therefore too early to judge effectiveness, currently assessing the risk to inform the development of plans.

<u>October Update</u>
• There is a delay in Consort providing a lifecycle programme of work to NHS Lothian, now expected for November 21
• This has tiggered formal correspondence from the Board to Consort on several issues.
• Paper to be considered at F&R, once proposed programme received from Consort.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021</td><td>CMT/Board June 2021</td></tr>
<tr><td></td><td></td><td>N/A</td><td>High 15</td></tr>
<tr><td rowspan="2">3455</td><td rowspan="2">Violence & Aggression
(Reported at H&S Committee)

There is a risk of violent and/or aggressive behaviour of individuals, in mental health, learning disability services, and emergency departments; resulting in harm to person and poor patient and staff experience plus potential prosecution by HSE.

Executive Lead: Alex McMahon</td><td colspan="2"><u>Staff Governance Committee</u>

October 2020 - moderate assurance accepted on processes in place, limited assurance on implementation of required actions.

December 2020 - moderate assurance accepted on processes in place, limited assurance on implementation of required actions, specifically on the use and provision of personal alarms.

May 2021 HCG Staff Governance accepted Limited Assurance re progress of actions to mitigate this risk and Moderate Assurance in terms of current staff safety.</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>

• Internal audit due to report and will inform improvement plans in addition to quarterly reporting through local H&S Committees to the Lothian committee which take place in August 2021

<u>October Update</u>
• Meeting to discuss internal audit recommendations and to agree management actions due to place. A plan will be developed which will include generic actions and those relevant to the management of this corporate risk.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021</td><td>CMT/Board June 2021</td></tr>
<tr><td></td><td></td><td>High 15</td><td>High 15</td></tr>
</table>

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td rowspan="2">3328</td><td rowspan="2">Roadways/Traffic Management

There is a risk that the road traffic infrastructure on the 4 acute sites (RIE, St John’s, WGH, REH) is inadequate, due to the volume of traffic as a result of increased demand for parking plus construction projects causing interruption to traffic flow. This impacts on access to services, increasing levels of staff abuse and the potential physical harm to staff, patients, and the public.

Executive Lead: Jim Crombie</td><td colspan="2"><u>Staff Governance Committee</u>

October 2020- limited assurance accepted regarding safe traffic management at the acute sites.

December 2020- limited assurance accepted regarding safe traffic management at acute, East and Midlothian sites. Moderate assurance accepted for REH and community sites.

June 2021 Board - Governance and Management remain the same as does grading and adequacy of controls

Paper to be presented to Staff Governance in October 2021</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>
• Running action plan in place with oversight of local plans.
• Further plans in development.
• Local plans effective to manage ‘business as usual’, however, effect of additional demand for parking due to Covid and current building work on site impacts effectiveness, safety and results in abuse of staff and complaints.

<u>October Update</u>
• Running action plan remains in place with oversight of local plans. Further plans continue to be in development.
• Paper to be presented to staff governance in Oct 2021.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021
High 12</td><td>CMT/Board June 2021
High 12</td></tr>
<tr><td>1076</td><td>Healthcare Associated Infection

There is a risk of patients developing an infection:
1) as a consequence of healthcare interventions because of inadequate implementation and monitoring of HAI prevention and control measures.
2) linked to the built environment as a consequence of non-compliant design, maintenance or monitoring. This includes infections associated commonly occurring environmental organisms e.g. Pseudomonas aeruginosa.</td><td colspan="2"><u>Healthcare Governance Committee</u>

January 2021 - Moderate assurance accepted. Standing item on HCG agenda.

March 2021 – moderate assurance accepted overall, limited on ventilation systems in RIE theatres.

May 2021 HCG accepted Moderate Assurance against plans in place to deliver the standards.

July 2021 HCG accepted Moderate Assurance against plans in place to deliver the standards.

August Board received the HAI annual report and metrics continued to be monitored through the Board performance report.</td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	3) associated a failure to decontaminate reusable invasive and semi invasive medical equipment effectively. Potential increase in individual patient morbidity & mortality risk, extended length of stay and duration of treatment associated with healthcare associated infections. Executive Lead: Alex McMahon	**<u>Outcome of Executive Lead Discussions</u>** • **Current constraints numbers of IPCNs available to advise the service and the ability of the service to deliver the plans due to the pandemic and number of staff isolating. Significant pressures on the Infection & Control Team due to environmental risks at the RIE and other sites.** • **Confirmation of local plans in place. Organisational plan still in development, operational plans in place.** • **Did not meet LDP targets, however, performed well against many other Boards. Suspended many of the service audits due to Covid, so difficult to assess impact of plans at present with respect to infection control and prevention standards but plans are in place to reinstate these.** **<u>October Update</u>** • **ICPN capacity continues to be an issue, as not all vacant/new posts have been filled.** • **Local self- assessment audits have been restarted, with improved electronic capture however completion of the audits maybe hindered due to service capacity** • **QA of local audits through the ICPN has not been reinstated due to staffing pressures and having to respond to ongoing COVID requests.** • **An organisational plan to address this risk will be developed through the Pan-Lothian Group and will include anti- microbial prescribing.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		High 16	High 16

Appendix 2

Risk session for NHS Lothian Committee Chairs- 15th September

Overall Aim
To establish a consistent and effective approach to the oversight of Risk in Board Committees

Session Objectives
Enhance understanding of:

- NHS Lothian's Risk Management System at a corporate level by committee Chairs:
- Risk architecture, how are risks identified, assessed, recorded and the role of the Audit & Risk Committee
- How decisions are made to manage/treat the risk:
- Action plans, management oversight, measuring impact
- The role of Committees and Chairs in providing oversight:
- Key questions of management
- The linkage between risk management, levels of assurance and committee response
- Summary of discussion and next steps

Break out session 1 group 1

What are the key questions for management?
What is going well, not so well and why?

- Papers and plans often don't start out with thinking about and articulating risks and mitigation and that we need to be clear as to how they may contribute to management of a risk
- It was acknowledged that everything we do in healthcare is risky, therefore focus of senior management attention needs to be on very high and high risks and where risk cannot be mitigated through normal routes
- Papers need to focus on plans to mitigate risk, actions and timelines, and who is accountable for delivery, incorporating key measures and identifying key dependencies
- It was noted that the new role of CMT and detailed review and discussion of corporate risks gives more confidence to committees in taking assurance and providing onward assurance to Board
- Consideration of aspects of individual risks is often fragmented, crossing over between committees e.g. performance considered by Board/F&R with Healthcare governance committee (HCG) looking at through the lens of quality and patient safety
- Broader risks such as access to treatment need to be clear that levels of assurance for individual components may be different
- Committee members seek assurance about controls and determine 'risk appetite' with those areas where residual risk is high or very high requiring closer management and more detailed and/or frequent reporting
- It is helpful for committee members to feedback on specific areas where additional assurance is sought e.g. in business cases
- It was acknowledged that papers often contain a mix of tolerating (monitoring) risks and plans to manage
- There is a need for some consistency across committees/risks as to what 'high' looks like – more objective measure needed to agree scoring on the risk matrix.

Break out session 1 group 2

- The importance of a clear risk description when assessing plans to mitigate risk

- There is a disconnect between HCG committees' expectation and what mangers present at HCG as the papers do not always clearly reference the risk and/or set out plans to mitigate the risk

- Staff Governance split the agenda to clearly identify papers relating to risks on the Corporate risk register and is clearly set out in the committee work plan. It was agreed it would be useful for HCG to consider this approach.

- Measuring the impact of a plan informs the assessment of plans and recommended levels of assurance. This is an area for development, all risks have measures identified however that are not consistently used to demonstrate impact.

- Learning from other Boards Fife has a paper at the front of the committee minutes submitted to the Board which identifies areas of risk for escalation, they also have an integrated performance and quality report linked to committee oversight and risks. The group discussed this approach and were confident that each committee understood the risk they were responsible for.

- The finance risk description would benefit from a discussion re scope and scale as to overlaps with a number of other risks on the CRR e.g. access to treatment.

Improvement ideas

- A standardised reporting, template for risk mitigation plans reported to governance committees, would provide clarity for authors including the inclusion of measurement and assessment of levels of assurance

- Consider the work plans and agenda layout for committees to clearly identify papers relating to the CRR and those other agenda items

- Consider mechanisms for engaging new and existing board/committee members around roles and responsibilities re risk management.

Break out session 2 group 1

<u>Key issues for committee/chairs concerning levels of assurance?</u>
<u>Explore potential for a common response to levels of assurance?</u>

- There needs to be clarity on what committee is taking assurance on – accurate risk description, grading, actions to mitigate?
- It was noted that a variety of papers are presented to committees and their contribution to management of risks needed to be acknowledged
- For papers which directly address a specific corporate risk, content needs to be pegged to the measurement plan with data over time presented to monitor progress, and a level of assurance can be offered
- A paper may contribute to managing aspects of one or more risks e.g. a business case
- Depending on the granularity or specificity of risk, plans may impact on some elements but not all and not enough to impact on grading or to offer a 'blanket' level of assurance
- Papers are also received in relation to a committee's terms of reference, and any risks and mitigation identified in paper
- It will not always be appropriate or necessary to offer a level of assurance for all papers
- Where a paper is presented and committee agrees that assurance low, consideration may be given to escalation of risk to CRR, brought together at CMT

- Training is needed for authors and committee members in writing papers to include specific reference to risk and mitigation, and in seeking information to support levels of assurance
- It is important to recognise where risks are outwith our control – if so, is it our risk?
- It was agreed that there needs to be consistency between committees in agreeing levels on assurance based on confidence in management plans and timelines

Break out session 2 group 2

- The committees need to be clear concerning the expectation of management. The committee is looking for a robust plan to manage the risk with clear actions, timescales and measurement of impact.

- The levels of assurance are helpful, and it would be good to set them out specifically relating to risk mitigation plans

- Due to the differing levels of maturity of plans a standardised response to levels of assurance would not be helpful, with the expectation of no assurance which would require escalation to the Board.

- The new risk process recently put in place which include enhanced management oversight through the CMT, the revised CRR and the inclusion of management actions in the assurance table have all increase the level of assurance concerning the risk system.

- In other organisations it was common for the board to review all the risk on the CRR once year with management and this enhanced understanding of individual risks, plans and challenges. It was acknowledged that this would be useful to do but not at the present time due to system pressures, however board workshops may be an could be used in the future.

Ideas for Improvement

- Develop standard levels of assurance for risk management with a focus on risk mitigations plans to inform assessment of plans and levels of assurance

Next steps

- Circulate the notes of the meeting
- Develop a standardised risk management plan for managers to use when submitting risk papers to committees
- Develop standard assurance levels of risk management with a focus on risk mitigation plans
- Consider the work plans and agenda layout for committees to clearly identify papers relating to the CRR and other agenda items
- Consider mechanisms for engaging new and existing board/committee members around roles and responsibilities re risk management
- Develop a papers algorithm to clearly set out authors requirements re risk management

Appendix 3

Standard Level of Assurance for Risk Management

The Question for the Board or a committee to answer when reviewing risks

'What level of assurance do you have that there is a robust and deliverable plan to mitigate the risk and deliver the agreed outcomes within an acceptable timescale?'

Standard Descriptions for Levels of Assurance to be used on the Oversight of Risk Mitigation Plans

SIGNIFICANT

- There is evidence which provides reasonable assurance that the mitigation plan will be successful and deliver measurable agreed outcomes within an acceptable timescale. There may be an insignificant or no amount of residual risk that the plan will not be successful.

All of the following features are in place:

- Management has a firm understanding of the causes of the risk.
- Management has a deliverable plan which addresses those causes.
- Management are evidently delivering that plan.
- There is a robust system to measure the impact of the delivery of the plan on outcomes, and evidence of management taking corrective action when this is required.
- Over time, the plan is having the desired effect on reducing risk and delivering the agreed outcomes on time.

MODERATE

- There is evidence which provides reasonable assurance that the mitigation plan is likely to be successful and deliver measurable agreed outcomes within an acceptable timescale. There remains a moderate amount of residual risk that the plan will not be successful.

There is more uncertainty (compared to 'Significant' assurance) which can be caused by:

- There are a few known factors which may change the nature of the risk.
- While management may have a firm understanding of the risk and have developed a plan, there may be some factors which create uncertainty on aspects of the plan being delivered, e.g. the availability of funding, key personnel, co-operation with third parties.
- The system for monitoring the delivery of the plan and its impact on outcomes needs some development.

LIMITED

- There is evidence which provides some assurance that the mitigation plan will contribute to mitigating the risk, however there is a significant amount of residual risk and uncertainty that the plan will be successful and deliver the agreed measurable outcomes within an acceptable timescale.

A mitigation plan may offer limited assurance because:

- Management have not fully assessed the risk yet, or there are many known unknowns.
- The nature of the risk is large and complex, and while it may be fully understood, the mitigation plan is not fully developed.
- Management cannot produce a robust mitigation plan simply because the necessary resources are not available, or perhaps the plan depends on the actions of third parties.
- While there may be a delivery plan in place, there is evidence that the plan is not being delivered in practice.
- The system for monitoring the mitigation plan and the impact on outcomes is not properly developed.

NONE

- There is no or very little evidence that there is a plan which will deliver the agreed outcomes within an acceptable timescale.

This level of assurance may be appropriate when:

- ✓ The issue has just materialised, and management have had no opportunity to properly assess it.
- ✓ There is no mitigation plan at all.
- ✓ There is a plan however it is of poor quality.

Appendix 4

Reporting the management of Corporate Risks to Board Governance Committees

NHS LOTHIAN

Board Meeting
[Date of Meeting]

[Title of Responsible Executive Director]

[SUBJECT]

1 Purpose of the Report

1.1 The purpose of this report is to set out the risk mitigation plan to manage the _____ risk on the Corporate Risk Register (CRR).

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

2 Recommendations

2.1 [The paper should ask the committee to make decisions concerning the risk mitigation plan.]

2.2 [The report needs to recommend the level of assurance with respect to the robustness of the risk mitigation plan based on the standardised risk levels of assurance attached.]

3 Discussion of Key Issues

3.1 [Set out the risk description, grading and adequacy of controls, and attach the risk mitigation plan – see attached.]

3.2 Implementation of the Plan

3.2.1 [Summarise the key actions that have taken place. How these actions help with management of the risk and use data to demonstrate the impact, including impact on grading.]

3.2.2 [Set out the key future actions, rationale and potential impact and related timescales.]

3.2.3 [Describe how the implementation of the plan and impact of actions are monitored.]

4 Key Risks

4.1 [Set out the key risks to the delivery of this plan.]

5 Risk Register

5.1 [Note that this risk is on the Corporate Risk Register.]

6 Impact on Inequality, Including Health Inequalities

6.1 No change.

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

7.1 No change.

8 Resource Implications

8.1 [State the resources required – financial, workforce, technological, etc, to deliver this risk mitigation plan.]

[Name of person who wrote the paper]
[Job Title of person who wrote the paper]
[Date of Version]
[e-mail address]

List of Appendices
Appendix 1: [Specify Appendix]