NHS Lothian Board

Wed 09 December 2020, 09:30 - 12:30

MS TEAMS

Agenda

Declaration of Interests

1. Declaration of Interests

Verbal *Esther Roberton*

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. It is also a member's duty under the Code of Conduct to ensure that changes in circumstances are reported within one month of them changing. Please notify changes to Georgia.Sherratt@nhslothian.scot.nhs.uk

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

Items for Approval or Noting

2. Items proposed for Approval or Noting without further discussion

Decision *Esther Roberton*

2.1. Minutes of Previous Board Meeting held on 14 October 2020

For Approval *Esther Roberton*

14-10-20 Public Board Minutes (final draft to Board).pdf (16 pages)

2.2. Finance & Resources Committee Minutes - 23 September and 28 October 2020

For Noting *Martin Hill*

F&R 23-09-20 Minutes signed.pdf (9 pages)
F&R 28-10-20 Minutes signed.pdf (5 pages)

2.3. Healthcare Governance Committee Minutes - 08 September 2020

For Noting *Moira Whyte*

HGC 08-09-20 Minutes signed.pdf (7 pages)

2.4. Audit and Risk Committee Minutes - 24 August 2020

For Noting *Martin Connor*

If agreed at ARC 23/11

2.5. Staff Governance Committee Minutes - 29 July 2020

For Noting *Bill McQueen*

SGC 29-07-2020 Minutes Final (signed).pdf (7 pages)

2.6. Edinburgh Integration Joint Board Minutes - 24 August 2020

For Noting *Angus McCann*

Edinburgh IJB Minute 24-08-2020.pdf (4 pages)

2.7. West Lothian Integration Joint Board Minutes - 22 September 2020

For Noting *Bill McQueen*

WL IJB Minute 22-09-20.pdf (7 pages)

2.8. East Lothian Integration Joint Board Minutes - 27 August and 17 September 2020

For Noting *Fiona O'Donnell*

EL IJB Minute 27-08-2020.pdf (5 pages)
EL IJB Minute 17-09-2020.pdf (10 pages)

2.9. Midlothian Integration Joint Board Minutes - 27 August and 10 September 2020

For Noting *Carolyn Hirst*

MIJB Minute - 27-08-2020.pdf (9 pages)
MIJB Minute - 10-09-2020.pdf (4 pages)

2.10. Appointment of Members to Committees

For Approval *Esther Roberton*

9 December Board appointments report (AP draft 271120).pdf (2 pages)

Items for Discussion

3. Board Chair's Report - December 2020

Verbal *Esther Roberton*

4. Board Executive Team Report - December 2020

Discussion *Calum Campbell*

BET Report December 2020 FINAL DRAFT (1).pdf (20 pages)
Appendix 1 - BET Report December 2020.pdf (4 pages)

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

Verbal *Esther Roberton*

6. NHS Lothian Sustainable Development Framework and Action Plan

Discussion *Jim Crombie and Jane Hopton presenting*

SDF NHS Board December 2020 30112020.pdf (6 pages)
Master Draft SDF_30112020.pdf (27 pages)

7. COVID-19 in Lothian – Descriptive Epidemiology (Phase 1)

Discussion *Katie Dee*

- 2020 11 26 Descriptive epidemiology Board FINAL.pdf (3 pages)
- 2020 11 26 Epidemiology of COVID in Lothian Part 1 FINAL.pdf (41 pages)

8. Scheduled and Unscheduled Care Performance

Discussion *Jacquie Campbell*

- Board Paper_Sched Unsched Care_Final_Submitted.pdf (18 pages)

9. October 2020 Financial Position

Discussion *Susan Goldsmith*

- NHS Lothian Oct 2020 Board finance report - 091220.pdf (4 pages)

10. Discharges to Care Homes

Discussion *Alex McMahon*

Paper to follow

- Care Home Review Covering Paper for Board Final.pdf (5 pages)
- Care Home Review Report for Board Final.pdf (34 pages)

11. Project Bank Account Approval

Approval *Susan Goldsmith*

- 201119 Project Bank Account report Final Draft.pdf (3 pages)
- Know Your Client.pdf (2 pages)

12. Corporate Risk Register

Discussion *Tracey Gillies*

- Board Corporate Risk Register Report 9 Dec 2020 Final.pdf (9 pages)

13. NHS Lothian Pharmaceutical Care Service Plan 2020

Discussion *Katie Dee and Angela Timoney presenting*

- PCSP Board Paper 25 Nov 2020 FV.pdf (3 pages)
- PCSP 2020 FV Nov.pdf (63 pages)

14. RHCYP, DCN & CAMHS Project Update

Discussion *Susan Goldsmith*

- RHCYP + DCN Update for Board 09-12-20.pdf (3 pages)

15. Any Other Business

Verbal *Esther Roberton*

16. Future Board Meeting Dates

For Noting *Esther Roberton*

03 February 2021
07 April 2021
23 June 2021 * (Annual Accounts)
04 August 2021
06 October 2021
01 December 2021

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

Decision *Esther Roberton*

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 09.30am on Wednesday 14 October 2020 using Microsoft Teams

Present:

Non-Executive Board Members: Ms E Roberton (Chair) Mr M Ash; Mr M Connor; Dr P Donald; Cllr G Gordon; Mr M Hill (Vice-Chair); Ms C Hirst; Ms F Ireland; Mr A McCann; Cllr D Milligan; Mrs A Mitchell; Mr P Murray; Mr W McQueen; Cllr F O'Donnell; Mr T Waterson ; Professor M Whyte and Dr R Williams.

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

In Attendance:); Mr N Bradbury (Capital Finance Manager for item 74); Mrs J Butler (Director of HR & OD); Mr C Briggs (Director of Strategic Planning); Ms D Calder (General Manager for item 74); Ms L Cameron (Strategic Programme Manager for item 74); Mrs J Campbell (Chief Officer, Acute Services); Mr J Crombie (Deputy Chief Executive); Ms K Dee. Deputy Director of Public Health and Health Policy); Dr B Hacking (Director of Psychology for item 73); Dr L Hayworth (Consultant Medical Microbiologist for item 74); Mr P Lock (Director of Improvement); Mrs J Mackay (Director of Communications & Public Engagement); Mr D Pickering – Gummer (General Manager for item 73); (Mr D A Small (Director of Primary Care Transformation); Mr C Stirling (Site Director Western General Hospital for item 74) Mr A Payne (Head of Corporate Governance) and Mr D Weir (Business Manager , Chair and Chief Executive's Office)

Apologies for absence received from Ms K Kasper.

66. Declaration of Financial and Non-Financial Interest

66.1 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.

66.2 There were no declarations of interest.

67. Chair's Introductory Comments

67.1 The Chair advised that Ms Kasper had delivered a baby boy and had been discharged from hospital the previous day. She would try to join the meeting briefly at some point in the proceedings

67.2 It was noted that there were no members of the media at the current meeting although it was hoped that there would be at the next meeting.

67.3 The Chair commented that this would Professor McCallum's last meeting before she went on secondment. Ms Dee would act as the Interim Director of Public Health in the meantime. The Chair thanked Professor McCallum for her contribution over the previous 15 years and wished her well in the future. The advertisement for the Director of Public Health and Health Policy had been placed.

Items for Approval

68.1 The Chair reminded those present that the Board agenda was made up of two separate sections. The first was the section for approval commonly referred to as "the consent agenda". The Chair reminded members 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.

68.2 The Board agreed items 2.1- 2.11 on the agenda without further discussion.

Items for Discussion

69. Board Chair's Report – October 2020

69.1 The Chair advised that her report was verbal although she would be happy to produce a written update if the Board preferred. Board Members would advise off line.

69.2 The Chair advised in respect of the Edinburgh and Lothian Health Foundation that she had attended a workshop to review the Strategy.

69.3 The Board were advised that the Chair had participated in a planning meeting for Non-Executive Board Member recruitment. She was optimistic that a pool of good candidates would be identified. The shortlisting and timescale for recruitment to the various vacancies was detailed to the Board.

69.4 The Chair updated on discussion at a meeting of Chairs and the Cabinet Secretary Meeting where the focus of discussion had been around Mental Health, Test and Protect in Care Homes and Remobilisation. In terms of face masks there would be a Public Health Campaign. Health Boards and the Scottish Government were working collaboratively around Covid -19 restrictions.

69.5 The Board noted that the Chair had held a productive courtesy meeting with the Chair of IHSL.

69.6 The Chair reported that there had been good attendance at the recent MP/MSP meeting where there had been discussion around Care Homes, Test, and Protect amongst other issues. She had met with Mr T Sheppard MP separately. It was noted that Dental Practices would offer a full range of services from 1 November 2020.

69.7 The Board were advised that the Chair had also met with the City of Edinburgh

and Edinburgh Poverty Commission colleagues who were keen to engage with the Board.

69.8 A further meeting had been held with the Chairs and Vice Chairs of Integration Joint Boards (IJBs) where discussion had touched on Non-Executive workloads.

69.9 The Chair advised of further engagement she had had around the Edinburgh Cancer Centre and the engagement of the Royal Society of Arts in work streams moving forward.

70 Board Executive Team Report – October 2020

70.1 The Chief Executive summarised his entry in the circulated report and reminded the Board that this would be Professor McCallum's last Board meeting before she left to take up a Secondment opportunity. He reported in relation to Test and Protect that Mr Crombie and Ms Dee had done sterling work in getting the numbers up. The Board were advised that the planning for the Regional Covid 19 Testing Hub continued with the expectation that this would be in place in mid-December, which would give an increase in capacity of 6000 tests in the East per day.

70.2 Unscheduled Care planning continued and was jointly chaired by the Chief Executive of NHS Lothian and NHS 24 respectively. The Call Mia initiative was being rolled out for Minor Injuries.

70.3 The Chief Executive advised that he and Mrs Goldsmith had attended the Scottish Parliament Health and Sport Committee on 15 September 2020 to provide evidence on the financial impact of Covid for NHS Lothian.

70.4 The Chief Executive advised that the IJB Chief Officers would be invited to attend future Board Meetings.

70.5 The Board noted in respect of media coverage around the Influenza Vaccine programme and shortages of vaccine that in Lothian the correct priority groups were being targeted – the over 65s and vulnerable groups.

70.6 The Chair commented that the system had experienced a difficult few weeks with issues around Covid at Ward 15 at the Western General Hospital and in a West Lothian Care Home.

70.7 Mr McQueen questioned in respect of the Regional Hub what the speed of return was for tests and whether this would be quick enough. He also sought advice on whether the capacity would be as high as the system wanted. He advised that he would also welcome an update on the fact that 15 Dental Practices would be unable to restart seeing patients. In conclusion, he also asked for additional information around Thrive Edinburgh and their efforts in helping people in distress and whether lessons could be learned for use in the rest of Lothian and indeed the Prison population.

70.8 The Chief Executive advised in respect of Test and Protect that if the additional 6000 daily tests were secured and if the laboratories were up and running this would provide significant additional NHS capacity. It was anticipated that test results would be available within a 24-hour maximum period. The Scottish Government had agreed to fund the engagement of more contact tracers. The increasing incidence of Covid was putting pressure on Contact staff and ways of streamlining the process were being worked through with NSS. Contact Tracing would remain under pressure until Covid incidences reduced.

70.9 Mr Small commented in terms of Dental practices coming back on stream that there was a need to look in more detail about who could restart services. Mr McQueen was advised that initially Thrive Edinburgh had focussed around Mental Health patients and had been community based. Professor McMahon would provide further information off line.

70.10 Mr Murray commented on media reports about consistency in accessing GP practices who he reminded colleagues were independent contractors. He questioned whether the Board should consider making a statement about what it would reasonably expect in term of patient access. He also sought advice on whether lessons were being learned in terms of infection protection and control following outbreaks and incidents.

70.11 Mr Small advised that he was aware of media GP issues around access and aspects around hidden ill health. Guidance was being worked up that would need to be agreed by the Lothian Medical Committee in term of patients that needed to be seen on a face-to-face basis.

70.12 Professor McMahon commented in terms of infection control and prevention that there had been a number of outbreaks in Care Homes. The Care Inspectorate had carried out unannounced inspections and common themes had emerged around compliance with infection control and the use of PPE. Support had been provided to Care Homes in terms of education and training in these areas. It was noted that the Cabinet Secretary had asked Executive Nurse Directors to put increased focus and resources to support Care Homes. Finding people with the appropriate skills to undertake this work would be challenging. Professor McMahon felt that there were issues around consistency around everyday messages.

70.13 The Board were advised that the Chief Nursing Officer had commissioned a Tertiary Review of 4 Care Homes where there had been significant outbreaks.

70.14 Mr Small updated the Board on the position in respect of the vaccination programme and concerns that had been expressed at the Board about potentially running out of vaccine particularly for older people. He advised that it had been anticipated to deliver 10000 vaccines in 8 weeks and 6500 had been delivered in a 6-week period, which was ahead of the anticipated uptake. Steps were being taken to see if extra vaccine could be secured in early November. There were however no issues about the availability of vaccine for the over 65 age group. There was a small risk for the under 65-age range. It

was noted that there were many options around where people could be vaccinated.

70.15 Professor McMahon reported that electronic prescribing would be available at the end of October at REAS.

70.16 The point was raised that there were staffing challenges around the Short Stay Elective Centre. Work was underway to look at increasing health care professional training opportunities for school-leavers. The Chief Executive reported that even pre Covid it had not been possible to achieve full staffing levels. He commented that staff represented the largest cost in the NHS and if the country were going into economic decline, it would be important to strike a balance to ensure the system was not destabilised.

70.17 The Board were advised that the National Integrated Workforce plan increased that number of controlled staff groups. The point was made that if the NHS continued to rely on traditional recruitment routes it would not deliver the staff numbers necessary to run the service this winter. The Chair agreed advising that there was a need for innovative solutions going forward.

70.18 Ms Hirst welcomed the development of the communication strategy on the redesign of urgent care. The Chief Executive reminded the Board that he Co-Chaired the National Group and that discussions continued about the model. There would be an internal soft launch throughout November but a formal launch could not happen until December when the national position would be available.

70.19 The Board were advised in term of the flu vaccination that 6500 NHS staff had been vaccinated in the first 6 weeks. The system was on track to vaccinate all staff wishing to partake in the programme. The position in respect of Social Care Staff was more problematic as the vaccine came from different sources. The Board noted the generally positive progress being made with the vaccination programme.

70.20 The Board received the Board Executive Team report.

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

70.1 The Vice Chair provided the Board with an update on the following issues that had been discussed at the Finance and Resources Committee on 23 September 2020. The first of these had been about the Initial Agreement for the Edinburgh Cancer Centre and this was on the Board agenda for discussion. The second issue had been about the Legal Advice around the Public Inquiry and again this was on the agenda for discussion in the Private Session.

70.2 The Vice Chair reported that the Committee had also discussed the NHS Lothian Sustainable Development Framework and Action Plan. He commented that this was a comprehensive document although it still required

further work as it was currently in draft. The Committee had endorsed the work to date and recognised the importance of this work moving forward. The final Framework would come to the Board for approval in December 2020.

70.3 The final issue that the Vice Chair brought to the Boards attention was the discussion that had been held around the Procurement Annual Report where NHS Lothian had retained its Superior A+ status. The Committee had welcomed this positive assessment.

70.4 Ms Hirst advised as Acting Chair of the Midlothian IJB that she had welcomed the presentations at the last Board meeting around Unscheduled and Scheduled Care. She had felt that these had been valuable presentations and continued input from IJBs would be important in terms of being clear about local impacts. She commented that she would be keen to repeat the process in future.

71 Covid-19 Public Health Update.

71.1 Professor McCallum advised that the number of Covid-19 cases were rising across the community and vulnerable populations. She commented that was a need to get back to lower levels. Test and Protect was essential in the control of the virus. It was noted that for schools a national tool kit would be adopted. The Chair commented that she welcomed the emerging clarity around schools.

71.2 Mr Murray questioned how the impact on deprived communities and ethnic and minority populations would be encapsulated. Professor McCallum advised that monitoring data was available from Public Health Scotland allowing a review of areas of deprivation and individuals. She advised that there were many practical measures that could be used to help affected populations to live with Covid and to help them to self-isolate. The Scottish Government were working to look at what an updated risk assessment for winter would look like. The Chair advised that this would be a long-term issue.

71.3 Dr Donald advised in terms of testing that it would be useful if the Board could have an understanding of testing strategies in terms of who were tested, where and when. It would also be useful to learn whether testing in Care Homes was comprehensive as well as noting the Scottish Governments change to the guidance. Dr Donald felt that there would be benefit in having a constantly updated Lothian position document. Professor McCallum advised that she had an advanced draft covering these issues and would share this before going on secondment.

71.4 Mrs Mitchell sought an update on what had changed over the previous few weeks in terms of admission to ICU. It was noted that admissions were starting to increase across the whole pathway. The Chief Executive commented that this was the start of a challenging period and upon reflecting on this, he had re instituted Gold Command. If this position continued for any length of time, it would have a significant impact on performance.

71.5 Mrs Mitchell commented on the reference in the paper about the student community and sought advice on how big an issue this was and what was being done to address it. Professor McCallum reported that work was ongoing with all of the Universities and Colleges to develop a shared response. The response to specific outbreaks and clusters was detailed to the Board. The Board were advised that the University of Edinburgh was looking at its accommodation strategy and the number of students in common areas. The position was stabilising and would be reviewed the following week.

71.6 Professor Whyte commented on the combined efforts of the University and Public Health in managing the outbreak at Pollock Halls. The cases were reducing and robust arrangements were in place to manage students who were self-isolating. She commented that there was a need for a policy decision around the testing strategy for the student population.

71.7 Mr McQueen commented that in parts of England there had been reported rates of 600 per hundred thousand of population and questioned whether Lothian was in a different spectrum from this. Professor McCallum advised that the reported English position was an exception and that Lothian with a current rate of 110 per hundred thousand of population was in a different position. She commented that the virus had not changed and there was a need to get the "R" number below one to reflect the position earlier in the summer. Work was underway with the Scottish Government around the October school holidays to reduce the risk. Mr Briggs advised that effective testing was now in place but there was no clear link between positive cases and what was presenting at the front door of the acute sector.

71.8 The Chair advised that the Public Health Minister had been keen to record the amazing job being done by Public Health and other staff.

71.9 Mrs Campbell updated on the number of Covid patients in the general wards and critical care at the RIE, WGH and St John's Hospital. Gold Command, Tactical Groups and Silver Command had been established for the acute sector to manage people through the system

71.10 The Board received the update report and agreed the recommendations in the circulated paper.

72 Scheduled and Unscheduled Care Performance.

72.1 Mrs Campbell advised that the focus remained on the most urgent patients and that numbers were reducing. Outpatient activity was still seeing a reduction in demand of 13% with activity being at 74% of pre Covid activity and continuing to build. The availability of face-to-face appointments and the use of Near Me and telephone consultations was discussed. The Board were advised that the focus at the front end meant that routine patients were waiting longer. In order to help with this a "keeping in touch" process had been established with consideration being given to making this a central model.

72.2 The Board were advised that Surgical and TTG remobilised theatres were

working at 84% of pre Covid activity. The impacts of turn round times because of social distancing and the donning and doffing of PPE was discussed. Again, the focus was on urgent patients.

72.3 Performance against the 31-day cancer target was positive although the 62-day position was under pressure. The main issues were in Urology and Colorectal. The September position was demonstrating some progress. In terms of the Endoscopy turnaround time, it was noted that additional rooms at the WGH were being looked at. These should be available in mid-November and would increase productivity. An update was provided on the second robot for Prostectomy that would release wards at the WGH for bladder cancer. Radiology performance was positive.

72.4 Mrs Campbell reported in terms of Unscheduled Care that there was a significant focus on Call Mia. The RIE was the site causing most concern in performance terms with mitigating action being considered. Occupancy levels were currently on excess of 95% and this had been discussed at Gold Command with Health and Social Care Partnerships (HSCPs) in term of increasing bed capacity in Community Hospitals.

72.5 Mr Murray referenced the comment in the paper about mitigation around face-to-face appointments and questioned the impact of the changes in approach on patient outcomes. He was clear that there was a need to ensure outcomes were compatible to face-to-face appointments. In terms of Delayed Discharges, he noted that this remained on the risk register as a very high-risk. He questioned whether there was a likelihood that the position would revert to the previously high numbers.

72.6 Mrs Campbell advised in terms of patient outcomes that patient satisfaction from Near Me engagement was compiled nationally. Ms Gillies commented whilst there were benefits to Near Me that there was a need to move to face-to-face appointments. In terms of virtual consultations, she questioned whether this resulted in patients coming back to the service later.

72.7 The Chief Executive advised that in terms of the Delayed Discharge low point in the first wave of Covid that he had asked IJB Chief Officers for an SBAR to come to Gold Command the following week to pull the position back to where it had been and for this to be achieved by mid-December. He reminded the Board that the UK had the second lowest number of acute beds per head of population in Europe. The reality was that acute beds were under pressure hence the need for IJBs to work to sustain low Delayed Discharge numbers.

72.8 The Vice Chair commented in terms of latent demand that it would be important to consider to what extent this would result in a wave of referrals from GPs. He commented that the reported 21% reduction in referrals suggested that the referral pathway from GPs was not operating in the normal way. He questioned whether work was being done in this regard and whether other solutions had been found.

72.9 Mrs Campbell advised that the position was being monitored by trend and by

specialty based on urgency using a clinical profile. The use of initiatives like Refhelp were being considered to ensure the best evidence base for referring patient's into secondary care. Ms Gilles advised that there was a need to consider that some of what happened previously had not been the correct way of seeing patients and that the current redesign process would not disadvantage them. There was a need therefore to recognise that some patients would not in future navigate into face-to-face meetings. The Board were advised that the system was now seeing patients that might have previously been seen in Out Patients and who were now presenting with more advanced conditions. The Vice Chair questioned to what extent GPs were involved in the analysis work. It was noted that Refhelp was GP led.

72.10 Ms Hirst commented in terms of the impact on Equality and Health Inequalities that the digital divide would increase. She questioned whether anything could be done in conjunction with The Edinburgh and Lothian Health Foundation and others to address this. It was noted that the completion an Equality Impact Assessment would inform what the Board could potentially do in this area.

72.11 The Chief Executive advised that the Scottish Government recognised that models of care needed to change and that this would need to go through a major change process. Dr Donald welcomed the 6-week trial at the WGH in respect of Same Day Emergency Care. She commended the Flow Centre collaborative approach.

72.12 Dr Williams commented on the backlog of delayed presentations from GPs and commented that 90% of patients continued to be treated in Primary Care. He felt that there was a need to support GPs in anticipation of the tsunami of cases yet to be progressed. He commented that in the past the only way to provide additional resource to Primary Care had been to close acute beds. Given that there were not enough beds he was concerned that he acute sector would be funded at the expense of Primary Care.

72.13 The Chief Executive in response advised that it was a fact that NHS Lothian did not have enough capacity to meet demand and the point made by Dr Williams was true. He commented that any financial resources that NHS Lothian had should be invested in the area of greatest return. This was a challenge for the Board to address. He stressed however that the reality of the position was that there was not enough capacity to meet demand.

73 Lothian Recovery Plan Updates.

73.1 The Chair welcomed Dr Hacking and Mr Pickering – Gummer to the meeting advising that they would update on recovery progress in respect of Psychological Therapies and Child and Adolescent Mental Health Services (CAMHS).

73.2 Psychological Therapies – Professor McMahon reported that the Scottish Governments access target for psychological therapies (PT) was that 90% of patients should commence treatment within 18 weeks of referral. Public Health Scotland had reported that for the quarter April – June 2020 that NHS

Lothian had seen 74.1% within 18 weeks and 78% at the end of March 2020 compared to the Scottish average of 74.3%. NHS Lothian was ranked fifth of 12 NHS Boards. The July to September data was reporting an improving position at 81.4%. This masked areas that were not performing well the detail of which were provided.

73.3 Dr Hacking updated the Board on work that was being done to maximise the workforce through job planning and the administrative allocation of patients to reduce the burden on Clinicians. It was noted that although the service (PT) was benchmarking well against Scotland and that there was more work to be done. She advised that she was keen to continue with consistent scheduling of Out Patients and to increase the consistency and standard of PT. Management reports were now being used and this had introduced clarity into individual and team scheduled appointments and returns as well as new appointments.

73.4 Mr McQueen questioned why it was a substantial management challenge to get people to work to job plans as expected. He felt that this would be a key question for the Board and the Chief Executive. He hoped that the forensic approach on reasonable performance continued .He questioned in terms of standards whether other Health bodies in England and Scotland did not have versions that could be adopted in Lothian.

73.5 Professor McMahon advised that the Executive Team echoed the sentiments expressed and that it was important that the Board were supportive of the management focus moving forward. He reminded colleagues that this was a delegated function that sat with IJBs although it had been agreed that REAS would manage the process. It was positive that sustained performance through Covid had been reported. However, there was a need to optimise the Psychology capacity in order to reduce the backlog and start to see new patients. It would be important to maximise capacity to address the Mental Health impacts of Covid on parts of the population. Group therapy and digital options also needed to be maximised.

73.6 Dr Hacking commented in terms of standards that the Scottish Heads of Psychology met three weekly to update each other and to share good practice. The NES Psychological Therapies matrix was also being updated. This was in addition to the Programme Board established by Dr Hacking to monitor progress.

73.7 Mr Murray commented that the culture would have been ensconced over a period and would take effort to unpick. It would be important to work with staff to solve the challenges that had been identified. In terms of the delegated nature of the service, he advised that in time it would be a useful aspiration to see community orientation to the services provided. He commented that it was important to recognise the point made in the paper that digital consultation was not suitable in every case.

73.8 Professor McMahon commented in terms of the necessary changes that it was important that everyone worked in partnership to achieve the outcome

needed. This included working with IJB Chief Officers to maximise capacity and meet the needs of patients. Professor McMahon advised that he and Dr Hacking would be happy to attend IJBs to ensure everyone was on the same page. The Chair advised that the Planning, Performance and Development Committee would get into the detail of issues like this in future.

73.9 Dr Hacking commented in terms of the use of digital that there were still people on the waiting list that only wanted treatment on a face-to-face basis. This was part of discussions with the Scottish Government as there was a need to produce guidance around this position. The key issue was to consider what would be regarded as a reasonable offer. It was noted that digital poverty was a significant issue for some people in this client group.

73.10 Dr Donald commended the work being done and commented on the importance of engaging with the Primary Care and the Third Sector to help people to find some support. Dr Hacking advised that young people and women were struggling most with the pressures of Covid in terms of increased distress. This had not yet manifested in an increase in referrals for PT. Work would continue with other sectors to look at issues like digital poverty.

73.11 Mr McCann commented on the need for good management control and was confident that this was being provided. He commented on the staffing deficit and issues around temporary rather than permanent contracts. Professor McMahon advised that a Programme Board had been established and was chaired by the Chief Officer of the Edinburgh IJB and was attended by all Chief Officers as well as himself and Dr Hacking. Agreement had been reached through this forum to make funding recurrent and this helped with the recruitment position.

73.12 The Board agreed the recommendations in the circulated paper and supported Dr Hacking with the ongoing work around culture.

73.13 Child and Adolescent Mental Health Services (CAMHS) – The Chair commented that the late Dame Denise Coia had presented to Board Chairs the outcomes of the Taskforce that she had led. Professor McMahon advised that the report was reflected in the recommendations in the Board paper.

73.14 Professor McMahon advised that the debate around PT would be echoed when considering CAMHS. He advised that at the beginning of the year a significant number of new staff had been engaged through the recurrent investment of £3m into the service. Significant work had been done although the impact of Covid had tempered this to some extent.

73.15 The Scottish Government's access target for CAMHS is that a minimum of 90% of patients should commence treatment within 18 weeks of referral. Public Health Scotland had reported that for the quarter April – June 2020 that NHS Lothian had achieved a position of 51.7% and this was below the Scottish average of 59.3%. Across Scotland, the April to June position had fallen drastically because of Covid.

73.16 Mr Pickering –Gummer advised that the focus was on the most vulnerable patients and that a digital Near Me approach had been adopted. The areas of most impact had been in ADHD and Autism. In addition, the use of non-medical prescribers would be of benefit moving forward and this work force would be grown. The Board were advised of a number of other actions that the service wanted to take forward. It was noted that the benefits of the workforce could be maximised through job planning and the better management of patients into the system. Additional administrators would be recruited to work alongside Clinicians. Recruitment to permanent posts would be the key area of focus.

73.17 Mr Pickering – Gummer advised that he was proud of the staff response to Covid although this did not excuse the current performance position. Covid had highlighted the need to understand better data around job planning. The Project Team had been asked to focus on three areas and the detail of these was provided to the Board.

73.18 Dr Donald advised that she was concerned about the significant number of referrals that were returned to the referrer. She questioned what advice was given to GPs about alternative routes. Mr Pickering –Gummer advised that he was working to understand the reasons for this and to ensure that support was in place.

73.20 The Chief Executive commented that it was important that the Board were comfortable about the way that work needed to be driven forward. It was important for the Board to be honest that the system could and should be doing better in this critical area. The Chair concurred advising it was important for the management team to have the backing of the Board moving forward.

73.21 The Board agreed the recommendations contained in the circulated paper.

74 Initial Agreement - Edinburgh Cancer Centre Development

74.1 Mr Crombie advised that there were a number of members of the team available to answer questions around the detail of the Initial Agreement.

74.2 The Board were advised that in developing in the Initial Agreement that a proper oversight and governance process had been undertaken. He felt it was important to get the support of the Board for this programme.

74.3 Mr Stirling , Site Director, WGH apologised for the length of the document advising that this reflected the complexity of the programme which was being undertaken on behalf of the East Region. It was noted that NHS Lothian was the most populace part of the Region and the area where population growth was most significant. The incidences of cancer were increasing, as were survival rates.

74.4 The Board were advised of the significant drivers behind the programme to support the future of cancer services. It was noted that the Board had recently supported investment in the existing Cancer Centre although this did not

represent a long-term solution for cancer services for the Region. The timescale set out in the Initial Agreement reflected the detail of the permanent solution. Oncology enabling works were being carried out for existing services. Mr Stirling advised that the proposals for the new service had significant benefits for patients and families and that there were Regional and National opportunities. There were also economic benefits in terms of jobs in the building phase as well as clinical, academic and research benefits.

74.5 Mr Murray commented that a key issue was that 2029 was a long way away and questioned to what extent the Board could offer ongoing motivation to give momentum to the programme. He questioned the possible contribution of the Edinburgh and Lothian Health Foundation in the mix of funding moving forward. Mr Stirling advised that Foundation funding could only be provided to provide additionality over core requirements and they were not focussed on this proposal at this point. He commented that there were opportunities to develop cancer funding and this had been discussed with the Foundation.

74.6 Mrs Goldsmith advised that the issue went beyond the Foundation. The challenge was around the health component of Capital that was extremely limited with the Cancer Centre not yet being in a position to be funded. The issue was how to raise the profile of the need for the Cancer Centre for the population of the Region. This would include the economic benefits previously referenced. Mrs Goldsmith stressed that the Foundation could only fund enhancements. A potential role for the Foundation would be to work with other partners including the Third Sector to raise the profile of the project through a proactive fund raising position. She commented that the preparation of the site including the demolition of DCN would be beneficial to the wider WGH site master planning process.

74.7 Mr Crombie advised his ambition was to progress quickly whilst still adhering to strict governance requirements. It was noted that the pathway up to the Scottish Government was complex and continued to be worked through. A Communications Strategy was being developed. The Chair advised given that the project benefitted other Health Boards that it would be helpful to obtain their support that would strengthen the overall proposition.

74.8 Mr Ash commented that the presentation to the Finance and Resources Committee had been helpful. He felt that that there was no logical reason not to support the Initial Agreement. There would be a need to prepare an argument with appropriate emphasis for different audiences. He felt that if the paper was accepted by the Board then other Health Boards should be written to formally asking for support. Mr Ash commented that there was a lot of discussion about community support and he felt this needed to focus out with normal NHS structures. He stressed the need for future iterations of any Business Case to be financially viable.

74.9 The Vice Chair commented that during the Finance and Resources discussion it had been noted that clarity around the benefits had not been discernible and that there was a need to make more of the potential for community , Regional and National benefits. He stressed the need to put

forward the strongest possible Business Case supported by the widest range of Stakeholders possible. He questioned whether the Board should get involved in supporting the case enthusiastically to the Cabinet Secretary. The Chair and Chief Executive would discuss off line.

74.10 Professor Whyte advised that there would be benefit in engaging with Cancer Research UK as they had access to extensive data and had designed cancer impacts around Covid – 19. They had also played a pivotal role around new facilities in Manchester and Cambridge. Professor Whyte advised that the University could assist in developing the case for the wider economic benefit. The Chair commented on the need to play in links with the University around issues like Research and Development. Mr Stirling would pick up on the offer made by Professor Whyte off line.

74.11 The Board agree the recommendations in the circulated paper subject to enhancing some of the sections to reflect in particular that comments made at the Finance and Resources presentation.

74.12 The Chair acknowledged that there had been a Covid – 19 outbreak in Ward 15 at the WGH. The Board would be briefed on this on Private Session. The Chair on behalf of the Board thanked the team for their support during this difficult period.

75 August 2020 Financial Position and Quarter One Financial Forecast

75.1 Mrs Goldsmith advised that with the passage of time a better understanding of both direct and Covid costs would emerge as well as the impact on service delivery. The circulated paper also provided an assessment of the year-end financial out turn currently estimated at £107m if no action was taken. This excluded Social Care costs that were being discussed by IJB Chief Finance Officers and the Scottish Government.

75.2 The Board were advised that the £107m included estimates of increased capacity to support mobilisation and was dependent upon securing access to the Private Sector. The Scottish Government had issued an allocation of £78m of which £18m was ring fenced to Social Care to support Covid. It was reported that Test and Protect would be fully funded by the Scottish Government. Mrs Goldsmith advised that her team had received significant requests for resources in respect of the second wave, winter and challenges on capacity. In terms of spending resources, the rate-limiting factor was the ability to recruit staff.

75.3 Mrs Goldsmith advised that an assessment of what the financial position would look like moving into future years would be considered at a forthcoming Finance and Resources Committee. It was noted that work as underway with other Health Boards around step up costs and an assessment of what new capacity would look like.

75.4 Mrs Mitchell questioned whether the key risks assumed current Covid levels. She felt there was need to consider contingency as well as Brexit issues. Mrs

Goldsmith commented that the main constraint on the system was around the ability to create or access additional capacity. East and Midlothian HSCP had come forward with proposals around their Community Hospitals to support the Acute Sector. She advised that the replacing of lost capacity would drift into the following year with resilience being a key challenge.

75.5 Mrs Goldsmith advised that questions around Brexit were difficult to respond to with a key issue being around staff availability. The other element was around ward supplies and there would be a need to model the upward cost profile around this.

75.6 Mr Murray commented that previously NHS Lothian had held a degree of pride in managing its financial position and this had been severely impacted upon by Covid. Mrs Goldsmith advised that the Finance Community were working together and sharing intelligence to ensure resources were prioritised to areas of most need.

75.7 The Board agreed the recommendations in the circulated paper.

78 Corporate Risk Register

78.1 Ms Gillies advised work had recommenced in terms of exploring risk around Brexit particularly as the deadline was approaching without an agreed exit. Robust work had been done earlier in the year and would be updated. Issues around the availability of supplies and drugs was discussed within the context of changes in practice and behaviours because of Covid. Patients were also holding more supplies in their own homes. There was a need to work through the consequences of these issues including the financial impact.

78.2 The Board agreed the recommendations contained in the circulated paper.

79 RHCYP, DCN & CAMHS Project Update

79.1 Mrs Goldsmith reported that work on site continued with the date for handover still reporting as 25 January 2021. Construction issues were being progressed with there being evidence of extra resources being deployed at weekends to deliver to timescale. CAMHS work would be concluded on 26 October 2020.

79.2 The Chair welcomed the positive briefing on progress. She was advised that the CAMHS physical move would occur towards the end of autumn.

79.3 The Board agreed the recommendations contained in the circulated paper.

80 Terms of Reference of Planning, Performance and Development Committee

80.1 The Chair discussed in significant detail the proposed terms of reference of the Planning, Performance and Development Committee. This discussion include consideration of the Chairing arrangements and the desired system wide approach to include community engagement.

80.2 The point was made that the Committee was wide ranging and it would be important to consider how the agenda would be constructed to include not losing the benefits of the existing Board Development Sessions. The Chairing arrangements for the Committee were robustly discussed and would be kept under review. It was agreed that the working of the Committee would be reviewed after 6 months. Initially the Board Chair would Chair the first few meetings. This position would be reviewed following the completion of the Board Member Appointment process at which point the spreads of responsibilities would be considered.

80.3 The Board agreed that the focus of the first meeting would be around Covid, The Edinburgh Poverty Commission and the Sustainable Development Action Plan. Topics for future discussion should be signalled to Mr Payne.

80.4 The Board agreed the recommendations contained in the circulated paper subject to the above points being reflected.

81 Future Board Meetings

81.1 The schedule of Board and Board Committee dates were approved subject to two changes in relation to Finance and Performance Review Committee dates. Diary invites would be issued to Board Members.

82. Next Board Meeting

82.2 The next Board meeting would be held on 9 December 2020.

83 Any Other Business

83.1 There was no other business.

84 Standing Order 5.23 Resolutions to take Items in Closed Session

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

Chair's Signature ……

Date ……

Mrs Esther Roberton
Interim Chair – Lothian NHS Board

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 23 September 2020 by videoconference.

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

In Attendance: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Mr N. Bradbury, Finance Business Partner; Denise Calder, General Manager, Western General Hospital; Ms Lyndsay Cameron, Strategic Programme Manager, Cancer Services; Ms J. Campbell, Acute Services Director; Mr M. Cambridge, Associate Director of Procurement; Mr I. Graham, Director of Capital Planning and Projects; Mr Larry Hayward, Consultant; Dr J. Hopton, Programme Director, Facilities (item 28.2); Mr C. Marriott, Deputy Director of Finance; Mr A. Payne, Head of Corporate Governance;. Ms T. Shearer, Group Chief Executive – The Piper Group (Shadowing Mrs Goldsmith); Mr C. Stirling, Site Director, Western General Hospital.

Apologies from Members: Professor A. McMahon, Executive Nurse Director, Ms. T. Gillies, Medical Director, and Mrs E. Roberton, Interim Board Chair.

Apologies from Others: Mr J. Crombie, Deputy Chief Executive.

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.

32. Committee Business

32.1 Minutes from Previous Meeting (26 August 2020)

32.1.1 The Committee reviewed the minutes from the meeting held on 26 August 2020. were approved as a correct record. The members highlighted that the minutes (at 27.4.5) should read 'own vehicles' rather than 'on vehicles, and that the minutes (at 27.5) should refer to 'Shawfair' rather than 'Shawfield'. With those corrections made, the Committee approved the minutes.

32.2 Cumulative Action Note

32.2.1 Mrs Goldsmith provided the Committee with an update to Item 15 on the action note, which related to the contract management process for the Royal Infirmary of Edinburgh. She advised that the manager who is leading this work is leaving NHS

Lothian. In order to progress the issue, management will be following the process within the NHS Lothian organisational change process.

32.2.2 The Committee discussed Item 2 of the action note which related to the resourcing of the strategic planning function, and the briefing which the Director of Strategic Planning had provided. Mr Hill reminded the members that the original concern was whether or not integration joint boards have sufficient resources to carry out their role. Mr Campbell commented that the briefing showed there had been a distribution of resources for strategic planning. He highlighted that it was for each integration joint board to decide whether it wished to make a further investment in strategic planning and equally, where to disinvest in order to resource any change. Mr Campbell highlighted that his view is that it would be better if the whole system used resources collectively. He is currently working on establishing a new Planning, Performance & Development Committee, and making use of the same baseline information.

32.2.3 The Committee agreed that it would be appropriate to set up a forum where there could be a collective discussion with the integration joint board chief officers to identify whether further resources are required, and agree how to progress any issues. Mr Campbell agreed to take this forward. **CC**

32.2.4 The Committee accepted the Cumulative Action Note.

32.3 Corporate Risk Register

32.3.1 Ms Bennett presented the report, highlighting that there is a need to review all risks light of Covid-19, and that a risk relating to BREXIT will be added back on. Ms Bennett explained that work was currently underway to align the level of assurance on risks with the risk grading. There is an intent to hold a committee chairs development session, so there was a shared understanding of what the Board expects committees to do when overseeing risks.

32.3.2 Mr Murray asked whether there was an opportunity to review the current grading for the RHCYPDCN risks. Mrs Goldsmith advised that the RHCYPDCN Oversight Board will be reviewing the situation and this may trigger a review of the corporate risk.

32.3.3 The Committee accepted the recommendations in the report.

33. Capital

33.1 Property and Asset Management Investment Programme

33.1.1 Mr Graham presented the previously circulated paper and highlighted key points. He advised that he will keep the Committee updated on the major trauma unit and the modular unit. He advised that due to the uncertainty for funding for development of the Royal Edinburgh Hospital, the Lothian Capital Investment Group has commissioned further work on masterplanning options for the site.

33.1.2 Mr Hill asked whether the costs associated with the major trauma ward at the Royal Infirmary of Edinburgh were being managed within the limits of the approved budget. Mr Graham advised that the works in the brief are not significant, and he was confident that the costs are being managed.

33.1.3 Mr McQueen referred to the primary and community care projects, and asked if the Board can take a risk and proceed with the projects which are within the Board's delegated limit. He highlighted that given the population is evidently growing, the Board should be prepared to take risk. Mr Graham advised that while the Board can take a risk, it needs to consider its overall priorities and how best to use the available delegated budget. Those projects were submitted to the Government because they are driven by additional population demand. Mrs Goldsmith advised that the Board has in the past proceeded with primary care projects. However the dynamics have evolved over the years, with the need to address backlog maintenance and comply with relevant standards. The Scottish Government does not regard that the Board's formula capital funding is to be used for developments. If the Board did proceed and take a risk, then the funding would have to come from the formula funding.

33.1.4 Mrs Goldsmith advised that it may be necessary to bring a report to a future meeting on the additional modular capacity at the Royal Infirmary of Edinburgh.

33.1.5 Mrs Goldsmith highlighted that there is insufficient capital funding available to proceed with Phase 2 of the Royal Edinburgh Hospital. She explained that this means that from the perspective of strategic planning there is not a connection to how the Board uses other sites. Consequently she suggested that the issue needs to be considered in the context of strategic planning, rather than asset development and management. Mr Murray supported this view. Mr Campbell agreed to discuss this with the Director of Strategic Planning. **CC**

33.1.6 The Committee accepted the recommendation within the report, namely to accept moderate assurance around the delivery of the 2020/21 Property and Asset Management Investment Programme.

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33.2 <u>Edinburgh Cancer Centre Capital Development – Initial Agreement</u>

33.2.1 Mr Stirling presented the initial agreement, which relates to a major regional project.. Ms Cameron set out the process of development and consultation with stakeholders to get to this stage.

33.2.2 Mr Hill commented that he was aware that there were significant enabling works underway on the site, however he was unclear how much of that related to the new cancer centre. Ms Cameron clarified that the majority of the existing enabling works is not part of the new cancer centre, but enables the provision of services until the new centre is open.

33.2.3 Mr Murray commented that he was impressed with the effort and detail that had gone into preparing the draft initial agreement. He highlighted that the Board should consider what impact will Covid -19 have on the Board's long-term ambitions on

cancer, and whether that impact necessitated speeding up the delivery of the new cancer centre.

33.2.4 Mr Murray asked how the respective sharing of staff costs were calculated. Mr Bradbury advised that the model is that normally used by the South-East and Tayside ('SEAT') regional planning processes, and was the same as that used for oncology enabling. Mr Bradbury advised that a significant amount of work is still to be done on costing, and the figures are indicative at this point.

33.2.5 Mr Murray highlighted that he expected that there would be connections between the cancer centre and work in the community, but noted that integration joint boards were not recognised as a key stakeholder. Ms Cameron acknowledged that they have been missed out and agreed to pick this up. **LC**

33.2.6 Mr McCann highlighted that it is challenging for non-executive Board members to consume the volume of information in the initial agreement, but highlighted that this is not a criticism of the merits of the business case. Mr Hill suggested that there should be an additional briefing session for Committee members on this major project before the Board meeting of 14 October, and other Board members invited to join if they wish. Mr Stirling confirmed that he and the team would be happy to do so, and welcomed questions in advance. The Committee supported having a further briefing session. **AP**

33.2.7 Mr McCann suggested that the strategic risks should reflect that the problems experienced in other capital projects, to ensure that there is learning. Mr Bradbury advised that the initial agreement does incorporate a lot of learning from previous projects, and that the level of optimism bias is higher than was the case in previous projects. Mr Stirling advised that further detailed work is required in relation to the essential services hub (which is referred to in the initial agreement), so no costing on that has been prepared at this point. There are links to site masterplanning and other regional and national work.

33.2.8 Mr McQueen highlighted that it needed to be clear how the Board will define what benefits it is trying to achieve, how they will be measured, and what the process is to manage the trade-off between cost and sustainability aims. The report states that there will be an increase in revenue costs in the range from £19m-£31m, so it is important to understand what is driving that increase, and what benefits it will yield. He asked whether once the new centre is built, will we have a higher throughput of patients with better outcomes for them as a result of this extra revenue cost? Mr McQueen stated that he did not see the answer to these questions within the current list of benefits. Mr Hayward advised that he expects that the answer to the latter questions will be 'YES', however he acknowledged that this needs to be made clearer.

33.2.9 Mrs Goldsmith advised that there are additional revenue costs due to introducing improved infrastructure, which provides a facility which meets current relevant standards and increases space. There is also increase in costs to create the capacity to service the increase in absolute demand more services, which the current infrastructure cannot meet. There is a need to develop a trajectory of costs from now up to when the new facility is operational. There also needs to be an active

link between the process of continuously managing revenue costs, and the development of the business case.

33.2.10 Mr Hayward commented that the service has learned through the experience of responding to Covid-19 that it is possible to make decisions and take action quickly. In his view it should be possible to expedite the project, and from the Government's perspective, it is an important infrastructure element of economic stimulus. Mr Stirling advised that the team can provide more information on service development and innovation at the future briefing session.

33.2.11 Professor Whyte commented that the partnership between the University of Edinburgh and NHS Lothian is strong. The conduct of clinical trials gives patients access to the latest developments, and also saves the Board money. Within Lothian we are leading in some areas, but are limited in some areas. A proper dedicated cancer centre is extremely important, and she highlighted that the Christie Institute in Manchester is a good example of one which generates wider benefits.

33.2.12 Mr Hill concluded the discussion by stating that NHS Lothian should be very clear on all of the benefits that the centre will bring. Additionally we should not simply accept that it will be years before the centre is operational, and we should challenge the current processes so that the project can be brought forward.

33.2.13 The Committee accepted the recommendations in the report, which included approving the initial agreement for submission to the NHS Board on 14 October, and thereafter to the Scottish Government's Capital Investment Group in November 2020..

33.3 Royal Hospital for Children and Young People/ Department of Clinical Neurosciences

33.3.1 Mrs Goldsmith provided a report which gave an update on the progress on Supplemental Agreement 4. She advised that management will try to mirror the approach taken with Supplemental Agreement 2, in the interests of miminising time and cost.

33.3.2 Mrs Goldsmith explained that she had intended to present a report on the overall costs associated with Supplemental Agreement 4 . She advised that there has been significant technical, due diligence, and management cost for all parties. Mrs Goldsmith advised that she is working on a report on the cost of all changes (not just Supplemental Agreement 4), sharing this with the Government, and will bring a report to a future meeting of the committee.

33.3.3 Mrs Goldsmith advised that the project is still on track to be complete by the end of January 2020. There is a need to continually manage risks associated with Covid-19 but good progress is being made. She advised that management are working with clnical services to develop a timetable for them to re-locate to the new facility, but highlighted that they will not move at the end of January. Mr Graham highlighted that two out of the five medium-value changes are already complete, and there is good progress on the others. In response to a query from Mr Hill, Mr Graham advised that the reported risk relating to the independent tester is a matter for commercial negotiation, and is not a significant risk.

33.3.4 The Committee agreed to:

- Approve the adoption of the risk and commercial template of Supplemental Agreement 2 into Supplemental Agreement 4 to document these further enhancement works;

- Recommend to the Board that it delegate authority to the Chief Executive and/or the Director of Finance to complete Supplemental Agreement 4 and sign it on behalf of the Board; and

- Take significant assurance that the technical, legal and commercial basis of Supplemental Agreement 4 has been and will be approved through the existing Executive Steering Group and Scottish Government's Oversight Board, in line with that adopted for Supplemental Agreement 2.

34. Revenue

34.1 August 2020 Financial Position/ Quarter One Review

34.1.1 Mr Marriott presented the previously circulated paper. In response to a query from Mr Hill, he explained that there is no direct relationship between the year-to-date costs for Covid-19 (£43m) and the £11m which the Scottish Government provided to integration joint boards to maintain care services. Mr Hill commented that is difficult to assess the size of the risk of unfunded Covid-19 expenditure.

34.1.2 Mr Murray referred to the reported reduced/ expenditure/ offsets of £18.3m, and asked if the Board was allowed to carry forward funding to future years. This would cover the costs of a return to normal activity levels. Mr Marriott highlighted that the Board started the financial year with both a care deficit and a financial deficit, and the primary focus at the moment is work through the impact of Covid-19 and understand what the year-end financial position will be. NHS Lothian has not ring-fenced funding for the areas of reduced services, and there will be funding challenges for NHS Scotland next year. Mr Marriott highlighted that NHS Lothian's offsets are higher than other boards, and the scenario-planning focuses on financial outlook, rather the profile of service delivery. In response to a query, Mr Marriott confirmed that the Board does not have cashflow issues.

34.1.3 Mr Marriott presented the results of the Quarter One review, which forecasts a 2020/21 year-end outturn of a deficit of just under £107m. He advised that there should be some certainty on Government funding at the end of October. The finance team will review the forecast again at the end of January 2021.

34.1.4 Mr McCann asked whether NRAC funding was being discussed for 2021/22. Mr Campbell stated that as a minimum the Board should get its share, but also highlighted that it is unfair to simply link NRAC funding to organisational performance. There is an issue in terms of a lack of infrastructure, and a disparity between the infrastructure in Glasgow and Edinburgh.

34.1.5 With regard to the additional cost of remobilisation, Mr Hill asked what decisions still need to be taken regarding remobilisation. Mr Marriott explained that the bulk of the costs related to activities to achieve access targets. Mrs Campbell advised that management are looking to issue a tender to see if the independent sector can provide capacity for orthopaedic services. This would provide the orthopaedic service some protection from the impact of a second wave. There are a number of other services which have requested support.

34.1.6 The Committee agreed that based on the information at this stage, NHS Lothian remains only able to provide limited assurance on its ability to deliver a breakeven position in 2020/21.

34.2 Sustainable Development Framework and Action Plan

34.2.1 Dr Hopton presented the report.

34.2.2 Mr McQueen welcomed the framework and action plan and asked how the organisation can effectively engage staff in taking it forward , and keep the document live. Dr Hopton explained that is possible to incorporate this into appraisals and personal development planning. Individuals can do things in both their work and private lives, and no action is too small. She explained that the framework has been kept purposely simple so that it can be easily translated into the plans of everyone, and management will update the framework continuously.

34.2.3 Mr Murray commented that this should be an issue for the whole Board, and the Board needs to give explicit commitment to it. This is important for communication with community planning partnerships and other stakeholder organisations. Dr Hopton agreed that Board level support is needed, however at the moment the subject and how it is communicated requires some further thought and development.

34.2.4 Mr McCann commented that it will be important to be able to communicate the financial benefits of implementing the action plan, as that will encourage buy-in to the strategy. Dr Hopton explained that the Executve Leadership Team has agreed to give further consideration to establishing analytical support to work through the detail, as this will help identify the potential financial benefits.

34.2.5 Mr Hill asked how we can secure the potential gains through changing the approach to using pharmaceuticals. Dr Hopton confirmed that pharmacists are interested in exploring this in a future webinar, and they will be considering polypharmacy, reducing waste, and reducing the use of drugs which have a high carbon impact. NHS Lothian is effective at prescribing, however there is more that can be done.

34.2.6 Mr Hill stated the integration joint boards need to own this subject, as well as health boards. Mr Campbell commented that if we can develop the right approach it can be part of the governance framework.

34.2.7 The Committee agreed to:

- endorse the Sustainable Development Framework and Action Plan, recognising the importance of endorsing the framework to set ambitions and a direction for engagement on the NHS within Scotland, across NHS Lothian and with partner organisations;

- recommend the Sustainable Development Framework and Action Plan to the NHS Board;
- note the current opportunity for NHS Lothian to maximise the benefits of the high level of interest and motivation from staff and the important opportunity of a Green Recovery from Covid 19; and
- note the support for the Framework from the Executive Leadership Team and their further consideration needed to address the immediate and high priority gaps in capacity to implement and develop the Framework and Action Plan.

34.3 Procurement Assurance and Procurement Annual Report 2019/20

34.3.1 Mr Cambridge presented the report, highlighting that NHS Lothian had retained an assessment of 'Superior – A+' in the latest Public Procurement Reform Programme assessment cycle. He highlighted that this is the result of a great team effort which puts the function in a strong position to support financial recovery. In 2019/20 procurement activity delivered £2.1m of savings.

34.3.2 Mr Cambridge provided an update on a project to develop a collaborative approach to procurement in the East and North of Scotland. A Programme Board is in place, and the intent is to present a business case to partner NHS Boards in February 2022. Mr Cambridge highlighted that Covid-19 and no-deal BREXIT may create slippage to normal procurement business.

34.3.3 Mr Murray asked if there could be an elevated commitment to the sustainability agenda within the approach to procurement. Mr Cambridge confirmed that he welcomes this, and it is part of the procurement action plan which supports the Board's sustainability action plan. He commented that it would be better if all Boards had firmer Board operational targets on sustainability, rather than worthy aims which not all Boards are systematically progressing.

34.3.4 Mr McQueen advised that he would welcome a fuller description of how savings and cost avoidance are calculated within the 2020/21 Procurement Annual Report.

34.3.5 The Committee agreed to the recommendations in the report, which included taking significant assurance that the NHS Lothian procurement function is in a strong position to support the organisation, and to approve the publication of the annual report.

34.4 Public Sector Reform Act Disclosures

34.4.1 Mrs Goldsmith presented the report, and the Committee agreed to approve the disclosures for publication.

34.5 RHCYPDCN – Legal Advice

34.5.1 Mrs Goldsmith summarised and presented the legal advice. The Committee considered advice and agreed that it was appropriate to instruct further advice on the time bar issue. The Committee agreed it would be appropriate to consider that advice before exploring the issue further.

35. Committee Business

35.1 Role of the Committee on Oversight of Governance during the Inquiry

35.1.1 Mr Campbell presented the report. Mr McQueen asked if the Board has tasked an individual to monitor what is happening at the inquiry in order to get real-time feedback. Mr Campbell agreed to explore that point. **CC**

35.1.2 Mrs Goldsmith advised the Committee that Lord Brodie has given the Board an opportunity to prepare an opening statement, its perspective on events. She advised that she intends to present this to the October Board, and will circulate a draft to Committee members for comment. **SG.**

35.1.3 The Committee agreed to adopt the following extended governance scope during the period of the public inquiry:

- scrutinise the expenditure/ value of the legal support provided;
- identify any key issues that need reporting to the NHS Board; and
- consider any lessons learned and how they can be adopted in all future developments.

35.2 Reflection on the meeting

35.2.1 The Committee agreed that the key issues to highlight to the Board were the initial agreement on cancer services, legal advice, sustainability, and to acknowledge the very positive assessment of the procurement function .

36. Date of Next Meeting

36.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 28 October 2020**.

37. Meeting Dates in 2020

37.1 Further meetings would take place on the following dates in 2020:
- 25 November 2020.

Signed by the Chair
Date: 11 November 2020

Original kept to file

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 28 October 2020 by videoconference.

Present: Mr M. Hill, Non-Executive Board Member (Chair); Ms T. Gillies, Medical Director; Ms S. Goldsmith, Director of Finance; Mr A. McCann, Non-Executive Board Member; Mr B. McQueen, Non-Executive Board Member; Professor M. Whyte, Non-Executive Board Member.

In Attendance: Mr M. Egan, Director of Digital (item 40.3); Mr I. Graham, Director of Capital Planning and Projects; Dr J. Hopton, Programme Director, Facilities (item 41.3); Mr P. Lock, Director of Improvement (item 40.3); Mr A. McCreadie, Head of Management Accounts; Mr M. Pryor, Asset Development Director.

Apologies: Mr C. Campbell, Chief Executive; Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Mr P. Murray, Non-Executive Board Member; Mr J. McGinty, Non Executive Board Member; Mr 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.

38. Committee Business

38.1 Minutes and Actions from Previous Meeting (23 September 2020)

38.1.1 Members accepted the minutes from the meeting held on 23 September 2020 as a correct record.

38.1.2 The updated cumulative action note had been previously circulated.

39. **Matters Arising**

39.1 Public Private Partnership Contract Management

39.1.1 The chair welcomed Mr Pryor to the meeting and he spoke to the previously circulated paper. It was agreed that work in getting the adjudicator in place should begin soon and Ms Goldsmith advised that Scottish Futures Trust would bring technical support. Two roles were being secured in NHS Lothian for project management support through the organisational change process.

39.1.2 Members accepted the recommendations laid out in the paper and accepted significant assurance. An update on progress would be brought to the Committee at the meeting in January 2021.

40. Capital

40.1 Property and Asset Management Investment Programme

40.1.1 Mr Graham presented the previously circulated paper. It was noted that there had not been an outcome yet on the Scottish Government's capital spending review. Some work was being done to show the risk to infrastructure if there was not sufficient investment. It was hoped that the Scottish Government would commit to the new cancer centre in its manifesto.

40.1.2 Members accepted the recommendations laid out in the paper and approved the 2020/21 -2024/25 Property and Asset Management and Investment Programme, accepting moderate assurance on the delivery of the 2020/21 Asset Management and Investment Programme.

40.2 Partnership Centre Bundle (Blackburn, Alliemuir, Pennywell): Post Project Evaluation, September 2020

40.2.1 Mr Graham presented the previously circulated paper. It was noted that there had been a change in the accounting standard during the application process which had meant that there was limited time at the end to complete the application, which was complex due to the number of parties involved. Work had been ongoing earlier on change to the new standard, but at short notice there had been an instruction that the application needed to be completed or the opportunity for funding would be lost.

40.2.2 One of the challenges of this project had been working with the different groups for a multi use building and more work needed to be done on ensuring the most efficient relationship. The primary care team was small and was developing skills in this area. Models for partnership centres were much improved compared to previous years and user feedback was generally good.

40.2.3 Mr Graham advised that the evaluation document would be shared with stakeholders through health and social care partnership, primary care and community links and would be part of published documentation for preparing business cases. The Finance and Resources Committee could also take into consideration learning from previous projects when approving business cases.

40.2.4 Mr Graham advised that there had been significant improvement on partnership working through Integration Joint Boards in more recent projects.

40.2.5 Mr Graham advised that confidentiality at reception desks was part of design and operational protocol to be agreed early in the process. This was the case across the estate and was not specific to primary care centres.

40.2.6 Members accepted the recommendations laid out in the paper and accepted significant assurance on the post project evaluation process.

40.3 Initial Agreement – Digital Strategy

40.3.1 The chair welcomed Mr Lock and Mr Egan to the meeting and Mr Lock gave a presentation. A paper had been previously circulated.

40.3.2 It was noted that the model for upgrade of equipment prioritised seniority of staff rather than clinical need. This was due to a calculation of efficiency gain – staff of higher grade cost more so had a higher time efficiency gain if less time was spent on travel or logging into equipment on different sites.

40.3.3 Although the number of NHS Lothian staff was approximately 24,000, the number of active users on the system was approximately 32,500. This included primary care staff, Health and Social Care Staff and staff on secondment mostly in the analytics team; NHS Lothian provided devices for most of these.

40.3.4 The Digital Oversight Board would be a dedicated management Committee to bring oversight to the digital strategy at the executive level. Members would include the executive leadership team and eHealth department leads. The first meeting would be held the following week where the terms of reference would be agreed.

40.3.5 The business case for the refresh programme was in progress and it was hoped that this could be implemented quickly. Most of the distribution of new equipment would be carried out by a contractor with a small project team of NHS Lothian employees responsible for coordination and survey of staff. This model had worked well on recent projects.

40.3.6 The potential cost and efficiency benefits of introducing digital appointment booking for patients was noted. Mr Egan advised that there had been national work on this but progress had been slow. A local solution could be discussed.

40.3.7 Mr Egan advised that decommissioned equipment had hard drives removed and was sent to an approved charity for refurbishment and reuse.

40.3.8 The digital strategy would be progressed through the capital plan with the business case going to the Lothian Capital Investment Group for approval as appropriate for the cost level.

40.3.9 Members accepted the recommendations laid out in the paper and approved the strategic direction set out.

41. Revenue

41.1 Month 6 Financial Position

41.1.1 Mr McCreadie presented the previously circulated paper. He noted that the financial impact of a second wave of COVID-19 was not yet clear. Physical capacity and workforce were limited resources even if funds were made available to purchase them.

41.1.2 Members accepted the recommendations laid out in the paper and accepted limited assurance on reaching a breakeven position in 2020/21.

41.2. Financial Plan 2021/22 – Initial Assessment

41.2.1 Ms Goldsmith noted that this was the start of the process for next years' financial plan and would be used for yearly reviews and also to inform the Scottish Government on expected future costs. The reduction in capacity due to COVID-19 measures was a concern, along with population growth at a higher rate than anywhere else in Scotland.

41.2.2 Mr McCreadie spoke to the previously circulated paper. Figures for additional COVID-19 costs had been kept separate as much as possible from capacity costs as there had been a backlog of cases before COVID-19. However, COVID-19 had caused this to get bigger. The projected spend on improving access was based on the estimated availability of additional private capacity and workforce to purchase. It was agreed that the full cost to reset the backlog should be worked up to show the extent of the challenge. This would be included in the next update. **SG**

41.2.3 Mr McCreadie advised that the 2% staff pay uplift was based on the full staff numbers and did not include temporary fluctuations or look at specific roles. Due to the large number of staff this approach was usually a sufficient estimate.

41.2.4 It was noted that the NRAC funding formula was not related to population and there was not a full understanding within it of the connection between cost and demographic change and it did not include whether population growth was in the demographic groups that generated the highest NHS costs.

41.2.3 The concern was raised that concentration on the financial position could increase the access to treatment deficit and it was noted that there should be a balance of priorities. Ms Goldsmith noted that there was a need to better describe the relationship between funding, NRAC share, the impact on services and access to care, and the strategic challenges.

41.2.4 Members accepted the recommendations laid out in the paper.

41.3 <u>Climate Change and Sustainability</u>

41.3.1 The chair welcomed Dr Hopton to the meeting and she gave a verbal update. The Sustainability Framework had been deferred until the Board meeting in December to give time to include the comments received. It had been sent to staff side through the Partnership representative for comments and there would also be engagement with the local councils and Integration Joint Boards.

41.3.2 The non domestic energy efficiency fund framework was available for applications for funding especially for smaller projects and work was ongoing to design projects ready for applications by the end of March 2021. This would be approved through Lothian Capital Investment Group first.

41.3.3 Sustrans was offering an opportunity for a post to work with NHS Lothian as part of their active travel fund. Expressions of interest were due by 6 November 2020 so the team was looking to get commitment to this to maximise the engagement with staff on cycling and walking to work. The post would be fully funded for the first year but NHS Lothian would contribute 50% in years two and three and they would be employed by Sustrans. The Committee agreed to support this in principle.

41.3.4 More work was needed on carrying out environmental impact assessments in development and building projects as part of the integrated impact assessments carried out and Chris Bruce, Lead on Equalities and Human Rights, was working on a development meeting to take this forward. This would also cover Health and Social Care Partnerships and Integration Joint Boards.

41.3.5 The Biodiversity Report would be available in December 2020 and would be submitted to the Finance and Resources Committee at its January 2021 meeting. **JH**

42. Committee Business – private session

42.1 Legal Advice

42.1.1 Ms Goldsmith spoke to the previously circulated paper. Members agreed to proceed with the next steps laid out in the paper.

42.2 Reflection on the Meeting

42.2.1 Mr Hill agreed to highlight at the next Board meeting the discussion on the digital devices programme and the financial update for 2020/21 and for 2021/22. Ms Goldsmith would also update the Board on the legal advice discussed, in the private session.

43. Date of Next Meeting

43.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 25 November 2020**.

44. Meeting Dates in 2021

44.1 Meetings in 2021 would take place on the following dates:
- 20 January 2021
- 10 March 2021
- 21 April 2021
- 2 June 2021
- 14 July 2021
- 25 August 2021
- 13 October 2021
- 17 November 2021.

Signed by the Chair on 25-11-2020
Original in file

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 8 September 2020 by video conference.

Present: Professor M. Whyte, Non Executive Board Member (chair until 12.00); Ms P. Collings, Patient and Public Representative; Dr P. Donald, Non Executive Board Member; Councillor George Gordon, Non Executive Board Member; Ms C. Hirst, Non Executive Board Member (chair 12.00-13.00); Ms P. Whalley, Patient and Public Representative.

In attendance: Ms M. Barrow, Chief Officer, Midlothian Health and Social Care Partnership; Ms C. Bebbington, Primary Care Manager, West Lothian Health and Social Care Partnership; Ms J. Bennett, Associate Director for Quality Improvement and Safety; Ms J. Campbell, Chief Officer, Acute Services; Ms L. Cowan, Chief Nurse, East Lothian Health and Social Care Partnership; Ms T. Gillies, Medical Director; Mr I. Gorman, Head of Operations, East Lothian Health and Social Care Partnership; Ms L. Guthrie, Lead Infection Prevention and Control Nurse (item 26.1); Ms G. McAuley, Nurse Director, Acute Services; Professor A. McCallum, Director of Public Health and Health Policy; Ms T. McKigen, Services Director, Royal Edinburgh Hospital (item 29.3); Professor A. McMahon, Executive Nurse Director; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Ms A. Wall, Associate Director of Pharmacy; Dr C. Whitworth, Medical Director, Acute Services.

Apologies: Mr J. Crombie, Deputy Chief Executive; Ms M. Hughes, Chief Nurse, West Lothian Health and Social Care Partnership; Ms F. Ireland, Non Executive Board Member; Ms A. Macdonald, Chief Officer, East Lothian Health and Social Care Partnership; Ms J. Macrae, Chief Nurse, Edinburgh Health and Social Care Partnership; Ms J. Morrison, Head of Patient Experience; Ms J. Proctor, Chief Officer, Edinburgh Health and Social Care Partnership; Ms L. Rumbles, Partnership Representative; Mr A. Short, Chief Officer, West Lothian Health and Social Care Partnership; Professor A. Timoney, Director of Pharmacy.

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.

24. Minutes from Previous Meeting (14 July 2020)

24.1 The minutes from the meeting held on 14 July 2020 were approved as a correct record.

24.2 The updated cumulative action note had been previously circulated.

25. Patient Story

25.1 Ms Whalley read out feedback from a patient who had been on the waiting list for several months for an operation which was then cancelled due to the COVID response. Follow up with GP and at the Emergency Department had indicated that the need for the operation was urgent, but it was not available.

25.2 Members noted that this would be a common scenario as waiting times deteriorated due to routine operations being cancelled. A communication strategy was needed to help patients to understand the situation. Ms Campbell advised that this was recognised and that action was being taken. The need for support to primary care and acute staff to ensure appropriate communication when patients made enquiries was also noted.

25.3 Letters were sent to patients on the waiting list and it was suggested that the patient and public representatives could be involved in reviewing the content of these.

25.4 Communication with patients regarding alternatives to surgery should be considered when routine waiting times are very long, as the risk benefit balance would be altered.

26. Emerging Issues

26.1 <u>COVID-19 Response and Remobilisation</u>

26.1.1 Ms Gillies gave a verbal update on the plans to reopen services while maintaining safety measures to reduce risk of transmission of COVID-19. The Board was working closely with the Scottish Government on implementing 4 nations guidance that included guidance regarding physical distancing and cohorting of staff and patients. Implementation of this guidance was likely to negatively impact on waiting times and access to treatment and there was more work to be done on where the balance of risk lay.

26.1.2 The chair welcomed Ms Guthrie to the meeting and she went over the 4 nations infection control guidance issued by the Health Protection Agency in England on behalf of the four UK nations. The previous guidance had advised a two pathway system separating COVID and suspected COVID patients from non COVID patients. The new guidance wa for a three pathway system with a ‘red’ pathway for patients who had tested positive for COVID or had symptoms of COVID and were awaiting a test result, ‘amber’ for patients where there was no suspicion of COVID infection but who may have been in contact with COVID in the community in the past 14 days, and ‘green’ for patients who were attending hospital for elective surgery and had self isolated for 14 days and received a negative COVID test result. Ms Guthrie described the range of precautions to be taken with patients in each pathway and what the implications might be for capacity.

26.1.3 Ms Gillies advised that the guidance should have been implemented from 7 September 2020 but this had not been possible as the risks and implications for patient access, given the majority of patients had not had contact with COVID-19, were still being worked through. The risk register should be updated to reflect this. The aim was to have a risk based approach to the guidance and, where it was not being followed due a greater risk to patient access, this decision would be supported by a rationale and a risk assessment. It was noted that some areas in England were also taking a risk based approach rather than full implementation of the guidance. **TG**

26.1.4 Ms Guthrie advised that there would need to be a rationale if testing of all patients and staff for COVID-19 was to be considered as a negative test was not reliable unless the patient had isolated since the sample was taken, and increased laboratory capacity would be required. Patients would still need to be placed while waiting for the result.

26.1.5 Members agreed to support the working through of the implications of the guidance and a risk-based approach rather than immediately implementing the guidance in full. The risk register should be updated as there could no longer be moderate assurance on the access to treatment risk. **TG**

26.1.6 A paper laying out these issues and the results of the assessment would be presented to the full Board.

27. Health and Social Care Partnership Assurance Reports

27.1 East Lothian Health and Social Care Partnership Annual Report

27.1.1 A paper had been previously circulated. Ms Cowan gave a presentation. Ms Cowan advised that interactions with the care home sector had been positive during the COVID-19 period and that care home management had been grateful for support. Discharge of patients to care homes was now quicker as telephone rather than physical assessments were taking place. A care home team carried out staff education sessions in care homes.

27.2 Ms Cowan described the current key risks as general practice sustainability and the developing needs of primary care provision and understanding what COVID-19 had done to change these.

27.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance that governance arrangements were in place.

27.2 Edinburgh Health and Social Care Partnership

27.2.1 A paper had been previously circulated. Unfortunately due to sickness no one from the Health and Social Care Partnership was available to present; the paper would be brought back to the next meeting. **JP**

27.2.2 No risks were noted in the risk section of the paper; this was to be explored further regarding care home and home nursing risks and mitigations. It was noted that some examples of good practice were also present in the paper including the establishment of the Clinical and Care Governance Committee chaired by Dr Richard Williams and the addition of palliative care as a supported service.

27.2.3 A decision on the recommendations was deferred to the next meeting.

27.3 Midlothian Health and Social Care Partnership

27.3.1 A paper had been previously circulated and Ms Barrow gave a presentation. The low number of complaints received for services was noted as a positive indicator.

27.3.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance that governance arrangements were in place. Ms Barrow agreed to bring a short paper to the next meeting describing the change in the governance committee structure. **MB**

27.4 West Lothian Health and Social Care Partnership

27.4.1 Ms Bebbington presented the previously circulated paper. She noted that any risks to delivery of person centred, safe and effective care would be raised at regular meetings with staff and senior management across the Partnership which would then feed into the Senior Management Team meetings and subsequently to the Partnership's Healthcare Governance Committee.

27.4.2 Members accepted the recommendations laid out in the paper and accepted moderate assueance that governance arrangements were in place.

27.4.3 All four Healthcare and Social Care Partnership annual reports had been discussed by the patient and public representatives group prior to the meeting. Ms Whalley reported that they had noted that all four Partnerships used different reporting methods which made it difficult to compare data. Ms Gillies advised that a system was in development which primary care practices would sign up to for recording data.

27.4.4 The patient and public representatives group had commended the use of patient experience stories in East Lothian. They had noted that Midlothian was the only Partnership that completed the sections of the paper template on impact on inequalities and engagement with service users.

27.4.5 Professor Whyte advised that NHS Lothian had oversight on the Healthcare Governance processes of the Health and Social Care Partnerships and required assurance that appropriate processes were in place. Both the Council and the NHS Board were responsible for the Partnership so reporting was to both groups.

28. Person Centred Care

28.1 Patient Experience and Feedback

28.1.1 Ms Morrison presented the previously circulated paper. The response time to complaints was not within 20 days, but Ms Hirst noted that dialogue with patients and clinicians and a better quality response was as important than meeting the target. This could be measured by the low uphold rate of appeals to the Public Services Ombudsman.

28.1.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance, as well as supporting the development of the business case.

29. Safe Care

29.1 Safe Patient Care During COVID-19

29.1.1 Ms Gillies presented the previously circulated paper and noted that since the end of March non executive directors' patient safety walk arounds had not taken place due to

pressure on staff, including dealing with requests for feedback and changing guidance. A virtual version of walk around meetings with key staff could be considered once the new guidance had been implemented. Dashboards were being used to capture ward level patient safety data and were useful monitoring tools.

29.1.2 Members accepted the recommendations laid out in the paper and accepted significant assurance that monitoring was in place and moderate assurance that safety improvement plans were in place.

Professor Whyte left the meeting and the Chair was taken over by Ms Hirst

29.2 Healthcare Associated Infection Update

29.2.1 Professor McMahon presented the previously circulated paper; members accepted the recommendations laid out and accepted moderate assurance.

29.3 REAS Governance – inpatient adult services

29.3.1 The chair welcomed Ms McKigen to the meeting and she presented the previously circulated paper which covered specifically REAS services which were delegated to the Integration Joint Boards but which were managed operationally by NHS Lothian using NHS Lothian staff and facilities.

29.3.2 It was noted that there had been a delay in full implementation of Near Me virtual patient consultation technology but that an order of devices for staff had now been received.

29.3.3 Professor McMahon advised that there would be close working with appropriate community services, for instance the crisis centre in Leith with 6 beds, to help reduce delayed discharges from REAS services. Edinburgh Health and Social Care Partnership would be requested to provide a paper focussed on this work to the next meeting. **JP / AMcM**

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

30. Effective Care

30.1 Safe and Effective Cancer Care as part of COVID-19 Remobilisation

30.1.1 Ms Gillies presented the previously circulated paper. The impact of the new COVID guidance on demand and capacity as previously discussed were noted. Ms Gillies advised that later stage presentation due to lack of access to services would lead to poorer outcomes.

30.1.2 Ms Gillies advised that some work was being done to increase chemotherapy and radiotherapy provision with social distancing in the community, but noted that for example in breast cancer 80% of the curative result was based on surgery, so access to surgery remained the priority.

30.1.3 A further report would be submitted in January 2021 including data on presentation stage and on systemic anti cancer treatment. **TG**

30.1.4 Members accepted the recommendations laid out in the paper and accepted limited assurance on access to treatment for cancer patients.

30.2 Move to new hospital – Department of Clinical Neurosciences and Children's Outpatients

30.2.1 Ms Gillies gave a verbal update and reported that inpatient and outpatient Department of Clinical Neurosciences services were now in the new hospital along with 70% of children's outpatient services. Staff were reporting positive experience working in the new hospital. The move for Children's inpatients and CAMHS services was anticipated to be a few weeks after the January 2021 handover date recently announced.

31. Exception Reporting Only

31.1 Pregnancy and New Born Screening Annual Report

31.1.2 Ms Gillies advised that this report had originally been on the agenda for this meeting but had been removed due to ongoing discussion on governance reporting as screening services were reopened.

31.2 Resilience Annual Report

31.2.1 The report had been previously circulated for information. Ms Gillies advised at a later date work would be done to draw out themes how well resilience plans had worked in light of COVID-19.

31.3 Members noted the following previously circulated papers:

31.3.1 Blood Transfusion Annual Report;
31.3.2 Edinburgh Transplant Service Annual Report;
31.3.3 Resilience Annual Report;
31.3.4 Sexual Health and Blood Borne Virus Programme Board Annual Report.

32. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

32.1 Area Drug and Therapeutics Committee, 5 June 2020;
32.2 Clinical Management Group, 11 February, 14 April, 11 May 2020;
32.3 Information Governance Sub Committee, 28 January 2020;

33. Corporate Risk Register

33.1 Ms Bennett presented the previously circulated paper. It was agreed that access to treatment was a risk for this Committee and based on discussions at this meeting a paper on this would be brought to the next meeting. **TG**

33.1.2 Members accepted the recommendations laid out in the paper regrading risks and new risks.

34. Date of Next Meeting

34.1 The next meeting of the Healthcare Governance Committee would take place at **9.00am** on **Tuesday 10 November 2020** by video conference.

23. Further Meeting Dates

23.1 Dates for 2021 to be confirmed.

Signed by the Chair
Date: 10 November 2020

Original kept to file

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 9.30 on Wednesday 29 July 2020 via Microsoft Teams

Present: Mr W. McQueen, Non-Executive Board Member (Chair); Ms A. Mitchell, Non-Executive Board Member; Councillor J. McGinty, Non-Executive Board Member; Mrs Katharina Kasper, Non-Executive Board Member (Whistleblowing Champion); Ms H. Fitzgerald, Partnership Representative; Ms J. Butler, Director of Human Resources; Miss T. Gillies, Medical Director; Councillor D. Milligan, Non-Executive Board Member; Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive and Professor A. McMahon, Executive Nurse Director.

In Attendance: Ms R. Kelly, Deputy Director of Human Resources; Ms A. Langsley, Associate Director of Organisational Development and Learning; Mr G. Curley, Director of Operations, NHS Lothian (Item 10.1.1); Ms C McDowall, NHS Lothian Speak Up Ambassador (Item 11.2); Ms H Monaghan, NHS Lothian Speak Up Ambassador (Item 11.2); Mr C Bruce, NHS Lothian Lead on Equalities and Human Rights (Item 11.5); Ms R Suleiman, NHS Lothian Equality and Diversity Adviser (Item 11.5) and Mr C Graham, Secretariat Manager.

Apologies: Mr A. Joyce, Non-Executive Board Member and Ms C. Hirst, Non-Executive Board Member.

Chair's Welcome and Introductions

Mr McQueen thanked Ms Mitchell for her commitment and work for the Committee over the years and also thanked her for the detailed briefing provided ahead of today's meeting. It was noted that Ms Mitchell had accepted the role of Vice Chair of the Committee.

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.

8. Minutes and Action Note of the Previous Meeting of the Staff Governance Committee held on 27 May 2020

8.1 The minutes from the meeting held on 27 May 2020 were approved as a correct record.

8.2 The Committee noted the updated cumulative action note and accepted that due to the Covid19 pandemic much of the normal committee business had been paused. A fuller update on outstanding actions would come to the October 2020 meeting.

9. Matters Arising

9.1 No matters arising not covered on the agenda.

10. Assurance and Scrutiny

10.1 Corporate Risk Register

10.1.1 3328 – Risks Associated with Traffic Management - The Committee received the report providing information on the risks, their significance and the mitigating actions being taken and further assurance required relating to Traffic Management across NHS Lothian.

10.1.1.1 The Committee noted the contents of the paper and agreed to accept limited assurance given the significant issues and mitigating actions being deployed.

10.1.2 3455 –Management of Violence and Aggression - The Committee noted the report providing a further update on work being undertaken to improve the current level of support to staff on Violence and Aggression (V&A) management.

10.1.2.1 The Committee agreed to take a moderate level of assurance regarding the implementation of the actions and a moderate level of assurance in relation to the process.

10.1.3 3527 – Medical Workforce Sustainability - Miss Gillies updated the Committee on the current level of risk in relation to medical workforce sustainability. There was discussion around Doctors in Training; NES recruitment; job planning, Extra Programmed Activities (EPAs); pension changes; appointment panels process and incentives to work within NHSL

10.1.3.1 The Committee acknowledged the unprecedented measures that have been taken to support sustainability during the Covid-19 pandemic within both the trained and training grade workforces. The Committee also noted the changing position for recruitment of trained doctors, in terms of fill rates and the often reduced number of applications.

10.1.3.2 The Committee also acknowledged the measures underway to recruit further clinical fellows to support services where there are gaps and noted that there is a need for a greater emphasis on developing more permanent workforce solutions along with the substantial change to the UK pension tax regulations which should remove the vast majority of staff from pension tax charges, whilst changes to the UK public sector pensions are under consultation.

10.1.3.3 The Committee noted that the level of risk remains unchanged at high and that the impact of The Covid-19 pandemic and any further waves had the potential to increase risk further. The committee agreed to accept a moderate level of assurance that the controls in place mitigate any risks to immediate patient safety and quality of care related to this.

10.1.4 3828 – Nurse Workforce – Safe Staffing Levels - Professor McMahon updated the Committee on the risk around safe staffing levels which had been refocused to reflect the issues arising from the Covid-19 pandemic and any pending second wave.

10.1.4.1 The Committee noted that the Health and Care Staffing (Scotland) legislation (commonly referred to as the “safe staffing legislation”), programme had been temporarily suspended by the Scottish Government in March 2020. The work in Lothian to address the nursing and midwifery staffing levels to manage the COVID 19

pandemic to date and what will be deployed in the event of a second wave was also noted along with the detail of the plan to manage the additional workforce and how staff could be engaged on a more permanent arrangement.

10.1.4.2 The Committee supported the increased risk level of risk ID 3828 as a consequence of the Covid-19 pandemic and the uncertainty around staffing requirements as the pandemic progresses to any pending second wave. The risk will be increased to high with a risk score of 12, from medium with a risk score of 6.

10.1.4.3 The Committee would also took significant assurance that there is a robust mobilisation plan and mechanism to co-ordinate the responses across the nursing and midwifery workforce and agreed to accept limited assurance that there was sufficient capacity in the event the pandemic required that the Board delivers a full surge plan in acute and community, including supporting the NHS Louisa Jordan Hospital.

10.2 **Health and Safety Assurance**

10.2.1 Miss Gillies provided an update on the risk assurance levels for the quarter three Health and Safety prioritised risk topics - Safer Clinical Sharps; Fire Safety and "Other" Risk Assessments. These had been submitted to and discussed at the NHSL Health and Safety Committee from most local area H&S Committees in February 2020.

10.2.2 There was discussion on the H&S Team's work in supporting staff face fit testing and risk assessments and the pressures on the Team around this; the further development of the documentation on which the local committees levels of assurance are based and water safety. There would be a separate paper on water safety brought to the next Staff Governance Committee. **TG**

10.2.3 The Committee noted that the H&S team are currently developing and updating their intranet pages to allow staff access to all relevant guidance and documentation required to enable the evaluation of data that is linked to assurance level evidence required and proposed future documents are currently being piloted at REH, SJH and WLHSCP.

10.2.4 The Committee agreed to the proposed overall assurance levels for the three risk topics specifically Moderate for Clinical Sharps, Limited for Fire Safety and Moderate for "Other" Risk Assessments.

10.3 **Staff Governance Workplan Update**

10.3.1 Mrs Butler gave an update on the impact of Covid-19 on the Staff Governance workplan and the governance processes surrounding this.

10.3.2 The Committee noted the position around the restarting of some of the national programmes of work and the position on key Staff Governance workstreams, supporting the extension of timelines where necessary due to the impact of the Covid-19 response.

11. Healthy Organisational Culture

11.1 Whistleblowing Monitoring Report

11.1.1 Mrs Kelly introduced the standard report sharing the monitoring data for the Whistleblowing cases that have been raised within NHS Lothian. It was noted that there had been one further whistleblowing case raised since the last report to the Committee in May 2020.

11.1.2 The committee were advised of the current position with the implementation of the new National Whistleblowing Standards which it was noted was currently under discussion between the SPSO and Scottish Government. Possible implementation dates of February or March 2021 had been discussed been as yet there was no final decision. The Committee noted that the Director of HR and OD had notified Scottish Government of the practical difficulties in implementing the new standards and associated transformation programme as we start to remobilise services and with the potential challenges of the winter period. The Committee shared these concerns.

11.1.3 There was also discussion about staff confidence in the whistleblowing process and whether this impacted the number of cases, given that the number of cases raised recently has been lower than previously. The Committee recognised that there was a number of other services and support mechanisms available to staff, (particulary during the response phase of the pandemic) to support local resolution that avoided more formal escalation other the Whistleblowing Policy. Mrs Butler referred to the increased contacts with the Speak Up service during this period. It was agreed that for the next Staff Governance Committee the paper would include an appendix detailing the extant processes to remind committee members of the arrangements. **JB/RK**

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

11.2 Speak Up Initiative Update

11.2.1 The Chair welcomed Ms McDowall and Ms Monaghan, NHS Lothian Speak Up Ambassadors, to the meeting. Ms McDowall and Ms Monaghan gave an update on Speak Up as it comes to the end of its first year..

11.2.2 The Committee recognised the success of Speak Up and noted that they had provided a resource where staff could speak to someone in confidence and have the opportunity to feel heard in a safe environment. There had been 35 internal promotion events undertaken in the first 12 months along with presenting at the Leadership Conference and the Scottish HRD meeting.

11.2.3 The Committee noted the current progress with the implementation of Speak Up in its first year, supported the future direction and commended the work of the Speak Up Ambassadors.

11.3 Learning From COVID

11.3.1 Ms Langsley provided an update on activities being undertaken to promote and harvest the individual, team, system and national learning from Covid-19 in a structured way as it was important to map this and manage strategically. There had been 27 senior leader interviews conducted, below CMT Level, with staff with specific roles around Covid-19. The intention was to provide a summary of key themes back to the Corporate Management Team to look at lessons learned and actions to take forward. The analysis work was at an early stage and was being undertaken by the University of Edinburgh and this was funded through the Edinburgh and Lothian Health Foundation. The Committee noted there would be a further update on the refreshed staff experience and engagement framework to the October Committee meeting and that there may be an opportunity to have the findings of this work set out and discussed more widely at a Board Development Session in future.

11.3.2 The Committee noted that actions were in place to support the reflective learning opportunities in response to Covid-19 which will inform our remobilisation plans and help us work towards the future state, recognising that this practice will help us embed some of the positive transformations that Covid-19 necessitated.

11.3.3 The Committee agreed to take a significant level of assurance that NHS Lothian is taking a proactive and structured approach to learning from Covid-19 and implementing lessons learnt at a strategic level whilst supporting team and individual learning.

11.4 Staff Wellbeing During COVID 19

11.4.1 Ms Langsley reported on the ongoing staff wellbeing response to Covid-19. This was an update to the paper presented at the May 2020 Staff Governance Committee.

11.4.2 There was discussion around the “Here4U” Helpline ; the success of the “Hub in a Tub” intervention and the sustainability of future charitable donations; peer support and looking to close the gap of provision of support to staff working from home.

11.4.3 There was also discussion on the pausing of the iMatter national staff experience tool and the move towards a short pulse survey. This was currently under consideration by the National Scottish Workforce Governance Committee. In relation to staff currently shielding or risk assessed through the Occupational Health Service it was noted that there was to be revised guidance nationally and there would be some upcoming MS Teams sessions for managers to hear about the risk assessment process.

11.4.4 The Committee noted the actions in place to support the ongoing staff wellbeing activity in response to Covid-19 and plans to continue this work in a structured manner through the reactive, recovery and renewal phases of our response to the pandemic.

11.4.5 The Committee agreed to take a significant level of assurance that NHS Lothian continues to place staff wellbeing at the forefront of activity and had robust plans in place to progress this work as NHS Lothian moves in to the next phases of the Covid-19 pandemic.

Mr McQueen welcomed Ms Suleiman and Mr Bruce to the meeting.

11.5 Advancing Race Equality - Mrs Butler introduced Ms Sulieman and Mr Bruce from the Board Equalities team.

11.5.1 Ms Suleiman and Mr Bruce provided an update on actions being taken within NHS Lothian to advance race equality, now and in the medium to long term.

11.5.2 There was discussion around the actions as outlined in Appendix 2 of the paper, that had been agreed with the Executive Team following discussions with the BME Staff Network. The actions are as follows:

1. Ensure executive leadership attendance at the next BME staff network meeting. The date and details of how to attend virtually will be publicised in Speed Read.
2. Work with Partnership, other Boards, and Scottish Government, to ensure we contribute to and adopt a Risk Assessment that explicitly acknowledges and reflects ethnicity and its impact on risk.
3. Support all managers to proactively identify and talk with BME staff to have supportive conversations and offer appropriate risk assessments
4. Ensure that as evidence continues to clarify, we are better prepared for any second wave of Coronavirus infection, and able to proactively support and protect as necessary any and all our staff who may be at increased risk.
5. Develop our Race Equality Action Plan in partnership with the BME Staff Network

11.5.3 In addition, the Committee noted that further actions would be required following two letters from the Scottish Government around race equality and the wider equalities agenda and that these actions would be endorsed through the Board's Corporate Management Team in the first instance.

11.5.4 The Committee noted the actions proposed to address the concerns and issues raised through the BME Staff Network as contained within the Action Plan at Appendix 2 and agreed to receive a update report at the 21 October 2020 meeting which would outline the progress made against each of the actions and also the actions agreed as a result of the letters from the Scottish Government. . It was also suggested that April 2021 would be an appropriate timescale for a fuller report to come to the Staff Governance Committee.

11.5.5 In relation to advancing the workplace equalities agenda more generally it was agreed that this should be built into the Committee's workplan and an update provided at every meeting. **JB/RK**

Mr McQueen thanked Ms Suleiman and Mr Bruce and they left the meeting.

12. Capable Workforce

12.1 Mandatory Training and Appraisal Compliance - Ms Langsley updated the Staff Governance Committee on the current position on mandatory training and appraisal.

12.2 It was noted that it still was not possible to report on mandatory training as a consequence of the move to eESS in March 2020. The work to address this at a national level had been paused due to COVID but it is hoped that this will be progressed in the coming months.

12.3 Ms Langsley added that the ability to report on appraisal compliance had not been lost and it was noted that current compliance as at April 2020 was 39% against 49% for the same period last year. It was noted that staff appraisals had been paused due to the pandemic.

12.4 The Committee noted that draft guidance had been prepared for undertaking appraisals over MS Teams and nationally Lothian was in a unique positon of having the most accurate and robust reporting and methodology.

12.5 There would be a further update on how other boards were approaching these difficulties, brought to the October Staff Governance Committee.

AL

12.6 The Committee agreed to note the challenging position in relation to a lack of mandatory compliance reporting and the actions in place to support appraisal virtually via MS Teams.

12.7 The Committee agreed to take a limited level of assurance that compliance levels with mandatory training are satisfactory and that appraisal compliance will improve in the short term.

13. For Information and Noting

13.1 Staff Governance Statement of Assurance Need - The Committee approved the updated Statement of Assurance Need for 2020/21.

14. Any Other Competent Business

14.1 There was no other business.

15. Date of Next Meeting

15.1 The next meeting of the Staff Governance Committee would take place at **9.30** on **Wednesday 21 October 2020**.

16. Further Meeting Dates in 2020

16.1 Further meetings would take place on the following dates in 2020:
- 16 December 2020.

Signed by the Chair
Date: 21 October 2020

Original kept to file

Minute

Edinburgh Integration Joint Board

10.00am, Monday 24 August 2020

Held remotely by video conference

Present:

Board Members:

Angus McCann (Chair), Councillor Ricky Henderson (Vice-Chair), Councillor Robert Aldridge, Colin Beck, Andrew Coull, Councillor Phil Doggart, Christine Farquhar, Councillor George Gordon, Kirsten Hey, Martin Hill, Jackie Irvine, Jacqui Macrae, Councillor Melanie Main, Ian McKay, Peter Murray, Moira Pringle, Ella Simpson and Richard Williams.

Apologies: Judith Proctor

Officers: Tom Cowan, Tony Duncan, Rachel Gentleman, Lauren Howie, Jake Montgomery, Angela Ritchie and David White.

1. Minutes

Decision

1) To approve the minute of the Edinburgh Integration Joint Board of 21 July 2020.

2. Rolling Actions Log

The Rolling Actions Log for July 2020 was presented.

Decision

1) To agree to close the following actions:
   - Action 1 – IJB Risk Register
   - Action 3 – Committee TORs and Good Governance Handbook
   - Action 5 (2) – Home First
   - Action 7 – Winter Plan 19/20

- Action 10 (1, 2, 3) – 2020/21 Financial Plan
- Action 13 – IJB Governance

2) To note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted.)

3. West Edinburgh (Maybury) General Medical Services Provision

Approval was sought for a proposal to provide General Medical Services in West Edinburgh. An Initial Agreement was presented for consideration, which if approved would be presented to NHS Lothian's Finance and Resources Committee.

Decision

1) To agree the proposal to provide General Medical Services in West Edinburgh.

2) To note that NHS Lothian had invited Edinburgh Health and Social Care Partnership to submit an Initial Agreement for this proposal following the conclusion of the 2020-21 Capital Prioritisation Process.

3) To approve the proposal and agree the presentation of the Initial Agreement to NHS Lothian's Finance and Resources Committee.

4) To request that the comments made during the discussion were reflected at the upcoming NHSL Finance and Resources Committee meeting to be considered when taking forward the business case.

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

4. Annual Performance Report

The draft Annual Performance Report was presented for approval prior to publication in line with the required publication date.

The report noted that the overall performance for the year had remained for the most part in line with national averages, with encouraging signs of improvement in many areas.

Decision

1) To approve the draft Annual Performance Report.

2) To agree a publication date of Monday 31 August 2020.

3) To refer the APR to the next Performance and Delivery Committee meeting.

4) To request information on the number of times last year's performance report was accessed online.

5) To request that information was included in the performance report on the estimated number of health and social care workers outwith those employed by the Council and NHS including unpaid, third and independent sectors.

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

5. Evaluation of 2019/20 Winter Plan

The IJB considered the 2019/20 Winter Plan at its meeting in November 2019. An evaluation report had been submitted which provided an overview of the suite of winter planning actions and services, and an evaluation of the impact of each.

It was noted that winter planning for 2020/21 had commenced with priorities based on lessons learned from the Covid-19 pandemic to date.

Decision

1) To note the Local Review of Winter 2019/20 Report, which was included at Appendix 1 to the report by the Chief Officer.

2) To note that one of the successful outcomes of Winter 2019/20 was that the additional Social Work and Mental Health Officer posts had been funded on an ongoing basis.

3) To note the lessons learned from the COVID-19 pandemic attached at Appendix 2 to the report, which would inform future planning.

4) To note that planning was underway with regards to the key priorities for Winter 2020/21.

5) To agree that the views of the other Lothian IJBs on the process should be sought and to consider providing feedback to the Scottish Government on this.

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

Declaration of interest

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

6. Finance Update

An update was provided on the IJB's projected in-year financial performance.

Decision

1) To note the current year end forecasts provided by the IJB's partners.

2) To note the work ongoing to refine and further understand these.

3) To note that, given the inherent uncertainties, limited assurance on a break-even position could be given at this stage.

4) To note the report had not yet been considered by the Performance and Delivery Committee as noted in the report, but that it would be discussed by the Committee at a future meeting.

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

7. Fair Work and the Living Wage in Adult Social Care

A report provided an update on the implementation of the nationally agreed contract uplifts, the implications for the 2020/21 financial plan and sought approval to implement the uplift and issue the associated direction to the Council.

Decision

1) To agree to implement the nationally agreed 3.3% contract uplift at a cost of £6.0m.

2) To note that this would increase the financial plan gap by £3.4m.

3) To note that the Chief Officer and Chief Finance Officer would continue to work with partners to identify how this would be addressed.

4) To agree to receive an update at the IJB's meeting in October 2020.

5) To agree to issue the direction attached at Appendix 1 to the report by the Chief Finance Officer to the City of Edinburgh Council.

6) To request the figure of the assumed uplift which was previously included in the financial plan.

7) To note that a report would be submitted to the Board meeting in October 2020 setting out options which would enable delivery of a balanced position.

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

8. Annual Review of Standing Orders

The IJB reviewed it's Standing Orders on an annual basis to ensure they remained fit for purpose. It was recommended that no changes should be made to the Standing Orders.

Decision

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

2) To note that the next annual review of the Standing Orders would be presented to the IJB in May 2021.

3) To note the decision taken under emergency powers in relation to the Interim Standing Order for deputations.

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

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within WEBEX VIRTUAL MEETING ROOM, on 22 SEPTEMBER 2020.

Present

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

Non-Voting Members – Allister Short, Robin Allen (substituting for Jo MacPherson), David Huddlestone, Mairead Hughes, Alan McCloskey, Caroline McDowall, Ann Pike, Patrick Welsh and Rohana Wright

Apologies – Jo MacPherson

In attendance – Carol Bebbington (Head of Health), Nick Clater (General Manager - Mental Health and Addictions), Sharon Houston (Business Support Team Manager), Lorna Kemp (Project Officer), Yvonne Lawton (Head of Strategic Planning and Performance), Aileen Maguire (Community Health and Care Partnership), James Millar (Standards Officer) and Isobel Penman (Interim General Manager)

1 ORDER OF BUSINESS

The Chair ruled that agenda items 12 (*Presentation on Commissioned Services - Care at Home*) and 13 (*Care at Home*) would be considered after item 5 (*Note Minutes of Meeting of West Lothian Integration Joint Board Strategic Planning Group held on 30 July 2020*) and that agenda item 8 (*Strategic Commissioning Plan – Alcohol and Drugs Services*) would be considered after item 15 (*Clinical Governance Annual Report*).

2 DECLARATIONS OF INTEREST

There were no declarations of interest made.

3 MINUTES

The Board approved the minute of its meeting held on 11 August 2020 as a correct record.

4 MINUTES FOR NOTING

The Board noted the minutes of the West Lothian Integration Joint Board Strategic Planning Group meeting held on Wednesday 30 July 2020.

5 PRESENTATION ON COMMISSIONED SERVICES - CARE AT HOME

A video presentation was shown, which provided information on Care at

Home Commissioned Services.

Decision

To note the video presentation.

6 CARE AT HOME

The Board considered a report (copies of which had been circulated) by the Head of Social Policy providing an update on the delivery of Care at Home services in West Lothian.

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

Decision

To note the terms of the report.

7 MEMBERSHIP & MEETING CHANGES

A nomination had been received for the appointment of Steven Dunn to replace Martin Murray as Staff Representative for the council and non-voting member as of 22 September 2020.

The Board was also asked to appoint a non-voting member to the Audit, Risk and Governance Committee to replace Martin Murray.

The Board was also asked to appoint a new Chair to the Health & Care Governance Group.

Decision

1. To appoint Steven Dunn as a non-voting member, replacing Martin Murray as West Lothian Council's staff representative effective as of 22 September 2020.

2. To appoint a non-voting member on Audit, Risk and Governance Committee to replace Martin Murray at a later date.

3. To appoint a new Chair to the Health & Care Governance Group at a later date, after consultation with senior officers; a report to be brought to the next meeting before a decision was made.

8 JOINT INSPECTION OF THE EFFECTIVENESS OF STRATEGIC PLANNING IN THE WEST LOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP

The Board considered a report (copies of which had been circulated) by the Chief Officer providing an update on the joint inspection of the effectiveness of strategic planning in the West Lothian Health and Social

Care Partnership and the resulting recommendations.

During discussion, members suggested that using timescales and up-to-date data in the action plan would help with assessing the effectiveness of planning and action implementation.

It was recommended that the Board:

1. Note the inspection report and its recommendations; and

2. Approve development of an action plan to address the recommendations contained in the report for submission at the next meeting of the IJB in November 2020.

Decision

To approve the terms of the report.

9 STRATEGIC COMMISSIONING PLANS - REFLECTIONS AND UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Officer:

1. Providing members with a progress report in respect of commissioning plans for mental health, learning disability and physical disability services and an update on the further development of the commissioning plan for services for older people;

2. Presenting reflections on the pandemic response from engagement with planning and commissioning boards and the IJB's Strategic Planning Group;

3. Presenting members with updated strategic commissioning action plans for mental health, physical disability and learning disability services following a review of each plan in light of experience from responding to the COVID-19 pandemic; and

4. Following implementation of a revised planning structure in April 2019 to support implementation on the IJB's Strategic Plan, providing members with an update on its effectiveness.

It was recommended that the Board:

1. Note progress in relation to the development of the commissioning plan for older people;

2. Note the reflections from members of the Strategic Planning Group and the wide range of stakeholders they represented, on responding to the pandemic and the important role the feedback would have in shaping the future of the partnership;

3. Approve the updated action plans supporting strategic commissioning plans for mental health, physical disability and learning disability services; and

4. note the update on the implementation of revised planning and commissioning structure and keep the structures under review.

Decision

1. To approve the terms of the report.

2. To acknowledge Lorna Kemp's work and to thank all officers involved in producing the paper on Covid-19 reflections.

10 AUDIT OF THE 2019/20 ANNUAL ACCOUNTS

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer advising members of the outcome of the 2019/20 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 Auditor's 2019/20 Annual Audit Report including the management action plan;

2. Agree the audited 2019/20 Annual Accounts for signature; and

3. Note the Audit Risk and Governance Committee's recommendations for agreement, following the Committee's review of the Annual Accounts and Annual Audit report on 9 September 2020.

Decision

To approve the terms of the report.

11 WEST LOTHIAN IJB 2020/21 BUDGET UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2020/21 budget position, including updated Covid-19 financial implications and, based on this, providing a forecast outturn position for the year.

During discussion, members were assured that funding continued to be pursued for additional health and social care costs resulting from the Covid-19 pandemic.

It was recommended that the Board:

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

delegated functions taking account of delivery of agreed budget savings;

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

2. Note that further updates on the 2020/21 budget position and progress towards achieving a balanced budget position would be reported to future Board meetings.

Decision

1. To note the terms of the report.

2. The Chief Officer and Chief Finance Officer to jointly write to the Scottish Government requesting further clarity regarding funding relating to Covid-19.

12 SUPPORTING CARERS IN WEST LOTHIAN

The Board considered a report (copies of which had been circulated) by the Head of Social Policy providing members with an overview of the investment made to support unpaid carers in West Lothian.

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

Decision

To note the terms of the report.

13 CLINICAL GOVERNANCE ANNUAL REPORT

The Board considered a report (copies of which had been circulated) by the Clinical Director providing an annual update on clinical governance arrangements and an overview of clinical service developments.

It was recommended that the Board:

1. Note the contents of the report;

2. Be assured that services are being developed which are integrated and innovative; and

3. Recognise the commitment of staff in delivery of safe effective and person-centred care whilst managing the response to the Covid-19 pandemic and associated challenges.

Decision

To note the terms of the report.

14 STRATEGIC COMMISSIONING PLAN - ALCOHOL AND DRUGS SERVICES

The Board considered a report (copies of which had been circulated) by the Chief Officer presenting the strategic commissioning plan for Alcohol and Drug Partnership (ADP) services in West Lothian and seeking the Board's approval of the plan.

It was noted that further discussions with NHS Lothian might be considered regarding target numbers for drug and alcohol related deaths.

It was recommended that the Board approve the strategic commissioning plan for Alcohol and Drug Partnership services as detailed in Appendix 1 to the report.

Decision

To approve the terms of the report.

15 CHIEF OFFICER REPORT

The Board considered a report by the Chief Officer providing a summary of key developments relating to West Lothian IJB and updating Board members on emerging issues.

It was recommended that the Board note and comment on the key areas of work and service developments that 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.

16 REDESIGN OF URGENT CARE - IMPLEMENTING THE NATIONAL MODEL IN LOTHIAN

The Board considered a report (copies of which had been circulated) by the Chief Officer providing an update on the national redesign of urgent care programme and the project delivery across Lothian.

The potential benefits as well as risks of the approach were then discussed.

It was recommended that the Board note the planned phased approach across Lothian of the implementation of the national redesign of urgent care.

Decision

To note the terms of the report.

17 WEST LOTHIAN SEASONAL FLU PROGRAMME UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Officer presenting the West Lothian Seasonal Flu Vaccination Delivery Plan.

The importance of flu vaccination was reiterated and communications and logistics to that effect were then discussed.

It was recommended that the Board:

1. Note the contents of the report;

2. Acknowledge the planning for delivery of the flu programme and support implementation as outlined in the plan;

3. Recognise the challenges of delivering the programme due to the impact of Covid-19 on our health and social care system; and

4. Be assured that effective plans were in place to deliver the flu programme this winter to protect those at risk, prevent ill health and minimise further impact on health and social care services.

Decision

To note the terms of the report.

18 WORKPLAN

A workplan had been circulated for information.

Decision

To note the contents of the workplan.

East Lothian
Integration Joint Board

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 27 AUGUST 2020
VIA DIGITAL MEETINGS SYSTEM

Voting Members Present:
Councillor F O'Donnell (Chair)
Councillor S Akhtar
Dr P Donald (Items 4 – 6)
Councillor N Gilbert
Ms F Ireland
Mr P Murray

Non-voting Members Present:
Mr D Binnie
Ms L Cowan
Ms C Flanagan
Mr I Gorman
Ms A MacDonald
Mr T Miller

Officers Present from NHS Lothian/East Lothian Council:
Ms L Berry
Mr P Currie
Ms L Kerr
Ms J Ogden-Smith

Clerk:
Ms F Currie

Apologies:
Dr Richard Williams

Declarations of Interest:
None

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD OF 25 JUNE 2020 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board (IJB) meeting on 25 June 2020 were approved.

2. MATTERS ARISING FROM THE MINUTES OF 25 JUNE

There were no matters arising.

3. CHANGES TO THE MEMBERSHIP OF THE IJB AND ITS AUDIT & RISK COMMITTEE

The Chief Officer had submitted a report informing the IJB of changes to its voting membership. The IJB was also asked to appoint a replacement for a retiring voting member on the Audit & Risk Committee and to appoint a new Chair of the Committee.

The Clerk outlined the background and recommendations contained in the report. She invited nominations from members to appoint a replacement for Alex Joyce on the Audit & Risk Committee and to appoint a new Chair of the Committee. Fiona O'Donnell nominated Dr Patricia Donald to replace Mr Joyce on the Committee and to take up the role of Chair. This nomination was seconded by Peter Murray. There were no other nominations.

Decision

The IJB:

i. Agreed to note the appointment of Dr Richard Williams as a NHS Lothian voting member of the IJB, as a replacement for Alex Joyce, and for the maximum term of office;
ii. Considered nominations and agreed to appoint Dr Patricia Donald to replace Mr Joyce on the Audit & Risk Committee; and
iii. Considered nominations and agreed to appoint Dr Donald as Chair of the Committee.

4. HEALTHCARE GOVERNANCE

The Chief Officer had submitted a SBAR report advising the IJB of the requirement for Health & Social Care Partnerships (HSCPs) to produce an annual report on healthcare governance arrangements for the NHS Lothian Healthcare Governance Committee (HGC).

Lorraine Cowan gave a detailed presentation of the report advising members that the HGC's role was to give assurance to NHS Lothian that all services, including those of the HSCPs, have robust governance arrangements in place to assess risks and adverse outcomes for services and their patients and clients, and to take preventative and reactive steps to improve outcomes. The East Lothian HSCP report would be considered at the Committee's meeting on 8th September. Ms Cowan highlighted examples of governance arrangements across different services and the processes for monitoring actions on complaints and adverse events through regular inspections and service audits.

In response to questions from the Chair, Ms Cowan outlined plans for delivery of the flu vaccine across the county. She also advised that nursing recruitment had been very successful and that while there was likely to be increased pressure to recruit to the District Nursing service in coming years to replace staff who were retiring, additional funding had been allocated for this.

Alison MacDonald confirmed that there were no concerns about recruitment at present and she highlighted further recent success in filling vacant posts within Occupational Therapy and Physiotherapy.

Iain Gorman provided further detail on the planned programme of flu vaccinations and steps being taken to encourage uptake in high risk groups. He also addressed the question of continuing anxieties about GP services, the likelihood that telephone or virtual consultations would continue to replace many face-to-face consultations, and the arrangements being put in place to remobilise other GP services.

Mr Murray noted in paragraph 3.44 of the report instances of aggression or violence against staff and asked that it be put on record that the IJB supported a zero tolerance policy on such matters. He also welcomed a number of improvements and good practice highlighted in the report and suggested that a summary be prepared for members. The Chair supported this suggestion.

Ms MacDonald responded to further questions on the need for additional Directions to resource some of the work highlighted in the report and the multi-agency approach to dealing with the increase in drug-related deaths. She also confirmed that there were no GP practices within East Lothian where lists were closed or getting close to being full. However, she acknowledged the need for reprovision or expansion of facilities in some areas.

As Chair of the Clinical and Care Governance Committee, Fiona Ireland commended the report and indicated that issues that appeared to be 'unmitigated' risks had been raised with Ms MacDonald and addressed in good time. Ms Ireland also advised that corporate service issues had been raised with NHS Lothian. She added that as a result of work undertaken previously, East Lothian HSCP had been well placed to support care homes though the pandemic and that this should be celebrated.

Dr Patricia Donald raised further questions about encouraging take up of the flu vaccine in the under 65s who were at greatest risk, and concerns that the shift in workload from secondary to primary care would fall mainly on GP practices.

Ms MacDonald and Mr Gorman outlined some additional steps being taken to encourage vaccine take up and emphasised the importance of a strong communications strategy. They also agreed with the need to be mindful of the impact that moving work from secondary to primary care would have on GPs and wider practice staff. They highlighted CTACs as one possible way of managing the increased pressure on services.

Decision

The IJB agreed to:

i. Accept that the delivery of healthcare governance arrangements across East Lothian HSCP services continues to provide moderate assurance to committee members;
ii. Note the trends in performance across various measures to 31st July 2020 compared to the data previously reported to the Committee in September 2019;

iii. Note that the East Lothian Clinical Care Governance Committee is well established as a sub-committee of the East Lothian IJB and reports to the IJB on a regular basis; and

iv. Accept that the East Lothian healthcare governance structures allow for early identification of risks and for the mobilisation of actions to ameliorate and where possible remove risks.

5. IJB ANNUAL PERFORMANCE REPORT 2019/20

The Chief Officer had submitted a SBAR report reminding the IJB of the update provided to its June meeting and the agreed position nationally that all annual performance reports should be published by 30th September.

Paul Currie outlined the background and advised members that the annual performance report had been designed for production in print form only as it did not comply with new legislative requirements for accessibility. A new simplified version would be prepared which would be suitable for all devices or 'on-screen' readers.

Members proposed some minor changes and additions to the report. Ms MacDonald confirmed that there was still time for further suggestions to be submitted. While the aim was to publish by 31st August, it was more important to ensure that the report properly reflected the work of the HSCP and the input from IJB members.

Decision

The IJB agreed to:

i. Accept the delayed 2019-20 Annual Performance Report and the account it gave of delivery and performance across the HSCP's services over the year; and

ii. Note that as the 2019-20 Annual performance report covered the period 1st April 2019 to 31st March 2020 it provided a limited account of COVID-19 related actions which began in March and developed over the following months. These actions were described in other reports, and would feature in the 2020-21 Annual Performance Report.

6. FINANCIAL UPDATE

The Chief Finance Officer provided a verbal update on the financial position for 2020-21.

Claire Flanagan informed members that the situation remained challenging and that work was continuing with the IJB's partners to understand the full impact and costs associated with COVID-19, including those attached to the mobilisation and remobilisation plans. The full Quarter 1 review had yet to be concluded but it was clear that the IJB was currently in an overspent position as a result of additional costs. Ms Flanagan indicated that a comprehensive Quarter 1 report would be presented to the IJB at its next meeting. In the meantime, she reassured members that she continued to link into all reporting processes to support the flow of additional funds to deal with COVID-19.

Ms Flanagan responded to questions from members. She confirmed that, if not for COVID-19 costs, the IJB would currently be closer to a break-even position. She added that COVID-19 has also resulted in delays in taking forward localised savings plans. In relation to social care and supporting external providers, she confirmed that

£1.4m of additional funding had been received to date and that support for external providers under the sustainability principles may be extended.

Ms MacDonald said that number of delayed discharge beds required in East Lothian had been low. While beds had been commissioned at Leuchie House and Haddington Care Home these were mostly for individuals in the community whose packages of care had become fragile. She also explained that the sustainability payments for care homes were to support numbers pre-COVID, rather than new beds, and that these payments were beginning to reduce and would stop completely by the end of November.

In response to a final question from the Chair, Ms Flanagan advised that while it was difficult to give an exact figure, the amount spent on COVID-19 in the first three months of 2020-21 exceeded the additional funds provided to date.

Decision

The IJB agreed to note the update on the financial position for 2020-21.

Signed .....

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

East Lothian
Integration Joint Board

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 17 SEPTEMBER 2020
VIA DIGITAL MEETINGS SYSTEM

Voting Members Present:
Councillor F O'Donnell (Chair)
Dr P Donald
Ms F Ireland
Councillor S Kempson
Councillor P McLennan* (s)
Councillor J McMillan* (s)
Mr P Murray (Items 1 – 6)

Non-voting Members Present:

Ms L Cowan	Ms C Flanagan
Mr I Gorman	Ms M McNeill
Mr T Miller	Ms J Tait
Dr J Turvill	Mr P White

Officers Present from NHS Lothian/East Lothian Council:

Mr P Currie	Ms C Goodwin
Ms L Kerr	Ms R Laskowski
Ms J Ogden-Smith	Mr D Stainbank

Visitors Present:
Ms E Scoburgh, Audit Scotland
Ms E Symon, Audit Scotland

Clerk:
Ms F Currie

Apologies:
Councillor S Akhtar*
Councillor N Gilbert*
Dr Richard Williams
Mr D Binnie
Ms A MacDonald

**(s) = substitute*

Declarations of Interest:
Item 5 – Mr P White declared an interest as an employee of ELCAP. However, this interest was not of a degree that would require his withdrawal from the meeting during consideration of this item.

The Chair asked members whether they would agree to hear Item 8 in private. This was agreed.

The Chair also asked members is they would agree to hear an urgent item – a verbal update on Primary Care – after Item 7 (before entering private session). This was agreed.

1. CHAIR'S REPORT

The Chair welcomed Councillors Paul McLennan and John McMillan to the meeting and thanked them for substituting for Councillors Akhtar and Gilbert. She also wished to place on record her thanks to all staff across the Health & Social Care Partnership (HSCP) for their efforts during the past 6 months and she acknowledged the additional difficulties faced by patients and those with caring responsibilities.

2. 2019/20 AUDITED ANNUAL ACCOUNTS

The Chief Finance Officer had submitted a report presenting the IJB's annual accounts for 2019/20.

Claire Flanagan presented the report informing members that the accounts had been considered and approved by the Audit & Risk Committee at its meeting on 15th September. She outlined the key sections of the accounts including the management commentary, statement of responsibilities, remuneration report, annual governance statement and the comprehensive income and expenditure statements. She concluded that, once approved, the accounts would be signed electronically on behalf of the IJB.

Ms Flanagan responded to questions from members. She indicated that the IJB's reserves currently amounted to £2.4m, however, this was below the 2% recommended in the IJB's Reserves Policy. She outlined the governance arrangements put in place during the emergency recess period and expanded on the actions identified in the Chief Internal Auditor's annual review report.

Duncan Stainbank advised that while COVID-19 had not had a significant impact on the arrangements to 31 March 2020, a review of governance arrangements would form part of the Internal Audit plan for 2020/21.

Esther Scoburgh confirmed that the external audit for 2020/21 would also include a review of governance arrangements, as it did every year, and it would consider the impacts of COVID-19.

Peter Murray commented that the actions agreed following the Chief Internal Auditor's review represented important issues for the IJB and he suggested that any report on progress should be presented to the IJB for consideration, as well as the Audit & Risk Committee.

The Chair referred to the potential financial impact on Directions and agreed that there was a role for the IJB in monitoring these actions.

The vote on recommendation (ii) was taken by roll call:

Dr Patricia Donald	Agreed
Ms Fiona Ireland	Agreed
Councillor Susan Kempson	Agreed

Councillor P McLennan	Agreed
Councillor J McMillan	Agreed
Mr P Murray	Agreed
Councillor Fiona O'Donnell	Agreed

Decision

The IJB agreed to:

i. Note the report of the independent auditor; and
ii. Approve the annual accounts for 2019/20 are now signed electronically on behalf of the IJB by the Chair, the Chief Officer and Chief Finance Officer; following the anticipated approval of the annual accounts at the IJB's Audit & Risk Committee on 15th September.

3. INDEPENDENT AUDITORS' REVIEW OF THE ANNUAL ACCOUNTS

a. AUDIT SCOTLAND ISA 260 LETTER TO THOSE CHARGED WITH GOVERNANCE OF THE EAST LOTHIAN IJB

Esther Scoburgh outlined the contents of the covering letter which accompanied the auditors' report and confirmed that it was their intention to issue an unqualified audit opinion.

b. EAST LOTHIAN IJB 2019/20 ANNUAL AUDIT REPORT

Ms Scoburgh presented the annual audit report highlighting the key messages from the audit in relation to the annual accounts, financial management and sustainability, governance, transparency and best value. She informed the members that while COVID-19 had not had a significant impact on the position for 2019/20 the continuing implications remained uncertain and would be followed up as part of the 2020/21 audit work. She confirmed that Audit Scotland had no recommendations to make as a result of the 2019/20 audit.

Mr Murray asked about the risk identified in relation to financial sustainability and the possibility of an update on how the funding gaps were to be bridged. Ms Flanagan explained that the five year rolling financial plan was currently being updated and would include further detail on this.

The Chair asked if the plan included additional money from the Scottish Government to deal with COVID-19. Ms Flanagan said that plan pre-dated this funding.

Ms Scoburgh reiterated that the impact of COVID-19 would be included in the 2020/21 audit work. She also drew members' attention to the positive outcome of the review of best value reporting in 2019/20 and indicated that this would be reviewed again in future audits.

Councillor John McMillan observed that there was clearly a strong and constructive relationship between the Chief Finance Officer and Audit Scotland, and this was reassuring. He welcomed the comment about best value reporting and also paid tribute to the staff involved in the new community hospital, Well Wynd Hub and other key services across the county.

Decision

The IJB agreed to note the annual audit report and ISA 260 letter from Audit Scotland.

4. FINANCIAL UPDATE 2020/21

The Chief Finance Officer had submitted a report providing an update to the IJB on its year to date financial position in 2020/21 and the recent Quarter 1 financial reviews, undertaken by both the IJB partners.

Ms Flanagan presented the report summarising the position in the health and social care budgets, drawing attention to key pressures and indicating that regular dialogue continued with the partners over the likely impact of mobilisation and remobilisation plans. She reported that at the end of Quarter 1 the IJB was £1.1m overspent, with a projected year end position of £2.8m overspent.

She continued to submit regular reports to the Scottish Government and to monitor the position closely. She informed members that the longer term financial plan which would usually be presented had been delayed due to COVID-19 and would be brought forward at a later date. A further update on the Remobilisation Plan – which involved input from the HSCP - would also be presented to a future meeting.

The Chair asked for an update on the impact on scheduled care.

Fiona Ireland indicated that there was no general update at present but that the Remobilisation Plan covered elements of this work. Referring to the expansion of the Care Home Team, she advised that due to work undertaken previously to establish positive links East Lothian had been in a good position to support care homes through COVID-19. However, she queried the overspend in the Set Aside budget given that attendance at A&E had reduced.

Ms Flanagan advised that one of the greatest pressures had been the junior medical staffing budget which made up over half of the total overspent in the Set Aside budget.

In response to questions from Councillor Paul McLennan on scenario planning, Ms Flanagan indicated that the forecasts continued to be refined based on services being enacted as part of the Remobilisation Plan. In addition, the Scottish Government had provided considerable guidance on what to include in reporting.

Iain Gorman advised that, in terms of capacity, there was a level of agility within services to respond to an increase in demand. He said it was likely that there would be local pockets of demand rather than the significant overall peaks seen previously. The position and key risks would continue to be monitored closely and actions developed in discussion with the HSCP, NHS Lothian and East Lothian Council.

In response to further questions from the Chair, Ms Flanagan indicated that she and colleagues continued to work closely with counterparts in NHS Lothian and East Lothian Council to understand the key cost drivers and the impacts for the current financial year and the longer term. She added that while the IJB had received additional funding from the Scottish Government to deal with COVID-19, NHS Lothian had yet to receive anything extra.

Dr Patricia Donald supported the expansion of the Care Home Team but also recognised the need for an increase in the budget for care at home services. She asked about the recent announcement of additional funding for care homes in England and whether there would be any consequential funding for Scotland. Ms Flanagan agreed tolook into this.

Decision

The IJB agreed to:

i. note the Quarter 1 financial forecasts provided by the partners;
ii. note the work ongoing to refine and understand these; and
iii. note the financial impact and uncertainties of COVID-19 and the remobilisation of services for both partners.

5. EAST LOTHIAN IJB DIRECTIONS 2020-21

The Chief Officer had submitted a SBAR report presenting to the IJB the proposed Directions for 2020-21.

Claire Goodwin presented the report advising that following a review by the Change Boards of the 42 active Directions, and taking account of the comments from IJB members, it was proposed that 22 Directions remain unchanged, 15 be revised and 5 retired.

Ms Flanagan and Mr Gorman provided clarification to members on the wording of some of the Directions.

In response to a question from Paul White, Rona Laskowski advised that the learning disability strategy had been developed in consultation with service user representatives, and including this in the housing strategy provided the opportunity to review the range of provision offered. However, she emphasised that the choice would always lie with the service user and their family.

Mr Murray commented that including SMART objectives within Directions would provide consistency in monitoring and evaluating their effectiveness. On the issue of reprovision and the review of social care, he said the IJB needed to find way of including its views in the process to avoid ending up with a model it may not otherwise have considered.

Councillor McMillan said he had found the report fascinating and recommended a briefing for other Elected Members within the Council. He also echoed Mr Murray's comments regarding SMART objectives.

The vote on the recommendations was taken by roll call:

Dr Patricia Donald	Agreed
Ms Fiona Ireland	Agreed
Councillor Susan Kempson	Agreed
Councillor P McLennan	Agreed
Councillor J McMillan	Agreed
Mr P Murray	Agreed
Councillor Fiona O'Donnell	Agreed

Decision

The IJB agreed to:

i. the continuation, revision or retirement of Directions as set out, noting that on finalisation and communication with partners these will have clear progress measures attached;

ii. that Change Boards should continue to engage with partners on further development of the existing and any new Directions as required; and

iii. note that the planned review of Change Boards, the issues arising from COVID-19 and other internal and external factors are likely to require further changes to Directions during the current year.

6. REDESIGN OF URGENT CARE – IMPLEMENTING THE NATIONAL MODEL IN LOTHIAN

The Chief Officer had submitted a SBAR report informing the IJB of the Scottish Government national review of adult urgent care.

Paul Currie presented the report outlining the background and purpose of the review which would reflect and expand on the work of the Lothian Unscheduled Care Programme Board (LUCPB). He indicated that the delivery of improved urgent care was even more pressing in the light of COVID-19 and he provided details of some of the work underway to develop a new 24/7 care pathway. He advised that the four Lothian IJB Chief Officers were involved in the review and further updates would be provided at future IJB meetings.

In response to a question from the Chair, Mr Gorman acknowledged that resources would be required if there was to be a shift in workload from secondary to primary care and he was mindful of the existing pressures on services. He advised that further discussions would begin next week regarding the second phase of the work and the setting up of services at local level.

Ms Ireland said she was reassured by Mr Gorman's comments on local services as she had concerns about putting in place an additional step at a national level which may confuse people and make access to care more complicated.

Councillor McLennan encouraged a strong communication strategy and the creation of a matrix of data showing up take of services across the county, perhaps broken down to Ward areas, to inform any change in local services.

Mr Gorman acknowledged the point about communication and also agreed to bring back more concise information on local services within future progress updates.

Dr Jon Turvill said that the review was both encouraging and concerning. As a GP, he was aware that many of his colleagues across primary care settings had concerns that work would be displaced back to practices which were already under enormous pressure, and without adequate resources to support any additional workload. Many GPs were also heavily involved in triaging as a result of COVID-19 and to take them away from this work would create other problems. However, he recognised the benefits of reviewing the system as a whole and welcomed the intention behind it.

Dr Donald agreed that this issue was very complex. However, she welcomed the strong collaborative approach being demonstrated and the intention to create an integrated system to support patient flow. Referring to a recent announcement in England regarding a change to the 111 telephone service, she also emphasised the importance of a good communications strategy.

The Chair concurred with these comments saying that she shared the aspiration for additional flexibility within local services and she also urged that there be as wide a communication as possible as work progressed.

Decision

The IJB agreed to:

i. note the planned work to direct appropriate activity from the acute hospital front door to other provision utilising NHS24 and the 111 telephone service; and
ii. receive regular updates on progress of the redesign programme as phases 1 and 2 begin to deliver.

Sederunt: Peter Murray left the meeting.

7. WINTER PLANNING

The Chief Officer had submitted a SBAR report outlining the services which would help to provide winter resilience within East Lothian.

Mr Currie presented the report setting out the background to the current situation and the actions planned to address demand and taking into account the added concerns around COVID-19. He advised that the flu vaccine programme had been scaled up this year but that the full range of delivery would depend on supply and demand. As with previous years, a number of local actions were being planned to address wider demand for services and he referred members to the report for additional detail on the four key areas for this year.

The Chair welcomed the plans and said it was a tried and tested formula to build capacity as close to home as possible. However, she had concerns that some older people may be wary of going to the GP to get their flu jab and asked about monitoring of take up.

Dr Turvill said that an overall increase in take up was anticipated, particularly as a result of COVID-19. While he acknowledged concerns about attendance, he advised that GP practices were being proactive about reducing risks and introducing a number of measures to protect patients, for example the Harbours practice was conducting immunisations outdoors.

Mr Currie added that the emphasis this year was not just on immunising the public but also on immunising staff and this would be an important part of the programme.

Decision

The IJB agreed to:

i. note the planned service development and delivery arrangements to prepare for the additional service pressures which, as in previous years, were likely to arise in the Lothian acute hospitals during the winter months;
ii. note that the East Lothian HSCP Flu Programme was being established;
iii. note that the usual winter demand this year is likely to be adversely affected by the continuing presence of COVID-19 and the possibility of further peaks in COVID-19 presentations; and
iv. note links were established to the continuing work through the Lothian Remobilisation Plan and the work underway to review unscheduled care.

URGENT ITEM – PRIMARY CARE UPDATE

Mr Gorman provided a verbal update on the work to implement the Primary Care Improvement Plan (PCIP). He referred to the changes to services as a result of COVID-19 and advised that since July work had been underway to remobilise as many key services as possible. Progress was going well and a number of services were now available including MSK and mental health.

He also provided an update on four key areas within the PCIP: pharmacotherapy, community treatment and access centres, vaccination transformation programme and support around urgent care. He confirmed that a detailed paper would be circulated early next week and he would be happy to respond to questions from members.

The Chair thanked Mr Gorman for the update and welcomed the blend of geographical services. She suggested that members hold their questions until they had had the opportunity to read the paper and she asked them to note the verbal update.

Decision

The IJB agreed to note the verbal update on primary care.

SUMMARY OF PROCEEDINGS – EXEMPT INFORMATION

The IJB unanimously agreed to exclude the public from the following business containing exempt information by virtue of Paragraph 5.9.1 of its Standing Orders (the Integration Joint Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation).

Progress Report and Update on the East Lothian Council Internal Audit report on Homecare Services

The IJB considered a progress report prepared following the East Lothian Council Internal Audit on Homecare Services. The IJB agreed to note the contents of the report.

PRIVATE

8. PROGRESS REPORT AND UPDATE ON THE EAST LOTHIAN COUNCIL INTERNAL AUDIT REPORT ON HOMECARE SERVICES

A SBAR report was submitted informing the Committee of the audit report on Homecare Services and providing an update on progress with the actions identified following the audit.

Mr Gorman advised members that there were two reasons for discussing the report in private session: firstly, the audit report was confidential; and, secondly, it was likely over the coming months that there would be a renewed focus on provision of homecare services. While he felt that they had addressed the concerns identified from the audit, as a result of anxieties about external markets and providers struggling, there may be a need in the coming months to invest more in in-house services.

Mr Currie presented the report outlining the main findings of the audit work which had looked at a range of issues and had provided an outcome of 'moderate assurance'. He summarised the progress to date on the actions identified in the original audit report, concluding that the majority of actions had been completed despite delays due to COVID-19.

The Chair informed members that the report had been presented to the Audit & Risk Committee on 15th September and she had received reassurances around rolling hours, travel times and staff using public transport.

Councillor McMillan acknowledged that the audit report was about systems rather than outcomes but he asked whether there had been any comment on the effectiveness of the service.

The Chair accepted his point and suggested that the recommendations before the IJB be amended to include an action to monitor progress and report back in 6 months.

Mr Gorman advised that the audit had followed closely on a positive report from the Care Inspectorate which had assessed the service as 'very high'. The audit had identified other concerns and had provided an insight into learning more about the quality of the service.

Lorraine Cowan added that the audit had taken place at the time when the service was taken in-house and they had worked closely with staff to ensure that appropriate actions were taken to keep both clients and staff safe. They were now looking at specific outcomes, such as quality and capacity, and reviewing the care plans of every client in the service. The feedback from clients and families had also improved during this period. She concluded that the intention was to make the service as robust as possible in advance of the anticipated winter pressures.

Councillor McMillan welcomed this additional information and the examples of joined up working.

Mr White welcomed the quality of care rating of 'very high' in the Care Inspectorate report and the reassurance this would offer service users.

Councillor McLennan asked if the experience was the same for clients and staff across the county as a whole or whether there were still issues in more rural areas. Ms Cowan said that the Hospital to Home service was now providing packages in these areas and that the service was working to be as flexible as possible.

The Chair proposed the following amendment to the recommendations: “iii. To note that progress would be monitored and a further update provided in 6 months”. This was seconded by Dr Donald.

The vote on the amendment was taken by roll call:

Dr Patricia Donald	Agreed
Ms Fiona Ireland	Agreed
Councillor Susan Kempson	Agreed
Councillor P McLennan	Agreed
Councillor J McMillan	Agreed
Councillor Fiona O’Donnell	Agreed

The recommendations were then approved, as amended.

Decision

The IJB agreed to:

i. note the progress made by the Home Care Services in delivering actions agreed following the February 2020 internal audit, albeit with delays arising from COVID-19;
ii. note that the lasting impacts of COVID-19 would require the service to continually review agreed actions to ensure they remain relevant to the service and client needs and as such may require formulation of new actions; and
iii. note that progress would be monitored and a further update provided in 6 months.

Signed .....

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

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
MIJB Minute	Thursday 27 August 2020	2.00pm	Via Microsoft Teams.

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

In attendance:		
Morag Barrow (Chief Officer)	Claire Flanagan (Chief Finance Officer)	Caroline Myles (Chief Nurse)
Mike Ash	K. Chapman(User/Carer)	Jamie Megaw (Strategic Programme Manager)
Mairi Simpson (Integration Manager)	Wanda Fairgrieve(Staff side representative)	Fiona Huffer (Head of Dietetics)
Alison White(Chief Social Work Officer)	Jim Sherval (Public Health Consultant)	Johanne Simpson
Leah Friedman (Operational Business Manager)	Gordon Aitken (Democratic Services)	

1. Welcome and introductions

The Chair, Councillor Johnstone, welcomed everyone to this virtual Meeting of the Midlothian Integration Joint Board.
The Board noted that the arrangements for today's meeting had been agreed in advance to take account of the current public health restrictions as a result of the current Covid19 (Coronavirus) pandemic.

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

The Minutes of the undernoted Meetings of the Midlothian Integration Joint Board were submitted and approved as correct records:

MIJB held on 13 February 2020 -

Special MIJB held on 12 March 2020

MIJB held on 16 April 2020

5 Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
5.1 Covid-19 Data Presentation Jim Sherval provided a presentation on the high level data available on the national position as well as that of Midlothian with regard to Covid-19, during which it was noted that:	To thank Jim for his extremely helpful and informative presentation and that this position would continue to be monitored.	All to note	Ongoing

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
Lothian had the third highest level of: • Covid related cases within Scotland with Midlothian accounting for 645 cases equating to 11% of all cases in Lothian. • Although the position was still unclear, deprivation did not appear to be a major factor in this matter. • There did not appear to be a higher rate of fatalities within Midlothian in comparison to other areas • That 60% of Midlothian Care Homes experienced some form of outbreak. • That the infection rate within Midlothian Care Homes was currently higher than those recorded across NHS Lothian as a whole. There followed a general discussion on this presentation after which Morag Barrow made reference to the Lord Advocate's Review into all areas of Covid and that as a result of all the exceptional hard work undertaken by all concerned that Midlothian was now in a strong position in the event of a second outbreak.			
5.2 Membership of the Midlothian Integration Joint Board and Appointment of Audit and Risk Committee Members The purpose of this report is to provide information about a proposed change in the NHS Lothian Board voting members on the Midlothian IJB and to seek approval for the appointment of members to fill	(a) To endorse the proposed change within the NHS voting membership of the Midlothian Integration Joint Board; and (b) To appoint Caroyn Hirst, Mike Ash and Councillor Milligan as members of the MIJB Audit and Risk Committee.	Clerk.	

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
vacant positions on the MIJB Audit and Risk Committee. Board Members were asked to: (i) endorse the proposed change within the NHS voting membership of the Midlothian Integration Joint Board and (ii) approve the appointment of Carolyn Hirst, Mike Ash and Councillor Derek Milligan as members of the MIJB Audit and Risk Committee.			
5.3 Chief Officers Report - Report by Chief Officer The paper set out the key service pressures and service developments which had occurred across Midlothian IJB over the previous month and looks ahead to the following 8 weeks. The Board in discussing the report made particular mention of the Midlothian Community Hospital: Glenlee ward and noted that the Chief Finance Officer and Chief Officer were pursuing avenues of funding and would report back to IJB with a proposed Business Plan once all options had been explored for a decision on future usage. There was also a general view expressed that although the IJB had "punched above its weight" during the recent Covid pandemic, that concerns remained over the level of support in terms of staffing that was available to it. Morag Barrow agreed to pursue this matter within Midlothian Council.	(a) To pursue avenues of funding and report back with a proposed Business Plan once all options had been explored for a decision on future usage; (b) That the level of support in terms of staffing that was available to the MIJB be further explored by the Chief Officer; and (c) To otherwise note the content of the Chief Officer's Report.	Chief Officer/ Chief Finance Officer Chief Officer	

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
5.4 IJB Improvement Goal Progress This report's purpose was to provide a summary of the progress towards achieving the IJB's Improvement Goals. Board members were asked to review performance across the indicators and note further information was included about performance in Midlothian against the Core Suite of Indicators. Jamie Megaw was heard in amplification of the report after which there was a general discussion on this matter.	To note the performance across the indicators and that further information was included about performance in Midlothian against the Core Suite of Indicators.	All to note.	
5.5. Annual Performance Report 2019-20 The Midlothian Annual Performance Report provided information on the health and wellbeing of the people of Midlothian. It also described local health and care services, the financial performance of the Partnership and the quality of health and care services delivered during 2019-20. Board members were asked to approve the content of the Annual Report. Mairi Simpson was heard in amplification of the report after which there was a general discussion during which consideration was given on how to better publicise the level of work being undertaken and achieved by the IJB.	(a) To approve the content of the Annual Performance Report; (b) To note that the data related to the Health and Care Experience Survey was for 2017-18 due a delay in publishing 2019 data by the Scottish Government; and (c) To further explore use of digital platforms and Council websites to better publicise the level of work being undertaken and achieved by the IJB.	Chief Officer/ Mairi Simpson	

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
5.6. General Practice Remobilisation in Midlothian The purpose of this report was to update the IJB on the remobilisation of primary care and the plans for the 2020 seasonal flu vaccination programme. Board members were asked (i) to note the changes to access to General Practice in Midlothian as a result of COVID19 (ii) note the plans for remobilisation of primary care and progress implementing the Primary Care Improvement Plan and (iii) to support the plan for the 2020 Seasonal Flu Vaccination Programme. Jamie Megaw was heard in amplification of the report making particular reference to the flu vaccination arrangements being made due to the anticipated higher uptake in the traditional population cohorts; the age range for people eligible for the vaccine being reduced to either 55 or 50; eligible staff being expanded and that clinics would need to be run with appropriate PPE and physical distancing procedures in place.	a) To note the changes to access to General Practice in Midlothian as a result of COVID19 (b) To note the plans for remobilisation of primary care and progress implementing the Primary Care Improvement Plan; and (c) To support the plan for the 2020 Seasonal Flu Vaccination Programme.	All to note.	
5.7. COVID-19 Next Phase Planning and Winter Planning The purpose of this report was to provide an update on COVID-19 next phase and winter planning. Planning began in response to Midlothian's Pandemic Recovery Strategy which was drafted in June 2020.	(a) To note this update on next phase planning and contribution to the (draft) NHS Lothian Remobilisation Plan; and (b) To approve the approach to winter planning.	All to note	

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
This involved a programmed plan of actions to support individual services transitioning out of emergency mode, overarching workstreams around technology, staff wellbeing, finance, Third Sector and Communities, winter planning and acute/community flow. Board members were requested to note this update and contribution to the NHS Lothian Remobilisation Plan and approve the approach to winter planning. Leah Friedman was heard in amplification of the report after which there was a general discussion during which Morag Barrow highlighted that as a result of additional emergency funding from the Scottish Government it was anticipated that approximately 20FTE members of staff of a high calibre could be employed/redeployed.			
5.8 Clinical and Care Governance Report The purpose of this report was to provide assurance as to the clinical and care governance arrangements within Midlothian. It will highlight good practice and identify any emerging issues or risks. It was highlighted that additional reports would be submitted as appropriate throughout the year to provide updated information from specific service areas. Board members were asked to note and approve the content of this report as well as the proposed development of a clinical and care governance dashboard.	To note and approve the content of the report as well as the proposed development of a clinical and care governance dashboard. .	All to note	

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
Carolyn Myles was heard in amplification of the report after which there was a general discussion on this matter.			
5.9 Midlothian HSCP Older Peoples' Care Home Briefing Paper This report provided an overview of the ongoing work with Care Homes in Midlothian and the enhanced response now required following the release of Scottish Government Guidance. This work would continue to advance best practice, embed local clinical governance arrangements and provide ongoing assurance regarding the care of people in Midlothian Care Homes. Board members were requested to note this update on current COVID-19 work within Older Adult Care Homes in Midlothian and the significant work undertaken by the HSCP team in line with Scottish Government and Health protection Scotland guidance at all times. Carolyn Myles was heard in amplification of the report after which there was a general discussion on this matter.	(a) To note the update on current COVID-19 work within Older Adult Care Homes in Midlothian; and (b) To note the significant work undertaken by the HSCP team in line with Scottish Government and Health protection Scotland guidance at all times.	All to note.	
5.10 Strategic Planning Group The report provided an update on Strategic Planning Group discussions around Terms of Reference and membership. Board members were requested to:	(a) To approve the revised Terms of Reference for the Strategic Planning Group; (b) That the appointment of an elected Member from Midlothian Council be continued to establish whether this required to be a decision of the full Council or by the MIJB;	All to note. Clerk	

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
(i) Approve the revised Terms of Reference for the Strategic Planning Group. (ii) note the request for a member of the Local Authority to become a member of the Group (iii) note the proposal of the Strategic Planning Group to revise the Directions issued in May 2020 and (iv) note the Minutes of the meeting 15 July 2020. Mairi Simpson was heard in amplification of the report after which there was a general discussion on this matter.	(c) To note the proposal of the Strategic Planning Group to revise the Directions issued in May 2020; and (d) To note the Minutes of the Meeting of 15 July 2020.		

6. Private Reports

Exclusion of Members of the Public

In view of the nature of the business to be transacted, the Board agreed that the public be excluded from the meeting during discussion of the undernoted items, as contained in the Addendum hereto, as there might be disclosed exempt information as defined in paragraph 3 of Part I of Schedule 7A to the Local Government (Scotland) Act 1973:-

6.1 Unpaid Work, Analysis of Reoffending- Report by Chief Social Work Officer – Noted; and

6.2 Redesign of Urgent Care – Implementing the National Model in Lothian - Report by Chief Officer – Noted

7. Date of next meeting

The next meeting of the Midlothian Integration Joint Board would be held on Thursday 8 October 2020 at 2.00 pm. (**Action: All Members to Note**)

The meeting terminated at 4.05 pm.

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Special MIJB Minute	Thursday 10 September 2020	2.00pm	As a consequence of the current public health restrictions this was a virtual meeting held using Microsoft Teams.

Present (voting members):		
Cllr Catherine Johnstone (Chair)	Carolyn Hirst (Vice Chair)	Mike Ash
Angus McCann	Cllr Derek Milligan	Cllr Jim Muirhead
Cllr Janet Lay-Douglas (substitute for Cllr Pauline Winchester)		

Present (non-voting members):		
Morag Barrow (Chief Officer)	Claire Flanagan (Chief Finance Officer)	Caroline Myles (Chief Nurse)
Johanne Simpson (Medical Practitioner)	James Hill (Staff side representative)	Keith Chapman (User/Carer)

In attendance:		
Grace Cowan (Head of Primary Care and Older Peoples Services)	Mairi Simpson (Integration Manager)	Sarah Archibald (Public Health Practitioner)
Tracy McLeod (NHS Lothian)	Jim Sherval (Public Health Practitioner)	Keith Slight (Unison)
Mike Broadway (Clerk)		

Apologies:		
Tricia Donald	Cllr Pauline Winchester	Alison White (Chief Social Work Officer)
Hamish Reid (GP/Clinical Director)	Wanda Fairgrieve (Staff side representative)	Fiona Huffer (Head of Dietetics)
Ewan Aitken (Third Sector)	Jill Stacey (Chief Internal Auditor)	

1. Welcome and introductions

The Chair, Catherine Johnstone, welcomed everyone to this virtual Meeting of the Midlothian Integration Joint Board.

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 2019/20 Audited Annual Accounts - Report by Chief Finance Officer As a statutory body, the IJB is required to produce a set of annual accounts at the end of its financial year (31 March). These accounts are 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 requirements of the regulations and give a fair and true view of the IJB's financial position in 2019/20. 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.	• Noted the report of the independent auditor; and • Approved the MIJB's Annual Accounts for 2019/20.	Chief Finance Officer	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
The Independent Auditor reported his view to the meeting of the IJB's Audit and Risk committee on 3 September 2019. The IJB's Audit and Risk committee was satisfied with the report of the Independent Auditor and recommends that the Annual Accounts are approved by the IJB. The Chief Finance Officer in presenting the Annual Accounts to the Board summarised some of the key findings and conclusions contained in the Annual Audit Report and made particular reference to the new services and approaches detailed in the Annual Accounts. There then followed a general discussion on the Annual Accounts during which both Morag Barrow and Clare Flanagan provided clarity on the issue of overspends against key budgets, particularly in regards to Learning Disabilities.			
4.2 Prevention and Early Intervention: Update - Presentation The Board received a presentation on Prevention from Sarah Archibald, Tracy McLeod and Jim Sherval, who responded to Members' questions and comments. In discussing the contents of the presentation, the Board gave consideration to the issue of what, at a strategic level, the MIJB should prioritise in relation to prevention.	• Noted, and thanked Sarah Archibald, Tracy McLeod and Jim Sherval, for their Presentation; • Noted that the themes in the presentation would be picked up as part of the review of the Strategic Plan and also in future Directions; and • Agreed that the slides from the Presentation be circulated to Board Members for their interest.	Integration Manager Clerk	
Sederunt: Angus McCann (14:28) and Cllr Janet Lay-Douglas (14:41) both left the meeting during the foregoing item of business.			

5. Private Reports

Exclusion of Members of the Public

In view of the nature of the business to be transacted, the Board agreed that the public be excluded from the meeting during discussion of the undernoted item, as contained in the Addendum hereto, as there might be disclosed exempt information as defined in paragraph 11 of Part I of Schedule 7A to the Local Government (Scotland) Act 1973:-

5.1 Redesign of Urgent Care – Implementing the National Model in Lothian – Report by Chief Officer – Noted

6. Date of next meeting

The next meeting of the Midlothian Integration Joint Board would be held on Thursday 8 October 2020 at 2.00 pm. (**Action: All Members to Note**)

The meeting terminated at 3.21 pm.

NHS LOTHIAN

Board
9 December 2020

Chair

APPOINTMENT OF MEMBERS TO COMMITTEES

1 Purpose of the Report

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

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

2 Recommendations

The Board is recommended to:

2.1 Appoint Prof. Emma Reynish as a non-voting member of East Lothian Integration Joint Board for the period from 9 December 2020 to 8 December 2023.

3 Discussion of Key Issues

East Lothian Integration Joint Board

3.1 East Lothian Integration Joint Board has a vacancy for the non-voting position for a 'registered medical practitioner who is not providing primary medical services.'. Prof. Emma Reynish is the Clinical Director for Medicine of the Elderly at the Royal Infirmary of Edinburgh. It is recommended that the Board appoint Prof. Reynish as a non-voting member of East Lothian Integration Joint Board for the period from 9 December 2020 to 8 December 2023.

4 Key Risks

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

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

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

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

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

8 Resource Implications

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

Alan Payne
Head of Corporate Governance
27 November 2020
alan.payne@nhslothian.scot.nhs.uk

LOTHIAN NHS BOARD

Board
9 December 2020

Aim

The aim of this report is to update Board Non Executive Directors on areas of activity within the Board Executive Team Director's portfolios. This report , as requested at a previous Board Meeting, also includes contributions from Integration Joint Board Directors. Directors have been invited to focus on key strategic / operational issues to bring to the attention of Non Executive Directors, not otherwise covered in the Board papers.

1. Chief Executive

Gold Command

Gold Command continues to meet on a whole system basis three times per week to provide senior input into the management of Covid and Brexit. IJB Chief Officers are an integral part of the Gold Command process and this ensures that a holistic and supportive approach is adopted. Gold Command is chaired on a rotational basis by myself, Jim Crombie, Tracey Gillies and Alex McMahon as the Resilience Gold Leads with support from other Executive level colleagues.

Unscheduled Care

As previously reported in terms of Unscheduled Care given the anticipated system wide pressures of Covid across winter I continue to work with Angiolina Foster, Chief Executive NHS 24 to co-chair a group to wherever possible schedule some of the unscheduled presentations in order to protect our emergency flows and best meet the needs of patients.

The national redesign of urgent care programme has been progressed through the Lothian Unscheduled Care Programme Board to improve access to urgent care pathways so people receive the right care, in the right place, at the right time. The first phase is aimed at reducing and smoothing self-presenter attendance demand at acute hospital front doors to reduce overcrowding and protect public, patients and staff. The project in NHS Lothian is on track for delivery to meet the proposed launch planned for 1 December, with the national move to NHS24 acting as a single point of access for patients who would normally self-present to ED or MIU. For those people that NHS24 determine need further clinical consultation they will refer them to a local flow navigation centre to provide further assessment by providing virtual or face-to-face consultations in as scheduled a way as possible. The Flow Centre, which has been expanded and is now at full staffing with both administrative and nursing staff 24/7, will schedule patients into virtual or face-to-face appointments for minor injury assessments across the adult acute sites, and will provide time-zones for patients to attend SJH or RIE E.Ds. There will be an extensive local communication strategy in place to publicise and promote this new approach to accessing urgent care.

Lothian NHS Board Annual Review with the Cabinet Secretary

The Chair and I participated in the Lothian NHS Board Annual Review with the Cabinet Secretary on 16 November 2020. The Review was held on MS Teams and was a positive engagement. The written feedback from the Scottish Government has now been received and is attached at appendix 1.

2. Deputy Chief Executive

Public Health: After contributing additional leadership and resource to the NHS Lothian contact tracing service, we are now running a 7 day service operating 8am until 8pm with 80+ contact tracers per day. NHS Lothian (NHSL) has invested significant resource in a short period of time to meet the workforce model (currently 80 per day with 70 surplus) prescribed by the National Contact Tracing Centre (NCTC). The contact tracing workforce model has been an evolving framework, with NHS Lothian asked to respond and implement the requirements often within 10-14 day periods. A further round of contact tracing recruitment is ongoing and the operational focus is now on maintaining performance. Additional work has been ongoing to strengthen wider governance, process and risk management approach within Health Protection, Contact Tracing and the wider Public Health Department to adopt lessons learnt as we enter the winter period.

Short Stay Elective Centre (SSEC): The Short Stay Elective Centre Full Business Case (FBC) is currently being adjusted to take account of the response to Covid and its requirement to respond to the NHS Scotland Review Design Process (NDAP) comments. An ongoing review of the current design is underway which will take cognisance of the NHS Scotland Review Design Process (NDAP) comments and provide an accepted response. An updated clinical position has also been approved by the Elective Strategy Board, Acute CMT and the Project Board to increase patient accommodation. In addition, the Centre of Excellence has provided a framework for staged reviews and the project team are in the process of ensuring the alignment and availability of information in the appropriate format.

Brexit: A third meeting was held in November, where each HSCP and corporate function provided an update on their current position. Key points include:

- With regards to medicine supply, short-term work undertaken to improve resilience includes:
  - UK co-ordinated work on building a strategic reserve of key medicines.
  - Implementing a new reporting solution which will provide real-time central access to board-level medicines usage and stock-holding information.
  - Introducing a new role in the NP pharmacy team (Medicines Supply Chain Manager) to provide additional capacity in the management of medicines shortages and to support improvement projects relating to the supply of medicines.
  - Focussed engagement with a number of key suppliers to review lessons learned and consider steps to improve resilience including oxygen suppliers, homecare providers and wholesalers.

- Director of Finance and Chief Executive intend to work with national DoF colleagues to ensure a consistent approach is taken to report the financial impact and access any SG/UK government contingencies.
- Local IJB/ HSCP Brexit Groups had all re-convened and local business continuity and resilience plans were under development.
- Members of the strategic group were asked to continue to raise Brexit and support for staff, via their management team discussions, and to share the recently recorded session with Director HR & OD and immigration advisor/citizens advice immigration contact.

Further meetings are scheduled on a monthly basis.

Acute Car Parking: From previous reports you will be aware there was pre-existing pressure on parking across the acute campuses and these have been exacerbated by the Covid-19 climate. A pan Lothian staff engagement process is currently underway for all acute sites to take a coordinated approach, this includes identifying key themes from staff engagement, standardising the controls implemented across sites and aligning the timelines for these to go live.

This work will look to ensure;

- the safety of staff, patients and visitors on site,
- control measures are standardised across sites,
- the risk of delays to clinics and appointments due to staff or patient delays in car park facilities is minimised,
- the risk of violence and aggression towards car park staff is minimised
- access to blue light routes is maintained and not impacted by gridlock traffic

Corporate Office Reconfiguration & Homeworking Guidance: I chair a working group which is reviewing the safety and required measures of two corporate office facilities in NHS Lothian. The principles derived from this work will inform the pan Lothian approach to ensuring provision of safe working environments, both from home and in a corporate office. Considerations include; ventilation, cleaning requirements, physical distancing, mask wearing, equipment, wellbeing support, flow of movement and building capacity monitoring. A wide range of stakeholders are involved including; Infection Control, Health & Safety, Facilities, Partnership, I.T., HR, Planning and Communications & Engagement. NHS Lothian's current stance is for staff to work from home if they are able to do so, in line with the Scottish Government.

3. Executive Director of Nursing, Midwifery, & AHPs

We are going out to recruit to a new senior post in the organisation for infection prevention control, Interviews will take place on the 17th December. This post a new business manager and an HAI Scribe post will give much needed capacity to the team

Work with care homes continues to be a dominate feature of my role and that of my team but we now have in place a Lead Nurse for Care Homes and a Programme Manager. Other posts are also being recruited to in clinical education and infection control as well as project and admin support to meet the needs in relation to infection prevention control, PPE and education and training.

Significant amount of work has been underway dealing with a number of COVID outbreaks across our acute and community hospitals during the time since the last report to the Board. These have been flagged at our Healthcare Governance Committee on the 10th November.

4. Medical Director

- Work with GMC UK Responsible Officers reference group on future regulatory arrangements for Physicians Associates
- Work with SAMD to support preparation for the first phase of Redesign of Urgent Care
- Identification of resources and proposals for the next phase of Realistic Medicine
- Ethics support group discussion on ethical challenges of Covid vaccination programme
- Preparation for implementation of HEPMA at WGH
- Lothian and Armed Forces Veterans group- supporting the evaluation of this project which has run for three years across all four LAs and NHS with extensive third sector involvement
- progress on information governance arrangements in Dataloch and delegated Caldicott roles
- Discussion with regional partners in East of Scotland cardiac network on opportunities for workforce developments in cardiac physiology roles
- Exploratory meeting with regional ophthalmology colleagues on Scotland wide network arrangements for image sharing and storage between community optometrists and ophthalmology

5. Director of Finance

Over the last couple of months there has been a significant amount of work making an assessment of the financial consequences of the second wave of Covid. This is being closely monitored both at Director of Finance, and senior finance team level across Boards, and will feed into the Mid year review which is about to start. We have also prepared our first assessment of what the step up in expenditure is likely to mean for 21/22 to inform the one year Spending Review and the Scottish budget in January. Once again this is being managed, as far as possible, in a consistent, benchmarked way with other Boards. As part of the DoF community we have also been looking at the work undertaken by the National Infrastructure Board (Health) This is an important piece of work for all Boards as it pulls together the condition of our asset base and weights different factors in order to provide a baseline for the development of an NHS in Scotland infrastructure plan At this stage the Strategic priorities of Boards, which will require capital investment are not factored in and further engagement with Executive teams are planned over the coming months. In parallel a workstream is being established with SG colleagues to consider a rolling programme for equipment across Scotland, and NHS Lothian will be represented on this group.

In support of the Deputy CE and the Cancer Centre team we are due to meet with a number of colleagues from Scottish Government this month to present the Initial Agreement for the Edinburgh Cancer Centre, prior to their consideration of the IA in December. This will follow a similar format to that used to brief all Board members in advance of the last Board meeting.

Progress continues to be made on the proposals to strengthen the Board's PPP contract management arrangements with both Finance and facilities agreeing respective roles and responsibilities, and the structural changes required to deliver this. In terms of the RHCYP/DCN we continue to manage the transition from partial occupation and construction in the hospital to business as usual in terms of the Facilities management arrangements with IHSL. A further meeting took place with IHSL this month and relationships are positive as we work together and take the opportunity to learn about how well our collective processes are working. This is particularly relevant for the management of change going forward.

There has also been further dialogue between the CLO and the Public Inquiry team and a meeting planned with the CLO in advance of the Board will help inform how we support the initial work programme of the Inquiry team. A key consideration is ensuring that the document management systems are aligned.

Finally Craig Marriott, deputy Director of Finance , chaired the first "virtual" HFMA in Scotland conference (Healthcare Financial Management association) with circa 160 attendees over 3 days with 2 hours am and pm slots that delegates could participate in. There was a wide variety of speakers as well as a virtual run and a virtual quiz. Feedback has been incredibly positive, and Craig is now looking at how we could deliver a similar development session for finance staff early next year.

6. Director of Human Resources and Organisational Development

On 5th November we became a 'trailblazer' organisation for the Young Persons Guarantee. Becoming a trailblazer involves us committing to 5 key asks: -

- To support young people and prepare them for the world of work.
- To help those who need it most.
- To invest in a skilled workforce.
- To create jobs and opportunities for young people.
- To create an inclusive workplace which supports all young people.

We have also been asked to become a 'Best Practice' example where Scottish Government will showcase examples of our work in the follow up to the launch of employer 'trailblazers' on 5th November.

Youth employment is a key enabler of our workforce plan. #EarnLearnProgress
Over the last 18 months NHS Lothian along with 5 other Boards in the East Region have been collaborating on an options appraisal and business case to create an East Region Recruitment Service. Following approval of the Business Case, each of the 6 Boards were asked to note interest in leading the service. NHS Lothian were the only Board in the consortium to note interest. Following agreement by CMT a formal submission to lead and manage the service will be considered by an independent panel during December. The Staff Governance Committee are supportive of this direction of travel.

We have now launched the programme for our virtual 2020 leadership week – 'Leadership Everyone's Chance to Shine with Kindness'. A series of conversations,

workshops and self-care events will take place from 30 November – 4 December. The event is for all staff at all levels - leadership is about values and attitude, not position. Work has commenced on the development of a Staff Wellbeing Strategy in partnership with Kamwell and the Edinburgh and Lothian's Health Foundation.

7. Director of Public Health and Health Policy

COVID: The majority of work within the Directorate remains focused on the COVID pandemic. Overall, levels of COVID within Lothian are stable and are below the Scottish Average.

Health Protection response: The health protection team have been focused on investigating and managing cases and outbreaks of COVID. There are a large number of cases within schools and nurseries, however these are usually sporadic cases, with transmission within the school setting rare. The number of cases within Universities has significantly reduced since the start of the academic year and outbreaks are under control at present. In common with many other areas of Scotland, Lothian has seen an increase in COVID outbreaks in Care Homes in recent months, and we have around 10 active outbreaks at any given point in time, with further homes undergoing active surveillance and testing. Workplace transmission is being seen and there have been a number of outbreaks in these settings.

Phase 1 descriptive epidemiology: A report outlining the descriptive epidemiology of 'Phase 1' of COVID in Lothian is being finalised.

Scottish COVID Protection Levels: We have established a rhythm of weekly reviews of the indicators that inform the national protection levels, in conjunction with Local Authority Chief Executives. We are actively refining our intelligence picture to support this and are working with Local Authorities colleagues to strengthen our COVID prevention strategies.

Test and Protect: This service has been rapidly established to undertake contact tracing across Lothian. The service has recruited 137 staff to date, with a further 128 staff (existing NHS Lothian employees or Bank staff) trained as surge capacity. The service continues to develop and evolve in line with the pandemic response.

Shielding: We continue to coordinate work streams to maintain and adapt a master list of the 24,860 patients on shielding lists in Lothian. We have been providing advice to clinicians and teams on the application of national guidance and are monitoring COVID cases, hospital admissions, and mortality in people on the shielding list.

Screening: Public Health have been leading the restart of the six national screening programmes, following the pause during wave one of COVID. We have secured additional funding from the Scottish Government to support the remobilisation of the cervical screening programme, through increasing capacity within primary care and colposcopy.

As part of changes to the national pregnancy screening programme, we have implemented a new antenatal screening pathway for women in the first trimester (adding the offer of screening for Patau's Syndrome and Edwards' Syndrome). We have also introduced Non Invasive Prenatal Testing (NIPT) as an alternative to invasive diagnostic testing for women identified at higher risk for Patau's Syndrome, Edwards Syndrome or Down's Syndrome.

Health promotion annual report: we published our Health Promotion annual report in October. Highlights include: health literacy training for NHS staff; evaluating the staff wellbeing week; and developing Child Poverty Action Plans.

Maternal and infant nutrition: continues to be a priority for the board and our Neonatal Unit and Special Care Baby Unit provisionally passed their Unicef Baby Friendly Stage 2 Accreditation this Autumn. This supports the Board's commitment for NHS Lothian to be fully accredited as Baby Friendly across all sites.

Healthy Weight in Childhood: We have worked with partners in each Local Authority Area to secure £83,500 of funding to pilot the delivery of an evidence based Healthy Weight training programme for family workers/early learning childcare practitioners. This aims to build local capacity and strengthen support around childhood obesity prevention.

8. Chief Officer Acute Services

Scheduled Care: Within the Acute Division the focus continues to be remobilising services and optimising activity for out-patients, diagnostics and In-patient/day cases. This will be increasingly challenging for inpatient and daycase procedures as unscheduled admissions increase over the winter period. We have unfortunately had to significantly reduce the routine elective programme at RIE due to bed pressures. Protected beds have been identified in DCN to support cancer and urgent work. Work to look at how we provide additional protected elective capacity on all acute sites is ongoing.

Cancer: A case was submitted successfully to Scottish Government for the temporary placement of an additional surgical robot to support prostatectomy procedures and free theatre capacity at the Western General Hospital for additional bladder cancer surgery. This programme will reduce surgical waiting times for bladder and prostate cancer patients. As urology is one of the main services that contributes to NHS Lothian 62 day cancer performance it is anticipated that by May 2021, in conjunction with improvement work on the wider prostate pathway, it will also improve overall 62 day performance.

Unscheduled Care: The national redesign of urgent care programme is accelerating the work that was being developed through the Lothian Unscheduled Care Programme Board to improve access to urgent care pathways, so people receive the right care, in the right place, at the right time.

A pathfinder board will test the new urgent care pathway with NHS24 over the month of November, with the aim to learn from this to inform a national roll-out from 1 December 2020.

The second phase of the project will include improving professional (GP, SAS clinicians etc.) referral into same day community, and secondary care services, that will provide care closer to home and reduce hospital attendances and admissions. This phase will continue to be progressed throughout the winter period with the principal aim of improving accessibility of same day services, with an agreed response time.

The project is on track for delivery to meet the national timescale, with the expanded Flow Centre being at full staffing, including administrative and nursing staff 24/7 from 1 December, in readiness for the national move to NHS24 acting as a single point of access for patients who would normally self-present to ED or MIU.

The Flow Centre also now manages the COVID Triage Hub and is co-located. The Flow Centre also manages the administrative function of the Out of Hours Lothian Unscheduled Care Service (LUCS), so will be multifunctional over a 24/7 period.

Following Lessons Learned from another HB test of change in November the Flow Centre will move towards a model that supports best the management of unscheduled care flow.

Laboratories: Work and run-rates for laboratory testing remain steady at an average of 1,100 tests per day; our recruitment to RIE labs to provide sustainable staffing over winter is approximately 50% complete.

The increase in testing at the RIE (a previous plan aimed for 3,000 per day) has now been paused while the regional 'hub' is constructed at Lauriston Building – this is a significant project being carried out in conjunction with NHS National Services Scotland (NSS) and the Scottish Government with a handover from the initial construction phase due for mid-December. A process of commissioning and testing will precede the full operation of the laboratory, with the move to the live status of the hub thereafter being dependant on the recruitment of sufficient staffing.

Significant work has been completed to move the East Lothian and Midlothian care homes to testing at 'Partner Nodes' to protect NHS Lothian core capacity, and allow rapid turnaround of Care Home staff and clients. Two nodes are live - Moredun and BioBest – and the third node - PAJS in Linlithgow - is expected live in the week commencing 23rd November.

In terms of POCT (Point Of Care Testing) Lothian – in conjunction with all other Health Boards in Scotland – is awaiting Scottish Government Policy documents and the release of the LumiraDx system to be deployed. This is anticipated from mid-to late November 2020, within Lothian.

RHCYP: ventilation and associated works are progressing to programme and the building handover date remains 25 January. In the meantime, Children's services

continue to run outpatient clinics from the new hospital outpatient department and Nasal Flu clinics for also 2-5 year olds.

9. Director of Improvement

Work continues to shape a broad programme of improvement work to support positive change in the light of Covid-19 and to address emerging performance challenges.

Over the Autumn period this has involved the development and approval of a Programme Business Case for investment in end user devices to support services to adapt to new models of care in a post Covid environment. New and additional device requirements are now being gathered and prioritised. This links closely to work being progressed with outpatient teams across Lothian to consider how best to redesign services, now and in the future, given physical distancing constraints. More detailed redesign work continues with two services (Cancer and Dermatology) to help embed virtual working and other changes into business as usual practice.

Work progresses on the Unscheduled Care Programme with Jenny Long leading a complex programme of work to support the scheduling of unscheduled care via the 111 service. There has been a 'soft' launch of the Call MIA virtual Minor Injury service across all three acute sites, and the broader programme is scheduled to go live in early December. The Mental Health Programme has also been stepped up, with a focus returning to CAMHS and Psychological Therapy performance challenges. Following the last Board meeting, a detailed recovery plan has been developed for the CAMHS service and it is in the process of implementation..

10. Director of Strategic Planning

Continued engagement with the RSA, with public sector partners, and with nearly 100 staff from across the organisation in designing and gathering information to underpin the Lothian Strategic Development Framework.

In particular a lot of work has been undertaken to consider how the capital prioritisation process may be affected by the pandemic and how short-term and longer-term planning can be aligned better.

Picking up again the review of integration schemes.

A range of national issues have consumed a portion of time, including the national Test and Protect oversight group and design authority, developing the national framework for robotic-assisted surgery, and the national winter planning group.

I meet with SGHSCD's Director of Planning weekly and we are developing planning guidance for next year.

More broadly, the team continue to work on the South-East Scotland Trauma Network and Centre developments, the Scheduled Care recovery programme, contingency plans for diagnostics and critical care, business cases for the Short-Stay Elective Centre, Centre for Laboratory and Forensic Sciences, the development with the Director of Finance of a broader Project Management Office function, the COVID

vaccination programme, Children's Plans, and the masterplans for each of our four major sites.

Finally, the team coordinated the Annual Review with the Cabinet Secretary which involved a considerable amount of work and for which I would note my thanks."

11. Director of Primary Care Transformation

Flu Vaccination:

The Flu vaccination programme has vaccinated more people this year than at the same point last year. In all areas uptake for over 65's is over 75%, for under 65 at risk it is higher than last year, but vaccine supply issues in late October have slowed this part down, There will be a further push before christmas. The Primary Schools programme is progressing well. Uptake for 2-5's whilst better than last year is still lower than hoped for. Work is underway through social media to encourage parents to take up the appointments sent out. There will be lessons to be learnt from this year's programme that we will take into next year when all vaccinations will have to be removed from general practice.

Covid vaccination:

At this point covid vaccintion is in a very fluid situation. Huge effort nationally and locally is being made to get ready for delivery from the beginning of December, but much remains to be done. The first vaccine is still with MHRA for consideration, so the date of commencement of the programme is not known. Due to the rapidly changing situation, this will be updated verbally at the meeting.

12. Director of Communications, Engagement and Public Affairs

Call MIA expansion and the Redesign of Urgent Care

We have developed a communications strategy to support the rollout of Call Mia across Lothian and indeed the wider national campaign to support the redesign of urgent care. This will explain how access to urgent care is changing. The goal is to help more people get the right care in the right place and reduce pressure on our emergency departments. Operational issues at a national level mean the national campaign has been delayed till January. However we have developed an interim local winter communications plan that incorporates our Call Mia campaign and intend to launch this at the beginning of December.

Engagement

<u>Redesigning Urgent Care</u>
An Equality Impact Assessment has been carried out on proposals to redesign urgent care access. This project has received a lot of support from Engagement to recruit, set the session up and facilitate it. The final report is nearing completion which should inform our thinking as phased redesign evolves.

<u>Lothian Wide Engagement Forum</u>

A new engagement forum has been set up to more formally link leads from NHs Lothian and the area's 4 HSCPs. So co-ordinate engagement work across all HSCPs and NHS Lothian

Only recently have all the HSCPs got in place identifiable people in engagement roles, allowing us to move ahead with this Forum. A key piece of early work for the group is to input to the new pan-Lothian Engagement Framework (see below) prior to this going to the Chief Officers to gain collective commitment.

Lothian Engagement Strategy is out for consultation. This document will help to:

- Increase the profile of engagement across the Board area
- Contribute to increased prioritisation of engagement in service redesign, improvement and general development work.
- Ensure a coordinated approach to engagement across the Board and HSCPs whenever this will be of value.
- Provide the conditions for wider and improved engagement practice across the workforce by locking in commitments to staff induction and training in engagement.
- Help to cement a culture that embraces engagement as a valuable addition to the toolbox when it comes to service change and improvement. We hope the Framework will aid understanding of the value of engagement done well to enrich our service developments

Our Health – this is a partnership with Edinburgh Uni to carry out action research with elderly patients in order to understand how digital delivery impacts on this group is taking quite a lot of development time. Evolved from original plan to carry out this project to understand outpatient pathways as part of their review but the covid landscape has changed the scope

Covid-19 Outbreak Comms

The communication team has continued to deploy a significant amount of resource in recent weeks to support the Public Health work relating to Covid 19 outbreaks, principally, although not exclusively in care homes. In view of the multiple agencies involved in Care Homes and the management of outbreaks we have developed a communications protocol which has been agreed with HSCPs and Local Authorities to achieve greater understanding of the role of each agency and consistency of response across the system

Media

A proactive spotlight on the pressure Covid is placing on St John's hospital in particular received widespread coverage with a message reinforcing public health guidance. We are planning a similar focus on promoting the use of Covid Community Assessment Hub to educate people not to self-present at ED with Covid symptoms. Planning is also underway to promote a new ophthalmology pathway, launch a psychological service website and to highlight the work of NHS Lothian's research nursing team.

Visiting

NHS Lothian reinstated the restrictions on hospital visiting that had been put in place during the first 'wave' of the pandemic. This decision was taken at by Gold Command and introduced with immediate effect on just ahead of changes to Scottish Government advice recommending the same. These changes were widely publicised by the Comms Team on all our channels, in particular via engagement on social media and through media editorial with messaging that stressed our recognition of how hard these restrictions are for patients and their relatives and friends, but which emphasised the necessity of the measures for the safety of patients, staff and visitors. Opportunities for virtual visiting have also been emphasised.

MSPs / MPs Update

A well-attended and well received update meeting of MSPs and MPs was held on Friday 13th November. Members of the Executive Directors team briefed elected representatives on a range of issues including the impact of Covid 19 on our services across scheduled and unscheduled care, our winter planning activity, the redesign of urgent care and the planning for a Covid vaccinations programme.

13. Director/Chief Officer, Edinburgh Integration Joint Board

Operations

Command Centre

EHSCP stood up a Command Centre Oversight Team (CCOT) prior to lockdown and it remained in place throughout the peak COVID-19 period. The CCOT was stood down during the organisational remobilisation period that followed.

In response to the second wave of COVID-19 and the launch of the EHSCP winter programme, the CCOT has been re-established. The function of the CCOT is to provide a data informed and analytical overview of our capacity and resilience in response to the current surge in COVID-19 during the winter period. It will focus on wider system updates and trajectory analytics and current operational status updates. Should the need arise, the CCOT can be enhanced further to take on full operational control over resource deployment and delivery.

Delayed Discharge

EHSCP is committed to ongoing improvement in its position in relation to delayed discharges. We have just agreed a resourced Action Plan which targets the current level of delays with the aim to reduce the current level to that of Apr 20, which for Edinburgh was 49. This plan includes initiatives to reduce unnecessary delays in HBCCC for those ready to move into community placements; those who are in acute sites with a view to moving to care home placements as self-funders, but anxious about the commitment during this period. And, a joint (with acute colleagues) discharge tracking team who intend to positively impact on those with a Planned Date of Discharge to avoid them coming onto the Delayed Discharge list.

We are also continuing to develop our Home First Edinburgh approach, with resources and capacity working with NHS colleagues focussed on reducing delays. In terms of prevention, the roll out of a Hospital at Home service across the City seeks to reduce and prevent admissions to acute hospitals. We continue to analyse delayed discharge

categories and trends to better understand the symptoms and causes of delayed discharge in the City.

Flu Vaccination Programme
The Adult Flu Vaccination Programme for 2020 aims to increase the number of adults vaccinated in Edinburgh from c.85,000 in the two key target groups last year, to c.105,000 this year. This directly responds to ambitious government targets reflecting population protection concerns in pandemic conditions. A decision is awaited from Scottish Government about whether the campaign will now be extended to 55+ population. This would add substantially to the target figure and potentially overlap with COVID vaccine delivery arrangements.

NHSL members will be aware of the changes in the national GMS (GP) contract which directed the transfer of responsibility for the adult flu delivery programme from medical practices to HSCPs. In Edinburgh this was planned to take place in 2021, but due to delivery changes required to respond to COVID-19 conditions, and following advice from GPs across the City, we accelerated plans to change delivery in 2020. The adult programme in Edinburgh got underway over the weekend of 26 and 27 September and has now largely been delivered through a series of drive through and walk-through clinics at sites across the city during an 8-week period. The 9 'Drive –Thru' Sites were chosen to ensure the safety of people accessing them, and traffic management plans were part of the assessment of each site.

Medical Practices were zoned to the sites and timeslots were allocated to patients based on their practice and the first letter of their surname. The HSCP part of the programme is expected to deliver c67,000 vaccinations and the overall adult programme c95,000 against the government target of 105,000.

An evaluation of the programme will be undertaken, but patient support and response to the arrangements has been overwhelming. There are many lessons to be learned for next year building on the success of the programme this year and avoiding the over demand and waiting time difficulties which happened at approximately 6 of the 160 clinics which were delivered.

COVID-19 Vaccination Planning
EHSCP is working closely with NHS Lothian colleagues in the planning for COVID-19 vaccinations. Lessons learned from this year's flu programme will likely offer useful insights into the implementation of future vaccination plans for the City and pan-Lothian. The initial proposed sites are being analysed now, although we do need to better understand demand, flow and how this might translate through to delivery.

Care Homes
There has been an increase in COVID-19 cases over recent weeks, in line with the national increase in infections, and this is being closely monitored with the required testing regime in place. The Edinburgh Care Home Oversight Group (ECHOG) sits daily to consider the current situation, emerging issues, data and trends. A specialist team provides regular advice and direct support to care home management and staff. The ECHOG works closely with NHS Lothian colleagues and issues are escalated as required.

Route Map Programme Board

In July EHSCP set up a Programme Board to manage the reintroduction of services in accordance with national guidance and specifically the Route Map through and out of the pandemic. This Route Map Programme Board continues to sit weekly to consider requests to reinstate services set against national guidelines and includes consideration of associated risk assessments and consideration of mid to longer term milestones.

Thrive Edinburgh

A detailed review on Thrive Edinburgh was provided on the last update. It remains the central EIJB strategic mental health approach based around four pillars and 6 Adult Health and Social Care Commissioning workstreams.

Strategic

Transformation Programme

Although delayed by the impact and response to COVID-19, the EHSCP transformation programme re-started in Aug 20. The 4 programme boards are well supported by a wide range of stakeholders including NHS Lothian, Care Inspectorate, Health Improvement Scotland, 3rd and independent sector representation and the boards are now making steady progress.

Strategic Planning

Work on the next strategic commissioning cycle starts in earnest in the new year with the intent to publish the next 3-year plan for 2022-2025 in Mar 22 following EIJB approval. There will be planned preliminary activity progressed by EHSCP before then to inform the process. The next commissioning cycle seeks to better align financial planning and the mapping of transformation projects to EIJB strategic priorities. Work is underway on a concise higher-level strategic vision for the EIJB, which is not bound by time, and guides each 3-year strategic commissioning cycle.

Edinburgh Integration Joint Board (EIJB) – Public Engagement

The first of a new programme of EIJB public engagements under the theme of Your Health, Your Care, Your Future, was run on Tuesday 17 Nov 20 from 1000 to 1200 on a Teams Live platform. A second engagement following the same format will be run on 19 Nov 20 from 1900 to 2100. A total of 137 people signed up for the first event and numbers are approaching a similar figure for the planned second event. These events are designed around two elements: the first covering the role and aspirations of the EIJB and views from the public on what health and social care means to them. The second element is based on a Question Time format where the EIJB Chair fields questions that are submitted in advance and live to a panel of EIJB members and the Chief Officer.

All questions submitted are being consolidated and they will be published with responses on the EHSCP website shortly after the second event has taken place. Surveys are going out to those who signed up for the events to evaluate the impact. A public engagement working group is charged with designing a series of events throughout the year; utilising different channels, reaching out to different audience groups, culminating with an annual public engagement event in November.

14. Director/Chief Officer, East Lothian Integration Joint Board

Winter Planning
The partnership continues to adopt a 'home first' approach and work to maintain current performance on reducing delays to discharge. Our winter planning supplements the systems we have in place by increasing capacity in Hospital to Home Team, Discharge to Assess Team and Social Work Assessment Team.
Available inpatient resource at East Lothian Community hospital has been commissioned to support winter pressure of which 24 beds are staffed and 20 beds are being recruited to

The Flu Vaccination Programme for 2020/21 has been delivered by East Lothian GP practices via an agreed delivery plan, which was supplemented by HSCP clinics. Work is ongoing to support delivery of the Covid 19 vaccination programme

Primary Care
One of our largest practices continues to give concern with their ability to respond to demand and has had significant partnership support to manage this demand.

Care Homes:
Governance arrangements for East Lothian continue under the oversight of the Chief Nurse as per Scottish Government instruction of 17 May 2020 and updated letter of 21 September 2020. Care Home infection control and outbreak status are reported through the Care Home Operational Group.

The existing East Lothian Care Home nursing team has been extended and restructured to support all care homes within East Lothian through education input, Nurse Practitioner support to anticipatory care and long-term conditions support and to respond to acute illness presentations in residents. The team are supported by lead GP practices.

Social Care Capacity:.
There is a concern about ongoing capacity particularly in Care at Home Services however support from NHS Lothian will enable an increase in capacity over the winter period.

15. Director/Chief Officer, Midlothian Integration Joint Board

Winter preparedness

The HSCP have finalised our 2020/21 Winter plan. This has been developed with Midlothian Council to provide a joined up local approach to winter. The plan includes enhanced models of care supported by NHS Lothian winter funding process, the Midlothian Delayed Discharge action plan, planning relating to Brexit, and cross references the recent Scottish Government Adult Social Care Winter Preparedness plan. Recruitment is underway to augment and develop local teams, as well as to open an additional Older Peoples' ward at Midlothian Community Hospital, meaning that more Midlothian people can be supported closer to home.

Care Homes

The HSCP continue to support local care homes throughout the covid pandemic. This includes the provision of a local assurance infrastructure that supports the NHS Lothian Care home assurance process. Asymptomatic weekly testing of care home staff is now being lead by the HSCP. Relationships with External provider colleagues remains strong, and as a result, performance across the sector has remained good. Our Intermediate care facility recently had the first Care Inspectorate virtual inspection, receiving excellent feedback.

Community rehabilitation services update

In line with our Covid19 recovery work and implementation across Lothian of the Home First model for community services, Midlothian HSCP is continuing to develop our primary care and older people's services in line with our vision – to enable people to maximise their health gain and independence through a co-ordinated approach by all partners. The definition of rehabilitation is a process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients or service users, and their family carers. This work links also to the local response required to support the national work across NHS to scheduling of unscheduled care. Review of our current pathways for community referral within older people's rehabilitation services.

Initially we will focus on the creating of a single point of access for intermediate care services – which will be open to requests for assistance to support those experiencing a change in their needs within the community, support early planned discharge and promote reablement following a period of illness. This will be operational from 1st December 2020.

Equality Outcomes

Midlothian HSCP need to produce and publish new Equality Outcomes for 2021-2025 as part of the Public Sector Equality Duty (PSED) requirements.
Organisations across Lothians, including City of Edinburgh Council, Midlothian Council, West Lothian Council, Edinburgh HSCP and Midlothian HSCP have agreed to work together to draft and consult on their new Equality Outcomes. The organisations recognise the value of developing a common approach to equalities issues.

The organisations have identified joint equality principles and have now drafted joint equality outcomes. Consultation of both staff and public on the draft equality outcomes will take place across the Lothians from October onwards as per the requirements of the PSED.

16. Director/Chief Officer, West Lothian Integration Joint Board

United to Prevent Suicide

The West Lothian Mental Wellbeing and Suicide Prevention Group was established in

July 2020 to bring together partners from across West Lothian and to deliver both a local action plan for suicide prevention. A key part of the recent work was to develop a shared, common voice to state in West Lothian that 'we are all United to Prevent Suicide'.

Since its inception the group has delivered a local campaign on World Suicide Prevention Day and developed a draft action plan. A public consultation and focused consultation with those with lived experience supported by the Mental Health Advocacy Project, was held between 10/09/2020 and 25/10/2020. Over 500 individual comments from 129 participants were noted and have been used to develop the local action plan.

The final draft of the West Lothian Suicide Prevention Action Plan 2020-2023 is due to be reviewed by the Community Planning Partnership on the 30th of November. If the CPP Board approves the plan, it will be published in December alongside some additional campaign messages and videos supported by West Lothian College and local West Lothian sports teams and clubs. Suicide Prevention is all our responsibility and the Mental Wellbeing and Suicide Prevention Group looks forward to working with partners to progress the actions detailed in the plan. To find out more about the new National campaign please click here:
https://unitedtopreventsuicide.org.uk/

Older People Commissioning Plan

The West Lothian Integration Joint Board approved a new strategic commissioning plan for older people and people living with dementia at its meeting on 10the November 2020. The plan sets out an ambitious programme of change for the development of services in West Lothian over the next 3 years.

Development of the plan took account of engagement work carried out towards the end of 2019 but was also informed by experiences and changing working practices associated with the pandemic response. The IJB's Strategic Planning Group held a development session in July 2020 which allowed all stakeholders to reflect on things that needed to be changed, implemented or stopped as the partnership responded to Covid-19. Finding from that session were also used to shape the proprieties contained in the new plan which sets out 3 main priority areas:

- Programme 1 – Prevention and Early Intervention
- Programme 2 – Integrated Community Services
- Programme 3 – Acute Specialist Care

Urgent Care Pathways and Home First

In support of the work being done to develop urgent care pathways and with the aim of progressing our Home First approach further, we are working with Organisational Development colleagues to develop a programme to support culture and change within our health and social care teams. The aim is to ensure there is a common understanding and approach to Home First in West Lothian with clear focus on the need to develop community pathways which prevent hospital admission and timely hospital discharge.

17. The Board is asked to receive the report.

Policy/Strategy Implications	Policy/strategy implications will be addressed in the management of any actions resulting from these events, activities and issues.
Consultation	Board Executive Team
Consultation with Professional Committees	None
Risk Assessment	Risk assessment will be addressed in the management of any actions resulting from these events, activities and issues.
Compliance with Board Policy requirements on Equality and Diversity	Compliant
Resource/Staffing Implications	Resource/staffing implications will be addressed in the management of any actions resulting from these events, activities and issues.

Approved by

Name	Designation
Calum Campbell	Chief Executive

Author(s)

Name	Designation	Name	Designation
Calum Campbell	Chief Executive	Alison McCallum	Director of Public Health and Health Protection
Jim Crombie	Deputy Chief Executive	Jacquie Campbell	Chief Officer Acute Services
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		Colin Briggs	
Tracey Gillies	Medical Director		Director of Strategic Planning
Susan Goldsmith	Director of Finance	David Small	Director of Primary Care Transformation
Janis Butler			

Morag Barrow Alison Macdonald	Director of Human Resources and Organisational Development. Director/Chief Officer Midlothian IJB/HSCP Director/Chief Officer East Lothian IJB/HSCP	Judith Mackay Judith Proctor Allister Short	Director of Communications, Engagement and Public Affairs. Director/Chief Officer Edinburgh IJB/HSCP Director/Chief Officer West Lothian IJB/HSCP

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Esther Roberton, Interim Chair, NHS Lothian

Via email: ChiefExecutive@nhslothian.scot.nhs.uk

26 November 2020

Dear Esther

NHS LOTHIAN ANNUAL REVIEW: 16 NOVEMBER 2020

1. Thank you for attending NHS Lothian's Annual Review with your Chief Executive on 16 November via video conference. I am writing to summarise the key discussion points.

2. As you will be aware, the intention was for Ministers to conduct a full round of Annual Reviews during the summer. Whilst that has not proved possible due to the COVID-19 pandemic, Annual Reviews remain an important part of the accountability process for the NHS and, as such, we have arranged for Ministers to hold appropriate sessions with the Chair and Chief Executive of each Board via video conference. I was supported in the meeting by John Connaghan, Interim Chief Executive of NHS Scotland.

3. This meeting marked the five month anniversary of the appointment of Calum Campbell as Chief Executive of NHS Lothian. I wanted to formally welcome Calum to his new role and thank him for the significant contribution he made as both Chief Executive of NHS Lanarkshire and, during 2019/20, as Turnaround Director in NHS Greater Glasgow & Clyde. In the same way, I want to recognise and thank you for your work as Interim Chair in this most challenging of years, following your appointment in February.

4. The agenda for this year's round of Reviews has been split into three sections to cover: pre-Covid performance during 2019/20; the initial response to the pandemic from February/March to July 2020; and a forward look, in line with the current Board mobilisation plans (August to end of March 2021) and beyond.

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Pre-Covid performance during 2019/20

5. NHS Lothian had been escalated to level 4 on the national performance framework during 2019/20; specifically in relation to the issues with the new Royal Hospital for Children & Young People in Edinburgh. The Board was also at level 3 for performance issues in five areas: electives, unscheduled care, delayed discharge, mental health and cancer waiting times. You provided a helpful update on the former, confirming: that the transfer of the Department of Clinical Neurosciences is complete; that 70% of outpatient care has transferred; 80% of children's clinics have transferred; and that the move of Child and Adolescent Mental Health Services (CAMHS) services is planned for early in the New Year. You assured us that the Board leadership team is working very closely with local clinicians to agree the appropriate phasing of the remaining moves to the new hospital; and that this will need to be kept under review in light of emerging COVID-19 and other winter pressures. You further assured that a robust communications strategy is in place to ensure that local families know what services are available from each location, and when.

6. In respect of the Board's recovery plan for the five escalated performance issues, we noted that there had been some significant progress against trajectories made in the latter part of 2019/20. Unfortunately, some of this has been affected by the obvious impact of the COVID-19 pandemic, which necessitated the radical restructuring of services – including the suspension of all elective activity to protect emergencies, urgent and cancer activity – from late February. You assured us that the Board has nonetheless taken the time to review and strengthen its performance management focus; and that we should start to see the positive impact of this more markedly, once the COVID-19 emergency period concludes. We also noted that considerable efforts had be made under the new Board leadership to reinforce relations with local public health colleagues; and that a new Director of Public Health is due to be appointed imminently.

7. Looking at cancer waiting times: over the last five quarters, NHS Lothian did not meet the 62 day standard. The 31 day standard was met in the last three quarters. Some progress had been made against Board's recovery plan, pre-COVID. There remain significant challenges in urology and gastroenterology, which the Board remains committed to addressing. On mental health waiting times: there have been significant issues with long waits in both CAMHS and Psychological Therapies; the Board has been an outlier across Scotland – particularly for CAMHS. You assured us that this is a key priority area for NHS Lothian, with the Board fully committed to making significant and sustained progress in the longer term.

Initial response to the pandemic from February/March to July 2020

8. You provided a helpful overview of the Board's initial response to the pandemic from late February. As has been noted, this required an unparalleled, immediate and radical restructure of both services and ways of working in the NHS in Scotland, including in NHS Lothian. All Boards will need to learn from the pandemic experience and adapt; ensuring that the remarkable innovation and new ways of working demonstrated this year underpin the local strategy for a sustainable future. We also asked the local Area Clinical Forum and Area Partnership Forum to provide brief updates ahead of the Review and I would like to take this opportunity to, once again, formally record our sincere thanks to local staff for the incredible effort and unstinting commitment they have consistently shown, in the most testing of conditions. We were pleased to note the Board's ongoing focus on staff well-being: this must be maintained as an already fatigued workforce is faced with a very challenging winter.

Forward look

9. The Board's remobilisation focus has been underpinned by clinical prioritisation: meeting emergency, urgent suspicion of cancer and urgent demand, whilst maintaining the safety of patients and staff. We noted and welcomed the Board's early delivery in terms of the remobilisation of elective care, which significantly surpassed expectations. However, we understand that further progress may be limited by the operational impact of the recent resurgence in COVID-19 admissions; and the overall risks associated with pressures this winter. Our over-riding priority remains, as in the first phase of the pandemic, that the NHS is not overwhelmed. We agreed that Boards must have flexibility of approach, based on local disease prevalence and other pressures; whilst operating in way which is fully consistent with the clinical prioritisation framework. It is likely Boards will need to review and submit revised remobilisation plans next spring.

10. Local performance against the 4 hour A&E standard has been a challenge for some time, and was one of the areas previously identified for performance escalation. Of particular concern historically has been the number of over 12 hour waits in NHS Lothian. All Health Boards had seen unscheduled care pressures fall in the first phase of the pandemic, with the restrictions having a significant impact on attendances. However, as restrictions were scaled down following the initial lockdown, attendances have risen; and Boards face new pressures in A&E Departments and receiving wards due to the appropriate infection control measures and streaming of patients. That is why we are currently piloting the redesign of unscheduled care in NHS Ayrshire & Arran. We were pleased to note that NHS Lothian is fully supportive of this necessary redesign work, and is well placed to implement similar changes. We agreed that, as with any significant service redesign, we need to learn the lessons from the pilot and ensure we effectively mitigate against the identified risks.

11. We want to recognise the significant achievement locally with the enhanced seasonal flu vaccination programme: some 415,000 vaccinations have been delivered in NHS Lothian, compared to 252,000 last year; an increase of 64%. We agreed that a robust communications strategy will be crucial, for the benefit of all stakeholders, on our approach to the very significant logistical and other challenges associated with a vaccination programme for any viable COVID-19 vaccine.

12. It was also pleasing to note that effective whole system working with the four IJB Chief Officers and Local Authority Chief Executives has been very much the focus of the approach by the new leadership team in NHS Lothian during the pandemic. We agreed that this must be maintained and developed as the Board and its planning partners move from the emergency/winter response to operational recovery and, ultimately, renewal.

Finance

13. NHS Lothian met its financial targets and presented a £0.6 million underspend at the end of 2019/20. In addition, the Board provided non-recurring in-year support to both Edinburgh and West Lothian IJBs. Based on the funding to support additional costs as a result of COVID-19, you confirmed that NHS Lothian is continuing to work towards the delivery of financial balance in 2020/21.

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Paediatrics at St John's Hospital, Livingston

14. We wanted to recognise the significant work that had gone into the restoration of the 24/7, full inpatient paediatric service at St John's Hospital last month: this is a huge and most welcome boost for local communities.

Conclusion

15. We want to reiterate our thanks to the Board and local staff for their ongoing, incredible efforts, professionalism and commitment, in the facing of unprecedented and unremitting pressures during 2020/21.

16. We know you understand that there is no room for complacency, given the myriad of risks the NHS faces this winter. We will continue to keep local activity under close review and to provide as much support as possible. We are nonetheless confident that, under the Board's leadership team, NHS Lothian and its staff are well placed to continue to deliver for the benefit of local people.

Kindest regards

JEANE FREEMAN

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www.gov.scot

NHS LOTHIAN

NHS Lothian Board
9th December 2020
Deputy Chief Executive

SUSTAINABLE DEVELOPMENT FRAMEWORK AND ACTION PLAN

1 Purpose of the Report

The purpose of this paper is to recommend that the NHS Board endorse the Sustainable Development Framework and Action Plan.

2 Recommendations

NHS Lothian Board are asked to:

2.1 Endorse the Sustainable Development Framework and Action Plan, recognising the importance of the framework to set ambitions and a direction for engagement on the across NHS Lothian and with partner organisations and within NHS Scotland.

2.2 Note the current opportunity for NHS Lothian to maximise the benefits of the high level of interest and motivation from staff and the important opportunity of a Green Recovery from Covid 19.

2.3 Accept as significant assurance that the Finance and Resources Committee (23rd September) agreed to recommend the Sustainable Development Framework to the NHS Board.

3 Discussion of Key Issues

3.1 Climate change is the biggest threat to global health of the 21st Century. Policy and public consideration of the need for environmental sustainability is high.

3.2 The ambition and motivation and interest of staff and services from across NHS Lothian as a whole is also high. Workshops at the Western General Hospital and Royal Infirmary of Edinburgh and a recent Webinar were extremely well attended.

3.3 The NHS Lothian Sustainable Development Management Group has developed a Sustainable Development Framework and Action Plan (Appendix 1) for engagement across NHS Lothian and with partner organisations.

3.4 In this context, the actions underway are evolving constantly and this is the reason for presenting a framework upon which to base more detailed plans and actions. The intention is to set out an organisational ambition to reflect that of staff, and to provide tools which allow services and sectors across the organisation to see how day to day actions and service plans can contribute to transformation.

3.5 This Framework has been designed to:

- Set out the pathway we have taken to date and what we have achieved
- Build knowledge and understanding of climate change and sustainability across the organisation and a culture of learning and development
- Ensure that the carbon foot print of the NHS is widely understood within the service and informs strategic plans as well as quality improvements and day to day actions
- Put sustainability at the core of our organisation and ways of working and models of care.
- It identifies focus areas and carbon 'hot spots' where we can have maximum impact: maximises opportunities to simultaneously improve quality, reduce financial and environmental cost; enlists the demand, motivation and expertise of staff, patients and partners for change
- Monitor our impact on the environment, our progress on sustainability goals and the progress the action plan
- Engage our stakeholders and partners in planning and implementation

3.6 The framework is presented as a high level summary designed to set out NHS Lothian ambitions and promote further discussion, engagement and action among staff, patients and partners.

3.7 The framework has been based on:

- Previous work and plans within NHS Lothian and NHS Scotland
- Review of evidence and tools for planning for sustainable health care from key organisations and from plans and strategies from other health service organisations
- Engagement with staff at key events and communication channels developed throughout the preparation of the framework and actions, particularly the high level of motivation and ambition from across all staff groups.

3.8 The framework represents a significant step forward from the prior NHS Scotland approach of a focus on facilities, broadening the scope across the organisation as a whole and recognising the fundamental importance of sustainable models of care.

3.9 Table 1 below sets out a subjective initial assessment of the framework in terms of its scope, identifying key areas of strategic importance for which we require further input/and or development. The table itself is a tool for discussion and engagement. The table seeks to set the context of the triple bottom line by setting carbon costs along side estimates of financial costs.

3.10 These costs are indicative of scale. One of the key challenges faced in implementing the framework is to develop analytical support for strategic planning and monitoring the implementation of the action plan (see section 7 below and appendix 2). Over all this indicates where there is potential to look at significant areas of finance and use of resources from the perspective of sustainability, particularly environmental sustainability.

3.11 The table also highlights areas that are included in the Framework because of the high level of concern from staff and where there significant opportunities for a greener remobilisation and redesign of services are already explicitly identified.

3.12 The framework has been supported by the Executive Leadership Team, recognising sustainability as a generational issue already being considered a core by many staff and future NHS leaders and the need to engage wider partners in the challenges it brings.

3.13 The ELT also agreed:

- The need for direct reporting through and Executive Lead to ELT/CMT and then to F and R in recognition of sustainability as an issue for the whole organisation
- to identify resources for immediate high priority support for implementation
- the need for further discussion to identify priorities support through additional resources or re-orientation of existing roles and resources
- the importance of the Framework as a next step, but the need to develop a more detailed strategic action plan over the coming year as a key output of additional investment

3.14 The Sustainable Development Framework was reviewed and supported by the NHS Lothian Finance and Resources Committee on the 23rd of September 2020.

Table 1 Subjective Strategic Assessment of Action Framework

Sustainable Development Action Areas	% of health service carbon foot print	Recognised carbon hotspot	Wider environmental Impact	Profile of environmental impact and supporting evidence in professional organisations	Staff concern /interest	Remobilisation/ redesign opportunity	Current status of monitoring and performance management **(opportunity for improvement)**	Approximate spend
Focus areas								
Greenhouse Gas Emissions	100%							
Energy	24%	YES	High	Very High	High		Good **(High)**	£15M
Water	<1%		High	Very High			Poor **(High)**	£2.2M
Sustainable Use of Resources	46%				Very High			
Goods (and services)		YES			Very High		Poor (**Very high)**	£100M (£500M)
Core NDC[1] products								£23.5M
Waste management and disposal	<1%		High	Very high	Very High		Very poor **(Very high)**	£3.3M
Transport and Travel	15%	YES	High			Very High	Fair **(High)**	
Greenspace and Biodiversity	0%		High	High	High	High	Poor **(Very high)**	Not known
Built Environment	25%						Fair **(High)**	£110M[2]
Sustainable Models of Care								
Theatres and Anaesthetics		YES	High	Very high	Very High		Fair **(High)**	£16.5M[3]
Medical Equipment	*7%*	*YES*			*High*		*Good **(High)***	*£9M[4]*
Pharmaceuticals	18%	YES		Very High	Very High		Very High **(Very High)**	£282M[5]
Respiratory care and inhalers		*YES*	*High*	*High*				
Outpatients						Very high	Good **(Very high**)	£63M[i6]
Primary care (prescribing)				High	Very High	Very high	Very high **(Very High)**	
Critical Care		*YES*		*High*				
Greener laboratories		*YES*						*£10.4M[7]*
Renal services		*YES*		*Very High*				
Greener mental health care				*High*		*Very high*		
Prevention and early intervention								

[1] National Distribution Centre Products
[2] Projected capital investment 2020-2021
[3] Budget of pays and non pays under single cost centre (non pays £4.2M)
[4] Capital rolling programme annual allocation
[5] Figure from finance for 1819 total spend
[6] Based on ISD data for new and return outpatient appointments 2018-2019 all specialties and average cost of outpatient appointment £130
[7] Based on pays and non pays under single cost centre (non pays £2.3M)

4 Next Steps

4.1 To support the evolution of the action plan within this Framework, the Framework needs to be made available to the staff and the public.

4.2 The existing channels for engagement are the sustainability email address sustainability@nhslothian.scot.nhs.uk. There is also an active Facebook page Greener NHSLothian for NHS Staff only private group).

4.3 A communications strategy is prepared.

4.4 Additional resource and capacity to support the development of sustainability is required and prioritised gap and opportunity analysis was approved at Executive Leadership Team on 22nd September.

5 Key Risks

5.1 That NHS Lothian misses a timely opportunity to demonstrate transformational leadership in environmental sustainability in the public sector and NHS Scotland

5.2 That NHS Lothian fails to build on the ambitions, engagement and frontline innovation and leadership shown by staff

5.3 That NHS Lothian cannot meet its sustainability and climate change requirements because of:

- Lack of capacity or inadequate organisational design and processes for planning
- Lack of resources for delivery
- Difficulty in prioritising sustainability and climate change in the context of wider range of directives and requirements

6 Wider Impacts

6.1 The wider impacts are in relation to the environment, climate change mitigation in the context of the full set of UN Sustainability Goals.

7 Resource Implications

7.1 The total financial resource in direct scope of this work is £611M (total of spend identified in Table 1).

7.2 Dedicated resources for immediate priorities which are new roles have been agreed: data analytical support, sustainability co-ordinator and a sustainable energy manager.

7.3 As indicated in 4.4 further discussion is required on a wider analysis of capacity requirements, to consider funding or re-orientation of existing roles and capacity.

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27 November 2020

Appendix 1 Sustainable Development Framework and Action Plan September 2020

NHS Lothian

Sustainable Development Framework and Action Plan

Our Vision

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.

Goals / strategic objectives

1. NHS Lothian will have zero carbon emissions by 2045
2. NHS Lothian will contribute to enhancing our natural environment
3. NHS Lothian will promote climate resilience and ensure that its services are adapted to climate change
4. NHS Lothian will ensure that sustainable development is embedded in all its activities including governance and decision making, clinical practice, partnership working and advocacy
5. NHS Lothian will put sustainability at the core of its strategies for promoting health and well-being among staff, patients and the wider community

Introduction

We are proud of the contribution that the NHS makes to health, as a provider, developer and researcher of universal health services and treatments, as a major employer and contributor to national and local economies and as an institute responding to social and economic change and promoting public health.

In the face of climate change, the biggest threat to global health of the 21st century, we need to reassess and adapt to the challenge as an organisation and as individuals within the organisation.

This means understanding the impacts of climate change on health and illness, recognising that the NHS needs to be sustainable for future generations and understanding the interdependence and opportunity of sustainability goals such as those set out by the United Nations (UN).

The social, financial and environmental resources of the NHS are limited and need to be used and managed sustainably. Environmental sustainability, good financial management and better, more equal health need to be driven forward hand in hand. Sustainability means that we consider these elements together and prioritise action where positive change in one can benefit others. For example, a significant success in the last year has been switching to more sustainable anaesthetic gases which has not only reduced our carbon footprint, but also reduced costs. That is why our approach to sustainable development is based on:

Our NHS
Our People
Our Planet

Overview of this plan

In this short document we present an action framework to set out our ambitions, promote discussion, engagement and action.

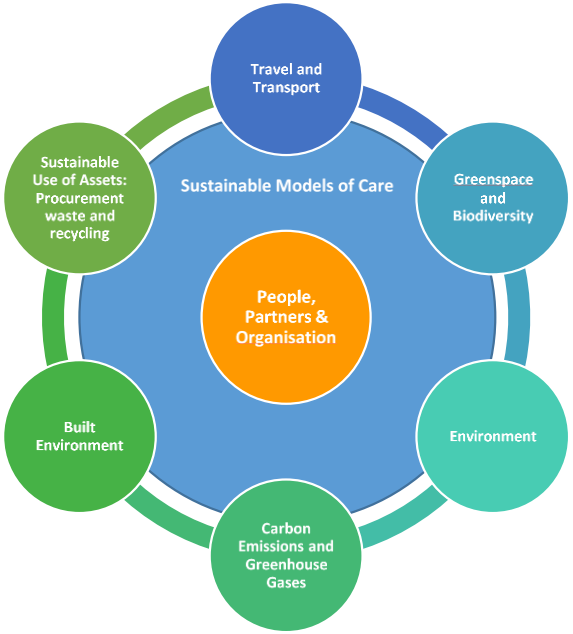
We have taken a significant step forward in broadening the scope of NHS Lothian's approach to sustainability. Rapid change needs to be a feature of our work, as we respond to the scale of the global challenge and to the commitment and demands of our staff, patients, partners and communities. As we progress, we hope this plan will develop rapidly, paving the way for still greater ambitions.

This document will be supported with additional resources which can provide more information on the issues and subject areas covered in the summary along with a more detailed interactive plan of actions.

Our Sustainable Development Action Framework forms the basis for this document and contains 4 main elements:

- In People, Partners and Organisation we outline the organisational change needed to put sustainability at the core of our organisation and to enlist the commitment, motivation and expertise of our staff, patients and partners, as well as the communities we serve.
- Sustainable Models of Care is where we start to look at the process of service redesign for sustainability. We present examples of how staff are making change happen now, across the organisation and across different aspects of our environmental impact.
- The Focus Area section categorises the main sources of our emissions in 6 areas – Greenspace and Biodiversity, Travel and Transport, Carbon Emissions, the Built Environment, Sustainable Use of Assets and our wider impacts on the environment – and proposes actions, goals and indicators for each.
- Monitoring Progress and Evaluating Impact is central to plotting our progress on the sustainability journey and this section of the plan outlines actions for improving the data sources and systems.

NHS Lothian Sustainable Development Action Framework

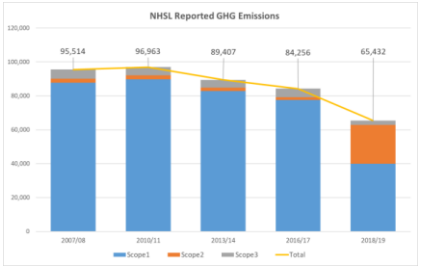


NHS Lothian's story so far and the challenge ahead

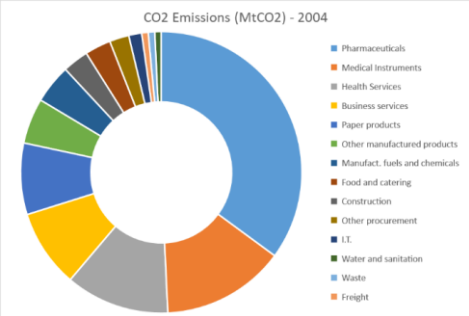
In managing and reducing our emissions we have reduced our impact on the environment, managed resources more effectively, contributed to actions on climate change and shown leadership as a major public sector organisation responsible for health.

NHS Lothian has been reporting on its annual Greenhouse Gas emissions since 2007/2008 following the internationally recognised approach for documenting the Carbon Footprint of an organisation, the Greenhouse Gas Protocol (GHG Protocol 12) as part of its Carbon Management Plan.

This chart shows that for the Green House Gases we have been monitoring and reporting on, there has been substantial progress. However, the emissions in scope relate only to our buildings and transport and represent less than 30% of the NHS Carbon Footprint and an even smaller proportion of our total resource utilisation.



We need to recognise the wider contribution 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, but this chart shows how much broader our scope needs to be.



This figure shows NHS Scotland emissions for 2004.

- NHS Scotland carbon footprint is estimated to 3.6% of Scotland's total carbon footprint and 23% of Scotland's public sector
- The travel and building energy sectors each contribute a quarter to the overall footprint, while procurement accounts for the other half (52%)
- Pharmaceuticals and medical equipment together comprise half of all procurement emissions for NHS Scotland

Over 70% of NHS Scotland emissions are from indirect sources, the products and services used, rather than being produced directly. 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 Scottish Government has set ambitious targets to reduce emissions by 75% by 2030 and net-zero by 2045 – the toughest statutory targets of any country in the world. To support this ambition we need to think and act across the whole of our organisation.

The Scottish Government has committed to take action now and has introduced the Climate Change Act 2019 which commits Scotland to net-zero emissions target by 2045, with interim targets of:

1. 2020 is at least 56% lower than the 1990 baseline
2. 2030 is at least 75% lower than the baseline
3. 2040 is at least 90% lower than the baseline

Scottish Government recognises that the public sector - as a provider of services, a major employer and procurer of goods and services - has an important role to play in decarbonising Scotland. Scotland's public bodies therefore must lead by example in combating climate change and making a valuable contribution towards achieving the emissions reduction targets. As one of the largest public bodies in Scotland, NHS Lothian is committing itself to meeting this target.

Programme for Government: Climate Change,
NHS CEOs in Scotland have endorsed 6 'must dos' from the Scottish Sustainability Strategy:

1. NHS Scotland will be a 'net zero' greenhouse gas emissions organisation by 2045 at the latest
2. All NHS Scotland new buildings and major refurbishments will be designed to have net-zero greenhouse emissions from April 2020
3. Each NHS Board should undertake a Climate Risk assessment covering all operational areas and produce a Climate Change Risk Assessment to ensure resilience of service under changing climate conditions
4. NHS Scotland transport GHG emissions from its owned fleet (small/medium vehicles) will be net-zero by 2032
5. The NHS supply chain will be reviewed to determine the extent of associated greenhouse gas emissions and environmental impacts
6. Each NHS Scotland Board should establish a Climate Change/ Sustainable Governance group to oversee their transition to a net-zero emissions service

People, Partners & Organisation

Adaptation to Climate Change

Adaptation to climate change is becoming increasingly important for the NHS as extreme weather conditions become more frequent and severe, posing a risk to public health and to the resilience of our services. Adapting to our changing climate and mitigating the negative effects as well as raising awareness among our staff, patients and partners will be a major priority. Producing an NHS Lothian Climate Change Risk Assessment and Mitigation Plan is a statutory requirement.

Aim: To work with our partners to make sure that NHS Lothian is prepared to deal with the effects of climate change by ensuring that we have invested in appropriate adaptation and mitigation measures.

Our Actions

- Appoint an Adaptation Lead and ensure that climate change mitigation is embedded in strategic reporting mechanisms
- Undertake a Climate Risk Assessment covering all operational areas and produce a Climate Change Risk Assessment and Adaptation Plan to ensure resilience of service under climate conditions
- Work with partners to plan for climate change adaptation and mitigation through membership of Edinburgh Adapts and ensure that the needs of vulnerable communities are addressed
- Invest in climate change adaptation and mitigations technologies
- Enhance the resilience of the NHS estate by maximising green space and biodiversity

Monitoring Progress

- Monitor and report on progress on the NHS Lothian Climate Change Risk Assessment and Mitigation Plan

e:Health

The e:Health transformations needed to support sustainable development were well under way before COVID 19 but have increased exponentially during the crisis. Technology to support home working, support remote consultations and reducing travel to a minimum have all become part of 'new normal' working practices throughout Lothian. These changes will be consolidated as sustainability becomes embedded as a key driver of our e:Health strategy.

Aim: Embed sustainability as a key driver for NHSL e:Health Strategy.

Our Actions

- Continue to roll out collaborative technologies such as Teams and Office 365, reducing travel needs and increasing collaborative and home working
- Continue the ongoing programme of making sustainable changes such as replacing desktops with virtual desktops and introducing Voiceover IP and monitoring the destination of surplus hardware to either 'certified destroyed' or reuse
- Continue to roll out, support and monitor the use of 'Near me'. Monitor the use of existing services such as Tele Presence and Video Solutions to inform future investment and upgrading
- Investigate the utility of e:Health solutions and tools in managing the built environment sustainably

Monitoring Progress

- Sustainability identified as key driver in NHS Lothian e:Health Strategy
- During COVID19 Teams has been enabled for all NHS Lothian and 8,000+ staff are now using it. Use will be monitored and impact on business travel calculated

Inequalities, Partners and Communities

The advantages of tackling climate change and inequalities in tandem – the co-benefits - are well recognised. Addressing health inequalities has long been a priority for NHS Lothian and was fundamental to establishing the Health and Social Care Partnerships and our work through Community Planning Partnerships (CPPs). It is through these mechanisms, which bring together local statutory and voluntary organisations and include active engagement with local communities (particularly those most in need), that NHS Lothian is seeking to mobilise joint action to address the climate change emergency.

A move to longer term prevention and early intervention is central to an integrated approach. Increasingly this will involve service users in setting priorities and co-designing services.

Food and fuel are fundamental for health and sustainability. The food we provide and way we heat buildings will be more sustainable. In addition, we will continue to work with partners (as employers, service providers and advocates) to ensure growing levels of food and fuel poverty are addressed through direct entitlements rather than charitable models of aid. Examples of existing joint work include:

- Shared approaches to energy use such as the planned WGH district heating system
- Moves towards shared local offices for NHS, Council and Voluntary Sector services
- Support for the Edinburgh Climate Change Commission
- Joint support for the Community Led Health movement which over many years has enabled local communities to tackle health inequalities and climate change together through such initiatives as community food projects, community gardens and 'Grow Your Own' initiatives

NHS Lothian also has a role to play in raising awareness of the advantages of an integrated approach across NHS Scotland, as well as ensuring that its own practices are characterised by best practice in patient involvement, employment and support for the local sustainable economy.

Aim: To build on work with our partners and communities to develop a coordinated approach that recognises the advantages of addressing sustainability and inequalities through early intervention and prevention.

Our Actions

- Promote joint initiatives to reduce emissions such as District Heating Systems and shared premises
- Establish and report patient feedback mechanisms and develop for ensuring patient views are recognised in service planning and redesign
- As part of the Community Planning system Sustainable Development Plans will be developed, implemented and monitored
- Good practice community engagement, patient involvement, policy and service delivery will be developed and disseminated through our communications activity, good practice events and case study analysis
- Support Edinburgh Climate Change Commission and learn from its work
- Develop NHS Lothian as an 'Anchor' organisation in the local sustainable economy, as an employer and purchaser of goods and services, and in relation to our greenspace, built assets and other infrastructure
- Work with our partners to contribute to the local food economy by developing public sector procurement of locally produced food
- Work with our partners to ensure that food and fuel poverty are addressed through direct entitlements rather than charitable aid
- Enhance understanding of the co-benefits of addressing sustainability and health inequalities through prevention and early intervention
- Continued support for the Community Led Health movement including development resources to support innovation in community engagement and health inequalities and sustainability

Monitoring Progress

- Put CPP Sustainable Development plans in place
- Good practice examples to be collated and disseminated
- NHS Lothian develops its strategy as an 'Anchor' organisation
- NHS Lothian continues to be a key contributor to national policy and practice
- Continued support for the Community Led Health movement extended to include innovation on sustainable development and health inequalities

Our People

NHS Lothian staff across the organisation have been changing clinical practice and lobbying for organisational change to make the service more environmentally sustainable. Endorsing and resourcing their commitment is at the centre of our drive for transformational change. Raising awareness, providing clear information about what staff members can do, enabling clinical networks and recognising and celebrating good practice will continue to be at the heart of our approach. Staff involvement in developing the Framework and Action Plan has been a priority. NHSL has benefited from staff bringing their concern for the planet to work and we will encourage them to continue to take action at home and in the wider community, becoming champions for sustainability as well as health.

NHS Lothian also has significant programme of developing the role of volunteers who could also contribute to the sustainability of our organisation.

Aim: To support and empower staff -and volunteers to change ways of working to improve sustainability and become champions for sustainable development in the wider community.

Our Actions

- Conduct a consultation programme across NHS Lothian to ensure staff views are incorporated into the Sustainable Development Framework and Action Plan
- Ensure relevant organisations and networks are consulted and supported to lead with sustainability e.g. Trade Unions, Professional Associations, Health Promoting Health Service, Health and Wellbeing Groups, NHS Lothian LGBT+, BAME, Young People and Disability networks
- Develop and resource an ongoing communications programme to support the NHS Lothian Sustainable Development Framework and Action Plan
- Develop and support sustainability networking across NHS Lothian
- Seek to maximise the contribution of volunteers to sustainability through both NHS Lothian's volunteer cohort and -through those provided by our Third Sector partners.

Monitoring Progress

- Consultation programme to include events held at major sites across NHS Lothian and online opportunities to engage
- Identify a dedicated communications lead to work intensively on sustainability to build on early successes and generate commitment and buy-in from our staff, partners and public
- Assess the benefits and resource implications of different Sustainability Networking models

Quality Improvement

Continuous quality improvement is a mainstay of service development throughout the NHS. The Quality Directorate will be at the forefront of supporting staff to identify and implement changes to improve sustainability and will take a lead with rolling out successful projects. In addition, they have a key role in co-ordinating the input of Finance, Organisational Development and Public Health in developing analysis and documentation of environmental value.

Aim: To support staff and promote organisational development to improve sustainability of NHSL services as part of a continuous improvement process.

Our Actions

- Quality Directorate coaches will be available to all staff wishing to develop and monitor sustainability projects
- Guidance for staff on carbon costing will be developed and integrated into the Quality Academy teaching
- Learning and good practice will be shared through case studies, Clinical Fora, Quality Networks

Monitoring Progress

- All staff have access to Quality Directorate support
- Support materials developed and used
- Increase in the number of projects written up as case studies, disseminated and replicated

Governance and Decision-Making

Effective and knowledgeable leadership is at the core of good governance and decision-making for sustainable development. NHS Lothian's Board and Senior Management Teams are taking a hands-on approach to leadership in this area, not only overseeing the integration of sustainability into strategy and policy, but also taking part in staff consultations and empowering teams across the organisation to transform the way they work. The imminent launch of the NHS Lothian Sustainable Development Framework and Action Plan, and the monitoring processes associated with it, will be crucial in making sure the organisation transforms the way it delivers it services

Aim: To ensure that NHS Lothian's decision-making and governance processes fully support and prioritise sustainable development by making sure sustainable development goals are fully integrated across NHS Lothian strategy and policy and reporting processes.

Our Actions

- Develop detailed reporting and accountability procedure to support the NHS Lothian Sustainable Development Framework and Action Plan
- Conduct a comprehensive consultation process with staff, partners and stakeholders to support the further development and implementation of the NHS Lothian Sustainable Development Framework and Action Plan
- Develop and implement a capacity building for sustainable leadership programme for NHS Lothian Board Members and Senior Management Teams
- Develop a comprehensive communications programme to support engagement with the framework and the development of our strategy
- Ensure that the Integrated Impact Assessment used across NHS Lothian and with our partners includes sustainable development
- Ensure that policies presented for review take account of the Board's sustainability commitments outlined in the Framework and Action Plan
- Review key business processes and planning to ensure that sustainability considerations are transparent and prioritised

Monitoring Progress

- NHS Lothian Sustainable Development Framework and Action Plan launched
- Reporting and accountability procedures put in place
- Leadership Programme developed
- Active Communications Strategy and campaigns
- Review of business processes and planning undertaken:
  - Annual Operational Plan
  - Remobilisation and Recovery Plan
  - Key NHS Lothian Policies
  - Property and Asset Management Strategy
  - Capital Investment Plans
  - Quality Improvement Strategy
  - Financial plan

Performance Management

Making rapid progress with integrating sustainable development into key parts of NHS Lothian's performance management and resource analysis systems is vital. The scale of the challenge of remobilising services in the context of Covid 19 means that there is a significant opportunity to ensure that sustainability is a foundation for the redesign of services and to make progress in managing performance through the lens of environmental sustainability, good financial management and better, more equal health outcomes.

A transparent methodology for measuring environmental, financial and social sustainability will be developed and implemented ensuring that corporately we are able to set goals and report on progress in these key areas.

There is an important opportunity to support the motivation and engagement of staff through the staff appraisal system ensuring all staff are aware and accountable for actions to support sustainability in their sphere of work.

Aim: To ensure that NHS Lothian's performance management and resource analysis systems support delivery of sustainable development commitments.

Our Actions

- Ensure that environmental as well as social and financial sustainability is embedded in performance management and review structures
- Develop a methodology for assessing the social, financial and environmental impact of new initiatives and models of care
- Ensure that the key principles of sustainability are explicit in plans for remobilisation and recovery
- Integrate Sustainable Development into our staff appraisal systems

Monitoring Progress

- NHS Lothian to put in place a Sustainability Investment Strategy with which promotes environmental, social and financial sustainability in key areas and across the system
- Reporting using this methodology is put in place
- Sustainable Development integrated into staff appraisal systems

Sustainable Models of Care

Sustainable Models of Care

Transforming how we plan and deliver services to make our models of care progressively more sustainable is at the heart of this strategy. It is where everything comes together to make rapid, real and lasting change on the ground happen. Proactive action by staff and clinicians, coordination with partners and engagement and co-production with patients and communities are key components of this process.

Early action has come from clinicians and staff in high carbon areas – so called 'hotspots'. Increasingly sustainability – environmental, financial and social – will be built into the way the organisation designs, plans and delivers all its services.

In this section you will find examples of staff led initiatives which have delivered rapid progress in recent months.

We tell the story of the significant reduction in emissions from anaesthetic gases over the last year. As we emerge from the Covid 19 crisis lessons for sustainability will be taken forward, particularly in high carbon areas such as ITU and respiratory care. The story of the recent Outpatient Re-Design work is also included, showing how environmental, economic and social considerations can come together to design a service more accessible to local communities as well as more sustainable.

The most sustainable model of care is one where fewer people need health care. Reorienting the service towards prevention, early intervention and reducing inequalities in health is therefore an urgent priority. When care is needed then enhancing services in the community is the most environmentally sustainable approach. A move towards prevention and primary care models is also the more financially and socially sustainable approach enabling communities to be involved in service design to ensure they meet local need.

Greener Theatres and Anaesthetics

Theatres and Anaesthetics is a carbon hotspot with high energy consumption, anaesthetic gases carbon impact, high consumption of products and high volumes of waste. Single use items are increasingly prevalent while re-useable surgical instruments have a life time carbon impact through requirements for sterilisation and transportation.

Anaesthetic gases are expelled into the atmosphere and contribute 5% of the carbon footprint for all acute NHS organisations. There is a huge variation of global warming potential of different gases: desflurane is 2540 times that of CO2 and nitrous oxide 245 times that of CO2, for example.

We can also reduce our emissions by managing energy demand and considering ways to make safe air handling and ventilation in theatres more intelligent and energy efficient.

Peri-operative waste accounts for a third of all NHS waste with each operating theatre producing 2300kg of anaesthetics waste and 230Kg of sharps waste per annum. The opportunities for carbon reduction are therefore significant and urgent.

In late 2019, in response to staff motivation and growing awareness of the need for action the Directorate of Theatres and Anaesthetics established a multidisciplinary Environmental Sustainability Group which will align with the Quality Improvement Teams and report directly to the Senior Management Team. The group brings together clinicians from across NHS Lothian sites and will work towards coordinated practice and a common baseline, building on the rapid progress made in reducing our emissions from anaesthetic gases. Four main groups of action projects have been identified by the group – Electrical, Anaesthetic Gases, Single Use Items and Waste Management.

Actions

- Review the controls of our theatre air handling units and scope the potential for investment in systems to improve control and monitoring
- Continue with clinical quality improvement work to reduce the use of desflurane and nitrous oxide and evaluate the environmental and cost impact. Phase out use of Nitric Oxide in Obstetrics and Emergency/Ambulance and replace with low emission alternatives
- Change over to new low emission Anaesthetic Machines
- Develop common practice and baseline in Theatre Set Back across NHS Lothian
- Review high volume single use products and review environmental impact of alternatives for re-use or recycling
- Manage and monitor our clinical and domestic waste contracts to implement measurement of waste from theatres
- Ensure that the business case for the re-provision of our Central Decontamination Unit and the surgical instrument cycle as a whole is designed to minimise the impact on the environment through its use of energy and the design of the surgical instrument and supply service
- Improve waste avoidance, sustainable waste management and recycling in theatres and anaesthetics
- Manage and monitor our clinical waste management contract to ensure that metal recovery and re-useable sharps boxes are introduced as soon as possible
- Explore options for investment in technology to monitor or reclaim medical gases
- Continue to develop multidisciplinary training on environmental sustainability across Theatres and Anaesthetics and include sustainability in anaesthetic medical curricula and nurse respiratory training
- Develop training and awareness raising on environmental issues for support staff
- Support staff led initiatives to raise awareness or take actions to minimise impact on the environment

Monitoring

- Consumption, costs and carbon emissions from anaesthetic gases reported in our Annual Carbon Emissions Report
- Weight, costs and recycling of waste across the waste streams reported

Action Snapshot

Anaesthetic Gas Reduction within NHS Lothian.

Initial action focused on desflurane reduction and monthly usage dropped by 70% within 10-months.

DMAIC is a framework that describes the activities associated with volatile reduction. Each step required MDT engagement from pharmacy, medical physics and theatres teams to achieve positive outcomes.

Define: establish a working group at each site to define the problem and agree objectives.

Measure: relying on skilled pharmacy technicians collate granular data on volatile usage in each area. With medical physics find out how many desflurane vaporiser are in circulation.

Analyse: who are the biggest and lowest users and why, which stock lists can lose or reduce desflurane and which anaesthetic machines can lose a desflurane vaporisers and speak to these teams.

Improve: remove superfluous desflurane vaporisers and amend stock lists.

Control: Maintain practice with strong infographics and education. Continue to improve using a test of change model.

DMAIC has been used to progress nitrous oxide reduction starting at the Western General Hospital. Careful measurement and analysis has led to the decommissioning of a leaking redundant manifold and a reduction in provision for another. Reducing projected theatre nitrous oxide usage by 90%.

Greener Primary Care

Primary care is fundamental to sustainable health care. It makes a significant contribution to our carbon emissions. Prescribing is by far the largest part of its carbon footprint with energy and water consumption, transport and travel and waste avoidance also being significant areas for action.

Primary care can also drive sustainable models of care across the whole of the health and social care system, through provision of care closer to communities which can alleviate the need for travel; through supporting the shift of the balance of care to prevention and early intervention; through its integration with communities to work to address inequalities in health.

The reach of primary care to the population is immense, with the majority of the population having contact with primary care every year providing the opportunity to engage with the public on the environment, health and well-being.

Lothian's Health and Social Care Partnerships have a local leadership role driving change for integrate systems with our local authority partners, voluntary organisations and local communities. As interest and determination from primary care to become more environmentally sustainable grows we need to build on this frontline commitment, engaging with existing networks such as Quality Clusters, Link Workers, Refhelp which are at the core of engagement with secondary care and patients and communities to effect change.

Actions

- Share good practice, resources e.g. the RCGP Green Impact tool
- Support virtual consultations/clinics, identification of co-benefits and engagement with key stakeholders
- Promote 'Realistic Medicine', care closer to home, reduce duplication of laboratory tests and polypharmacy, Primary Care Directorate to complete desktop utilities (energy and water) efficiency scoping exercise with all general practices
- Implement data analytical support to provide reports on utilities consumption for all practices and premises supplied through NHS Lothian
- Progress the NDEE Energy Efficiency programme for NHS Lothian owned community premises
- Provide support for building networks and environmental sustainability including active travel, green prescribing and use of green spaces
- Engage primary care in the development of the circular economy, waste management and recycling
- Put evidence on environmental sustainability at the heart of the management of pharmaceuticals and prescribing
- Incorporate NICE /SIGN guidance on use of metered dose inhalers
- Put primary care at the centre of NHS Lothian's strategic plans for remobilisation, re-design and capital planning for environmental sustainability

Monitoring

- Strengthen data collection and analysis in order to measure the carbon footprint of patient pathways, demonstrating opportunities to reduce environmental impact at the same time as enhancing patient and health care system experience
- GHG emissions from energy consumption in NHS Lothian owned community premises
- Water consumption
- Waste and recycling by waste stream and sector of primary care (dental, general practice, community pharmacy, optometry)
- Benchmarking GHG
- Develop methods and data to monitor the environmental impact of travel and transport in primary care
- Develop monitoring of prescribing to the triple bottom line, focussing on high impact pharmaceutical products

Action Snapshot

St Triduana's General Practice Goes Green
Inspired by the RCGP Green Impact for Health Toolkit, in 2019, St Triduana's developed an ambitious more sustainable primary care model project. The benefits would not only be a reduction in harm and waste, but set an example for their community – sharing with patients the urgent need to decarbonise our lives, alter our diets, be more active, and create greener, healthier neighbourhoods.
Projects are on-going, and they aim to demonstrate improvements in the following areas:

- An energy performance certificate helped to direct action to increase heating and lighting efficiency: estimated 35% savings on heating & lighting with introduction of LED lighting, insulation and double glazing
- Cycling Scotland Grant underway for bike racks, an upgraded shower room and installation of changing/drying room
- Trial of electric bikes for home visits
- With support from Changeworks, increased rates of recycling have been demonstrated
- Monitoring of clinical and confidential waste – to be reduced by half
- Recycling of clerical consumables: batteries, envelopes, printer cartridges
- Plastic water cooler replaced with mains fed water fountain - Predicted savings: £1000/year
- Audit of printed materials
- Review of stock ordering procedures to reduce waste
- Social prescribing champion working on green prescribing
- Promotion of physical exercise: weekly lunchtime pilates, community Parkrun, community gardening
- Improved polypharmacy reviews
- Patient focus: green project promoted on practice website & social media, collecting patient feedback with implementation of suggestions e.g. green notice board with ideas such as meat-free cooking, link worker fuel poverty initiatives

Pharmaceuticals

Pharmaceuticals account for around 25% of our carbon footprint and 16-18% of spend.

Meanwhile the amount of pharmaceutical waste we produce and the cost of disposal increases year on and year. Tackling this situation is urgent and will have multiple benefits, for our environment, our finances and our patients. At least 30% and in some areas as much as 50% of medicine waste is avoidable through improved prescribing, dispensing and patient support. Reducing medicine waste has a likely double carbon benefit, reducing upstream emissions (reduced manufacture and distribution costs) and downstream emissions (fewer medicines requiring disposal).

Pharmaceutical waste can be found in trace amounts in soil and groundwater throughout the world. This waste comes from a variety of sources, including hospitals. Levels of pharmaceuticals in the environment are likely to rise in years to come, as the global demand for pharmaceuticals grows.

We need to build environmental impact into our drug evaluation, formulary, prescribing management systems and clinical decision making processes.

Inhalers for asthma

At present metered dose inhalers (MDIs), prescribed for asthma and Chronic Obstructive Pulmonary Disease (COPD), contribute 3.1% of the UK health service carbon foot print, almost double that of anaesthetic gases. The hydrofluorocarbons (HFCs) in MDIs are powerful greenhouse gases up to 3800 times that of CO_2. We need to urgently review prescribing practice to ensure that where possible patients are moved to non-propellant devices (NPDs) and those for whom MDIs remain essential are trained to use them efficiently. The potential for rapid change is great; prescribing of MDIs is far higher in the UK than other European countries. The Scottish Government/NHS Scotland Respiratory Prescribing Strategy 2018-2021 as well as NICE and potentially SIGN guidance will provide support and guidance for prescribers and patients to promote awareness and encourage change.

Over prescribing of MDIs is also a problem and contributes to high levels of waste. As well as working with prescribers and patients we need to encourage our partners in Scottish Government and Local Authorities to review policy on inhalers in schools to ensure that provisions are age appropriate and efficient. We need to encourage NHS Scotland to use its influence and procurement power to encourage drug companies to develop carbon minimal alternatives and extend 'use by dates' on MDIs and NPDs.

We need to work with prescribers, patients, regulators and drug companies to ensure that recycling and reclamation of remaining MDIs becomes the norm – at present only 0.5% of the millions of inhalers prescribed annually are recycled.

Global concerns about antimicrobial resistance have already recognised that addressing this issue underpins progress on the UN sustainability goals. The importance of antibiotic stewardship in health care is a crucial part of protecting the effectiveness of antibiotics for the future.

Actions

Procurement

- Investigate the potential to influence national procurement process
- Review current prescribing indicators to extend criteria to include environmental sustainability
- Request that the Area Drug and Therapeutics Committee (ADTC) consider sustainability as a quality issue for prescribing
- Share the environmental benefits of initiatives that reduce prescribing e.g. through Link Workers and Realistic Medicine
- Explore opportunities to switch to reusable alternatives for single use items e.g. medicine pots.

Review of medication to reduce waste:

- Reduce pharmaceutical waste by encouraging regular review of medication and support adherence
- Review and extend successful waste reduction pilots in care homes, primary care and secondary care Disposal
- Communicate rationale for plastic medicine pots and create a recycling stream for them which is easy to identify and use
- Explore the opportunities to reuse and recycle
- Learn from the iodine recycling initiative and explore opportunities to replicate this
- Educate patients on the safe disposal of drugs to avoid environmental contamination

Asthma inhalers

- Raise awareness of the environmental impact of MDIs
- Revise the Lothian Joint Formulary to explicitly recognise sustainability
- Explore the options for an inhaler recycling scheme
- Work with partners to review policy on inhalers in schools in order to make them age appropriate and move towards generic emergency inhaler packages rather than holding inhalers for individual children
- Use the learning from improved asthma/COPD prescribing practice to build sustainability and environmental impact into our drug evaluation, formulary, prescribing management systems and clinical decision making processes

Antimicrobial Stewardship

Continue to develop our approach to Antimicrobial Stewardship in prescribing and strengthen this work in the context of wider sustainability goals

Monitoring

- Monitor the weight of pharmaceutical waste and feedback to the source teams responsible for the waste (community, primary and secondary care)
- Sustainability added to ADTC criteria
- Reviews of 3D Pilot and One Step Prescribing initiated
- Lothian Joint Formulary on MDIs revised to incorporate sustainability

Outpatient re-design

The outpatients redesign programme has been working on a range of initiatives such as Patient Initiated Follow-up, -Direct Test Pathways, Place of Care Criteria, Near Me Consulting, Symptom Based Pathways, Monitoring Clinics (community based) and Active Clinical Triage.

The Covid 19 pandemic accelerated the need to find new ways of working, particularly in relation to the roll out of telephone and video (Near Me) consultations. The need for social distancing and the growing demand for providing timely, safe and effective care will provide further impetus for redesign as the services recover and re-mobilise.

Carbon emissions per outpatient appointment have been estimated at between 40-78kg CO_2e compared to estimates of an in-patient bed day of 60 to 83 kg CO_2e[1].

Although each specialty has its own carbon foot-print across the pathway of care, across out-patients as a whole the main contributions to carbon and environmental impact are patient journeys, the use of energy intensive space and equipment within acute hospital settings and use of tests and supplies.

Conversely there is the opportunity for models of outpatient services to support a balance of care in the community and closer to home, to eliminate unnecessary use of products, tests and time, and to prevent hospital admissions which have a higher environmental impact.

Evidence to support these changes is broad and positive with triple bottom line evaluations reporting on social impacts for staff and patients, financial impacts to the NHS and to patients, efficiency and productivity as well as on environmental impacts.

Actions

- Support the development of business cases for investment in new outpatient models of care that include impact on the environment
- Review existing evidence base for specialty specific interventions, technologies and models of out-patient care which have high impact in terms of environmental and financial sustainability
- Continue to implement the changes promoted by the Outpatient Redesign Programme

Monitoring

- Out-patient space utilisation and refined estimates of GHG emissions
- Clinic appointments, telephone and Near Me consultations, laboratory tests, prescribing
- Use Near Me data set to estimate carbon impact of changes
- Tools for evaluation of staff and patient reported outcomes
- Develop outcome map for overall transformation process including outcomes for social and environmental sustainability

Action Snapshot

Environmental sustainability needs to be considered in any service redesign; any intervention that reduces demand for health care has the potential for a positive impact on the environment.

The out-patient oversight team, which oversees the current outpatient redesign programme, needs a framework for assessing the progress and impact of the redesign which takes account of the inherent complexity of the system and the impact on the sustainability of the service as well as on patients and staff. It was agreed that outcome mapping, a form of contribution analysis, would be useful to capture the changes taking place and measure their impact in terms of environmental, social and economic sustainability, the triple bottom line.

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[1] based on NHS SDU report 2007 Co2e values - SDU and ERPHO Indicative carbon emissions per unit of health care activity (briefing 23)

Critical Care

The importance and challenges of provision of critical care are clear, especially as we launch this strategic framework in the context of Covid-19. By its very nature, intensive care is intensive in terms of resource utilisation and its environmental impact. It is also intensive in terms of its demands on staff, patients and families. The sensitive nature of critical care potentially makes the consideration of sustainability and environmental impact particularly challenging, but in that challenge there are important opportunities. The main focus areas to consider within Critical Care are:

- The consumption of energy through environmental systems and equipment
- The choice of products and the move to zero waste through the need to reduce, reuse and recycle
- Environmental management and the consideration of toxins which are found in the critical care environment, from materials, equipment, disinfectants and sterilants
- Staff health and well-being and their contribution to sustainability at work and as members of the public

We know that the waste generated from Critical Care Units is substantial, some research and audit showing that a typical unit of 10 beds can produce half a ton of waste each week. The procurement and selection of products needs to take account of environmental impact in all dimensions, balancing the impact environmental impact of sterilisation and decontamination of reusable items with the impact of single use items, for example.

The evidence base on the lifecycle environmental impact of products and their use in critical care is growing, and there are opportunities to contribute to this through the development of research and audit in our own units.

Actions

- Ensure that critical care facilities have access to waste segregation
- Provide assurance to staff of effective management of waste and recycling by providing to support segregation of waste within Critical Care as well as ensuring that environmental impact is considered in procurement for critical care
- Actively support the health and well-being of staff, patients and visitors through green initiatives such as the use of external spaces
- Develop research and evaluation of the environmental impact of single use and reusable items alongside costs and effectiveness to inform product selection

Monitoring

- Waste segregation in place and monitored
- Environmental impact incorporated into procurement criteria for Critical Care
- Green space and biodiversity initiatives such as ITU gardens evaluated
- Decisions on single use versus reusable items is informed by evidence of environmental impact

Action Snapshot

Critical Care at the Royal Infirmary of Edinburgh have been working to unlock the benefits of the hospital's underused courtyards. The team have secured access to an internal courtyard space and have been trialling its use by intensive care patients. They hope that the using of the garden will give patients and their families the opportunity to have therapeutic sensory experiences that only a natural environment can provide.

The feedback from patients, families and staff has been positive and the team is now developing plans to create a garden that benefits patients and the environment.

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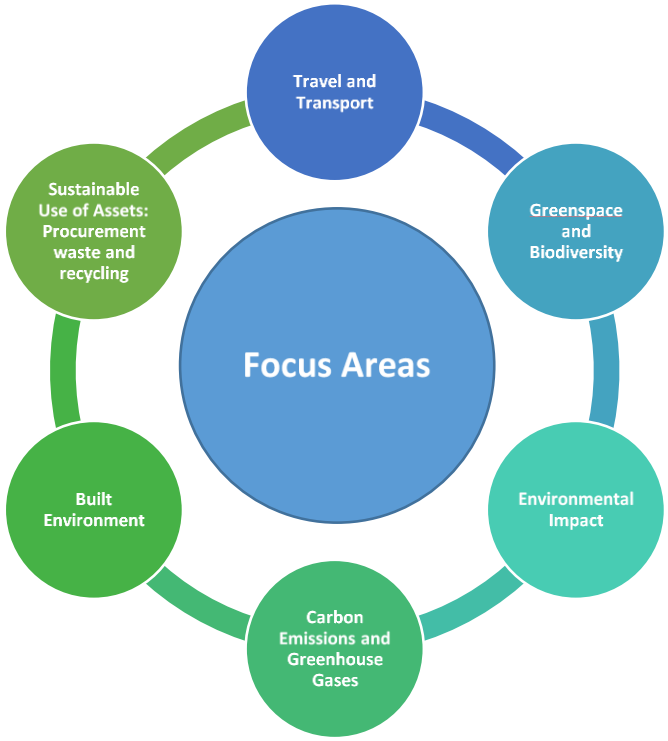
Focus Areas


Travel and Transport
Greenspace and Biodiversity
Environmental Impact
Carbon Emissions and Greenhouse Gases
Built Environment
Sustainable Use of Assets: Procurement waste and recycling
Focus Areas

Carbon/GHG Emissions

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.

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

Our Planet

- Monitor and report on Scope 3 emissions from our supply chain, to influence and reduce associated emissions from indirect sources
- Work with key stakeholders, such as the City of Edinburgh, Midlothian, East Lothian and West Lothian Councils, to maximise the impact of our actions and resources
- Work with supply chain partners to embed shared a sustainability vision and goals

Our People

- Share information of emissions sources and progress to educate and engage staff in achieving our carbon targets
- Utilise the expertise and knowledge throughout our staff to develop and implement actions that reduce emissions

Our NHS

- Improve reporting methodologies to better monitor our emissions and provide insight to determine the success of actions and areas for development
- Embed transparent and system wide reporting

Monitoring Progress

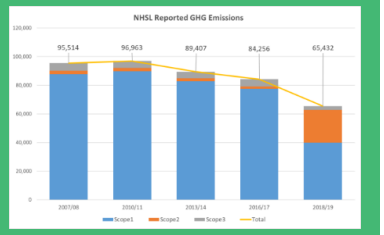
- Annual GHG emissions reporting, available to all staff
- Establish interim targets aligned with national zero-carbon pathways to 2045
- Increase use of analytics to provide deeper understanding of consumption, emissions, trends and impacts of actions

Action Snapshot

Public Sector Climate Change Reporting (PSCCR)

NHS Lothian has been calculating and reporting annual Carbon Emissions Reports since 2007/2008, as part of our first Carbon Management Plan (CMP).

The Scottish Government is expected to adopt an ambitious new target to reduce emissions by 75% by 2030 and net-zero by 2045, compared to 1990 levels – the toughest statutory target of any country in the world.



To date NHS Lothian have reduced building emissions by 61% and remains on track to achieve the proposed interim carbon emissions target of 70% by 2030.

Carbon Trust Standard (CTS)

NHS Lothian have a strong track record of successful energy and carbon management, evidenced by achievement of the Carbon Trust Standard (CTS). An externally verified and internationally recognised standards scheme for achieving real reductions in year-on-year carbon savings. NHS Lothian is the only NHS Board in Scotland to hold this accreditation, and have maintained this for 8 years.

CARBON TRUST STANDARD
REDUCING CO2 YEAR ON YEAR

Built Environment

Our Built Environment is critical to delivering our health care services. The buildings we use are varied, intensive and require the highest level of servicing to maintain safe and resilient environments for our staff and patients. It's essential we design and operate our assets efficiently to maximise resources and minimise environmental impact.

Improving our estate and embedding best practise in new builds and refurbishment will help to reduce emissions and improve our internal environments.

Aim: Reduce energy demand and emissions from existing buildings and embed sustainable design in our capital projects.

Our Planet

- Develop an energy efficiency strategy across our estate to identify, prioritise and implement measures to reduce demand for energy
- Increase the percentage of energy consumption generated from low carbon sources on our estate
- Review our capital planning and governance processes and application of Scottish Capital Investment Manual (SCIM) to ensure there is a stronger and transparent emphasis on sustainability in strategic assessments and continued through the business case development process
- Embedded Sustainable Design principles in all new and refurbishment projects.

Our People

- Optimise our existing buildings to reduce consumption and improve the internal environment for patients and staff
- Implement the findings from the Infrastructure Commission for Scotland, and maximise the benefits of investment for NHS Lothian and the community
- Share information on energy consumption to educate and engage staff about reducing energy consumption
- Reduce the impact of our buildings that contribute to environmental issues of air quality

Our NHS

- Maximise the efficient operation to reduce waste and costs of operating our estate
- Review and embed strategic governance and commitments of sustainability within capital planning processes, such as SCIM and BLM.
- Consider Digital Estate technology opportunities that support effective management tools and decision making to maximise carbon reduction investment

Monitoring Progress

- GHG emissions, utilities consumption and cost trend analysis
- Percentage of energy from renewable sources
- Building benchmarking and performance review, including post-occupancy review of capital projects

Action Snapshot

- St John's Hospital - Energy Centre - completed in July 2019, NHS Lothian undertook replacement of the aged boiler plant and inclusion of a new Combined Heat & Power Unit. After 9 months of operation, savings have been achieved in excess of £900k and 2,204TCO$_2$. The project took place while the site maintained services and is exceeding expected performance. Further similar projects are being considered including WGH.
- Western General Hospital (WGH) – Energy Infrastructure. A key site, responsible for 25% of NHS Lothian's energy demand. A project has commenced to replace the site energy infrastructure with a focus of developing a carbon pathway to 2045, build on existing initiatives, continue to decarbonise (demand reduction, energy efficiency, LZCT), continue to reduce operational costs and increase the estates resilience to climate change and improve energy security.

  Phase 1 has begun the journey of replacing the existing steam system with new underground district heating pipework.

Environmental Impact

Carbon emissions and greenhouse gases are a fundamental aspect of environmental sustainability, but there are other aspects of the health care environmental footprint that need to be managed and reduced. Key features include; water supply, waste-water, flooding, air quality, noise and specialist waste. These have a major and direct impact on health.

These include air pollutants such as nitrogen oxides and sulphur dioxide, other forms of pollution – particulate matter, radioactive waste and use of scarce but basic resources such as water. Concern about the pollution generated by health care is growing amongst staff and public, particularly in relation to the accumulation of pharmaceutical waste and plastics in water, sewage systems and the soil.

All public sector organisations including the NHS need to comply with environmental legislation but there are opportunities to go beyond compliance and assurance. We need to review and monitor a fuller environmental impact of our operations in line with a broader vision of One Planet Prosperity (SEPA).

Aim: We will develop our quality management systems to improve our environmental impact assessment and environmental performance.

Our Actions

- We will pilot the new Environmental Management System (EMS) Tool procured for NHS Scotland and based on ISO 14001:2015
- We will use the tool to broaden the scope of our approach to environmental management and through regular audits and reports will raise awareness of the opportunities and challenges for reducing environmental harm
- We will support the roll out and use of the tool across the organisation to ensure that it is accessible to staff who do not have in-depth knowledge of environmental sustainability or environmental management systems
- We will learn from and collaborate with partner organisations to shape the regulatory frameworks that can protect the environment, support sustainable health care and promote health and well-being
- Develop KPI's and targets as part of the EMS

Monitoring Progress

- Roll-out of Environmental Management System (EMS)
- Auditing of EMS compliance and progress against relevant targets

Action Snapshot

Flood Prevention Scheme

In natural environments, rain falls on permeable surfaces and soaks into the ground; a process called through infiltration.

In urban areas where many surfaces are sealed by buildings and paving, natural infiltration is limited. Instead, drainage networks consisting of pipes and culverts divert surface water to local watercourses and in some cases this results in downstream flooding and deterioration in river water quality caused when foul sewers are overwhelmed by surface water leading to a release of dirty water into rivers. Surface waste water can also include chemicals and materials harmful to the environment, such as fuel-spills and construction debris.

Sustainable drainage systems aim to alleviate these problems by storing or re-using surface water at source, by decreasing flow rates to watercourses and by improving water quality.

NHS Lothian has invested in a flood prevention scheme at the Western General Hospital with the aim to alleviate a recurring issue of damage and disruption caused to hospital buildings and local residents.

Due to problems, both up-stream and down-stream of the hospital, the existing surface water drainage system could not cope with period of excess rain. The project, undertaken by estates, was the installation of an underground water attenuation system. This involved the excavation of the existing Cark Park adjacent to Ward 1 to provide 725 cubic metres of surface water storage and reconfigured upstream drainage to the rear of Ward 1 and Maggie's Centre that provides capacity for large volumes of water run-off during periods of heavy rain. It also included the creation of a new regulated outfall to the open culvert running along the South boundary of the campus. This additional storage capacity reduces the impact of localised flooding but also provides further environmental benefits through filtration of the waste water at source.

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Greenspace and Biodiversity

The growing threat to public health from current climate and ecological crisis increases the need for action. NHS Lothian's estate provides diverse greenspace resources for both people and wildlife and these natural environments form the foundation of a healthy environment. The NHS estate contributes to biodiversity at multiple levels from bat roots in older buildings to purpose built gardens and greenspace.

Collectively, the outdoor estate is a valuable and under used asset. If planned and managed well, they can make a significant contribution to the physical and mental health and wellbeing of our staff, patients, visitors and local communities and is a key part of the NHS response to the climate emergency and to meeting Scotland's biodiversity commitments.

Aim: We fully realise the potential of the NHS outdoor estate as an environmental and health asset.

Our Planet

- Conduct a greenspace and biodiversity audit of the NHS Lothian estate with recommendations to protect, enhance and expand our environmental assets
- Prepare a greenspace management plan for each NHS site to improve biodiversity, climate resilience and encourage greater use
- Ensure good quality greenspace design is incorporated into new build hospitals and refurbishment programmes

Our People

- Encourage and support greater use of the NHS estate by patients, staff and visitors
- Develop connections between the NHS estate, community greenspaces and wider green networks
- Engage with NHS Lothian staff to raise awareness of the benefits and opportunities of increasing greenspace and biodiversity

Our NHS

- Incorporate the Edinburgh and Lothians' Greenspace and Health Strategic Framework into governance
- Encourage and support partnership working on a 'natural health service' approach to wider greenspace development and management

Monitoring Progress

- Delivery of Greenspace and Health Strategic Framework priorities
- Benchmark from biodiversity audit
- Biodiversity Net Gain across NHS Lothian estate
- Number of projects delivering biodiversity improvements

Action Snapshot

- Mapping the NHS estate – The extent of NHS Lothian's outdoor estate has recently been estimated. This will allow us to calculate the contribution our estate makes to our climate change mitigation and assess its value for both health and biodiversity.
- NHS Community Gardens – Community gardens at the Royal Edinburgh, Midlothian Community and Belhaven Hospitals provide vital resources for patients, staff and biodiversity. With the support of the Edinburgh and Lothian Heath Foundation we are investing in the future of these spaces.

- Greenspace management – A greenspace management plan is underway for the Royal Edinburgh Hospital with the aim of securing a green flag award to recognise the high quality environment it provides patients, staff and the community.

Sustainable Use of Resources

The goods we use constitute the largest proportion of our carbon footprint and reducing unnecessary use of resources across NHS Lothian will have a major impact. This is evident on a daily basis to our staff, patients and visitors. The level of concern amongst staff and level of motivation for change is high.

Procurement and waste management are therefore priority areas for action. NHS Lothian generates large volumes of waste and is committed to managing waste in a way that promotes sustainable development. By applying the waste hierarchy, rethinking traditional waste models and working closely with our staff and supply chain, we can move towards a circular economy approach.

Good food is essential for patient and staff well-being and a key area for improvement in procurement and waste management. Increasing local, seasonal food and more sustainably sourced fish with less reliance on meat products will potentially pay health, environmental and financial dividends. Such a move needs to be backed by a sustainable catering strategy (which embodies and exceeds national nutritional guidelines), procurement that enables the sourcing of local and seasonal food and imaginative presentation to support healthy choices. Food waste is an important area and the NHS Scotland Food Waste Guidance and Food Waste Calculator, recently developed by Zero Waste Scotland, will inform progress in this key area.

NHS Lothian plans to scale up its support for MedAid, an Edinburgh Medical Student charity which directs discarded medical supplies to under-resourced hospitals and clinics abroad. Their approach not only facilitates the reuse of equipment but also reduces waste and can potentially provide valuable data to inform procurement decisions.

Aim: Reduce resource use and improve waste management through engaging staff and suppliers in movement towards a circular economy.

Our Planet

- Engage with National Procurement and Zero Waste Scotland to support changes which accelerate the move to a circular economy in health care
- Make the use of criteria and weightings for sustainability within the procurement process stronger and transparent
- Work with local partners to seek the best outcomes for supporting a sustainable community, including reducing food waste

Our People

- Ensure that information on procurement decisions and environmental impact of products across their lifecycle is available to staff
- Review procurement processes to ensure that frontline staff can be actively engaged to provide information on the use of products
- Implement multidisciplinary waste management groups on all major sites and across community settings
- Promote a culture of reuse and refurbishment of items promoting and reporting on our use of Warp-IT to implement a more circular economy
- Make it easier for patients, staff and visitors to make healthy and sustainable food choices e.g. concessions and vending solutions

Our NHS

- Apply a higher weighting for social value in procurement processes
- Work with supply chain to embed shared sustainability vision and goals
- Ensure that NHS Lothian Catering Strategy is sustainable and embodies or exceeds national nutritional guidelines. Work with the supply chain to ensure that suppliers can deliver these requirements
- Ensure that NHS Lothian has the information it needs on waste to provide transparent information to services on waste generated and recycling
- Use NHSScotland Food Waste Guidance and Food Waste Calculator to reduce waste and ensure it is treated in the most sustainable way
- Strengthen contract management and reporting on performance of our waste management contracts to ensure that the full offer of services for innovation and environmental sustainability are delivered
- Invest in sustainable waste streams and recycling facilities upgrades
- Move from purchase/disposal model to circular economy procurement and ‘whole life’ purchasing

Monitoring Progress

- Reduction in procurement carbon footprint
- Reduced waste streams and volumes and increased recycling
- Environmental impact of waste management
- Report on the use of single use plastics and single use items
- Number of suppliers engaged with sustainability
- Evidence of movement towards a circular economy

Travel and Transport

Travel and transport of goods, services, staff, patients and visitors has a significant impact on local air quality, congestion and health. Delivering more remote working and consultations as part of a Sustainable Travel Plan and where travel is necessary, supporting staff, patients and visitors to use more active and sustainable travel methods will reduce the impact of these activities, leading to cost savings and health benefits.

Aim: To encourage remote working and consultations where possible and support sustainable and active travel in order to reduce the carbon and air quality impacts of our organisation and supply chain.

Our Planet

- Reduce the emissions from the fleet by making sure all new vehicles are low carbon and an adequate number of electric charging points are made available
- Reduce the impact of the 'grey' mileage by reviewing business travel and removing perverse incentives
- Reduce the impact of staff commuting and patient attendance by making services available locally and enabling remote working and remote consultations

Our People

- Implement Active Travel Strategy including Cycle Scotland accreditation
- Plan services in a way that minimises travel between sites
- Provide incentives for sustainable travel to work

Our NHS

- Work with local partners to develop an integrated transport system
- Invest in remote working and remote consultation technology and put in place management service development systems to support this
- Make minimising travel a criterion in procurement decision making

Monitoring Progress

- Environmental, social and financial benefits of remote working and consultations
- Reduction in 'grey' mileage
- Reduction in travel within the supply chain
- Improved air quality on sites

Action Snapshot

NHS Lothian has successfully introduced 37 fully Electric Vehicles (EV) in to service over the last 12 months and have plans to extend this further with a another 53 cars to be added to fleet in the coming months.

The EV fleet replaced older vehicles which operated using either petrol or diesel fuel. The transport department based at St John's Hospital in Livingston started operating electric vans on all lab van runs in September 2019 and this has been further extended to patient movement in early 2020. The lab van service have replaced 4 ICE vehicles with EVs and a further 3 will be added later in 2020 when older vehicles are replaced. East Lothian and Edinburgh Community Logistics have replaced previous EVs with newer version which enhanced the mileage per charge. Petrol cars have been replaced with EVs where this is appropriate for the service taking into consideration range & infrastructure to support the local operation. COVID 19 has seen a change in how vehicles are used and in some locations there have been requests for additional cars to support Covid-19 patients in the community. The cars allocated have been EVs.

Monitoring Progress and Evaluating Impact of this plan

Monitoring progress towards a sustainable NHS Lothian through the progress of this plan is essential. Appropriate measurements, indicators and defined outcomes need to be embedded at all organisational levels and threaded through the many corporate and service delivery processes and projects which form the basis of this plan.

At NHS Lothian Board level key metrics are required for governance and transparency to demonstrate that we are meeting both our legal requirements and our public accountability for resources and strategic planning.

At service level, staff and patients need feedback on the quality improvements they are seeking to make in implementing and maintaining specific changes.

Many of the changes that are made in the NHS are complex, designed to balance different, sometimes conflicting, priorities and take account of unintended consequences. Approaches and methodologies which can support the evaluation and mapping of multiple outcomes in our transformation of services will be key.

Our sustainability work and reporting to date shows that there are some areas where we have good metrics and data – on key aspects of our carbon footprint such as energy, carbon emissions from our own fleet and most recently medical gases. Other areas, such as waste and single use plastics in the supply chain have very poor or difficult to access data. There are areas which are core to the plan for which we have information – such as procurement, goods and supplies and pharmaceuticals – which are not analysed and reported through the lens of sustainability.

There are major gaps in the data, information and evidence and we need to make these clear and transparent.

Where there is data and information, we need to develop expertise in analysing this from the perspective of sustainability and become familiar with appropriate methods and tools.

There is a growing evidence base on environmental sustainability in health care, and we need to ensure that we have the capacity to use this evidence in our decision making and practice and contribute to the development of evidence through our existing and new research partnerships.

Actions

- Review best practice on metrics for sustainability
- Set out a matrix of key performance indicators and targets for sustainability for NHS Lothian, identifying significant gaps
- Invest in dedicated data analytical support to develop appropriate data sets and data linkage, data management, analysis and reporting tools for data sets in relation to this sustainable development framework
- Develop and roll out tools to support environmental sustainability in quality improvement projects
- Test the feasibility and value of outcome mapping to evaluate the environmental impact of transformation of out-patient services
- Review our organisational approach to evidence based practice and research in the context of environmental sustainability

Contact us:

sustainability@nhslothian.scot.nhs.uk email account

A Greener NHS Lothian Facebook group
https://www.facebook.com/groups/634498887306205/about/

NHS LOTHIAN

Board Meeting
09 December 2020

Interim Director Public Health

COVID-19 in Lothian – Descriptive Epidemiology (Phase 1)

1 Purpose of the Report

The purpose of this report is to brief the Board on the incidence of COVID-19 during the first four months of the pandemic in Lothian from March to June 2020.

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

2 Recommendations

Board members are asked to note that -

2.1 COVID-19 incidence in the first four months of the pandemic (March to June 2020) peaked in Lothian on the 22nd April 2020. Confirmed cases in the general population peaked first at the end of March 2020, followed by later peaks in health care workers and care home staff (20th April 2020) and care home residents (22nd April 2020).

2.2 Across Lothian, approximately one third of all positive cases during this first phase were in health and care workers and care home staff (32%), with just under a third in care home residents (29%).

2.3 There were significant differences in standardised incidence rates between Health and Social Care Partnership (HSCP) areas which may result from differences in case ascertainment[1] and/or differences in exposure as a result of different geographies, proportion of population in health and care work occupations, and outbreaks in care homes.

2.4 There was a pronounced socioeconomic gradient in COVID-19 infections. As the pandemic evolved, people from the most deprived communities in Lothian were more likely to test positive from the disease.

3 Discussion of Key Issues

Measures of COVID-19 in Lothian during the first four months of the pandemic underestimate the actual numbers of cases. This is due initially to limited testing resource being necessarily prioritised to those experiencing severe disease, key occupational groups and for controlling outbreaks in closed settings. As understanding of this novel coronavirus has emerged, case detection, assessment and case and outbreak management have evolved rapidly.

[1] Case ascertainment is the proportion of the total number of cases identified. Testing strategy, for example testing only priority groups, will affect the number of confirmed COVID-19 cases that are identified in the population. Case ascertainment was known to be low at the beginning of the pandemic.

There are, however, clear demographic differences in COVID-19 incidence, with respect to age, sex and geography. There are also different trends in COVID-19 incidence due to socioeconomic deprivation, occupation and setting. These differences are likely due, in part, to case ascertainment (due to testing policy) and also reflect differences in exposure and/or severity of the disease.

3.1 Age, Sex and Geography

There is a strong relationship between increasing age and COVID-19 incidence rates. Differences in COVID-19 incidence were observed between Health and Social Care Partnership areas.

For the first four months of the pandemic, there were very few cases among children and young people although this may be a reflection of testing policy which was tailored to reflect the apparent lower risk of mortality from COVID in younger people.

COVID-19 incidence rates in the working age population are higher in females than males in all age-bands up to (and including) age 50–59, most likely reflecting the high proportion of females in health and care worker roles. This pattern has also been observed in national and international data.

It is clear now that the severity of COVID-19 increases with age. Between March and June 2020 in Lothian, older people who became sicker from infection were more likely to have contact with the healthcare system and therefore test positive for the virus. Among people aged 65 years and older, incidence rates were higher in males aged 60 to 84, which likely reflects that men of these ages were more likely than women to experience more severe disease. COVID-19 incidence rates were higher in females aged 85 years and older, due to high numbers of cases in older female care home residents.

3.2 Settings

There was a clear association between testing and occupation in the first months of the pandemic. Care home residents accounted for 29% of all COVID-19 infections during the first four months of the pandemic; NHS staff and care home staff accounted for 32% of all positive cases in Lothian.

3.3 Socioeconomic Deprivation

There was significantly higher incidence of COVID-19 in the most deprived Lothian SIMD quintiles compared to the least deprived SIMD quintiles. This gradient increased as the pandemic progressed. Genetic sequencing suggests COVID-19 was initially introduced to Scotland by people returning from holidays abroad. After lockdown was introduced, rates in the most deprived quintile increased while those in the least deprived quintile decreased. This may reflect differences in case ascertainment (health and care and other key worker roles had access to community testing at the height of

the pandemic) but also increased exposure of people in low paid key jobs which could not be undertaken from home. The association between higher infection rates and deprivation and occupation in Lothian is repeated across Scotland and the rest of the United Kingdom.

4 Key Risks

This paper has explored the epidemiology of COVID-19 in Lothian and related this to the emerging evidence base around its differential impact on different population groups. NHS Lothian is already aware of the higher risk of COVID-19 infection and in individuals of: male sex, older age and certain ethnic minority groups and Occupational Health colleagues have conducted risk assessments accordingly.

5 Risk Register

No new risks are identified in this paper

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment was not required for this paper. The paper does show how COVID-19 infection rates were disproportionately higher in areas of multiple deprivation and care homes.

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

7.1 Not applicable

8 Resource Implications

8.1 Not applicable

Katie Dee
Interim Director of Public Health
26 November 2020
katie.dee@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Report on the Epidemiology of COVID-19 in Lothian to June 2020

REPORT ON THE EPIDEMIOLOGY OF COVID-19 IN LOTHIAN TO JUNE 2020

Public Health Intelligence Working Group
NHS Lothian Department of Public Health and Health Policy

PART 1 – INCIDENCE OF COVID-19 IN LOTHIAN (March to June 2020)

This report describes COVID-19 incidence and demography of cases in Lothian during the first four months of the pandemic from March to June 2020 and addresses the following key questions:

1. How has the incidence of COVID-19 in Lothian changed over time? How does this relate to changes in policy and testing criteria?
2. How does the incidence of Covid-19 differ by demographic factors (age, sex, deprivation and ethnicity)?
3. How does the incidence of COVID-19 differ by test group?
4. Have there been changes in the demography of cases over time?

Key Points Summary

COVID 19 incidence

- COVID-19 incidence in Lothian in the first four months of the pandemic (March to June 2020) is an underestimate due to initially limited testing resource being necessarily prioritised to those experiencing severe disease, key occupational groups and for controlling outbreaks in closed settings such as care homes.
- COVID-19 incidence in this first phase peaked in Lothian on the 22nd April 2020. Cases in the general population (severe cases requiring hospital admission) peaked first at the end of March 2020, followed by later peaks in health care workers and care home staff (20th April 2020) and a later peak in Care Home Residents on the 22nd April 2020.
- Across Lothian, approximately one third of all positive cases during this first phase were in health and care workers and care home staff (32%), with just under a third in care home residents (29%).
- There were significant differences in standardised incidence rates between Health and Social Care Partnership (HSCP) areas which may result from differences in case ascertainment[i] and/or differences in exposure as a result of different geographies, proportion of population in health and care work occupations, and outbreaks in care homes.
- Midlothian HSCP had a higher age standardised COVID-19 incidence rate in the first four months of the pandemic compared to the other HSCP areas. Midlothian also had a higher testing rate and proportion of tests that were positive compared to the other HSCP areas.

[i] Case ascertainment =proportion of the total number of cases identified. Testing strategy, for example testing only priority groups, will affect the number of confirmed COVID-19 cases that are identified in the population. Case ascertainment was known to be low at the beginning of the pandemic.

Incidence rates were higher in Midlothian in health care workers, care home staff, care home residents and the general population compared to other HSCP areas.

Demography of cases

- There are clear demographic differences in COVID-19 incidence, with respect to age, sex and deprivation. These differences are due in part to case ascertainment (due to testing policy) but also reflect differences in exposure and/or severity of the disease.

- In both sexes there is a strong relationship between increasing COVID-19 incidence rates and age in people aged 65 years over. Severity of disease increases with age and outbreaks in care homes exposed older people to infection.

- COVID-19 incidence rates in the working age population are higher in females than males in all age-bands up to (and including) age 50-59, potentially reflecting the high proportion of females in health and care worker roles.

- COVID-19 incidence rates were higher in females aged 85 years and older, due to high numbers of cases in older female care home residents.

- COVID-19 incidence rates were higher in males aged 60 to 84 and likely reflects that men of these ages were more likely than women to experience more severe disease and be tested in a healthcare setting.

- There were very few cases in children and young people aged under 20 years. However, this is a significant under-estimate of incidence in these age groups as they were less likely to be eligible for testing during this period, particularly when incidence was highest.

- There was strong evidence of inequalities in COVID-19 incidence in Lothian, with significantly higher age standardised incidence in the most deprived SIMD quintiles compared to the least deprived SIMD quintiles.

- In April, incidence rates in people of working age increased in the most deprived quintile and decreased in the least deprived quintile.

1. Introduction

1.1 COVID-19

Coronavirus 19 disease (COVID-19), the infectious disease associated with the novel severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2), was first observed in Wuhan City, Hubei Province, China in December 2019. The SARS-CoV-2 virus was identified and sequenced in China in early January 2020, human to human transmission confirmed by 20th January 2020 and the World Health Organisation (WHO) declared a Public Health Outbreak Emergency of International Concern on the 31st January 2020. COVID-19 was declared a pandemic by the WHO on the 11th March due to the rapid spread of the disease in countries outside China and the severity of the disease.

Our understanding of COVID-19 is still growing. Whilst the majority of infections cause mild to moderate disease, approximately 20% of cases result in severe disease which may require hospital admission and 5% may require critical care.(1) The infection fatality rate in high income countries has been estimated to be 1.15% (0.78-1.79, 95% prediction interval range).(2) Critical disease can include acute respiratory distress syndrome, sepsis, septic shock, cardiac disease, thromboembolic events and multi-organ failure. Atypical presentations also occur. There is an emerging evidence base around longer term health effects of COVID-19.

Increasing age and underlying health conditions have been shown to be significant risk factors for severe morbidity and mortality from COVID-19.(3,4) Social inequalities and being from particular Black and Minority Ethnic groups have also been associated with worse outcomes from COVID-19. (3,4,5,6)

People can be infected with and transmit the SARS-CoV-2 virus without any symptoms (asymptomatic) or in the two days before symptoms occur (pre-symptomatic), making it challenging to stop the spread of this virus. A recent meta-analysis (not yet peer reviewed) estimated that 17% of infections are asymptomatic (range of 4-41%). (7) The median time from infection to symptom onset is thought to be 5 to 6 days but with a range of up 2 to 14 days (ECDC).(8)

1.2 Context - Initial response to COVID-19 in Lothian January to March 2020

The first *suspected* case of COVID-19 in Lothian was notified to the Health Protection Team on 22nd January 2020. Case definitions of possible COVID-19 have developed over time. In Scotland, early definitions of a possible case included epidemiological and clinical criteria, for example combinations of recent travel to high-risk countries or contact with a case, and the presence of symptoms. Laboratory confirmation of COVID-19 is based on the RT-PCR[ii] test for the SARS-CoV-2 virus.

Initially, possible cases were assessed and tested at Lothian's Regional Infectious Diseases Unit (RIDU). From 6th February 2020, those with mild symptoms who met the possible case definition were tested in the community. This community testing was performed by an outreach team from RIDU with the later addition (from 28th February 2020) of a drive-through testing service.(9) 322

[ii] RT-PCR = Reverse Transcriptase Polymerase Chain Reaction – a test for the presence of genetic material (RNA) from the virus.

symptomatic patients (inpatients and community) were tested in Lothian before the first confirmed case of COVID-19 in Lothian was reported on 6th March 2020.

On the 12th March 2020, the UK government announced testing was to be reserved for patients requiring hospital admission and contact tracing would be stopped. The UK had moved from the 'Containment' phase to the 'Delay' phase. By the 13th March 2020, 665 symptomatic people in Lothian had been tested in the community (53% via the outreach team and 47% via the drive-through testing service) with 20 positive cases detected. A further seven cases had been reported in hospital inpatients during this period including the first case in Lothian on the 12th March 2020 with no known contact with a confirmed case or travel history.

From the 16th March 2020 people were advised to socially distance by the UK Government. The Chief Medical Officer (CMO) for Scotland announced on 20th March 2020 that there was evidence of sustained community transmission. Subsequently, genomic sequencing of the virus from the earliest known cases in Scotland has shown that sustained community transmission was occurring by the 11th March 2020. This genomic analysis identified multiple travel-related introductions of the virus from Europe and evidence that COVID-19 was spreading in Scotland before the first detected case on the 1st March 2020.(10)

Schools in Scotland closed from the 20th March 2020 and 'lockdown' was implemented across the UK from the 23rd March 2020.

1.3 Testing policy March to June 2020

Testing policy changed significantly over the course of the first four months of the pandemic both at UK and Scotland level, reflecting changes in case definitions, testing capacity, prioritisation of certain occupational groups and management of outbreaks in closed settings (see Appendix 1 for timeline of key dates and changes in case definitions). These changes in testing policy need to be considered when interpreting COVID-19 incidence and differences in demography of cases during this time.

NHS Lothian began testing healthcare staff and/or their household members through the Occupational Health Service (OHS) on 25th March 2020, to identify cases and to support other staff back to work by excluding a COVID-19 diagnosis. This service was also offered to care home staff from 2nd April 2020 and an outreach service was established for testing of care home residents and staff and other closed settings from 9th April 2020.

Initially, only the first two to five symptomatic cases in a care home were usually tested; testing was extended to all suspected cases after the 17th April 2020 and from 1st May 2020 all residents and staff were offered tests in care homes with ongoing outbreaks. Routine weekly surveillance testing of staff in all care homes was implemented in June irrespective of whether there were cases of COVID-19 identified.

Access to community testing varied during the first four months of the pandemic. Community testing of possible cases using the drive-through testing service was stopped on the 13th March in line with UK and Scottish government policy. From the 13th April, suspected COVID-19 cases in the

community with symptoms requiring them to be seen in the face to face assessment centres of the community COVID hubs were tested. However, this was a small proportion of the overall numbers contacting NHS24 and the community COVID hubs.

In April 2020, the UK government established regional testing centres and the associated Lighthouse laboratories to increase testing capacity. Key workers were able to use an online portal to arrange to be tested at a drive through testing site at Edinburgh Airport from 16th April 2020. Eligible key workers included NHS and social care workers, police officers, teachers, those in the justice system, supermarket and food production workers, journalists and transport workers. On the 1st May it was announced that symptomatic people aged 65 years plus and or those who could not work from home (plus their households) could access testing through the regional testing centres. From 18th May 2020, anyone age five years or over with symptoms was eligible to get tested at these sites.

1.4 Case definition of COVID-19 used in this report

For the purposes of this report, COVID-19 incidence is based on a positive PCR test result for SARS-CoV-2 virus conducted by NHS Scotland laboratories and UK government 'Lighthouse' laboratories (see Appendix 2 for more details). Except where explicitly stated otherwise, the report focuses upon the *first* positive PCR result for any given individual and the scope of the report is limited to NHS Lothian residents. We have used the earliest date we have reliable data for – the date the sample was collected. Ideally date of symptom onset would be used but this was not routinely available for all samples.

Analysis is presented for the Lothian population and where appropriate for the populations of the four Health and Social Care Partnerships (HSCPs).

A note of caution: as this report focuses (largely) on PCR laboratory results the understanding it offers is only informed by such laboratory confirmed cases. Given changes in case definitions and eligibility, and/or access to testing during the period, the proportion of cases which are detected will likely have varied considerably. Such case ascertainment may also vary between different demographic groups or geographies. These limitations and potential biases should be considered when interpreting this report. One way to further illuminate such differences is to look at other sources of data. For example, while trends in both hospital and intensive care admissions and deaths contain a 'lag' relative to transmission they arguably provide more consistent data around the more severe end of the COVID-19 disease spectrum.

2. Incidence of COVID-19 in Lothian (March to June 2020)

There were 3,033 cases with first positive sample collection dates recorded in Lothian up to the end of June 2020. Of these, 31 cases that were missing demographic data were excluded from the analysis in this report.

Figure 1 shows the incidence of new cases of COVID-19 per day in Lothian with reference to the key testing changes described above. Cases are presented by sample collection date which is the earliest date for which we have consistent data (see Appendix 2 for definitions). The data from the Lighthouse laboratories were not initially available to health boards. Retrospective addition of this data to NHS Scotland laboratory systems resulted in a spike of cases on 20th April 2020 (no dates were available for the samples tested by the Lighthouse laboratories between 15th and 25th April 2020 and so they were assigned the mid-point date in the system).

The 7 day rolling average of daily incidence of COVID-19 shows a steep increase from the 19th March 2020 (3 cases per day) to the 6th April 2020 (54 cases per day). It then plateaus and drops slightly before increasing to a second and higher peak on the 22nd April 2020 at 77 cases per day. The daily incidence then declines slowly to reach a 7 day rolling average of 2 cases per day on the 25th June 2020.

Differences are observed in the 7 day rolling average of daily incidence of new cases between Lothian's four Health and Social Care Partnerships (HSCPs) (Figure 2). The daily incidence of new cases in Edinburgh HSCP follows the same pattern as described above for Lothian. Midlothian HSCP's daily incidence, whilst similar, shows the first peak in incidence occurring slightly later on the 12th April 2020. West Lothian HSCP experienced a third peak in daily incidence in mid-May 2020 not observed in the other three HSCPs. East Lothian HSCP's second peak in mid-April 2020 was smaller than their first peak in early April 2020.

The cumulative crude rate of COVID-19 cases per 100,000 population for the first four months of the pandemic is highest for Midlothian HSCP (572 cases per 100,000) and lowest for West Lothian HSCP (256 per 100,000) (Table 1). When age-standardised rates (European Standard Population 2013) are calculated (which take account of differences in age structure of the population), Midlothian HSCP still has a significantly higher rate (615 EASR) than the other HSCPs.

Figure 1: Chart of daily incidence and 7 day rolling average of first positive COVID-19 cases in Lothian. *Case numbers fewer than 5 have been suppressed.
NB: Retrospective assignment of UK Lighthouse laboratory data from the period 15/04/2020 – 25/04/2020 to the midpoint date, 20/04/2020, created an artificial spike of cases on that date.

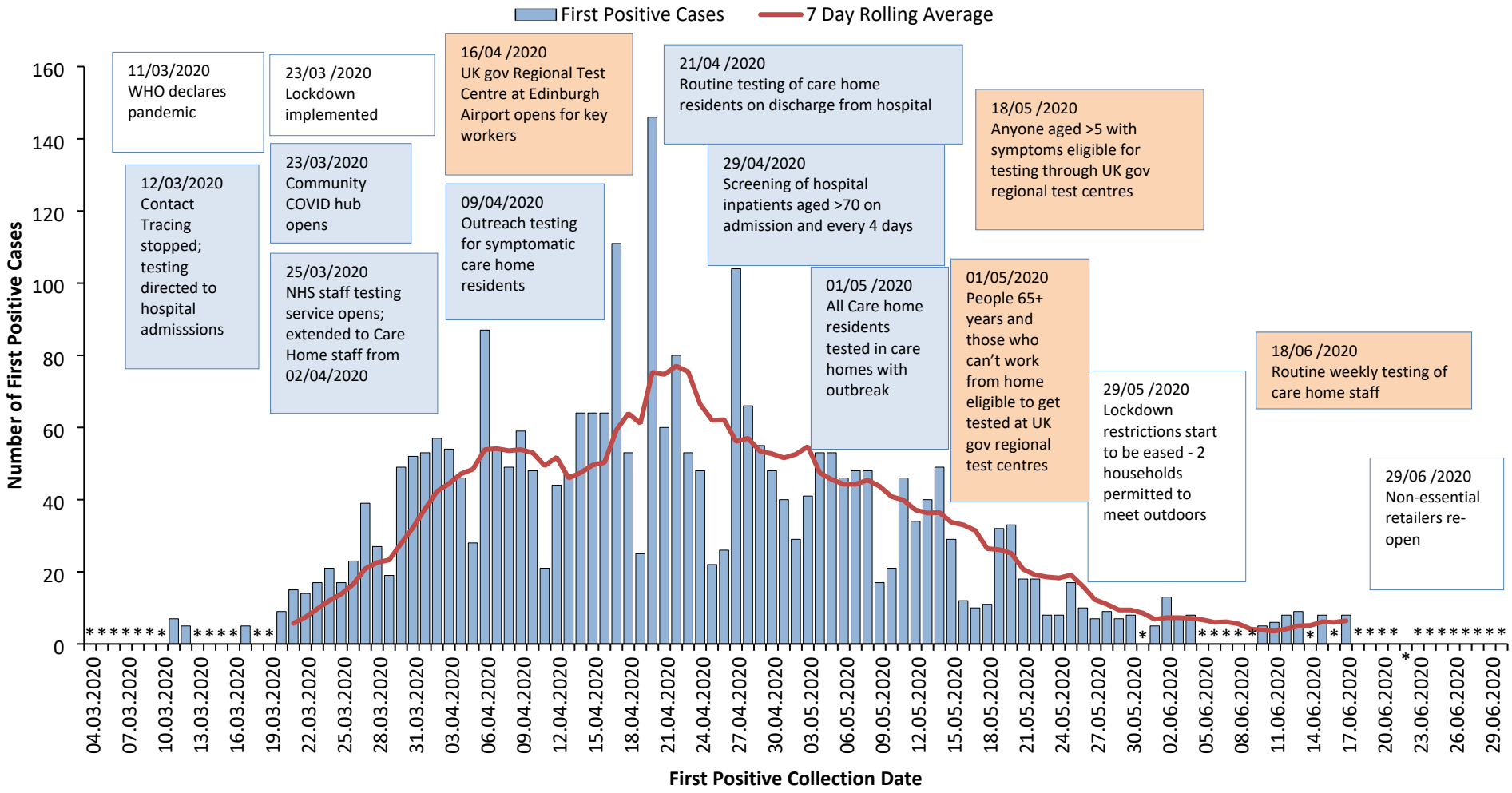


Figure 2: Chart of 7 day rolling average of daily COVID-19 incidence in Lothian, by Health and Social Care Partnership (HSCP) (small numbers have been suppressed)

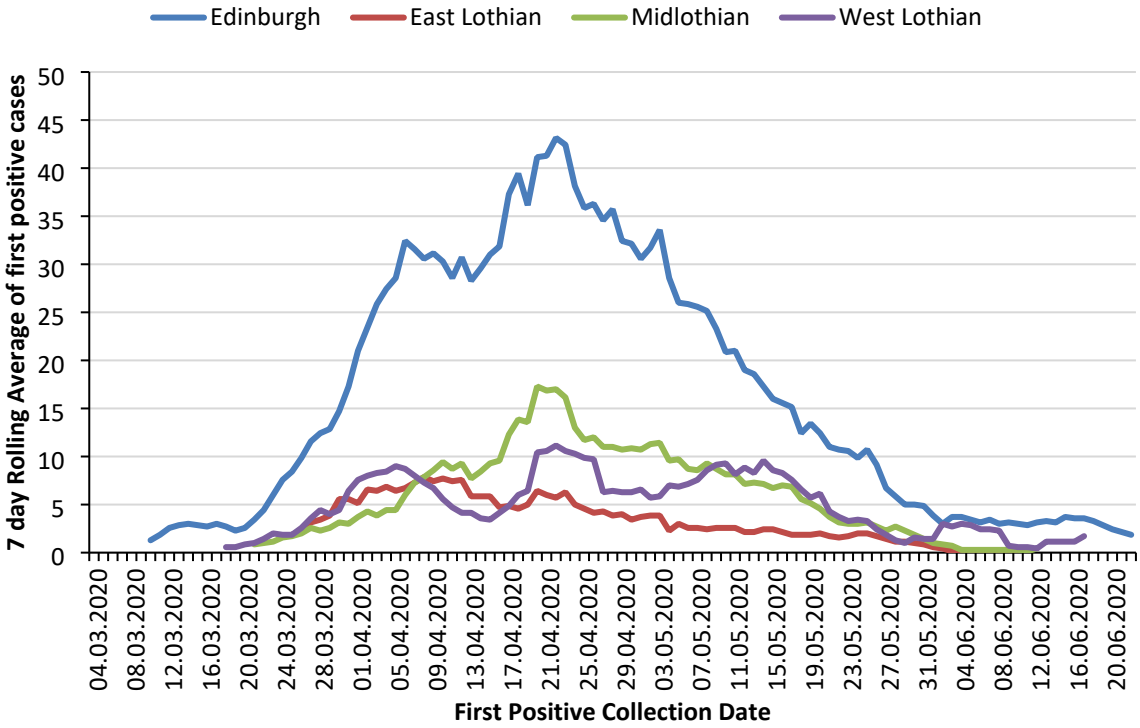


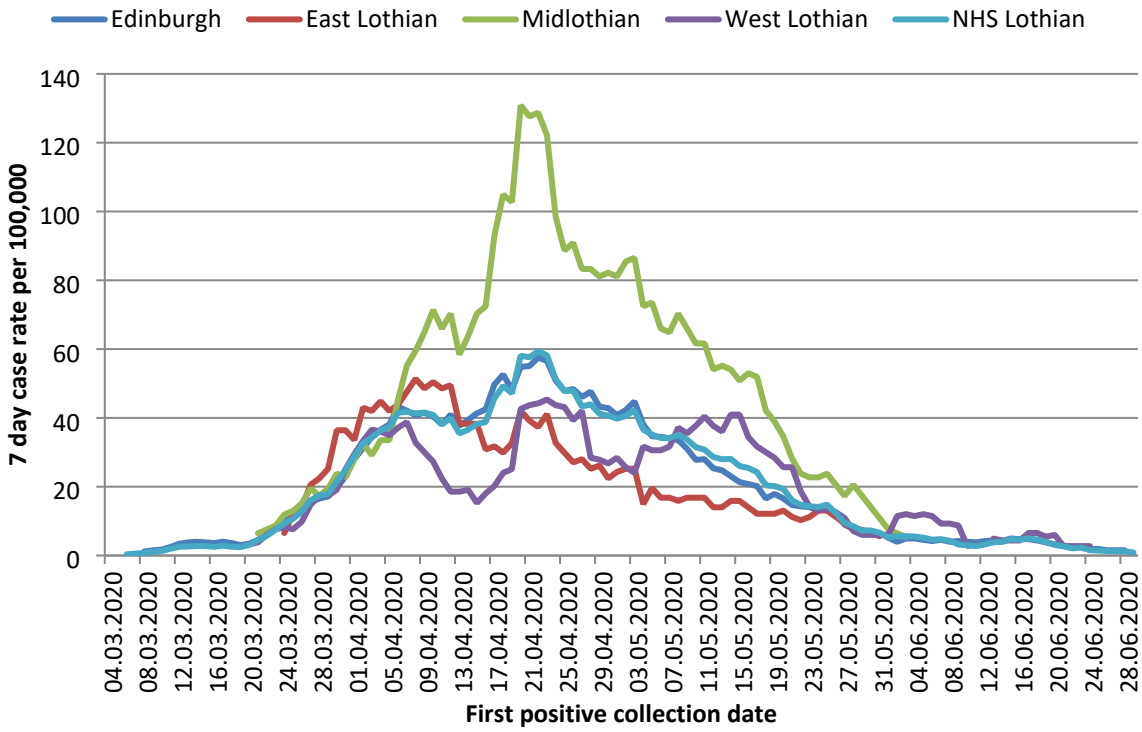
Table 1: Number, cumulative crude rate per 100,000 population and European Age Standardised Rate (EASR) of first positive COVID-19 cases across NHS Lothian by HSCP between 01/03/2020 and 30/06/2020. Rates have been calculated for the four month period and have not been annualised.[iii]

	Number of first positive cases	Rate per 100,000	EASR (95% Confidence Interval)
NHS Lothian	3,002	330.8 (318.9, 342.6)	355.1 (342.3, 368.0)
Edinburgh HSCP	1,728	329.2 (313.7, 344.7)	355.5 (338.3, 372.7)
East Lothian HSCP	276	257.7 (227.3, 288.1)	257.7 (227.1, 288.3)
Midlothian HSCP	529	572.1 (523.4, 620.9)	615.4 (562.2, 668.6)
West Lothian HSCP	469	256.1 (233.0, 279.3)	286.6 (260.1, 313.2)

[iii] An annualised rate is a rate that has been calculated for part of a year and is adjusted to make it comparable with an annual rate i.e. the rate for the whole year. Standardised rates are usually assumed to be annual rates. However, rates have not been annualised in this report as there is not yet an annual rate to compare COVID-19 incidence to. Rates have been standardised to allow comparisons across areas with different populations for the four month analysis period 1st March 2020 to 31st June 2020.

At the mid-April peak of the first four months of the pandemic in Lothian, Midlothian had the highest COVID-19 incidence rate compared to the other three partnership areas (Figure 3). Incidence rates before the end of March 2020 and after the beginning of May 2020 should not be compared across the HSCPs due to small numbers of cases for some HSCPs before and after these dates.

Figure 3: Chart of 7 day incidence rate of COVID-19 per 100,000 for NHS Lothian and HSCP (data where 7 day case numbers are fewer than 5 have been suppressed). NB rates in March and June for HSCP areas are based on 7 day case numbers fewer than 20 and therefore comparisons should be made with caution for these time periods.



3. Testing rates and proportion of positive tests

Testing between the 12th March 2020 and the 13th April 2020 was primarily focussed on four key groups – patients admitted to hospital with COVID-19 symptoms, NHS staff (and household contacts), care home residents and care home staff. Community COVID-19 face to face assessment centres began testing patients on the 13th April 2020. The UK regional testing centres opened at Edinburgh Airport on the 16th April 2020, extending testing to other key workers.

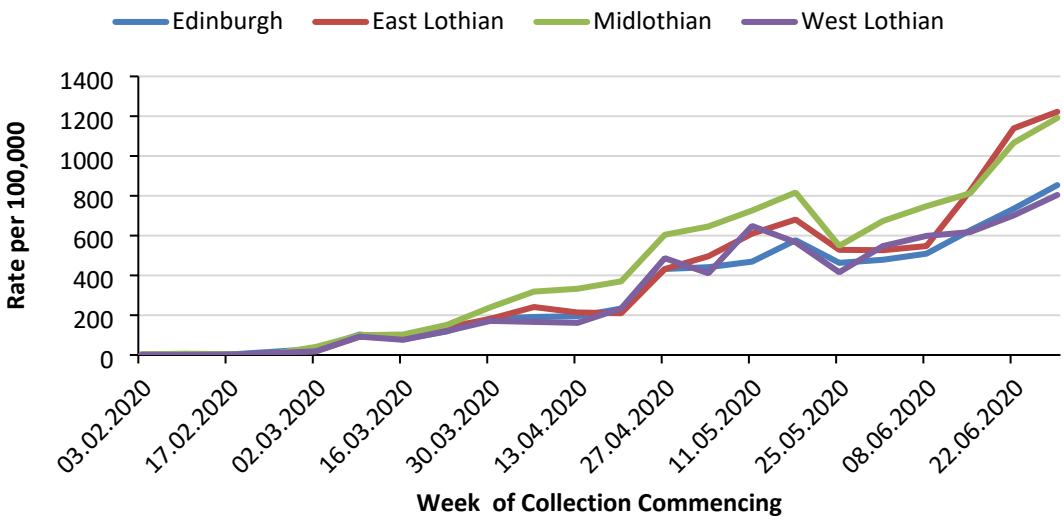
Testing capacity increased significantly during the first four months of the pandemic. In Lothian, 889 tests were carried out during the week beginning 9th March 2020 and 8,383 tests were carried out the week beginning 29th June 2020. Overall, Midlothian HSCP had the highest rate of testing within their population (Table 2). The testing rate in the Midlothian population was higher than other HSCPs from week commencing 16th March 2020 to week commencing 15th June 2020 (Figure 4). A possible explanation for this difference may be that a higher proportion of people resident in Midlothian were eligible for testing during the initial period (e.g. if more Midlothian residents

worked in occupations qualifying for testing or if they had a higher incidence of severe symptoms). Testing rate is based on the total number of tests (positive and negative) and includes repeat tests in individuals (such as care home staff and residents in care home outbreaks and screening of inpatients aged 70 years and over).

Table 2: Number of total tests (positive and negative tests including repeat tests), testing rate per 100,000 population and percent positive tests to 30 June 2020 for NHS Lothian and HSCPs. The percent positive tests exclude repeat positive tests for an individual. Some tests do not have postcodes so cannot be assigned to HSCP therefore the sum of HSCPs is less than NHS Lothian total

	Total number of tests	Testing rate per 100,000 population	Overall % positive
NHS Lothian	99,746	10,990	3.1%
Edinburgh HSCP	52,982	6,742	3.3%
East Lothian HSCP	11,817	8,201	2.4%
Midlothian HSCP	10,712	9,507	4.9%
West Lothian HSCP	12,432	6,850	3.8%

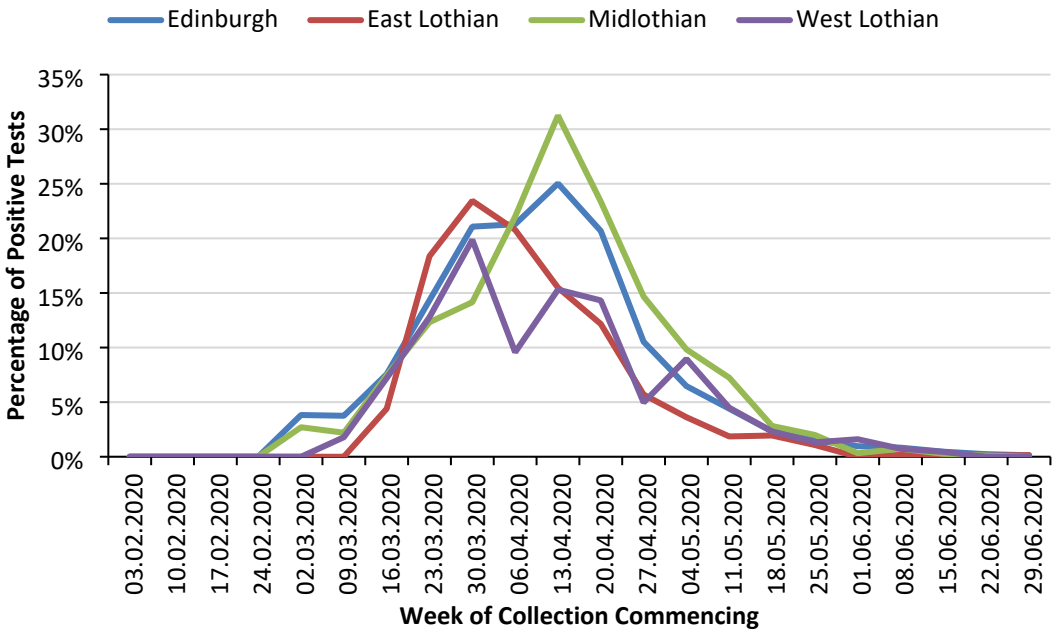
Figure 4: Rate of weekly testing per 100,000 population by HSCP area of residence



The proportion of tests that are positive (test positivity rate or percent positive) is an important measure for understanding the prevalence of the infection in the population being tested (provided there is sufficient testing of suspected cases). Test positivity rate (less than 5%) is one of several epidemiological criteria proposed by the WHO to indicate the epidemic is under control.[11] The test positivity rate has varied over the course of the pandemic. In Lothian, 2.8% of tests were positive the week beginning 9th March 2020, increasing to 23% positive tests the week beginning 13th April 2020 and falling to just 0.1% positive the week beginning 29th June 2020. Differences in the percentage of tests that are positive can reflect changes in prevalence of the virus within the population but they can also reflect changes in testing criteria. For example moving from community testing to only testing those admitted to hospital will likely increase the proportion testing positive. Conversely, screening staff and inpatients will likely decrease the proportion of

positive tests. Midlothian HSCP had the highest proportion of positive tests over the four months compared to the other HSCPs (Table 2) and also had the highest peak in proportion of positive tests (31.3%) during the week beginning 13th April 2020 (Figure 5).

Figure 5: Proportion of first positive tests (weekly) as a proportion of all tests (excluding repeat positives) by HSCP area of residence



4. How does the incidence of Covid-19 differ by demographic factors?

This section presents data for COVID-19 incidence by age, sex, deprivation and ethnicity for all first positive COVID-19 cases between March 2020 and June 2020. Some of the differences in demography observed across the population resulted from the testing policy (section 1.3) in the first four months. Therefore Section 5 looks at COVID-19 incidence within specific testing groups (i.e. care home residents, care home staff, health and other care staff and general population) and presents demographic analysis of these testing groups which helps to make sense of the demographic differences that are observed across the whole cohort of positive cases. Demographic differences in COVID-19 incidence both within the total population and testing groups are discussed in Section 6.

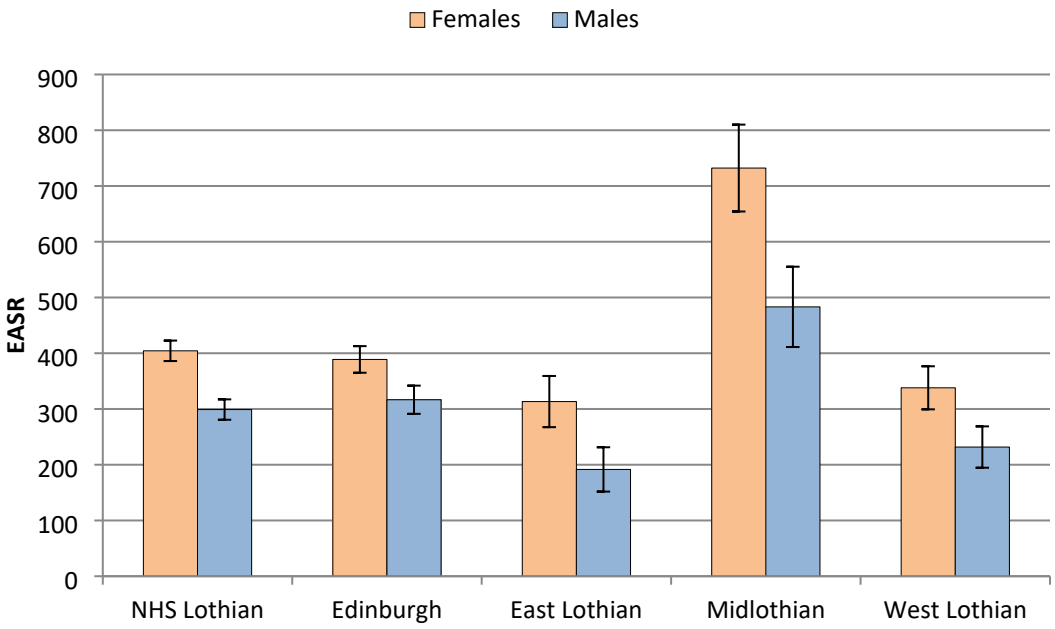
4.1 Sex

Overall, during the first four months of the pandemic, the cumulative COVID-19 incidence rate in NHS Lothian was significantly higher in females (408 cases per 100,000) than males (250 cases per 100,000) (Table 3). Of the four HSCPs, Midlothian had the highest age-standardised incidence rate in both females and males compared to the other HSCPs (Figure 6).

Table 3: Number of first positive COVID-19 cases, rate per 100,000 and European age standardised rates (ESP2013) in females and males between 1st March to 30th June 2020. Rates have been calculated for the four month period and have not been annualised.

	Total number of Cases		Rate per 100,000 (95% Confidence Intervals)		EASR (95% Confidence Intervals)	
	Female	Male	Female	Male	Female	Male
NHS Lothian	1899	1103	408.0 (389.6, 426.3)	249.5 (234.8, 264.2)	404.3 (386.0, 422.7)	299.0 (280.7, 317.3)
Edinburgh HSCP	1074	654	399.8 (375.9, 423.7)	255.2 (235.6, 274.7)	388.9 (365.0, 412.7)	316.6 (291.3, 341.9)
East Lothian HSCP	183	93	328.8 (281.2, 376.4)	180.8 (144.1, 217.6)	313.3 (267.4, 359.2)	191.6 (151.8, 231.3)
Midlothian HSCP	343	186	714.2 (638.6, 789.8)	418.6 (358.4, 478.8)	732.2 (654.2, 810.1)	483.2 (411.1, 555.2)
West Lothian HSCP	299	170	321.0 (284.6, 357.4)	189.0 (160.6, 217.4)	338.0 (299.4, 376.6)	231.7 (194.6, 268.8)

Figure 6: European Age Standardised Rate (EASR) of COVID-19 first positive cases in females and males in NHS Lothian and HSCPs to 30 June 2020. Rates have been calculated for the four month period and have not been annualised. Error bars represent the 95% confidence intervals.



4.2. Age and sex

The differences in COVID-19 incidence between the sexes is not consistent across all the age-bands. There are a higher number of cases in males aged 65 to 74 than females (based on 5 year age-bands) (Figure 7).

Incidence rates (which take account of the number of males and females in each age-band of the population) were higher in males than females between the ages of 65 and 89 years (based on 5 year age bands) (Figure 8). The higher rate of COVID-19 in females of working age compared to males, likely reflects the predominance of females in the health and care workforce (77% of the NHS Lothian workforce are female).[12]

The highest age-specific incidence rates were observed in those aged 90 years and older, with 5,361 cases per 100,000 in females and 3,839 cases per 100,000 in males. Incidence rates could not be calculated for the 0-14 age groups due to small numbers. The low number of cases in the younger age groups will be a significant under-estimate of the true incidence. Young people were only eligible for testing, for the majority of the time period that this report covers, if they were a household contact of NHS staff member or if admitted to hospital with suspected COVID-19.

Figure 7: The number of first positive cases of COVID-19 split by age-band and sex in NHS Lothian up to 30 June 2020 (* numbers fewer than 5 are suppressed).

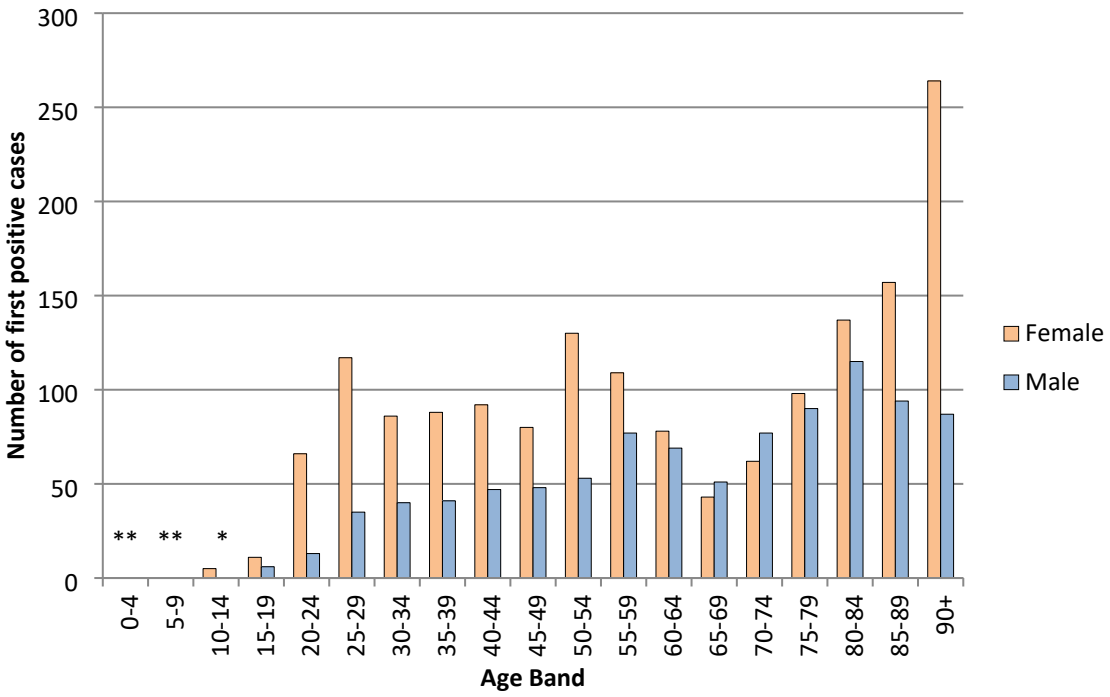
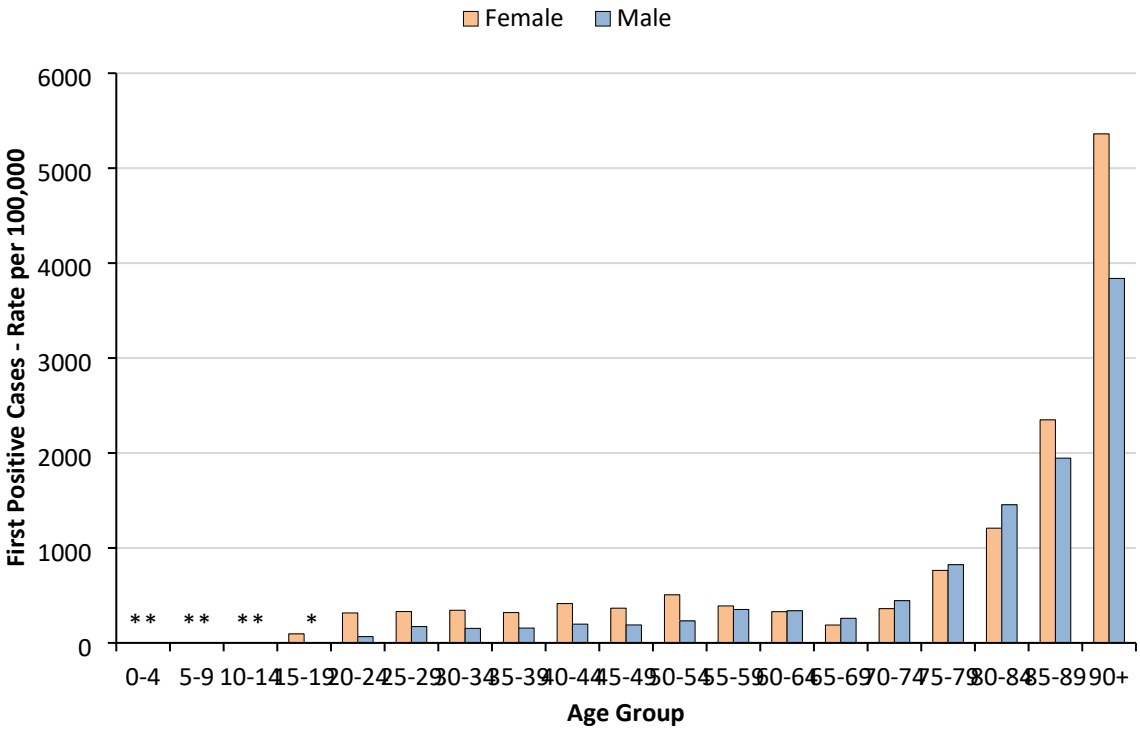


Figure 8: Chart of COVID-19 incidence rate per 100,000 by 5 year age-bands and sex for Lothian total between March and June 2020 (*rates for numbers fewer than 20 are suppressed)**.** Rates have been calculated for the four month period and have not been annualised.



4.3 Deprivation

The Scottish Index of Multiple Deprivation (SIMD) is an area based relative measure of deprivation across seven domains: income, employment, education, health, access to services, crime and housing. Small areas (datazones) are ranked from most to least deprived. In our analysis we have used SIMD quintiles, where SIMD quintile 1 is the 20% most deprived datazones in Scotland and SIMD quintile 5 is the 20% least deprived datazones in Scotland. In Lothian, the highest number of COVID-19 cases were in people resident in SIMD quintiles 5 and 2. However, in order to understand the relationship between deprivation and COVID-19 incidence it is important to take the population structure into account as the Lothian population is not distributed evenly across the SIMD quintiles.

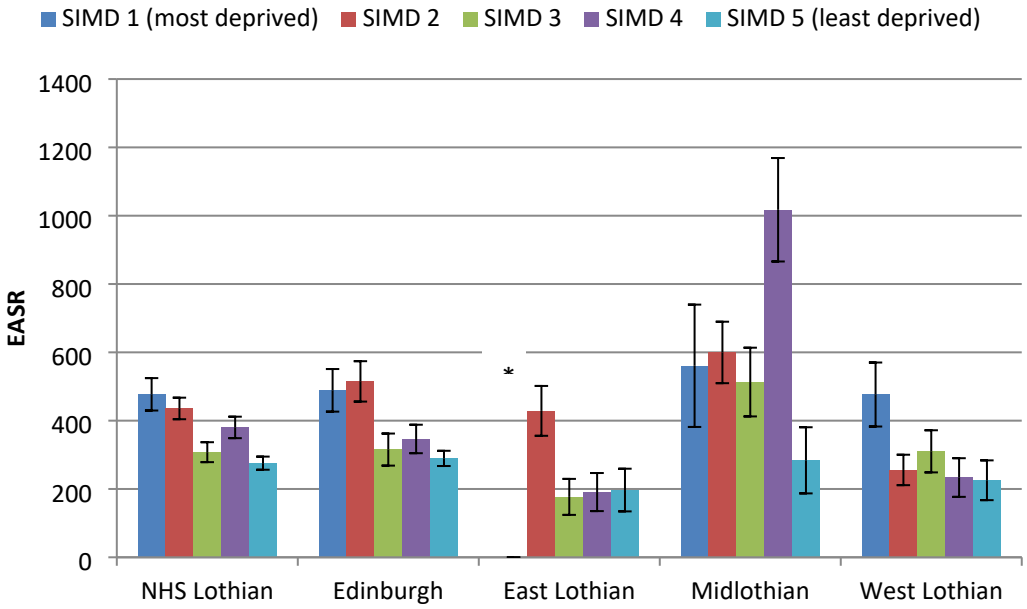
There is a gradient in the incidence rate of COVID-19 across the deprivation quintiles in Lothian for the first four months of the pandemic (Table 4; Figure 9). The COVID-19 incidence rate was significantly higher in people resident in the most deprived SIMD quintile (413 cases per 100,000 population) compared to the least deprived SIMD quintile (273 cases per 100,000).

Unlike the other HSCPs, Midlothian had a significantly higher age-standardised rate in SIMD quintile 4 (1,018 EASR; 95% CI 866 to 1169) compared to the other quintiles (Table 4; Figure 9). Further analysis has shown that this is due to high numbers of cases in care homes in Midlothian with postcodes that map to SIMD quintile 4.

Table 4: Crude rate per 100,000 population and European Age-Standardised Rate (EASR) with 95% confidence intervals, of first positive COVID-19 cases in NHS Lothian and HSCPs from 1st March to 30 June 2020. Rates have been calculated for the four month period and have not been annualised.

	NHS Lothian		Edinburgh HSCP		East Lothian HSCP		Midlothian HSCP		West Lothian HSCP	
	Crude rate per 100,000	**EASR (95% CI)**	**Crude rate per 100,000**	**EASR (95% CI)**	**Crude rate per 100,000**	**EASR (95% CI)**	**Crude rate per 100,000**	**EASR (95% CI)**	**Crude rate per 100,000**	**EASR (95% CI)**
SIMD 1	412.5 (372.8, 452.2)	477.1 (429.7, 524.6)	428.3 (376.5, 480.0)	488.8 (426.4, 551.1)	203.0 (83.0, 323.0)	*	532.4 (363.1, 701.6)	560.6 (381.6, 739.7)	386.7 (312.0, 461.4)	476.5 (382.8, 570.2)
SIMD 2	401.8 (373.2, 430.5)	435.7 (404.2, 467.3)	431.6 (384.3, 478.9)	515.0 (455.9, 574.1)	428.9 (356.3, 501.6)	428.7 (355.7,501.6)	560.1 (477.1, 643.1)	599.7 (509.7, 689.7)	247.3 (204.5, 290.1)	255.7 (211.2, 300.3)
SIMD 3	288.1 (261.4, 314.8)	307.7 (278.5, 336.9)	266.3 (229.2, 303.3)	315.3 (268.4, 362.3)	180.5 (127.2, 233.9)	176.8 (124.1, 229.5)	479.5 (387.8, 571.2)	513.0 (412.4, 613.6)	289.6 (233.1, 346.1)	310.2 (248.6, 371.9)
SIMD 4	341.2 (313.5, 368.8)	380.2 (348.8, 411.7)	314.9 (278.3, 351.4)	346.4 (304.7, 388.1)	184.2 (131.5, 236.3)	191.0 (135.2, 246.7)	919.5 (784.0, 1054.9)	1017.4 (866.0, 1168.8)	207.8 (160.5, 255.2)	233.5 (176.9, 290.1)
SIMD 5	273.4 (254.5, 292.4)	275.6 (256.3, 294.8)	294.9 (272.4, 317.3)	289.5 (267.2, 311.8)	194.8 (134.4, 255.1)	196.9 (134.4, 259.3)	263.0 (174.6, 351.4)	283.9 (187.1, 380.7)	184.1 (138.6, 229.5)	225.5 (167.3, 283.7)

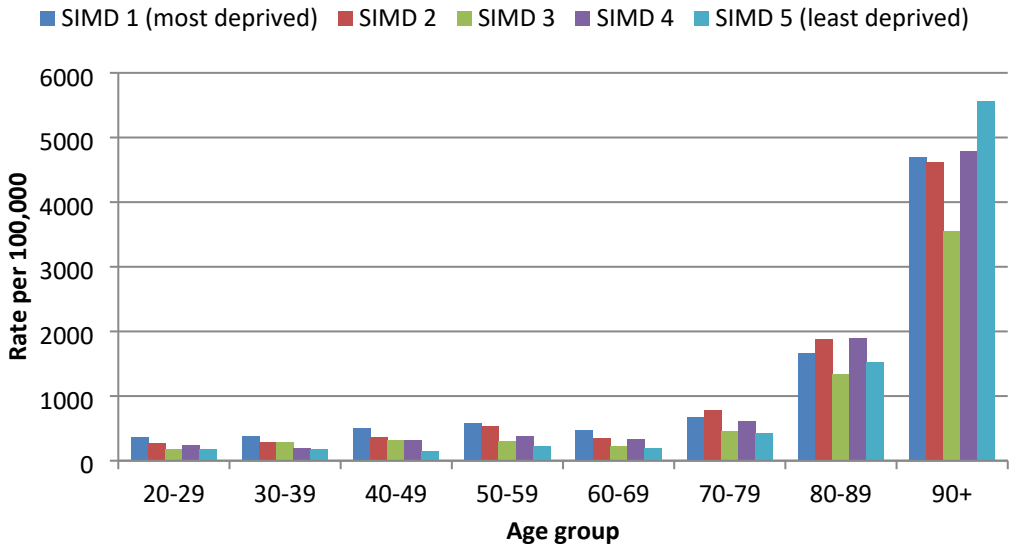
Figure 9: Bar chart of EASR of first positive cases by SIMD quintiles for NHS Lothian total and HSCP between 1st March and 30th June 2020 (* rates suppressed where case numbers are fewer than 20). Rates have been calculated for the four month period and have not been annualised. Error bars represent 95% confidence intervals.



4.4. Age and deprivation

In Lothian, COVID-19 incidence rate is highest in SIMD quintile 1, the most deprived quintile, in age-bands up to and including 60-69 years (Figure 10). However, in the oldest age groups, 80-89 and 90+, the highest incidence rates were in SIMD quintiles four and five respectively.

Figure 10: Bar chart of COVID-19 incidence rate per 100,000 population split by 10 year age groups and SIMD quintiles for Lothian between 1st March and 30th June 2020. Rates have been calculated for the four month period and have not been annualised.



4.5 Ethnicity

There is growing evidence of disparities with respect to incidence and outcomes from COVID-19 between people from different ethnic groups, both within the UK and Scotland.[3,4,5,6] Currently, Lothian data for ethnicity is incomplete; 29% of the cases in Lothian have unknown ethnicity status (Table 5). The only routine data currently available for ethnicity at a Lothian patient level is from TRAK. Ethnicity status is more completely recorded in primary care which may be available for future analysis. Rates are reported for groups where numbers are large enough (Table 5). The population estimates used to calculate rates for these groups are based on the 2011 Census data which may not reflect the current population. Given these caveats, it is important that the presented data are interpreted with caution.

Table 5: Number, proportion and rate per 100,000 population of COVID-19 cases between 1st March and 30th June 2020 by ethnic group using 2011 Census groupings. (*Rates are not shown where there are fewer than 20 known cases per ethnic group). Population estimates are based on 2011 Census groupings. Rates have been calculated for the four month period and have not been annualised.

	First Positive COVID-19 Cases		
Ethnicity	**Number**	**%**	**Rate per 100,000**
African	23	0.8	403.0
Asian, Asian Scottish or Asian British	74	2.5	220.0
Caribbean or Black	10	0.3	*
Mixed or multiple ethnic groups	7	0.2	*
Other ethnic groups	16	0.5	*
Unknown	863	28.7	n/a
White	2009	66.9	237.2

5. How does the incidence of COVID-19 differ by Test group?

In order to make sense of the demographic differences observed in COVID-19 incidence during the first four months of the pandemic it is important to consider the key groups that were prioritised for testing. We are able to distinguish four main groups within the Lothian testing data: 'Care Home residents' (29% of positive tests), 'Care Home staff' (15% of positive tests), 'Health and other care staff' (17% of positive tests), and the 'General Population' (39% of positive tests). Appendix 2 describes how these groups were identified from the testing data.

The 'Care Home staff' group (n=438) includes care home staff tested through the Occupational Health testing service and the Lighthouse laboratories (see Appendix 1 for detailed timeline for testing). An enhanced outbreak response was implemented from the 1st May 2020 with testing of all

staff in Care Homes with outbreaks. Routine weekly surveillance testing of staff in all care homes was implemented in June irrespective of whether there were cases of COVID-19 identified.

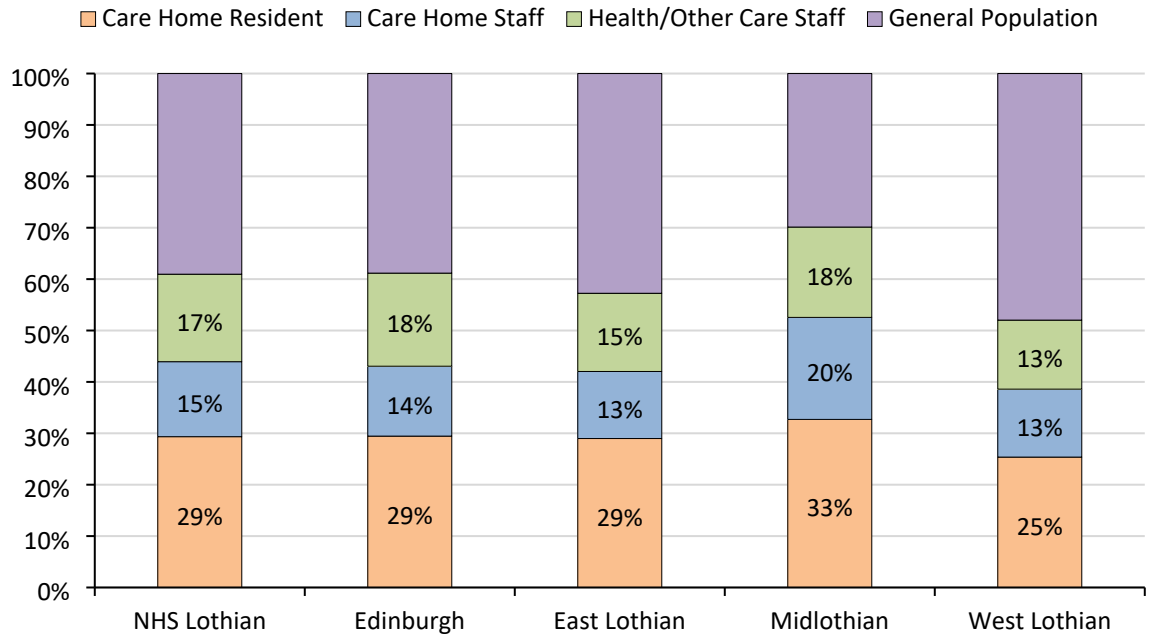
The 'Care Home residents' group (n=881) includes people who tested positive and were resident in one of the 188 residential care homes within NHS Lothian (5,806 registered places as of March 2020). A previously published analysis examining testing data between 10th of March and 2nd of August 2020 identified 69 (37%) Lothian care-homes which experienced a COVID-19 outbreak (defined as one or more residents testing positive for COVID-19). The majority of these outbreaks were in older people's care homes (n=66; 96%).[13] The median number of positive cases per care home was seven (IQR 2–17, range 1–65).[13] Initially, only the first two to five symptomatic cases in a care home were usually tested; this was extended to all suspected cases after the 17th April 2020 and from the 1st May 2020 all residents were tested in care homes with ongoing outbreaks. Numbers of cases in care home residents before 17th April 2020 are therefore likely to be an under-estimate.

The 'Health/other care staff' group (n=511) includes NHS staff and other staff groups, such as personal and social care staff, that were eligible for testing through the Occupational Health service (OHS). It should be noted that where possible cases have been assigned to the appropriate 'test' group however, if health and other care staff chose to get tested through the UK regional testing centres rather than through the OHS then they would appear in the 'General Population' group not 'Health/other care staff' group.

The 'General Population' group (n=1,172) includes people who tested positive in the community and patients who tested positive in hospital. It also includes household contacts of NHS staff that were tested through the OHS testing service (where these were identified as such in the data). The extent of community testing has varied over the course of the pandemic. There was very limited community testing between the 13th March 2020 and 16th April 2020. Between 16th April 2020 and 1st May 2020 testing was available for key workers through the regional testing sites and Lighthouse laboratories. This was extended to symptomatic people aged 65 years and over and those who couldn't work from home (plus their households) from 1st May 2020 and to all symptomatic people aged 5 years and over from 18th May 2020. 26% of the cases in this 'General Population' group were tested through the Lighthouse laboratories.

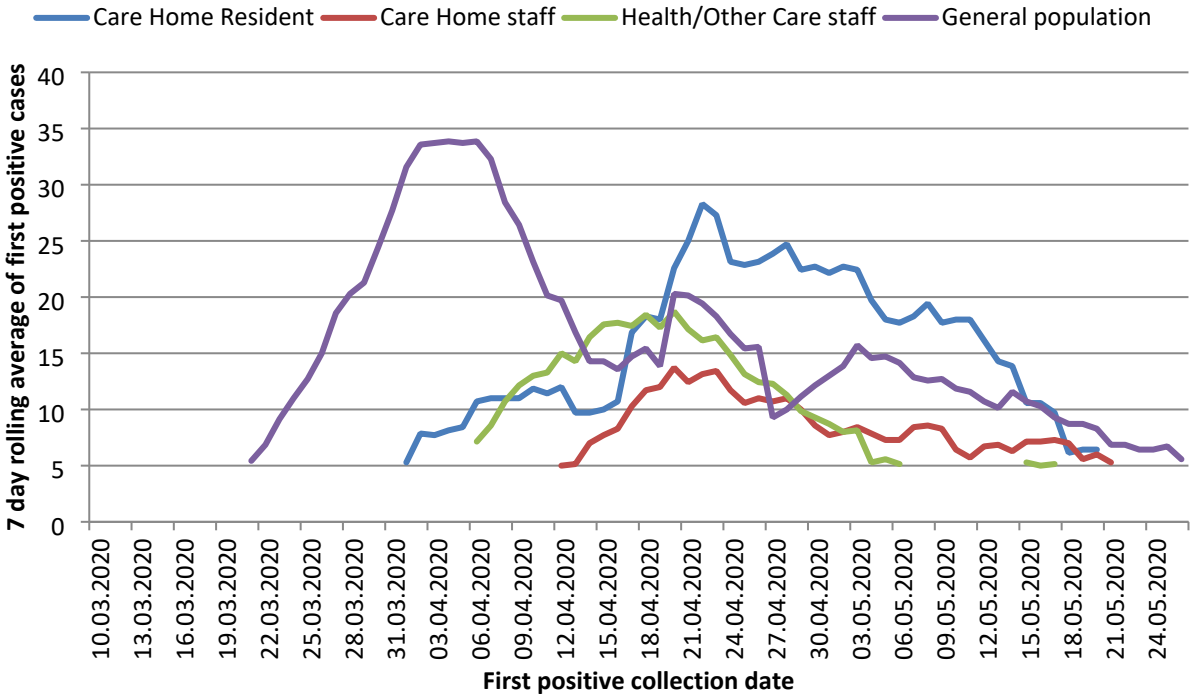
There is some variation between HSCPs with respect to proportion of cases by test group (Figure 11; Appendix 3 Table A2). Midlothian HSCP had the highest proportion of positive cases in 'Care Home residents' (33%; n=173) and 'Care home staff' (20%; n= 105) and the lowest proportion of positive cases in the 'General Population' group (30%; n=158) compared to the other HSCPs. West Lothian HSCP had the highest proportion of cases in the 'General Population' group (48%; n=225) compared to the other HSCPs.

Figure 11: Proportion of first positive cases by test group for NHS Lothian and HSCPs



COVID-19 cases peaked earliest in the 'General Population' with 34 cases per day (7 day rolling average) between the 2nd and 6th April 2020 (Figure 12). Testing in the general population during this time was restricted to hospital admissions and as such the incidence represents only the most severe cases. The second lower peak in the 'General Population' on the 20th April 2020 represents testing of key workers at UK government regional test centres and the Lighthouse labs. Cases in 'Health/Other Care staff' peaked on 20th April 2020 with 19 cases per day (7 day rolling average). Cases in 'Care Home Staff' peaked on the 20th April 2020 with 14 cases per day (7 day rolling average) and cases in 'Care Home residents' peaked on 22nd April 2020 with 28 cases per day (7 day rolling average). However, these incidence curves should be interpreted with caution as they will reflect testing policy to some extent. Not all symptomatic care home residents in a care home outbreak were tested before 17th April 2020; care home staff only had access to testing from the beginning of April and 'Health/Other Care staff' from late March 2020.

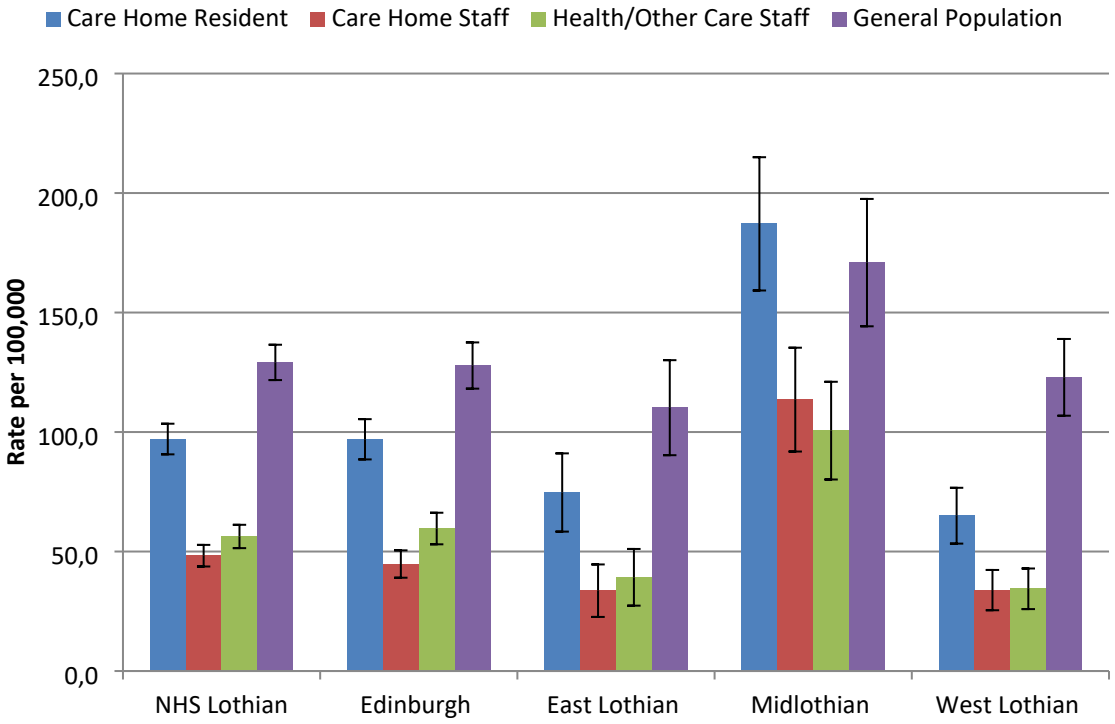
Figure 12: NHS Lothian 7 day rolling average of first positive cases by test group (data where 7 day case numbers are fewer than 5 have been suppressed).



COVID-19 incidence rates in all four test groups in Midlothian HSCP were significantly higher than in the other HSCPs (Figure 13). In Midlothian, the incidence rate in 'Care Home residents' (187 per 100,000) was higher than that in the 'General Population' group (171 per 100,000), whereas in the other HSCPs the incidence rate was highest in the 'General Population' (Figure 13). However, it should be noted that the denominator for these rates use the total population and do not take account of the number of 'Care Home Staff', 'Health/other Care staff' or 'Care Home residents' within each HSCP area. The proportion of people within these groups may differ by HSCP area and therefore comparisons between these rates should be made with caution. Midlothian HSCP may have a larger proportion of the population who work in the NHS for example who could access Occupational Health Service testing (rather than a higher rate within the NHS staff who live in Midlothian).

Changes in testing policy in care homes may have contributed to the higher numbers of cases detected in Midlothian both in care home residents and care home staff. Care homes experiencing outbreaks after 17th April 2020 will have had all suspected cases tested and from the 1st May 2020 all residents were tested when there was an outbreak within a care home. Five out of seven care homes with outbreaks in Midlothian had cases after the 1st May 2020. Although a strong association has been shown between care home size and COVID-19 outbreaks,[13] no difference in average size of care home was found in Midlothian compared to NHS Lothian.[14]

Figure 13: Rate of first positive cases per 100,000 by test group between 1st March and 30th June 2020. Error bars represent 95% confidence interval. NB the denominator for the rate calculation is the whole population within NHS Lothian or HSCP area.



5.1 Demography of positive cases in test groups

5.1.1 Age and Sex of positive cases in test groups

There was a higher proportion of cases in females compared to males in both the 'Care Home Resident' group (67.1%; n=591), 'Care Home Staff' group (80.1%; n=351) and 'Health/Other Care staff' group (73.4%; n=375). There was no difference in the proportion of positive cases in females compared to males in the general population group (49.7%; n=582).

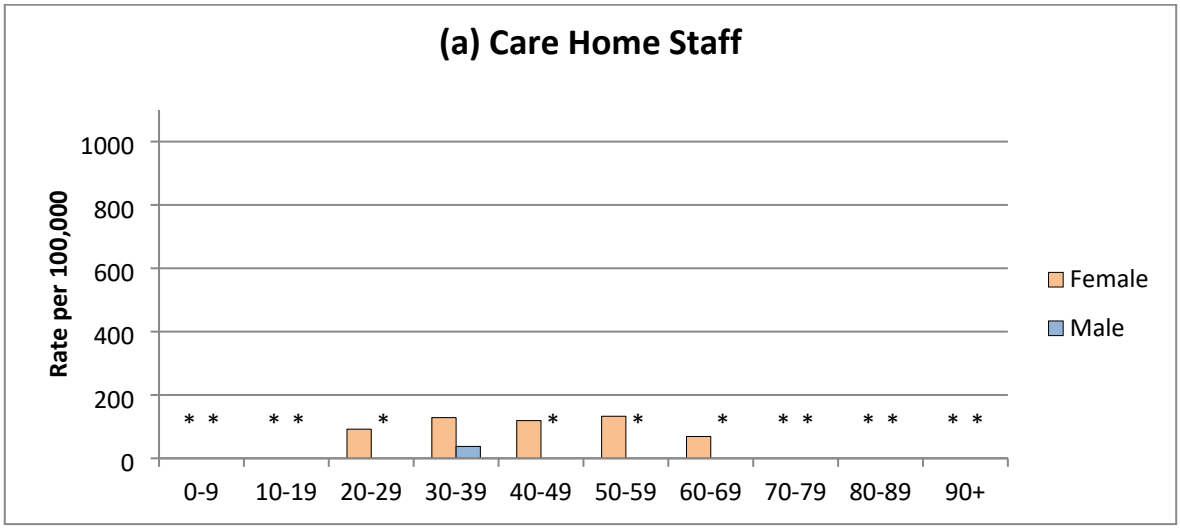
Incidence rates are highest in 'Care Home Staff' and 'Health/Other Care staff' in females aged 50-59 years (Figure 14a and b). Rates need to be interpreted with care as the denominator is the whole population. The low incidence rates in males reflect the low proportion of male staff in the health and care sector.

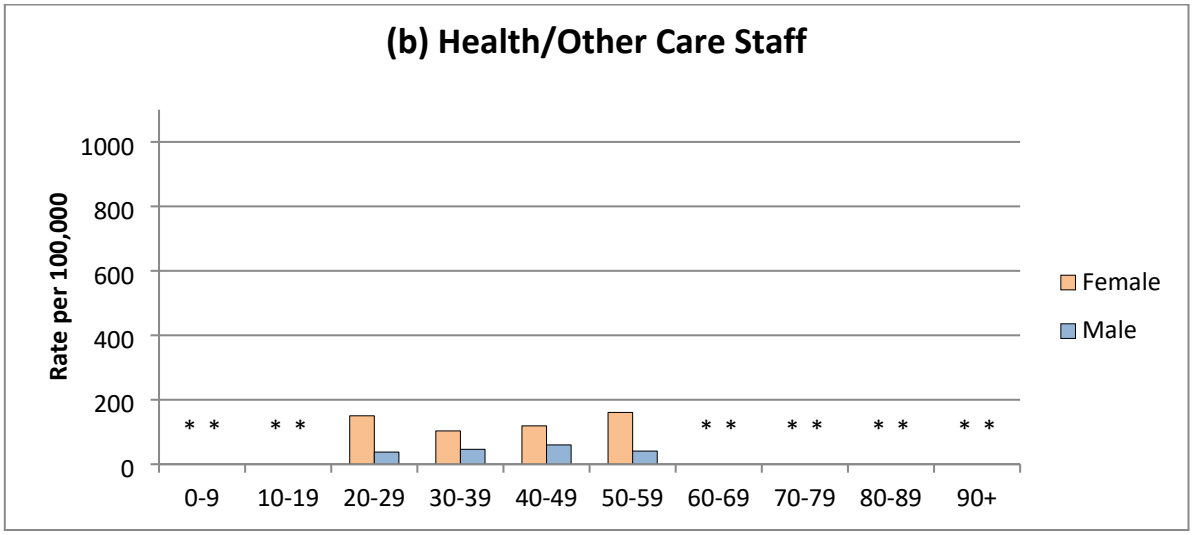
Within the 'General Population' group for those age 70 and older there is a relationship between increasing age and increasing incidence rate both in males and females, with higher rates in males than females (Figure 14c). Incidence rates are higher in males than females in this group from age-band 50—59 years and older. The 'General Population' group is a heterogeneous group including both community testing from the lighthouse and hospital testing of inpatients. The majority of cases 65 years and older were tested in an NHS Scotland lab (98%) and it is therefore likely that the majority of these older cases were those that were admitted to hospital. 42% of cases under 65

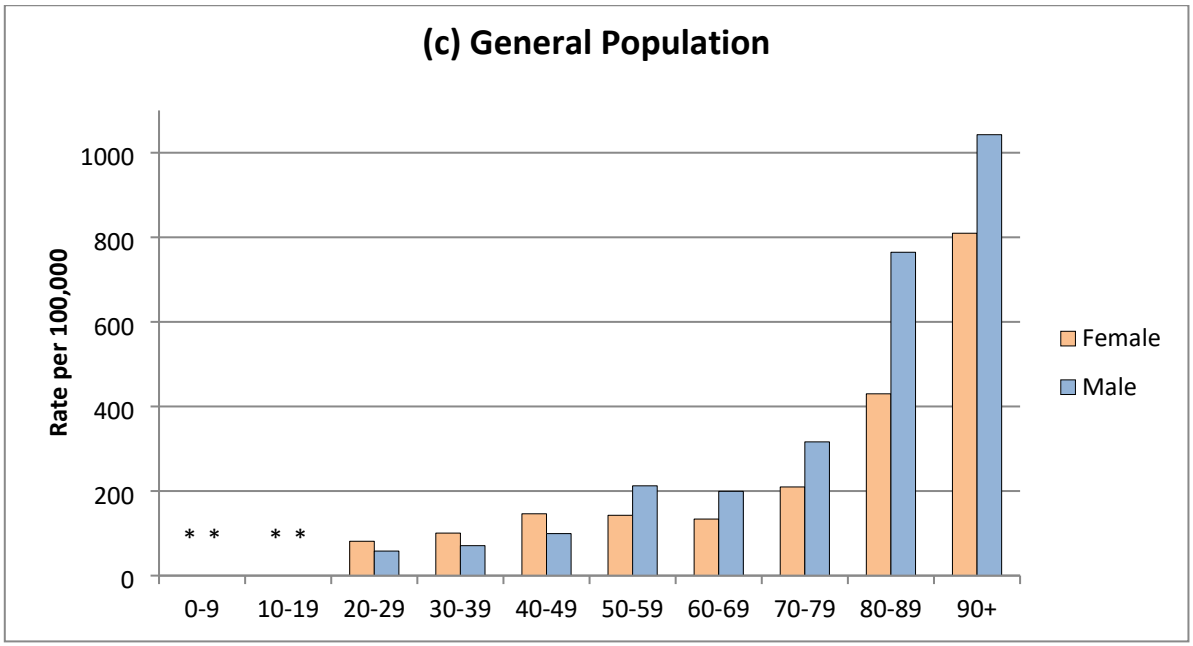
years in the 'General Population' group were tested through the regional test centres and Lighthouse laboratories which were reserved for key workers until the 18th May 2020.

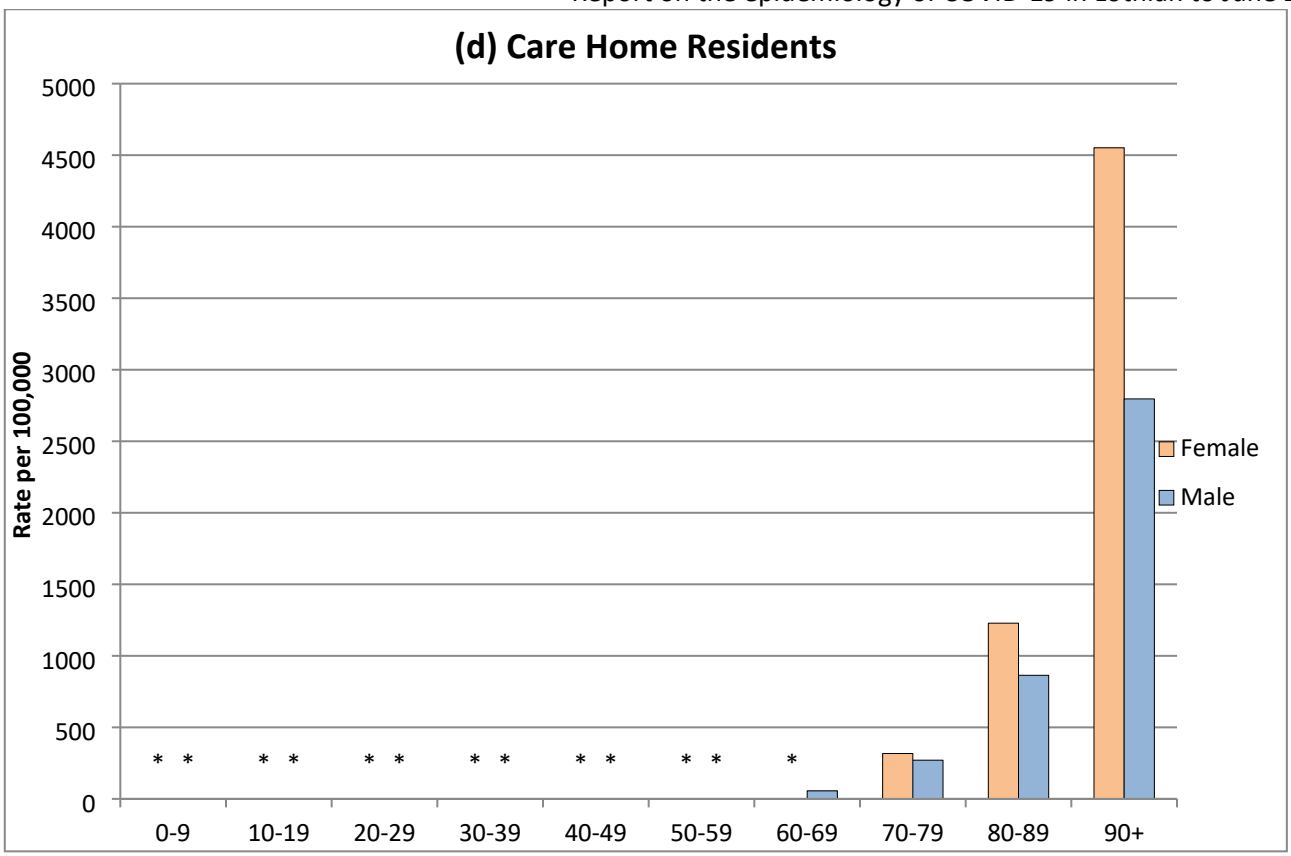
Incidence rates were higher in females than males in care home residents in age-bands 70-79 and older; incidence rates increased with age-bands (Figure 14d).

Figure 14: Age-specific rates per 100,000 (01/03/2020 to 30/06/2020) split by sex in (a) Care Home staff, (b) Health/Other Care staff, (c) General Population and (d) Care Home Residents (*rates for fewer than 20 cases are not shown). NB Due to the very high rates in the age-band 90 years and older, Figure 14(d) has a difference scale on the y axis than Figures 14 a-c.





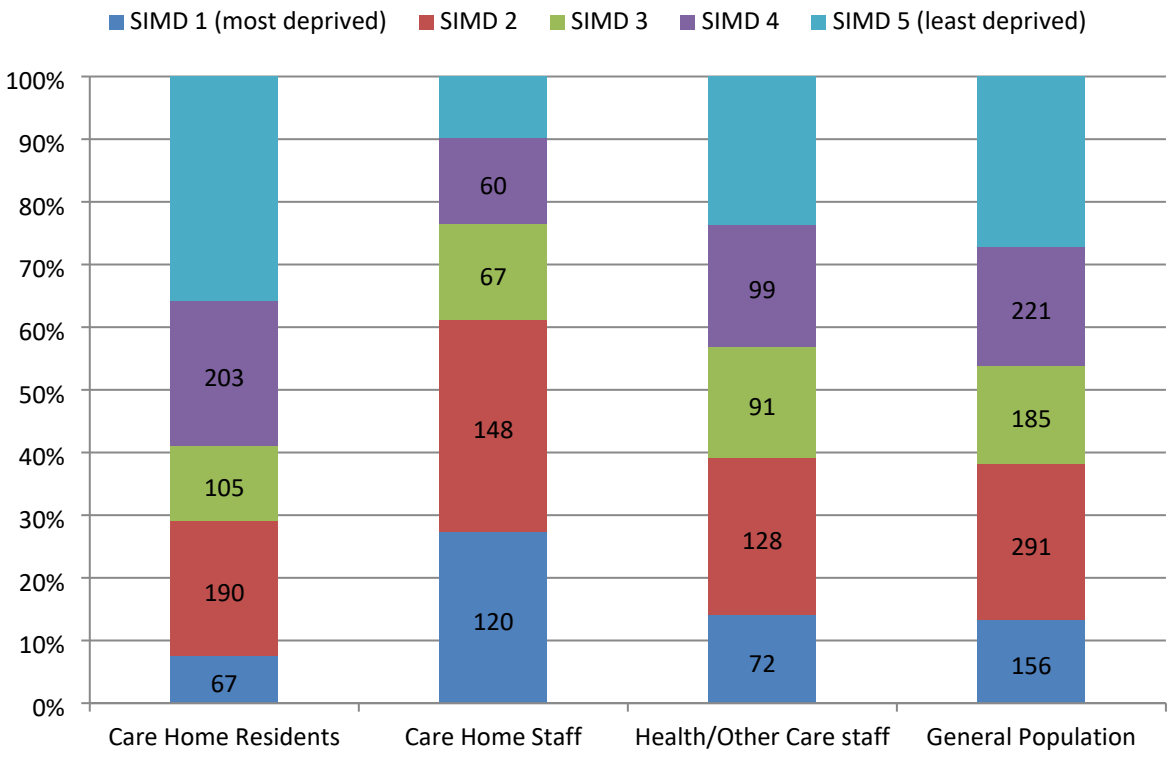



(d) Care Home Residents
Rate per 100,000
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
* * * * * * * * * * * * *
0-9
10-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90+
Female
Male

5.1.2 Deprivation of cases in test groups

The majority of cases (n=268; 61.2%) in 'Care Home Staff' were in people resident in the two most deprived SIMD quintiles (Figure 15). The majority of cases in 'Care Home Residents' were in the two least deprived SIMD quintiles (58.9%; n=519).

Figure 15: Proportion of COVID-19 cases in each 'Test' group by SIMD quintile

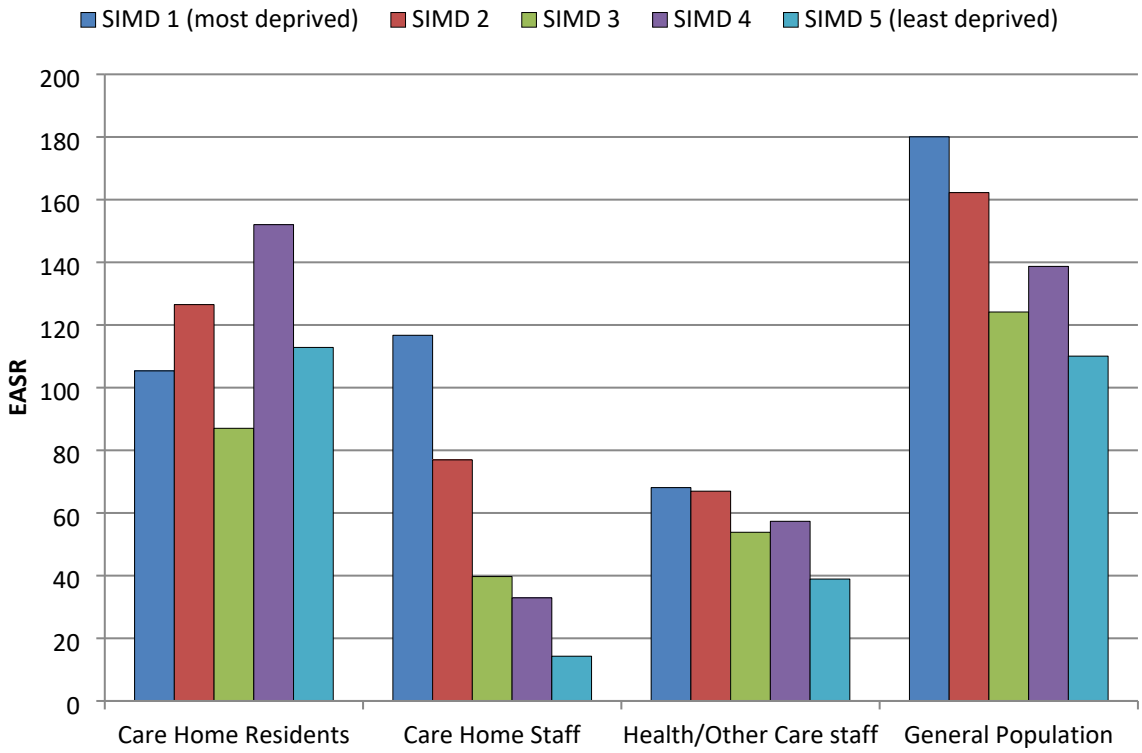


Whilst looking at proportion of cases by SIMD quintile can be misleading due to the population distribution across SIMD quintiles in Lothian, care also needs to be taken when looking at rates for these test groups as we are using the total population as a denominator. It is not appropriate to compare the rates between groups. Within group comparisons should also be made with caution.

'Care Home Staff', 'Health/Other Care staff' and 'General Population' have the highest age-standardised incidence rates in the most deprived SIMD quintile, whereas 'Care Home Residents' have the highest age-standardised incidence rate in SIMD quintile 4. The high rate in care home residents in SIMD quintile four reflects the location of care homes with outbreaks that map to quintile 4. The lower rate in the most deprived quintile likely reflects a lower number of care homes located in SIMD quintile 1 as opposed to a lower incidence rate within those care homes.

'Care Home Staff' show the biggest difference in rates by deprivation, with the rate in the most deprived quintile eight times higher than the rate in the least deprived quintile. However, as the whole population has been used to calculate rates, the high incidence rates in the most deprived quintile likely reflects the high number of care home staff who are resident in these areas.

Figure 16: SIMD quintile-specific COVID-19 incidence European Age Standardised Rate in four test groups (01/03/2020 to 30/06/2020). Rates have been calculated for the four month period and have not been annualised. NB: the denominator uses whole population in each SIMD quintile, as the total number of care home residents, care home staff, health/other care staff resident in each quintile is not known.



5. 2 Have there been changes in the demography of cases over time?

Analysis of weekly COVID-19 incidence rates by age, sex and deprivation shows some changes with respect to demographics of cases over the course of the first four months.

5.2.1 Age and sex of cases over time

Figure 17a and b shows age-specific weekly incidence rates for females and males respectively. Although age groups have been aggregated there are still small numbers in some age groups (0-19 age group is not shown due to low numbers) and across all age groups at the beginning and end of the four month period so comparisons should be made with caution for these periods.

The weekly incidence rate was highest in females aged 80 years and older during all time points between the end of March 2020 and mid-May 2020, peaking week commencing 20th April 2020 (Figure 17a). The incidence rate in the age-band 50-59 years peaked at a much lower rate on the 13th April 2020.

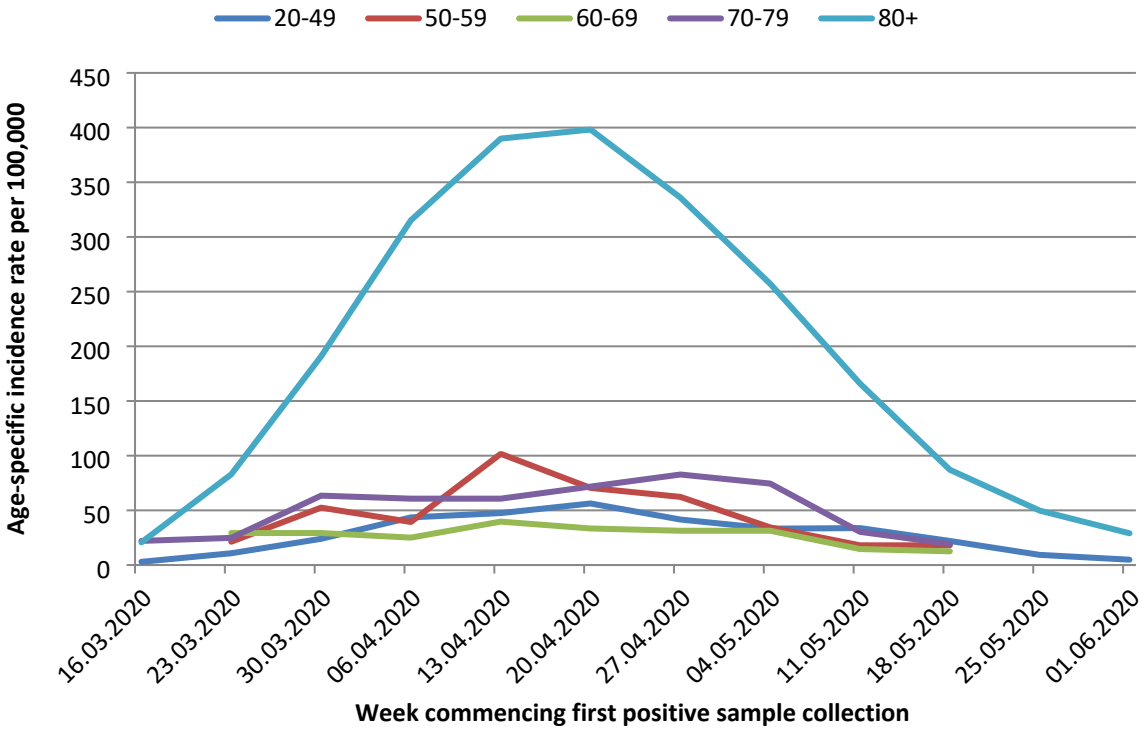
The weekly incidence rate was also highest in males aged 80 years and older during all weeks between the end of March 2020 and mid-May 2020, peaking a week earlier than the equivalent age-band in females during week commencing 30th March 2020 but at a lower rate (Figure 17b). The weekly incidence rate also peaked in males in the 70-79 year age-band during this week.

The test groups analysis in section 5 shows that these differences in time in peak incidence between males and females in the older ages reflect the fact that cases in care homes, where incidence was higher in women than men, peaked later than cases in the 'General Population'. The 'General Population' had a higher incidence rate in older males than females, the majority of which were cases that tested positive on hospital admission.

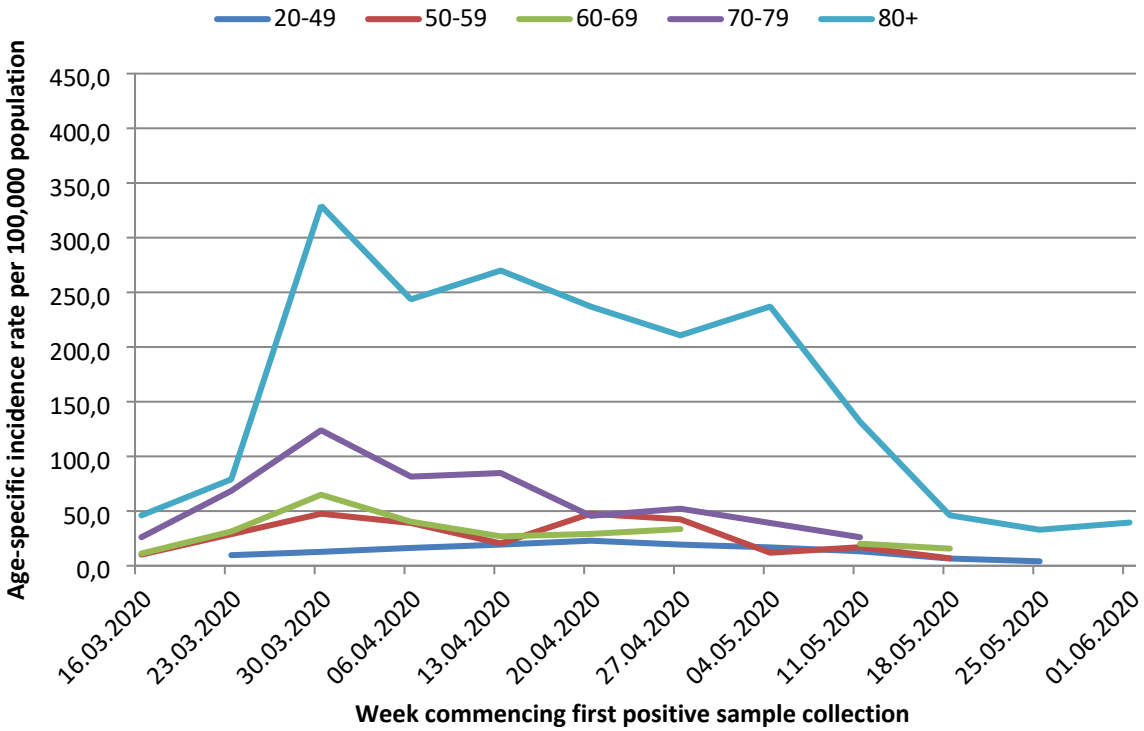
Weekly incidence rate in females of working age was higher throughout the months of April 2020 and May 2020 than in males. Although this was likely influenced by the higher proportions of females in health and care jobs that were eligible for testing, there was also a higher incidence rate in women under 49 years age in the 'General Population' which included people in other key worker roles.

Figure 17: Weekly COVID-19 incidence rate per 100,000 by age group (a) in females and (b) in males. Data for weeks where cases per age group were fewer than 5 are excluded.

(a) Females



(b) Males



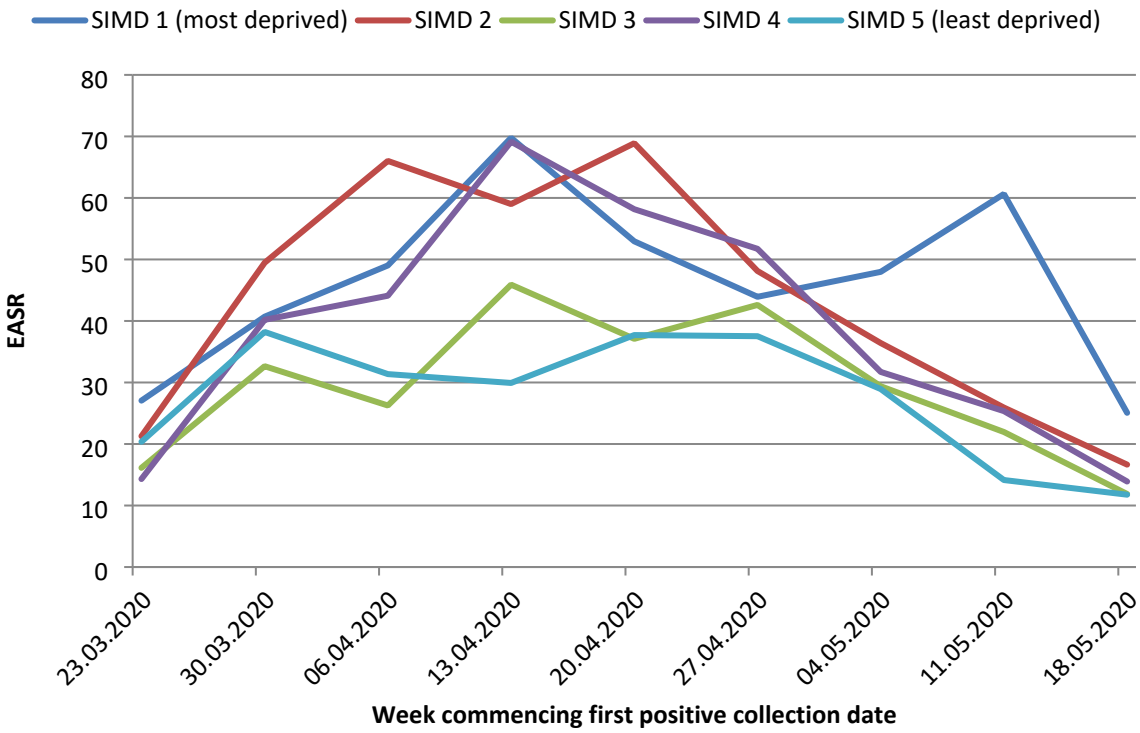
5.2.2 Deprivation and cases over time

SIMD quintile-specific age-standardised rates (EASR) have been calculated for weeks in the four month period where there were sufficient numbers of cases. The incidence rate in the most deprived quintile compared to the least deprived quintile is greater for all weeks from week beginning 23rd March 2020 to week beginning 18th May 2020 (Figure 18a). The difference between the most deprived quintile and the least deprived quintile is greatest week beginning 13th April 2020. The peak in quintile 4 for week beginning 13th April 2020 is likely partly due to cases in care home residents where the care home was located in quintile 4 (section 5.1.2).

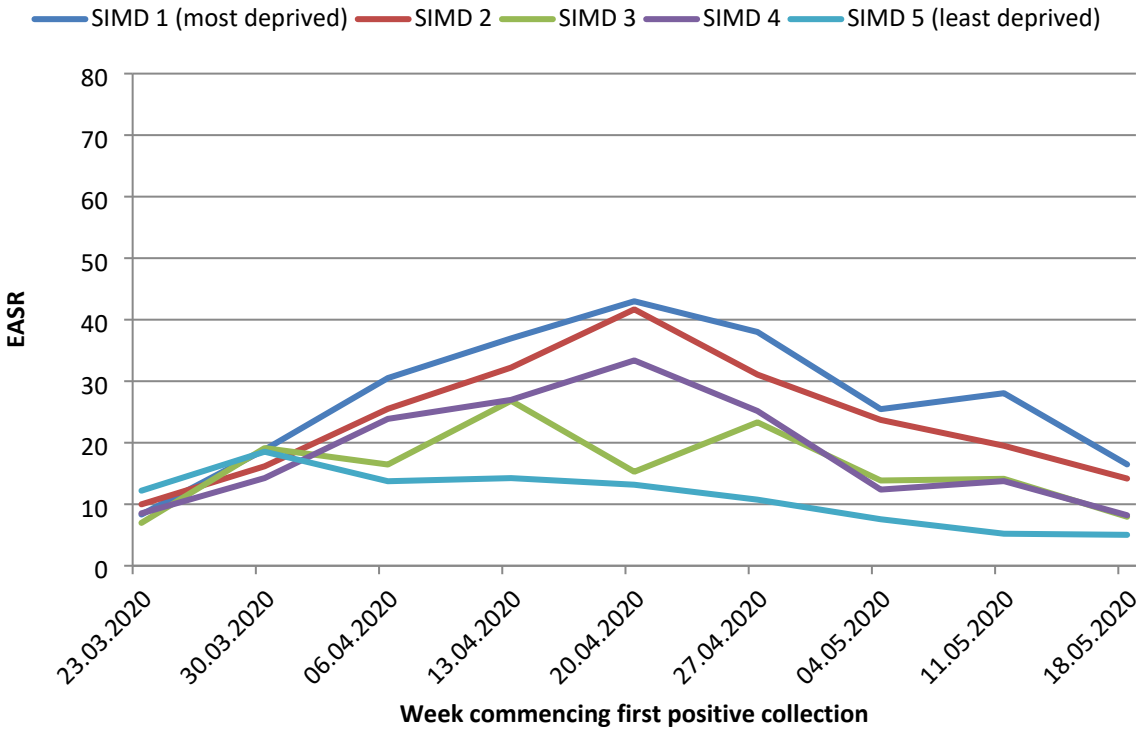
Weekly SIMD quintile-specific age-standardised rates were calculated for the under 65s separately as previous analysis showed there was an inequality gradient in those of working age. Weekly incidence rates for the under 65s are similar for week beginning 30th March 2020 but in subsequent weeks diverge (Figure 18b). The biggest difference between SIMD quintile-specific incidence rates are observed in week beginning 20th April 2020, when the rate in SIMD quintile 1 is more than 3 times the rate in SIMD quintile 5.

Figure 18: Weekly incidence age-standardised rate (EASR) by SIMD deprivation quintile (a) all ages (b) for under 65 years

(a)



(b)



6. Discussion

The COVID-19 incidence described in this report for the first four months of the pandemic (the 'first wave') in Lothian under-estimates the true incidence of the disease due to initially limited testing resources that were targeted towards priority groups. It has been necessary to look at cases within these tested groups to understand the epidemiology of COVID-19 during this period. COVID-19 incidence in children and young people is significantly under-estimated in our data as they were less likely to be eligible for testing when levels of community transmission were at their highest.

COVID-19 incidence in this first phase peaked in Lothian on the 22nd April 2020. However, there were differences in the timing of incidence peaks by testing group. The 7 day rolling average incidence of first positive cases by test group show that cases in the general population (severe cases requiring hospital admission) peaked first at the end of March 2020, followed by later peaks in health care workers and care home staff (20th April 2020) and a later peak in Care Home Residents on the 22nd April 2020.

Across Lothian, approximately one third of all positive cases during this first phase were in health and care workers and care home staff (32%), with just under a third in care home residents (29%). There were serial outbreaks in Care Homes between mid-March 2020 and end of June 2020 with positive COVID-19 cases in over one-third (37%) of care homes across Lothian.[13]

Differences in COVID-19 incidence were observed between the Health and Social Care Partnership areas both with respect to incidence rates and patterns of incidence. Midlothian HSCP had a significantly higher COVID-19 incidence rate in the first four months of the pandemic than the other HSCP areas and had previously been the subject of further investigation to explore possible reasons for this. [14] We included analysis by HSCP area, where possible, in this report to contribute to understanding why differences may exist between the HSCP areas. However, it is important to note that the data presented in this report pertains to place of residence only and not necessarily place of exposure. People may work in different HSCP areas than they are resident and we do not have data for those who work in Lothian and live out-with the health board area.

Whilst differences in incidence rates between HSCPs may reflect differences to some extent in case ascertainment (Midlothian had a higher testing rate) they also reflect a real difference in incidence (Midlothian had a higher proportion of tests that were positive). There was a higher incidence rate in all key test groups in Midlothian than in the other HSCP areas. Outbreaks in care homes have contributed significantly to the high incidence rates in Midlothian. Further work using viral genome sequencing is ongoing to better understand the early transmission of COVID-19 across Lothian.

Office for National Statistics (ONS) estimates for those considered potential 'key workers' to the COVID-19 response showed very little variation between local authority areas within Lothian (from 32% of the population in West Lothian to 33.6% in East Lothian).[15] However, it is still possible that there was variation by occupation group between areas which may have resulted in increased exposure/access to testing within the population.

There are clear demographic differences in COVID-19 incidence, with respect to age and sex. Some of these differences are due to differences in access to testing. Rates are higher in females than

males in all age-bands up to (and including) age 50-59 and in those aged 85 and older. In both sexes there is a strong relationship between increasing incidence rates and age in people aged 65 years over. This relationship of older age and incidence results both from case ascertainment (testing of older people admitted to hospital with more severe disease) and exposure (outbreaks in care homes). The higher incidence rate in working age females also reflects both case ascertainment (more likely to be in roles where they could access testing) and exposure through work in health, care and other key worker roles during the lockdown period. The Office for National Statistics estimated that 58% of those considered potential 'key workers' in response to COVID-19 were female, though this varied by occupation group with 79% of health and social care workers estimated to be female.[15] It is also possible that women may be more likely to seek testing for symptoms than men.

Although age-specific incidence rates are higher overall in females than males aged 85 and over, the rates are higher in males than females for these age groups in the 'General Population' group likely reflecting that a greater proportion of males than females were admitted to hospital in these older age-bands. Conversely, rates were higher in females than males in care homes in these older age-bands. However, as the total population was used as the denominator for these rates and not just care home resident population (which we do not have access to at patient level) then this may reflect the higher number of females than males in the care home population.

There was strong evidence of inequalities in COVID-19 incidence in Lothian, with significantly higher incidence in the most deprived SIMD quintiles compared to the least deprived SIMD quintiles. An inequality gradient was seen across all the test groups apart from 'Care Home residents', which had a higher incidence rate in SIMD quintile 4 due to the location of care homes with large outbreaks. The divergence in incidence rates between the most and least deprived quintiles in people of working age as the pandemic progressed is perhaps not surprising. Genetic sequencing suggests COVID-19 was initially introduced to Scotland by people returning from holidays abroad. [(10)] However, after lockdown was introduced, rates in the most deprived quintile increased whilst those in the least deprived quintile decreased. Again this will, in part, reflect differences in case ascertainment (it was mainly those in health and care and other key worker roles who had access to community testing at the height of the pandemic) but also increased exposure of people in low paid key jobs which could not be undertaken from home.

Testing capacity increased significantly over the course of the four months and COVID-19 tests are now open to anyone experiencing symptoms (although it is possible barriers to access may still remain). Analyses of cases from July onwards will therefore better reflect COVID-19 incidence in the Lothian population and will be reported on in due course.

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November 2020

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Acknowledgements: With thanks to Kate Mark, Janet Stevenson and Jim Sherval for their input and comments on the draft report.

Additional data

For analyses where only rates have been shown in the report, additional data tables are available on request.

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Appendix 1

Timeline of key events relevant to management of COVID-19 pandemic up to June 2020

Dates relating to COVID-19 testing are highlighted in blue

Date	Events
31/12/2019	World Health Organisation (WHO) informed of a cluster of pneumonia cases of unknown cause in Wuhan City, Hubei Province, China
12/01/2020	Novel coronavirus found in samples from cases; initial viral genetic sequence analysis suggested this was the cause of the outbreak
20/01/2020	China confirms human to human transmission of SARS-like illness
22/01/2020	Health Protection Team (HPT) notified of first possible case of COVID-19; possible cases sampled in Regional Infectious Diseases Unit (RIDU) and samples sent to Colindale laboratory for testing
23/01/2020	Health Protection Scotland (HPS) first issues guidance on novel coronavirus for Health Protection Teams; self-isolation advice for people returning from high risk areas
25/01/2020	First of a series of NHS Lothian preparedness Incident Management Teams (IMT) (Health Protection Team (HPT) chair)
30/01/2020	WHO declares Public Health Outbreak Emergency of International Concern
31/01/2020	First UK cases confirmed in York
06/02/2020	Community outreach testing starts in Lothian initially by the Regional Infectious Diseases Unit (RIDU) staff with Lothian Unscheduled Care Service (LUCS) driver
07/02/2020	Public Health England (PHE) novel coronavirus diagnostic test rolled out across the UK
25/02/2020	Updated self-isolation advice to travellers returning from Wuhan & Hubei; Iran; areas of Northern Italy under containment measures who returned after 19 Feb; and Daegu & Cheongdo, South Korea
28/02/2020	Drive through community testing service starts at Western General Hospital (WGH)
03/03/2020	First confirmed case in Scotland admitted to RIDU, returned from Italy
06/03/2020	First confirmed case in NHS Lothian resident
10/03/2020	High risk countries in PHE guidance updated to include **all** travellers from Italy returning on or after 9 March to self-isolate
11/03/2020	WHO Director General declares a pandemic due to the rapid increase of cases outside China
12/03/2020	Contact tracing stopped in UK; UK moved from containment to delay phase
16/03/2020	Social distancing announced, household contacts required to self-isolate
17/03/2020	Shielding announced by Scottish Government (SG) at First Minister Briefing
20/03/2020	Schools in Scotland closed
23/03/2020	Lockdown implemented by SG/UK Government
23/03/2020	Community COVID Hubs operational in Lothian
25/03/2020	Occupational Health Staff (OHS) testing site opened at WGH, 6 days /week Adults and children testing available, 9-5pm
02/04/2020	Staff testing expanded and moved to Chalmers site – adults and children, 9-7pm, 7 days week
08/04/2020	GPs allowed to book an appointment for patients at F2F assessment centre by phoning community COVID hub
09/04/2020	Outreach testing for symptomatic residents in closed /shared settings through OHS begins

Date	Events
12/04/2020	Outreach care home symptomatic resident testing through OHS begins
13/04/2020	Testing of patients at community COVID F2F assessment centres begins
16/04/2020	Drive through testing at Edinburgh Airport (UK Government Regional Testing Centre) opens
17/04/2020	Scottish Government policy shift from testing first few symptomatic residents in a care home to testing all symptomatic residents
20/04/2020	West Lothian staff testing site opened through OHS
21/04/2020	Routine testing of all care home patients on discharge from hospital begins
22/04/2020	Lighthouse Lab based at Glasgow University became operational (for UK government regional testing centres)
23/04/2020	OHS Questionnaire implemented in TRAK to collect data on Job Family etc for OHS testing service
29/04/2020	Screening of inpatients aged 70 years and over on admission and every 4 days
01/05/2020	Routine tests for Residents and Staff in Care Homes where cases of COVID-19 identified - Enhanced Outbreak Response (OHS)
01/05/2020	Surveillance testing in Care Homes without COVID-19
01/05/2020	SG announced that symptomatic people aged 65 years plus, or workers who cannot work from home (and their households) could access testing through the regional testing centres.
11/05/2020	Once a day exercise limit is removed
18/05/2020	Anyone aged 5 or over with symptoms is eligible to be tested through UK government regional testing centre
29/05/2020	Lockdown eased - people from 2 different households can meet outdoors as long as in a group of 8 or less
28/05/2020	Test and Protect rolled out in Scotland across Boards from this date
18/06/2020	Routine Care Home Staff Testing Programme - weekly testing of asymptomatic staff begins
22/06/2020	Face coverings made mandatory on all public transport in Scotland.
22/06/2020	Dentists reopen for patients in need of urgent treatment
29/06/2020	All staff in hospitals and care home who interact with patients or residents required to wear a medical face mask throughout their shift
29/06/2020	Non essential retailers reopen in Scotland

Appendix 2

Definitions

Positive cases

Positive Case - when lab result ZWUPC2 = 'POS' (iLabs data)
or LAB_TEST_RESULTS_DESCRIPTION = 'POSITIVE' (Lighthouse data)

First Positive Collection Date – first 'collection date' for an individual where result is positive (iLabs data) or first 'test start date' for an individual where result is positive (Lighthouse data).

First Positive Case – positive case where collection date is the First Positive Collection Date

Testing Groups

Care Home Resident – This involves a match to the list of CHIs identified through a labs identifier and a postcode, address and key word matching process which is updated every day (this is not a perfect process)

Care Home Staff – A combination of results from completion of OHS questionnaire, CHI numbers from early tests know to be for Care Home Staff, when 'ROLE_IN_CARE_HOME' = 'Staff' (Lighthouse data) or when the test is identified as having been from a care home via 'TEST_CENTRE_ID' = 'CHO' (Lighthouse data) or via one of the NHS test routes (CHST, EOR, EOR2, CSS) but a Care Home Resident is not identified from the above 'Care Home Resident' process

Health/Other Care Staff - A combination of results from test location code where the location is a reserved staff testing clinic (C19SCOP, TEMPMIU, COVCD) and completion of OHS questionnaire (this is not a perfect process because some other person types have sometimes been through these routes).

General Population – The remainder not identified by any of the 3 processes above. Includes household contacts of NHS staff tested through staff testing clinics and where identified as a household contact.

Scottish Index of Multiple Deprivation (SIMD)

The Scottish Index of Multiple Deprivation (SIMD) is an area based relative measure of deprivation across seven domains: income, employment, education, health, access to services, crime and housing. Small areas (datazones) are ranked from most to least deprived. In our analysis we have used SIMD quintiles, where SIMD quintile 1 is the 20% most deprived datazones in Scotland and SIMD quintile 5 is the 20% least deprived datazones in Scotland.

Analysis

Crude rate per 100,000

NRS mid-year population estimates 2019 were used to calculate the crude rate for the NHS Lothian population and HSCP populations per 100,000. The **crude rate** is calculated as follows:

Number of NHS Lothian first positive cases / NHS Lothian population estimate x 100,000

Cumulative crude rates for the 4 month period 1st March to 30th June 2020 use the total number of first positive cases in the 4 month period as the numerator. **7 day incidence rate per 100,000** is calculated using the sum of first positive cases over the previous seven days as the numerator.

Age-specific rates

Age-specific rates uses NRS mid-year population estimates 2019 for NHS Lothian and each HSCP broken by 5 year age groups (0-4, 5-9, 10-14, etc). The calculation for each age group is still per 100,000. In this report, cumulative rates for the 4 month period 1st March to 30th June 2020, or weekly rates have been calculated (using cases in a 7 day period). Age-specific rates have not been annualised in this report. **Age-sex specific rates**

Age-sex specific rates uses NRS mid-year population estimates 2019 for NHS Lothian and each HSCP by age group and gender. Rates are still per 100,000 for each gender and every age group.

Direct standardisation

The **European Age Standardised Rates** (EASR) calculate a rate which would have been found if the population of NHS Lothian and each HSCP had the same age-composition (proportion of total population in each five year age group) as a hypothetical European population, known as the European Standard Population (ESP 2013).

Age standardised and age-sex standardised rates were calculated using the ESP 2013.

Age standardised rates were calculated for each SIMD quintile (quintile specific age-standardised rates) using the ESP 2013. SIMD 2020 and Scotland level quintiles were used for deprivation analysis.

In this report, standardised rates have been calculated for the four month period from 1st March to 30th June 2020 using the cumulative number of first positive tests during this period. Standardised rates have not been annualised. An annualised rate is a rate that has been calculated for part of a year and is adjusted to make it comparable with an annual rate i.e. the rate for the whole year. Standardised rates are usually assumed to be annual rates. However, rates have not been annualised in this report as there is no annual rate to compare COVID-19 incidence to yet. Rates have been standardised to allow comparisons across areas with different populations or across SIMD quintiles for the four month analysis period 1st March 2020 to 31st June 2020.

Testing rates

Testing rate is based on the total number of tests (positive and negative) and includes repeat tests in individuals (such as care home staff and residents in care home outbreaks and screening of inpatients aged 70 years and over).

Test positivity rate/Percent positive

Test positivity rate (the percentage of positive tests) were calculated for all tests except repeat positive tests.

Exclusions from analysis: Cases missing CHI, date of birth, and postcode (n=14) and postcode only (n=17) were excluded from the analysis.

Laboratory Testing in Scotland

Testing for Covid-19 was developed for diagnostic use in February 2020. It is a RT-PCR (Real Time Polymerase Chain Reaction) test, requiring the extraction of RNA and then amplification/identification as Covid-19. The RNA is collected through swabbing patients (nose, throat or a combination), or via sputum, blood, urine or faecal samples. Test results are reported as either POSITIVE or NEGATIVE depending whether virus is detected. It should be noted that testing must be performed within a certain time of the sample being taken, otherwise the test is VOID. The term 'testing' is in fact misleading in the context of Covid-19 - there are in fact two phases: the 'sampling' of patients, and the subsequent 'analysis' or 'processing' of this sample.

With regards to processing, there are two strands in Scotland: NHS and non-NHS. Analysis of samples by the NHS was initially established in Glasgow and Edinburgh, but has since been rolled out to other Health Boards. It is performed in hospital laboratories alongside routine diagnostic work by Healthcare Professions Council (HCPC) registered Biomedical Scientists (BMS), in UKAS accredited laboratories.

Within Lothian, NHS analysis is performed in Royal Infirmary Edinburgh and two 'partner nodes' – Institute of Genetic and Molecular Medicine (IGMM - Edinburgh University) and Scottish National Blood Transfusion (SNBTS – Jack Copland Centre). Both SNBTS and IGMM analysis is subject to the strict quality guidelines of Lothian laboratories. Further 'partner nodes' might be established in the future, using both academic and commercial labs.

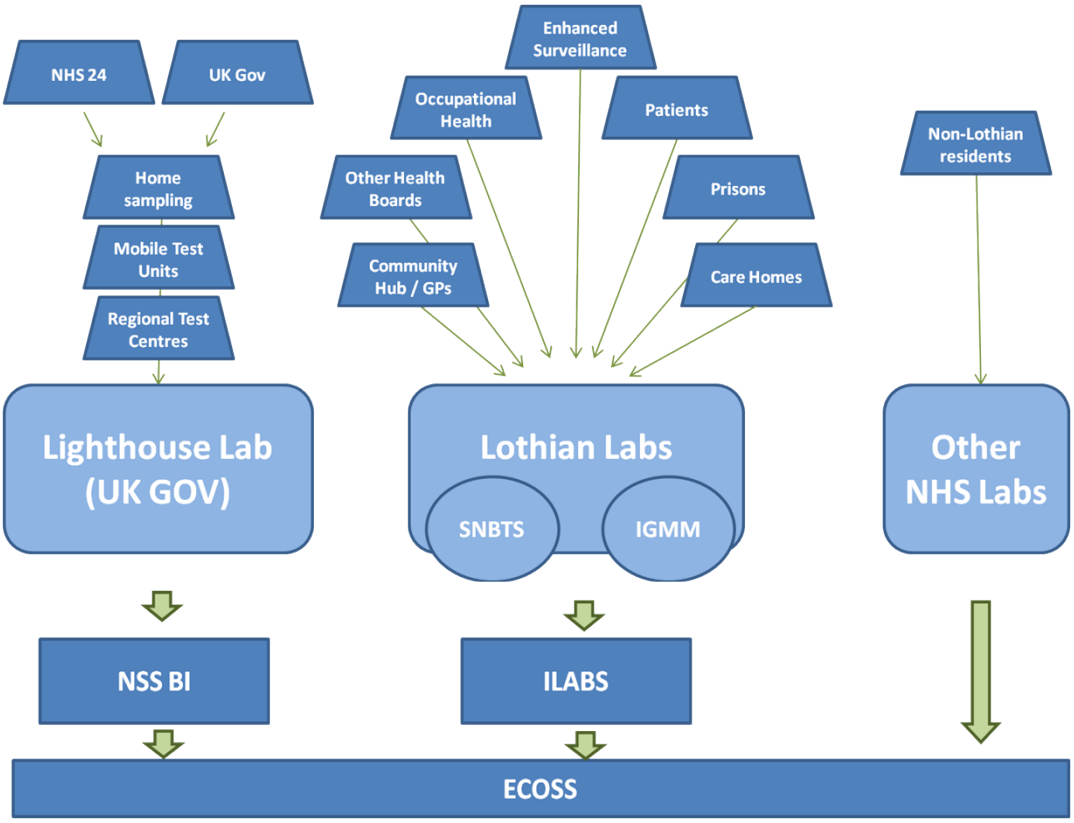
The UK government has established three non-NHS laboratories to support testing of Covid-19 throughout the UK – Milton Keynes, Cheshire and Glasgow – called 'Lighthouse Laboratories'. These are not bound by UKAS accreditation nor use state registered Biomedical Scientists. However Glasgow Lighthouse Laboratory's development has been closely supported by the NHS, and is a partnership between the Department of Health and University of Glasgow.

Lighthouse Laboratory processes samples taken at 'Regional Testing Centres' (such as Edinburgh Airport) established throughout Scotland in addition to 'Mobile Testing Units' and home-testing kits. These tests are generated from patients visiting 'UK.gov' website, and include patients who have contacted NHS 24.

Data from the Lothian laboratory analysers (including from SNBTS and IGMM) is passed into APEX, which is the Laboratory Information Management System (LIMS). A similar process is in place for other NHS Health Boards, although APEX is not the LIMS used throughout Scotland. APEX data is routinely downloaded into TRAK, but only where the patient already has a TRAK record (linked by CHI). It is also downloaded into an 'ILabs' extract which LAS received hourly.

The Lighthouse laboratory data is downloaded into NSS Business Intelligence daily at 10pm.

Positive results from ILabs (together with data from other Health Boards), is collated into ECOSS. Lighthouse lab data will also collate into ECOSS.



Lothian Oracle Datasets

Currently LAS deploys an Oracle 12c database which gives analysts access to TRAK (and other) data in a controlled, structured, consistent & timely manner. Access to the database can be made via any ODBC enabled software, eg, R, SPSS, MS Access, MS Excel, but the recommended route is via Oracle SQL Developer – an integrated development environment for Oracle products – it comes "shipped" with an Oracle database installation.

The testing data in this report was sourced from a locally produced Oracle view - COVID19.ILABS_LIGHTHOUSE_RESULTS_V which combined data from iLabs data (via reports produced by lab staff) and Lighthouse (via the national BI reporting system).

NHS LOTHIAN

Board Meeting
9th December 2020

Chief Officer, Acute Services

SCHEDULED & UNSCHEDULED CARE PERFORMANCE

1. Purpose of the Report

1.1 To update the Board on performance for Scheduled Care standards: New Outpatient (OP), Treatment Time Guarantee (TTG), Diagnostic key test and 31 & 62 Day Pathway Cancer pathways; and the Unscheduled Care 4EAS and Delayed Discharge Standards. Any member wishing additional information should contact the Executive Lead;

2. Recommendations

Board Members are recommended to:-

2.1 **Acknowledge** the impact of the first and second waves of Covid on OP, TTG and Diagnostic performance. The reintroduction of services and screening has not impacted cancer waiting times performance significantly, although some diagnostic capacity remains reduced. Please see 3.4, 3.5 and Appendices 1 & 5;

2.2 **Take limited assurance** that remobilisation actively underway will mitigate growing volumes of long wait patients for scheduled care and cancer services, against proactively dealing with a Covid second wave, winter activity and a known backlog of patients from the first wave of cessation of routine activity, impacting on over 52 weeks in January 21. Please see Appendices 1-3;

2.3 **Acknowledge** that 57.4% of patients were seen within the Treatment Time Guarantee (TTG) in September 20. Provisional management information indicates that 8,940 inpatients were waiting longer than 12 weeks by the end of October 20.
.

2.4 **Acknowledge** that 4 hour Emergency Access Standard performance is 89.5% for October 20. Further performance data is shown in Appendix 6.

2.5 **Recognise** that NHSL is prepared for the second phase of the national redesign of urgent care programme. Please see 3.8.

2.6 **Recognise** that while the number of delayed discharges have increased since April 2020, numbers are still historically low for Lothian. HSCPs continue to work with acute colleagues to improve discharge planning, transfers of care and embedding Home First approach to reduce number of delays and associated occupied bed days.

3. Discussion of Key Issues

3.1 A Scheduled Care Board has overseen Remobilisation since August 20. Outpatient demand remains lower than pre-Covid but capacity has also reduced due to physical distancing and infection prevention and control guidance. Activity has increased month on month since April (by 104% from April to September), and has stabilised at September

level in October. Management information indicates the number of Urgent new outpatient appointments (>4,600) in October has exceeded pre-Covid levels in February. Urgent Suspicion of Cancer outpatient appointments (>1,000) are higher than in February and exceed those in October last year (1,040), demonstrating the continued focus on managing the most urgent referrals. Despite this increased activity there has been an increase in the number of patients waiting over 4 weeks for an Urgent Suspicion of Cancer new outpatient appointment has increased by 271% from 119 to 441 from March to October, but the number waiting over 12 weeks for an Urgent new outpatient appointment has over halved (-56%) from 3,627 to 1,587 since May.

3.2 Mitigations for reduced face to face capacity include optimising virtual care such as telephone & video consultations. Demand management including active clinical referral triage, patient initiated follow up, opt-in programmes, advice only, patient-focussed booking and RefHelp updates.

3.3 Surgical and diagnostics capacity remains focussed on urgent, cancer and priority 2 patients i.e. those requiring surgery within 4 weeks. Inpatient and daycase surgical activity is aligned to critical care and elective bed capacity. Due to pressures on acute beds, very specifically at RIE we have had to reduce the number of elective beds to accommodate unscheduled flow. Dedicated orthopaedic elective bed numbers have reduced from 25 to 0, resulting in 150 routine procedures being cancelled. The site have implemented a small number of protected elective beds to maintain cancer and urgent activity. Theatre availability is maintained at 90%. Activity remains constrained due to increased turn-around time for infection prevention measures.

3.4 Cancer performance remains an area of significant focus but September saw deterioration in both 31 and 62 days performance, with an oversight board and the reinstatement of weekly MDT pathway tracking meetings. Performance for Urology performance, one of the largest tumour groups decreased slightly for the 31 day pathway but improved for the 62 day pathway. Prostate and Bladder pathways will benefit from an additional robot that will be sited at SPiRE, scheduled to start in December. It is anticipated this additional capacity will support reduction bladder cancer backlog and reduce the Robot Assisted Prostatectomy waiting list.

3.5 Endoscopy diagnostic activity remains lower than pre-Covid levels at </=6 patients per session, due to physical distancing measures and PPE. Endoscopy mobilisation plans include increased capacity in Leith Community Treatment Centre, a fourth room at WGH and expansion of sessions at East Lothian Treatment Centre. In addition the Regional Endoscopy Unit (QMH) access has recommenced, increasing capacity for high risk surveillance, routine patients waiting >52 weeks and Urgent/ Urgent Suspicion of Cancer patients. NHS Lothian October Endoscopy Service capacity is 61% of that pre-Covid. The Faecal Immunochemical Test (qFIT) is being used to prioritise patients appropriately, with patients reporting a high qFIT being expedited for investigation. Active criteria-led triage for upper endoscopy has been embedded, along with ongoing active clinical triage referral for surveillance queues. National Bowel screening recommenced on 12/10/20.

3.6 Core capacity to clear Radiology backlog and resume pre-Covid diagnostic and interventional capacity is being impacted mainly by extended timescales for cleaning regimes and vacancies and absences within key staffing (particularly radiography and ancillary support staff). Core rotas are being sustained within radiography but our ability to run *additional* capacity is being impacted. Radiology is demonstrating improved performance against Ultrasound, MRI and CT scanning wait lists, with trends

demonstrating continued and sustained performance from late Spring. In addition, external provision of CT and MRI is being sourced from local providers. Recruitment is progressing to increase workforce, to extend core scanner capacity at the DCN/RHCYP, RIE and SJH.

3.7 For Unscheduled care, the national redesign of urgent care programme is accelerating to improve access to urgent care pathways so people receive the right care, in the right place, at the right time. This will be achieved by:

- clear and concise public and staff information;
- access and triage through a national single point of access (111) 24/7;
- implementation of a flow navigation centre in each NHS board;
- optimising technological solutions for urgent care needs;
- & scheduling attendances for urgent care.

The first phase has been aimed at reducing and smoothing self-presenter attendance demand at acute hospital front doors, to reduce overcrowding and protect the public, patients and staff. Access to emergency care will remain unchanged but it is estimated that around 20% of people currently accessing care at acute front doors could receive the care they need at home, or closer to home. A new 24/7 pathway for urgent care, via a national single point of access provided by NHS24 on 111, will also encourage people who are not in need of immediate emergency treatment to get a clinical assessment by phone prior to travelling to a Minor Injury Unit or Emergency Department. Those patients who NHS24 determine need further clinical consultation will be referred to a local flow navigation centre to provide further assessment through virtual or face-to-face consultations in as scheduled a way as possible. A pathfinder board is testing the new urgent care pathway with NHS24 over November, with the aim to learn from this to inform the planned national roll-out from 1 December 2020.

3.8 The second phase will include improving professional (GP, SAS clinicians etc.), referral into same day community, and secondary care services, that will provide care closer to home and reduce hospital attendances and admissions. This phase will be progressed throughout the winter period with the principal aim of improving accessibility of same day services with an agreed response time.

3.9 The project is on track to meet the national timescale, with the expanded NHS Lothian Flow Centre being at full staffing including administrative and nursing staff 24/7 from 1 December, in readiness for the national move to NHS24 acting as a single point of access for patients normally self-presenting to ED or MIU. The Flow Centre will schedule patients into virtual or face-to-face appointments for minor injury assessments across the adult acute sites, and provide time-zones for patients to attend SJH or RIE EDs. To scale up our existing Call MIA pilot the Flow Centre took on public facing telephony from 2 November, in readiness for the wider roll out from 1 December. National messaging (planned for January 21) will build on existing winter campaigns, and include core narrative to guide and reassure. While the aim is to reduce patients self-presenting to EDs and MIUs, the emergency pathway for life-threatening injury or illness remains unchanged.

3.10 The RIE is the main driver of current unscheduled care performance (86.7%) due to a combination of managing activity through red and amber pathways and high occupancy levels. Improvement actions in addition to RUC, include weekly and daily debriefs, a joint length of stay reduction plan within medicine for the elderly with Edinburgh HSCP colleagues, inter-site transfer pathways and an ED improvement plan focussed on processes and reducing variability.

4. Key Risks

4.1 There is unknown risk for patient outcomes due to the impact of Covid on lengthening waiting times, reduced referral rates, delayed diagnosis/treatment and patient choice in not attending appointments, particularly where virtual care is not suitable.

4.2 Risks to scheduled care performance due to reduced capacity which is focussed on clinically prioritised care extending waits for routine demand. There is reduced access to our annual Golden Jubilee National Hospital allocation and independent sector and insource provider capacity. The requirement for Covid and non-Covid pathways, physical distancing, PPE and cleaning regimens, are all reducing capacity.

4.3 There is a risk to 4 hour EAS performance due to increasing unscheduled care demand whilst maintaining Covid and non-Covid pathways, increased elective activity and winter demand delayed discharges increase.

5. Risk Register

5.1 Corporate risk IDs 4191 (That patients will wait longer than described in relevant national standard & associated clinical risk); 3211 (That NHS Lothian will fail to achieve waiting time targets for inpatient/day case and outpatient appointments); 3203 (4-hr Target (Organisational)), and 4688 (4 Hour Emergency Access Standard (Patient)) reflect Covid.

6. Impact on Inequality, Including Health Inequalities

6.1 Capacity restrictions and waiting list delays may impact patient groups differentially. Covid's health impact will be reviewed within future public health work. The move to virtual healthcare could increase the 'digital care divide' for vulnerable groups with limited technology access. The development of new services e.g. monitoring services enable patients to have care closer to home, reducing travel, parking & time costs to attend an on-site appointment. Virtual clinics can also facilitate care. An equality impact assessment is being undertaken to mitigate potential negative impacts and a report will be completed in mid-December.

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

7.1 Public communications/ engagement events are ongoing & will inform models developed.

8. Resource Implications

8.1 Estimated additional costs associated with updates in this paper have been included within Quarter 1 submissions to the Scottish Government in Aug/Sept 2020. Specific proposals are considered through existing governance routes, or the Gold Command structure for rapid, tactical decisions. Following Mid-Year Review an updated forecast will be reported to the Board and Scottish Government through the financial planning

process.

Jacquie Campbell
Chief Officer, Acute Services
26th November 2020

Appendix 1 – Covid Impact on Performance

As part of the first wave of Covid and in line with Scottish Government requirements NHS Lothian ceased all non-urgent elective activity from 16th March this year. By the peak of the pandemic 72,000 outpatient appointments and 3,000 inpatient & day case procedures had been cancelled, resulting in a significant backlog.

This along with the impact of a Covid second wave, continued reduced capacity, and increased staff absence due to sickness or isolation, means that provisional information indicates there were 34,344 patients waiting longer than 12 weeks for first new outpatient appointments at the end of October 20. This is a 63% increase from March 20, when Covid cancellations began, but remobilisation plans have seen a month on month reduction in patients waiting more than 12 weeks since June, by >6,000 overall – please see Appendix 2.

Provisional management information shows that 8,940 inpatients were waiting longer than 12 weeks by end of October 20 – please see Appendix 3.

First wave cancellations significantly increased waits for key diagnostic tests including Endoscopy (the largest portion of Gastroenterology Diagnostics); and Urology Diagnostics (Cystoscopy). Radiology CT and MRI waits have decreased considerably since April 20 though, although CT waits have risen again in October, but remain lower than July figures. Radiology Ultrasound has continued to improve since May 20. Please see Appendices 4 & 5.

In terms of unscheduled care and further to the improved 4EAS standard performance, all cause health & social care delays fell significantly in April 20 but are increasing. They do remain historically low for Lothian however, and in October 2020 were 8% lower than the same time last year – please see Appendix 6.

The table below illustrates current performance for key unscheduled &scheduled care metrics:-

Metric		Oct 2020	Sept 2020	Aug 2020	Jul 2020	Jun 2020	Target
Delayed Discharges	**Standard	152	166	141	137	93	95 by March 2021
	**Standard & Complex	212	212	182	181	135	-
4 Hour ED Waiting Time		89.5%	89.8%	92%	94.8%	94.8%	95.0%
Outpatient >12 week waiting time [M]		34,344[P]	35,949	37,736	39,604	40,671	-
Treatment Time Guarantee [M]		8,940[P]	9,213	9,801	10,225	10,233	-
Cancer Waiting Times (31 day target) [M]		N/A	97.9%	98.1%	97.6%	92.2%	95%
Cancer Waiting Times (62 day target) [M]		N/A	85.5%	86.2%	82.1%	83.9%	95%

[M] Management information
** Standard (excl. code 9s and code 100s), Standard and Complex (incl. code 9s and code 100s

Appendix 2 - Outpatients

Outpatient performance is detailed below in terms of patients waiting over 12 weeks for a new outpatient appointment:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20 - provisional
NHSL OP >12 Wk Performance	**24,307**	**25,529**	**23,274**	**21,098**	**28,312**	**37,758**	**40,671**	**39,604**	**37,736**	**35,949**	**34,344**
OP Trajectory	26,269	25,051	20,393	18,100	-	-	-	-	-	-	-
Difference	-1,962	478	2,881	2,998	-	-	-	-	-	-	-

Please note that data provided above are management information and so may differ from published statistics

Additions to and Removals from the waiting list decreased in April although Removals to a lesser extent. Pent up demand has seen increasing additions month on month from May, with Removals also increasing but to a slightly lesser extent due to reduced capacity arising from physical distancing and infection control measures:-

	Oct 19	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Additions	29,569	25,485	19,344	8,775	11,881	15,270	18,724	19,416	21,590	22,416
Removals	28,098	26,474	23,135	11,059	11,995	14,673	15,270	17,755	19,256	19,824

Management Information

Urgent and USoC activity has increased to over February's levels:-

	Oct 19	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Urgent activity	5,402	4,623	4,592	2,738	3,566	4,438	4,393	4,630	5,006	4,707
USoC activity	1,040	779	808	588	791	855	971	1,089	1,028	1,092

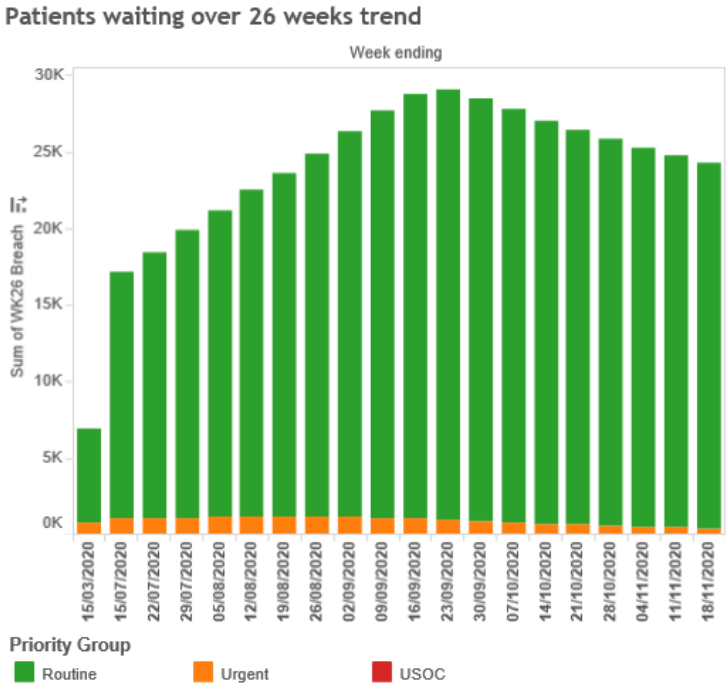
Management Information

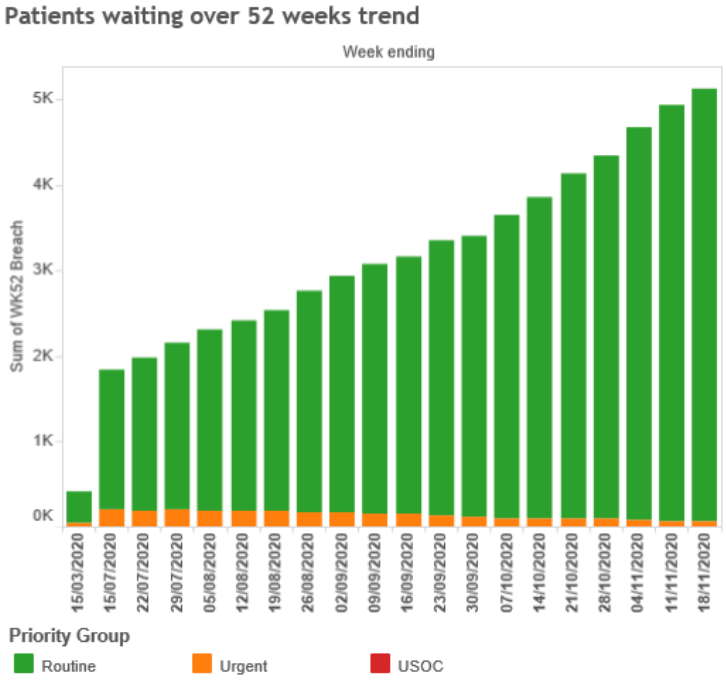
There has been a significant increase in virtual and telephone, alongside face to face Acute & AHP consultations:-

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Near Me & Other Virtual – New & Return patients	223	1,126	2,322	2,214	1,915	2,317	2,327
Telephone – New & Return patients	3,718	5,980	9,090	11,145	12,000	13,237	13,009
F2F – New & Return patients	42,156	45,271	54,610	57,443	60,434	70,995	73,259

Management Information

Outpatient urgent and routine long waits over 26 weeks are beginning to reduce again after peaking in September, and long waits over 52 weeks continue to increase, and will do as the second wave of Covid continues to impact capacity – please see below:-





USoC long waits are however continuing to reduce for both over 26 and 52 week waits.

Appendix 3 – Inpatients/ Day cases (TTG)

IPDC performance is detailed below, in terms of patients waiting over 12 weeks for an Inpatient or Day case procedure:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20 - *provisional*
NHSL TTG (IPDC) >12 Wk Performance	**2,622**	**2,788**	**2,753**	**3,404**	**5,750**	**8,638**	**10,233**	**10,225**	**9,801**	**9,213**	**8,940**
TTG (IPDC) Trajectory	2,839	3,190	2,922	3,100	3,141	3,028	2,900	2,873	2,959	2,917	2,856
Difference	-217	-402	-169	304	2,609	5,610	7,333	7,352	6,842	6,296	6,084
% of all patients seen, seen within the Treatment Time Guarantee	74.7%	74.2%	77.3%	80.2%	95.2%	89.2%	76.6%	63.8%	57.1%	57.4%	-

Please note that data provided above are management information and so may differ from published statistics
Performance figures are *Ongoing* Waits

Additions to and Removals from the waiting list decreased in April. Pent up demand has seen increased additions month on month since then, with Removals also increasing, albeit to a slightly lesser extent due as a result of reduced capacity through physical distancing, and implementation of infection control measures:-

	Oct 19	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Additions	5,054	4,414	3,370	1,497	1,740	2,270	2,576	2,867	3,323	3,181
Removals	5,093	4,514	3,228	1,029	1,122	1,662	2,186	2,582	3,171	3,251

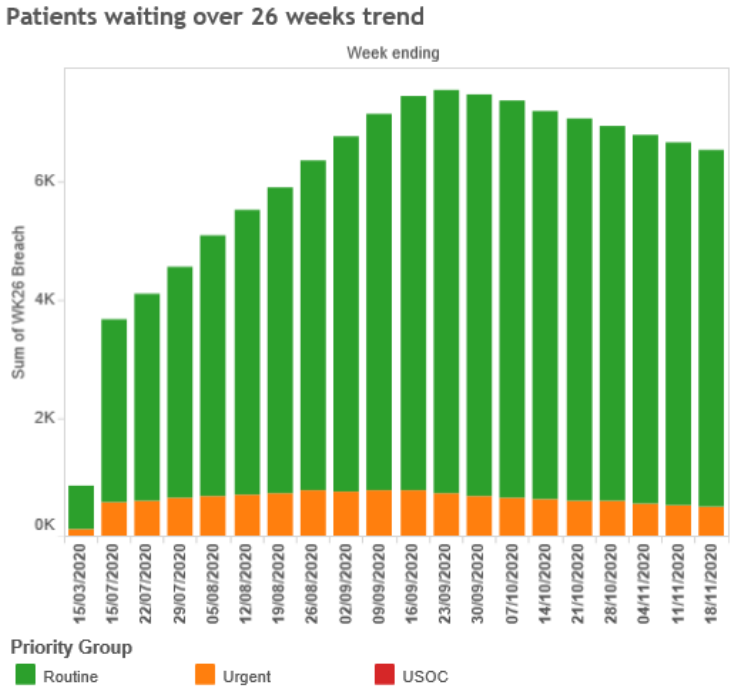
Management Information

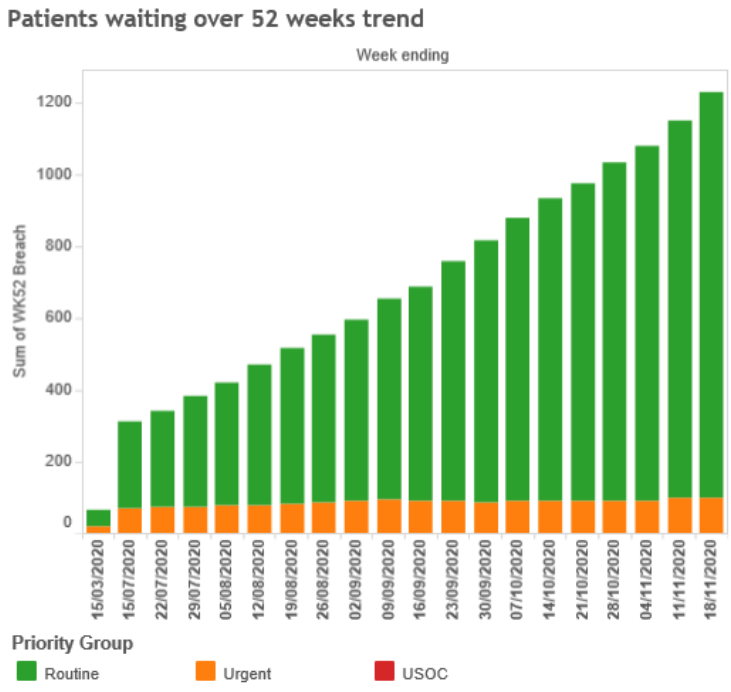
Urgent activity has increased beyond February 20 levels:-

	Oct 19	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Urgent activity	1,150	953	869	424	465	890	1,072	1,028	1,111	1,133

Management Information

Inpatient and daycase urgent and routine long waits over 26 weeks are beginning to reduce again after peaking in September, but routine and urgent long waits over 52 weeks are increasing, as they will continue to do as the second wave of Covid continues to impact capacity – please see below:-





Appendix 4 - Covid Impact on Diagnostics

Gastroenterology diagnostic performance is detailed below, in terms of patients waiting over 6 weeks for a diagnostic procedure:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Upper Endoscopy	625	374	792	1,276	1,823	1,909	1,871	1,759	1,816	1,895	1,851
Colonoscopy patients wtg over 6 wks	933	521	879	884	1,406	1,517	1,476	1,325	1,372	1,412	1,416
Flexible Sigmoidoscopy (Lower Endoscopy) patients wtg over 6 wks	340	297	332	331	464	502	503	517	556	603	590
Gastroenterology Diagnostic Performance	1,898	1,192	2,003	2,491	3,693	3,928	3,850	3,601	3,744	3,910	3,857

Urology diagnostic performance is detailed below, in terms of patients waiting over 6 weeks for a diagnostic procedure:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Flexible Cystoscopy (Urology Diagnostic) Performance	323	340	362	599	765	792	846	896	877	913	979

Radiology diagnostic performance is detailed below, in terms of number of patients waiting over 6 weeks for a radiology scan:-

Specialty Radiology - CT Lothian	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
CT Performance	101	112	97	203	1,049	1,000	743	394	219	194	273
Trajectory >6 weeks	100	40	0	0	200	200	100	100	100	100	100
Difference	1	72	97	203	849	800	643	294	119	94	173

Specialty Radiology - MRI Lothian	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
MRI Performance	87	260	588	448	2,070	1,973	1,329	987	652	512	501
Trajectory >6 weeks	150	150	0	0	500	400	300	300	200	150	150
Difference	-63	110	588	448	1,570	1,573	1,029	687	452	362	351

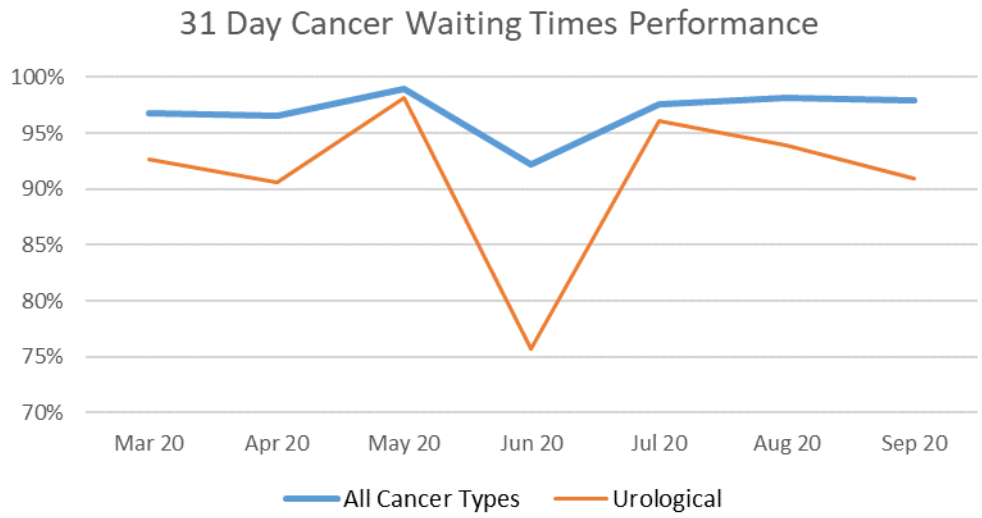
Specialty Radiology - General Ultrasound (not Vasc)	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
General Ultrasound Performance	<10	<10	<10	<10	2,565	2,668	1,879	1,039	602	594	520
Trajectory >6 weeks	10	0	0	0	0	0	0	0	0	0	0
Difference	-<10	<10	<10	<10	2,565	2,668	1,879	1,039	602	594	520

There were <10 breaches for Barium Studies in Oct 20, compared to 5 breaches in total across 2019/20.

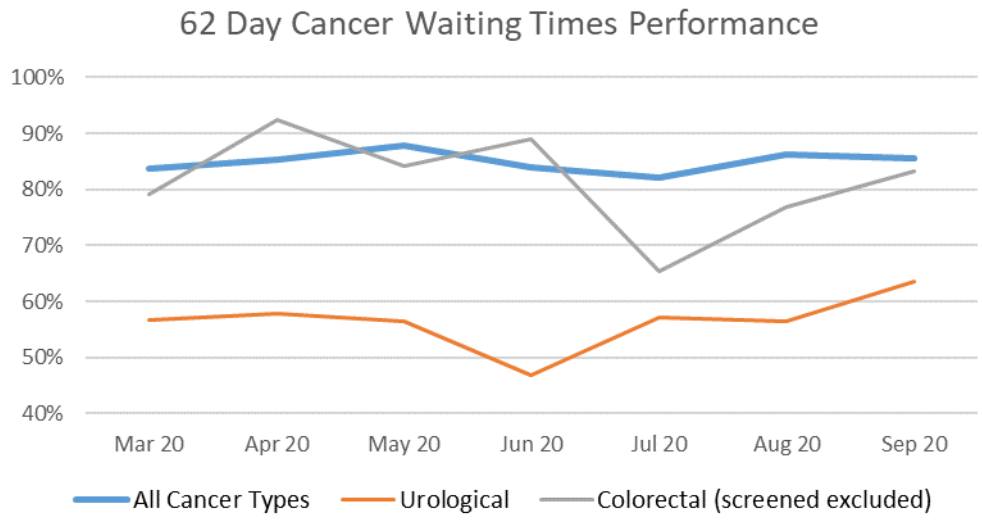
Appendix 5 - Covid Impact on Cancer Performance –

The following tables detail 31 and 62 day cancer performance against trajectory using management information. Please note that data provided are snapshots of management information and may be refreshed/differ from published statistics:-

31 Day performance, by Tumour Group, where under 95% for most recent month							
	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Urological	92.6%	90.6%	98.1%	75.7%	96.1%	93.9%	90.9%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%
All Cancer Types	96.8%	96.5%	99.0%	92.2%	97.6%	98.1%	97.9%



62 Day performance, by Tumour Group, where under 95% for most recent month							
	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Urological	56.8%	57.8%	56.5%	46.9%	57.1%	56.5%	63.6%
Colorectal (screened excluded)	79.2%	92.3%	84.2%	88.9%	65.4%	76.9%	83.3%
Cervical (screened excluded)	100.0%	50.0%	100.0%	100.0%	n/a	0.0%	50.0%
Lung	52.0%	83.3%	100.0%	52.0%	88.9%	93.3%	79.2%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	25.0%
All Cancer Types	83.8%	85.2%	87.8%	83.9%	82.1%	86.2%	85.5%



Appendix 6 - Unscheduled Care Emergency Department Performance, Attendance & Admission

4EAS performance

Performance against the 4hour Emergency Access Standard has decreased over recent months due to a number of factors including increasing attendances, maintaining Covid red and amber streams, increased Covid positive admissions, implementing physical distancing requirements within hospitals resulting in a reduced bed base and increasing delays. However, performance in October 2020 was 4% higher than October 2019. Chart 1 below shows 4EAS performance for NHS Lothian and Table 1 beneath shows the month to date figures for 4EAS by Site.

Chart 1: NHS Lothian 4 hour Emergency Access Standard Performance Jan 19 – Oct 20

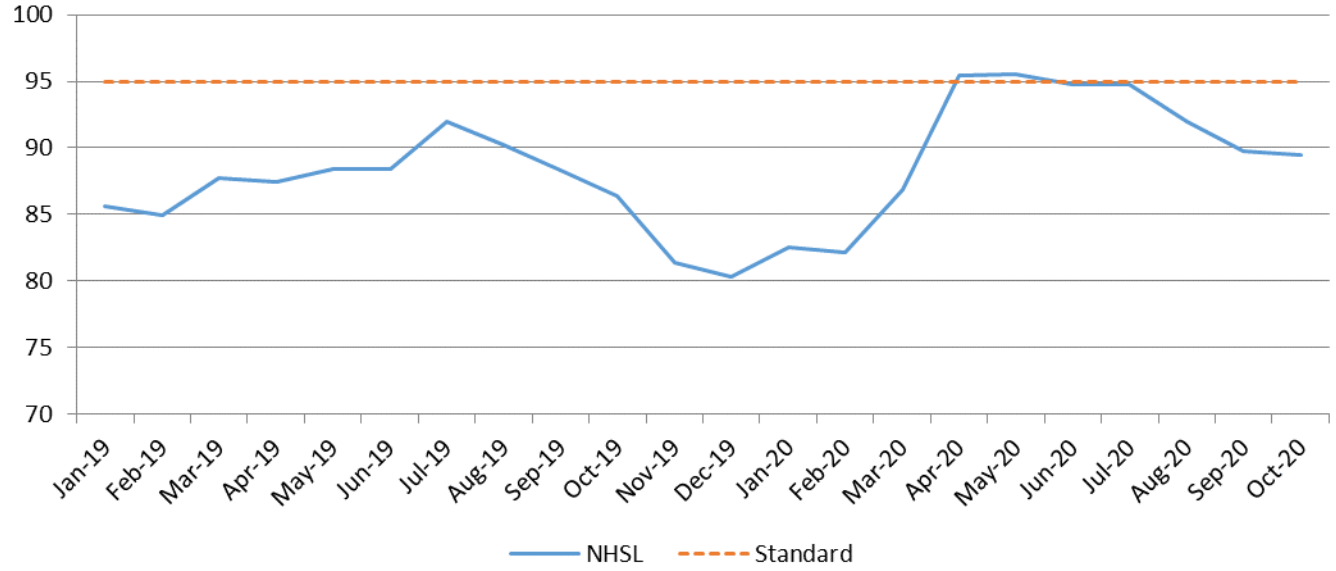


Table 1: 4 hour Emergency Access Standard Oct 19 vs Oct 20

	Oct 19	Oct 20	Difference
Royal Infirmary of Edinburgh	82.1%	86.7%	4.6%
Western General Hospital	82.7%	89.5%	6.8%
St John's Hospital	90.6%	88.8%	-1.8%
Royal Hospital for Sick Children	95.6%	97.7%	2.1%
NHS Lothian	**86.4%**	**89.5%**	**3.1%**

8 and 12 hour breaches have declined significantly since Covid began, to some of the lowest levels for over a year. 8 hour breaches are however increasing again.

8 Hour Breaches

Chart 2: NHS Lothian 8 hour Breaches Jan 18 – Oct 20

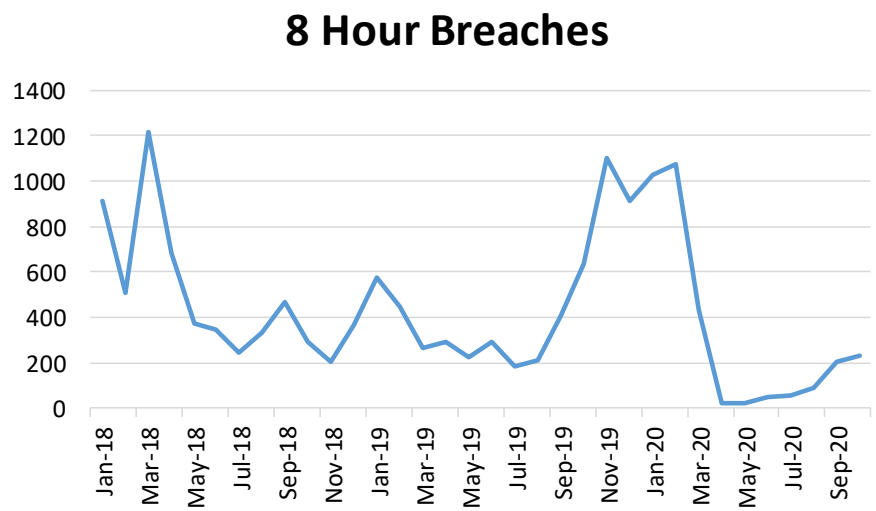


Table 2: *8 Hour Breaches Oct 19 vs Oct 20, by site

	Oct 19	Oct 20	Difference
Royal Infirmary of Edinburgh	357	156	201
St John's Hospital	182	20	162
Western General Hospital	<100	<60	<40
Royal Hospital for Sick Children	<10	<10	<10
NHS Lothian	637	233	404

*includes 8 hour breaches that went onto to become 12 hour breaches

12 Hour Breaches

Chart 3: NHS Lothian 12 hour Breaches Jan 18 – Oct 20

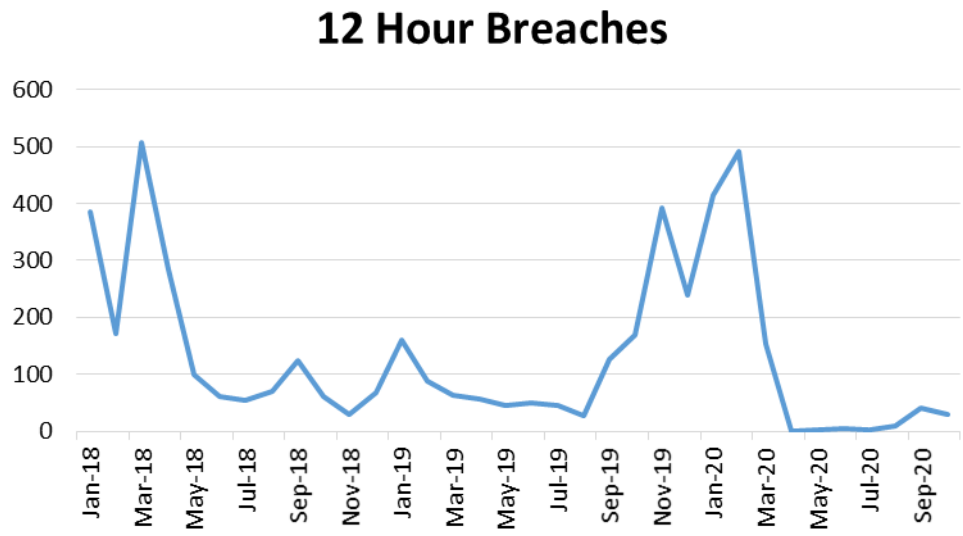


Table 3: 12 Hour Breaches Oct 19 vs Oct 20, by site

	Oct 19	Oct 20	Difference
St John's Hospital	99	<10	>89
Royal Infirmary of Edinburgh	56	16	40
Western General Hospital	<15	<15	<15
Royal Hospital for Sick Children	<10	0	<10
NHS Lothian	168	29	139

Chart 4: NHS Lothian Attendances Jan 18 – Oct 20

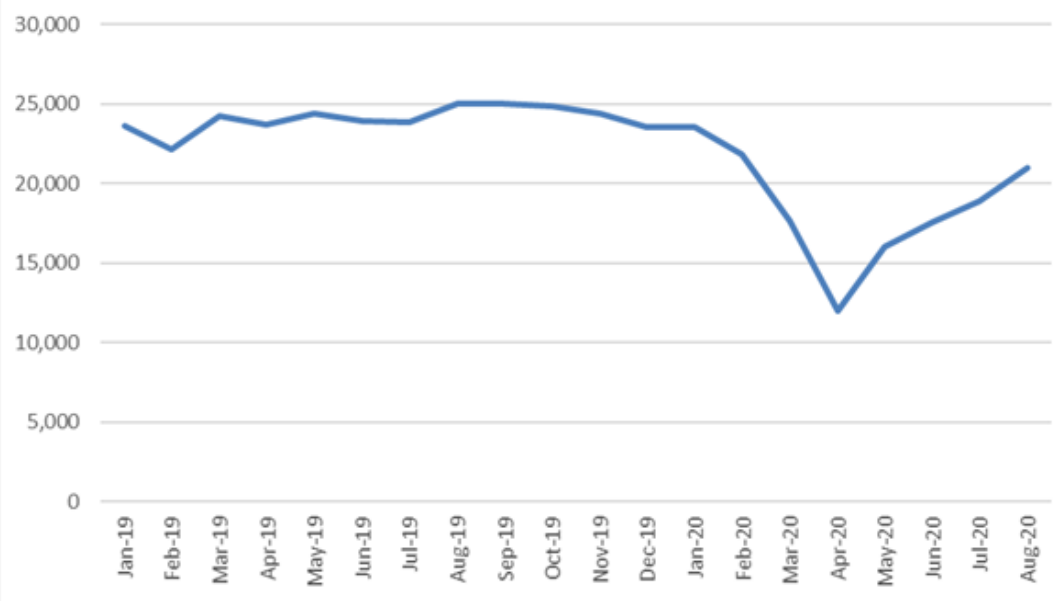


Table 4: ED Attendances Oct 19 vs Oct 20

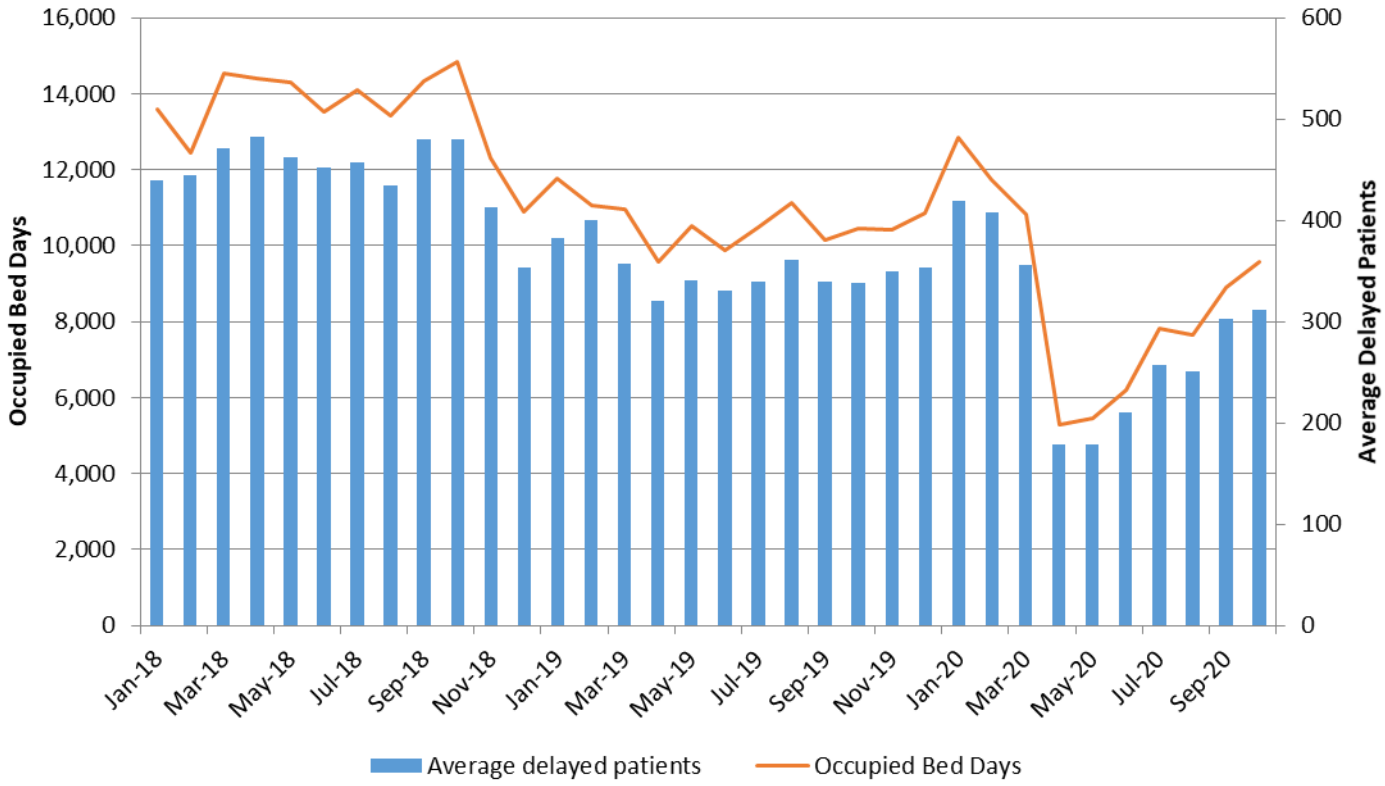
	Oct 19	Oct 20	Difference
Royal Infirmary of Edinburgh	11,143	8,864	2,279 (-20%)
St John's Hospital	5,160	4,099	1,061 (-21%)
Royal Hospital for Sick Children	4,481	3,395	1,086 (-24%)
Western General Hospital	4,076	2,901	1,175 (-29%)
NHS Lothian	24,860	19,259	5,601 (23%)

Delayed Discharges

Chart 5 illustrates the significant reduction in delayed discharge numbers in April 2020 as a result of the Covid-19 response. While the number of delayed discharges have increased since the low in April 2020, the numbers are still historically low for Lothian, and in October 2020 were 26 (8%) lower than the same time last year, equating to a reduction of 863 bed days.

The HSCPs continue to work with acute colleagues to improve discharge planning, transfers of care and implementation of a Home First approach to continue reductions in delays.

Chart 5: NHS Lothian Average Delayed Discharges and Occupied Bed Days[1] Jan 18 – Oct 20



[1] Average delayed discharges and occupied bed days includes code 9s and excludes code 100s

NHS LOTHIAN

Board Meeting
9th December 2020

Director of Finance

OCTOBER 2020 FINANCIAL POSITION

1 Purpose of the Report

1.1 This paper provides an update to the Board on the financial position at Period 7 for NHS Lothian.

1.2 This paper also sets out the financial impact from Covid-19 to-date.

1.3 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 The Board is asked to:

- **Accept** this report as a source of **limited assurance** that the Board will achieve a breakeven position in this financial year.

3 Discussion of Key Issues

Financial Position as at October 2020

3.1 At its meeting of the 25th of November, members of the F&R committee received a report on the NHS Lothian financial position for the first seven months of the year. This showed an in-month underspend of £20.1m bringing the year to date position to a £13.3m overspend against the Revenue Resource Limit. A summary of the position is shown in Table 1 below.

Table 1: Financial Position to 31st October 2020

	Mth 1 £000	Mth 2 £000	Mth 3 £000	Mth 4 £000	Mth 5 £000	Mth 6 £000	Mth 7 £000	YTD £000
Pay	(5,079)	(4,631)	(4,463)	(2,281)	(2,192)	(4,075)	16,137	(6,584)
Non Pays	(1,079)	(801)	(4,078)	(6,015)	(177)	(2,082)	2,411	(11,821)
Income	513	10	239	569	241	1,287	2,265	5,124
In Month Total	**(5,646)**	**(5,422)**	**(8,301)**	**(7,727)**	**(2,128)**	**(4,870)**	**20,813**	**(13,281)**

Funding allocations for Covid

3.2 The Scottish Government allocated £78m of funding to NHS Lothian last month in relation to Covid-19 costs incurred and estimated. This funding is split £60m for Health Board costs and £18m for H&SC Partnerships. For month 7, £26.5m of this funding has been released to offset costs incurred since April, hence the significant in month underspend shown above.

3.3 A two stage approach has been taken to allocating resource. In total, as noted above £26.5m of resource has been allocated to our financial position to date as follows:

- Circa £25.5m has been allocated against the specific Covid cost centres created at the start of the year to capture new costs coming through and reported centrally, eg student nurses. These areas are now in financial balance;
- £18m has been allocated to the Partnerships based on a split agreed by the IJB Chief Finance Officers. £1m has been released to date for elements including East Lothian Community Hospital beds, and services within Midlothian Partnership. This £18m funding stream is also intended to meet social care costs and Partnerships will give further consideration to allocating a share of this resource against costs in this area. This funding is in addition to an £11m allocation received earlier in the year.

3.4 At this stage, no funding has been allocated to other areas beyond that noted above. This is largely because of the level of offsets from activity reduction across many areas, which itself will be recognised as a source of Covid funding.

3.5 The year-to-date outturn of £13.3m recognises the components of Core and Covid related overspend as follows:

- Core (£2.8m) – This represents baseline expenditure for services excluding Covid, to be measured against the AOP estimated gap of £10.8m. The latest outturn estimate remains based on the year end forecast at Q1, which set a projected overspend of £4.8m. This will be updated for Q2, currently underway;
- Covid (£10.5m) – this overspend comprises:
    - Prescribing (£3.5m) – Boards have yet to receive a funding allocation for prescribing, and the full overspend is currently shown as Covid related;
    - GMS (£3.4m) – Funding has been received for public holiday payments to GPs and additional Covid related GP costs, however further discussion is taking place with Practitioner Services Division before allocation;
    - Lost efficiency (£3.6m) – This represents estimated non delivery based on those schemes identified at the start of the year in the AOP. Again, funding has not yet been allocated for lost efficiency due to wide variation across boards.

Financial Impact of Covid-19

3.6 The latest review of Covid-19 related costs up to the end of October 2020 shows that the Board have now incurred an estimated £53.3m of additional costs. The breakdown of these costs is shown in table 2.

Table 2: Breakdown of Covid costs to 31st October 2020

	YTD Covid Costs £000's
Medical & Dental	£5,668
Nursing	£21,875
Support Services	£3,529
Administrative Services	£1,815
Other Pay	£1,860
Total Pay	**£34,746**
Medical Supplies	£962
Equipment Costs	£2,607
Prescribing	£3,491
Gms Expenditure	£3,364
Administration Costs	£1,154
Other Non-Pay	£3,262
Total Non-pay	**£14,840**
Loss of Income	**£3,729**
Total Covid Costs	**£53,315**

3.7 41% of Covid costs to date relate to additional nursing staffing costs, which includes the student nursing cost element. Students and other fixed term staff where possible have now been moved into existing vacancies across all areas. Accordingly, the establishment in October is showing a reduction of 390 WTE's from the July peak.

3.8 Information continues to be worked through relating to the IJB position. The nature of disaggregating costs at cost centre level makes IJB financial performance reporting more complex with Covid-19 costs incurred across Set Aside, Hosted and Core areas, and this is compounded by the centralisation of significant cost elements as noted earlier in this paper.

4 Key Risks

4.1 The key risks relating to the delivery of a breakeven position include the following:

- As noted above, the achievement of financial balance is dependent on receiving full financial support from the SG to meet addition Covid-19 related costs.
- The impact of Brexit is unknown – and assumed to be cost neutral in estimates to the year end. Any additional Brexit-related costs have no additional funding allocations attached to them at this stage;
- The estimates for the year end outturn are predicated on the assumption that Covid related activity levels remain within planned levels. Any material deviation from this may impact on the ability for the health board to achieve a balanced outturn;
- Delivery of Financial Recovery Plans by individual Business Units to the level identified in the Financial Plan remains a key assumption which impacts on the achievement of Core performance.

5 Risk Register

5.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

5.2 The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

7.1 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.

8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith
Director of Finance
1st December 2020
susan.goldsmith@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
9th December 2020

Executive Director Nursing, Midwifery & AHPs

DISCHARGES TO CARE HOMES

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on the clinical audit and analytical investigation into discharges to care homes. It should be noted that one element of this work is in progress and it should not therefore be regarded as complete.

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

2 Recommendations

2.1 It is recommended that the Board:

2.2 Accept this detailed report on the review into the discharges to care homes, considering the pattern of testing undertaken and investigating the possibility that there may have been introduction of Coronavirus (SARS-CoV 2) from hospital into the home.

2.3 Acknowledge the complex processes that support discharges into care homes including the responsibilities of Health and Social Care Partnerships and Local Authorities and the professional accountabilities of social workers in this context.

2.4 Note that Virology is undertaking genome sequencing to inform further the assessment that has been made on the chains of transmissions within the individual outbreaks. This will complete the review and support any necessary communications.

2.5 Note that NHS Lothian has a duty of candour to appropriately communicate relevant findings to patients or their families which will be undertaken following completion of the internal review which will be once the virology results have been analysed.

2.6 Approve use of the internal review report to support learning across the organisation to improve administrative and clinical processes and in communication with the Scottish Government and Public Health Scotland to facilitate further learning given that this is an issue nationally.

2.7 Note that the detail of the review has been made available to the Lord Advocate's team for their consideration.

2.8 Approve moderate assurance of the process followed to examine the likelihood of hospital discharges introducing COVID into care homes, given the limitations in the methodology adopted.

3 Background

3.1 The significant number of COVID deaths in care homes during the height of the pandemic has raised legitimate significant interest about hospital discharges to care homes during that time. There is a need to understand if the virus could have been transferred from a hospital setting to a care home and if national guidance regarding testing and isolation requirements was followed. This has come in the form of discussion within the board and:

3.1.1 A number of Freedom of Information requests that were submitted to Boards by the media, citizens and politicians' offices;

3.1.2 A national review commissioned by the Scottish Government from Public Health Scotland (PHS);

3.1.3 The establishment of a team by the Lord Advocate to investigate deaths due to COVID-19 or presumed COVID-19, in cooperation with other relevant bodies where:

(a) the deceased was resident in a care home (this includes residential homes for adults, the elderly and children) when the virus was contracted or

(b) to the best of the certifying doctor's knowledge, there are reasonable grounds to suspect that the deceased may have contracted the virus in the course of their employment or occupation. Whilst not exhaustive, this may include deaths of care home workers, frontline NHS staff, emergency services personnel and public transport workers.

3.2 In response, NHS Lothian conducted an Internal Review of hospital discharges from 1 March to 31 May 2020.

3.3 The Internal Review comprised two phases which consisted of:

3.4 Phase 1 – an administrative audit of records to identify discharges to care homes, a clinical audit of these 570 records, review of the national PHS Report and a review of the COVID test history for the 787 discharges identified to care homes.

3.5 Phase 2 – in-depth and comprehensive audits/reviews of the 41 discharge episodes that were identified as requiring further review in Phase 1 (these included, an in-depth administrative audit, a clinical review by Infection Control and timeline review of all care homes identified). The decision making around each discharge involves a transfer of responsibility from the acute clinician providing care to the HSCP lead, informed by a social worker, to liaise and agree the discharge arrangements with the individual and any family member.

3.6 The initial findings of Phase 1 were shared with Board Members at their meeting on 24th September. A final report, excluding virology review, was discussed at the Board briefing session on 19 November 2020.

4 Discussion of Key Issues

4.1 The examination of hospital testing was undertaken for 787 discharges to care homes which occurred between March and May 2020.

4.2 This found that testing in Lothian followed a similar pattern to that outlined by PHS in their national report published in October, with the proportion tested growing over time, particularly following the Cabinet Secretary's statement on 21st April on the requirement for testing.

4.3 17.7% of Lothian discharges to care homes from the start of March to the 21st April were tested (Scotland: 18.1%) of which less than 5% were positive (Scotland: 12%). From 22nd April to the end of May 86.4% were tested (93% nationally), of whom 18.3% were positive in Lothian (Scotland: 18.6%)

4.4 The 787 discharges were analysed to determine the likelihood that they had introduced COVID into a care home. 41 were felt to warrant particular examination.

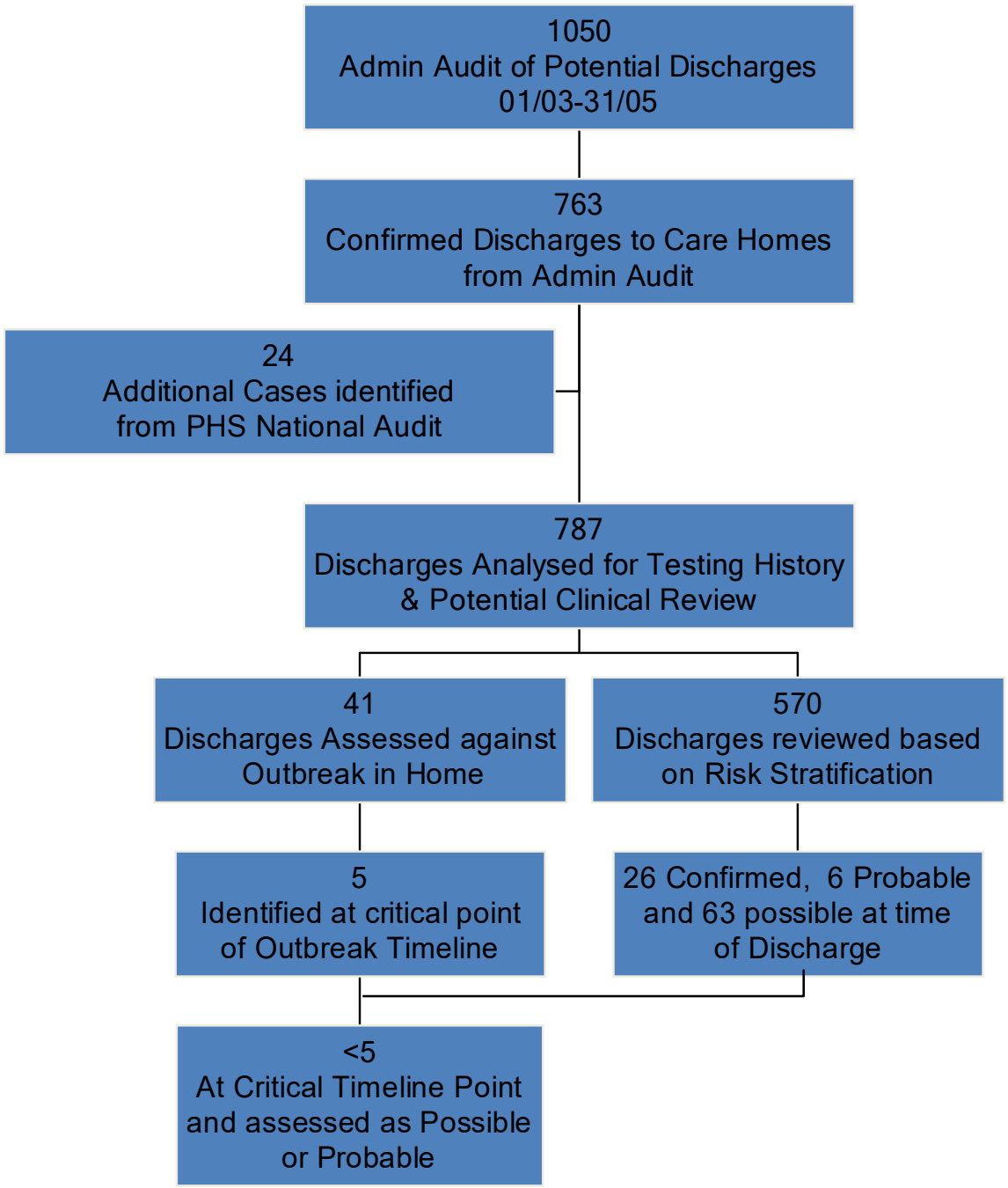
4.5 These 41 episodes, involving 38 patients as some patients had more than one discharge, were discharged to 21 care homes across Lothian. Further assessment narrowed the focus down to five discharges, each involving a different patient. All five occurred before the mandating of testing came into force in late April.

4.6 Once those deemed, through separate clinical review by Medicine of Elderly clinicians, as "unlikely" to have had COVID at time of discharge are set aside, the number of concern was reduced further, to less than five. Release of the exact number cannot be published under statistical governance disclosure control. In each of these instances, the need to ensure isolation of the patient in the care home was documented, the basis for the overall conclusion in the Medicine of Elderly review regarding good communication with homes on this issue.

4.7 Genome sequencing by Virology was not able to be completed in the timescales necessary for inclusion in the primary report. However, a full virology review of the cases identified as likely transmission events is currently being undertaken. Results may not significantly change the findings outlined in the report but it will provide a deeper understanding of the outbreaks noted above by clarifying the specific strains possibly introduced to the home by a patient discharged from hospital and any further transmission within the home.

4.8 The schematic on the following page summarises how the discharges were reduced from 1050 to fewer than 5.

Schematic Demonstrating Process to identify Discharges of Interest



5 Key Risks

5.1 The process undertaken for this review is complex. It also hinges on the availability of test results for those associated with care homes with COVID and identification of discharges to these facilities. This is not an infallible process and it is possible that a primary case in an outbreak, whether a hospital discharge or not, may have been overlooked.

5.2 Accordingly, the conclusions from this work need to be considered on that basis and more significant weight placed upon the exercise being progressed on behalf of the Lord Advocate.

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List of Appendices

Appendix 1: NHS Lothian Internal Review of Hospital Discharges to Care Homes from 1 March 2020 – 31 May 2020

NHS Lothian

Internal Review

of

Hospital Discharges to Care Homes

from

1 March 2020 – 31 May 2020

Date:	3 December 2020
Responsible Executive:	Alex McMahon, Executive Director Nursing, Midwifery & AHP's
Written by:	Andrew Jackson, Associate Director – Analytical Services Amanda Kirkpatrick, Strategic Programme Manager - Waiting Times Governance

Contents

1. Executive Summary

A significant number of COVID deaths in care homes during the height of the pandemic has raised public interest about hospital discharges to care homes during that time. There is a need to understand if the virus could have been transferred from the hospital to the care home and if national guidance regarding testing and isolation requirements was followed.

The Internal Review comprised two phases which consisted of:

- Phase 1 – an administrative audit of 1050 records to identify discharges to care homes, a clinical audit of 570 records, review of the national PHS Report and a review of the COVID test history for the resulting 787 discharges to care homes identified
- Phase 2 – in-depth and comprehensive audits/reviews of the 41 discharge episodes that were identified as requiring further review in Phase 1 (these included, an in-depth administrative audit, a clinical review by Infection Control and timeline review of all care homes)

Testing of Patients

Testing of the 787 discharges identified to Care Homes followed a similar pattern to that outlined by Public Health Scotland (PHS) in the national report published on 28 October 2020, with the proportion tested growing over time, particularly following the Cabinet Secretary's statement on 21 April 2020 regarding the requirement for 2 negative COVID tests prior to discharge. 17.7% of Lothian discharges to Care Home from the start of March to the 21st April were tested (Scotland: 18.1%) of which less than 5% were positive (Scotland: 12%). From 22nd April to the end of May 86.4% were tested, contrasting with 93% nationally of whom 18.3% were positive (Scotland: 18.6%)

Possible Outbreaks in Care Homes arising from Hospital Discharges

The in-depth review of the 41 discharge episodes found that 38 patients (some patients had more than one discharge episode) were discharged to 21 care homes across Lothian.

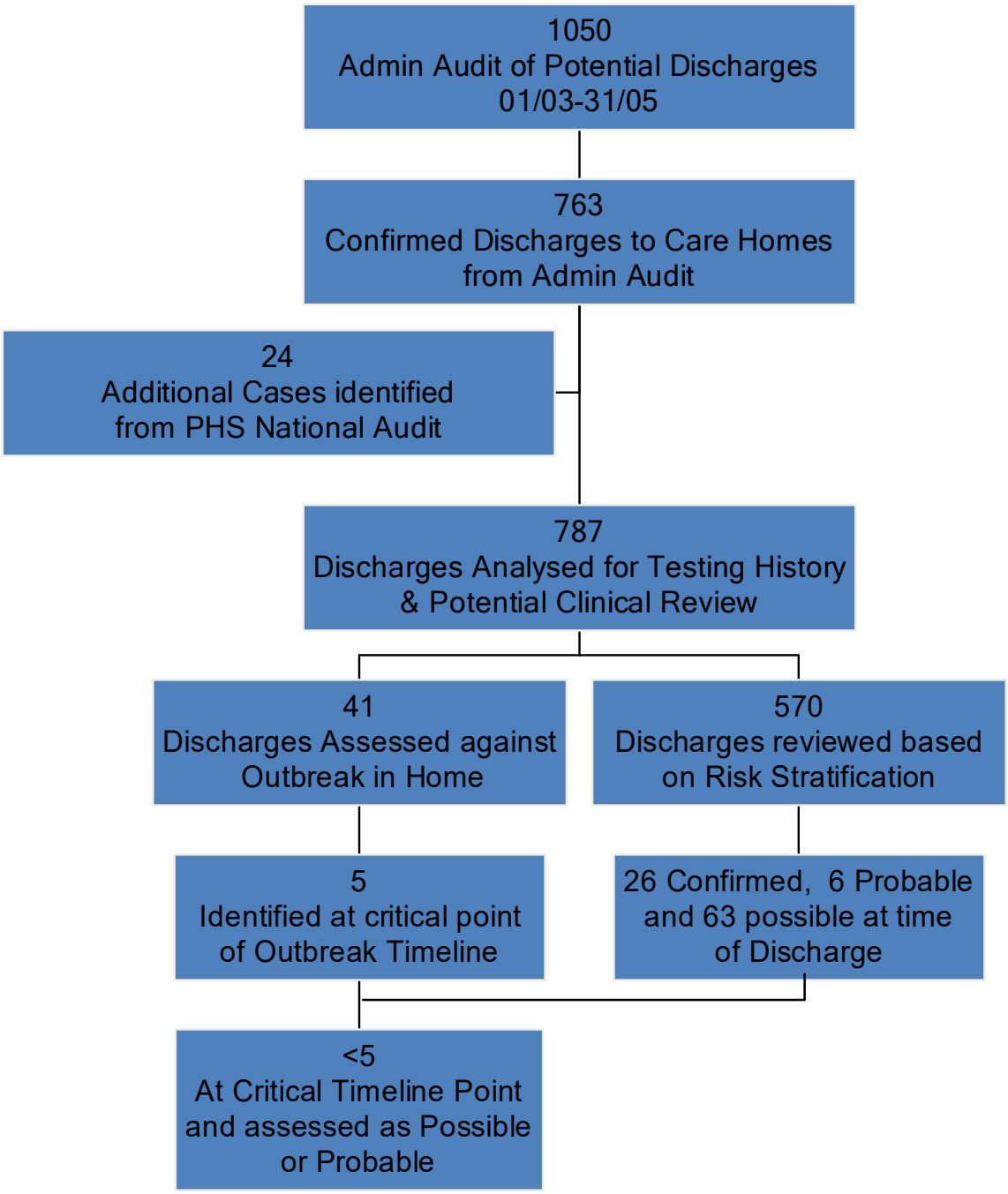
This review led to the identification of 5 discharges, each involving different patients requiring more detailed consideration and once those deemed, through separate clinical review by Medicine of Elderly clinicians, as "unlikely" to have had COVID at time of discharge are set aside, less than 5 remain requiring further assessment.

Statistical governance disclosure control prevents release of the exact number. All occurred before the testing mandate came into force in late April and in every case remaining the need to ensure isolation of the patient in the care home was documented.

The schematic on the next page summarises how the 1050 has narrowed down to less than 5.

Virology input was not able to be completed in the timescales necessary for inclusion in this report. Its availability will provide further understanding of the outbreaks in the above homes.

Schematic Demonstrating Process to identify Discharges of Interest



It is recommended that the Committee:

- Note that a full virology review, including genome sequencing, is being pursued for the cases identified as likely transmission events into a care home.
- Approve moderate assurance of the review process, given the limitations of the approach.
- Note that the recommendations accepted by the Board on 24 September continue to be progressed. These are that:
    - Full analyses be shared with Scottish Government, Public Health Scotland, Health Protection Scotland and Lord Advocate's investigation team;
    - Learning from the review be incorporated into clinical practice;
    - Data relating to Care Homes be improved
    - The families and care homes identified are met.

2. Introduction

The COVID pandemic has created unprecedented circumstances that NHS boards are doing their best to work through in the safest way possible for all patients and staff. The large number of deaths, particularly in care homes has generated significant and legitimate public interest. This has come in the form of:

- Freedom of Information requests from both the media, politicians' offices and citizens
- Public debate
- Lord Advocate's investigation
- a national report commissioned by the Cabinet Secretary from Public Health Scotland (PHS)

In light of this, NHS Lothian's Executive Leadership Team took the decision to conduct an internal review of discharges to care homes within the most critical COVID related time period of 1 March – 31 May 2020. The primary aim was to confirm that all discharges were conducted within national guidance in place at the time and to provide assurance to the NHS Lothian Board and the Scottish Government that patients were not inappropriately transferred to a care home possibly introducing hospital acquired COVID into the care home.

An internal review was started at the beginning of September 2020 and was led by Lothian Analytical Services (LAS) with significant assistance from Medicine of the Elderly consultants, Health Records administrative staff and Infection Control clinical staff.

3. Background

There have been a large number of deaths of care home residents from COVID. Clearly this is a cause for significant concern and an area where further understanding is necessary. Debate has focussed on whether discharges of hospital patients to care homes may have helped spread the virus. This particular aspect has been reflected in a number of Freedom of Information requests to Health Boards, in media coverage and public debate. It also led to the Scottish Government commissioning Public Health Scotland to produce a report into this.

Originally scheduled for the end of September 2020, the PHS report was released at the end of October given concerns over the data quality of records held nationally. Similar data quality issues in local data informed NHS Lothian's response.

Like other Health Boards, NHS Lothian had received a number of Freedom of Information requests in this area and the Director of Public Health was liaising with the Lord Advocate's team to ensure that they had the necessary information for their task. Both tasks required the identification of patients who had been discharged to care homes and given the importance of the issue, it was considered vital that this was done as accurately as possible. As past assessments on national records, undertaken by PHS (then ISD), had highlighted that these efforts would be undermined by poor data quality, it was agreed that records would be manually checked to identify the patients' discharge destination.

This was anticipated to be a significant undertaking; it would not be possible to address all the specific points raised in the FOI requests and was likely to take some time to complete. FOI applicants were advised of this approach, with no data being provided in the interim. The approach locally differed from other Boards, which led to some suggestions of secrecy from journalists investigating the matter.

4. Internal Review

The initial focus in Lothian was on identifying patients discharged to Older People's care homes within the Board area between March and May 2020, with 1050 potential instances identified. Manual assessment confirmed that 724 of these cases did indeed go to Older People's care homes in Lothian and the details of their testing was discussed at a private meeting of NHS Lothian's Board on 24th September 2020. The Board felt it particularly important to determine if patients were appropriately discharged to care homes given that some patients may have been COVID positive upon discharge and could have introduced it to the care home.

The timeline of discharges over this period was set out against the changes that occurred in national guidance and expectations in testing. These key dates are set out in the table below with those dates incorporated into analyses in bold.

Key Dates in Guidance Timeline

Effective Dates	Guidance
26th March[1]	HPS Guidance advises that isolation for those discharged from hospital "known to have had contact with other COVID-19 cases and ... not displaying symptoms" but otherwise advising risk assessment.
11th April[2]	HPS Guidance advises "Patients should continue to be isolated for a minimum of 14 days from symptom onset (or first positive test if symptoms onset undetermined) and absence of fever for 48 hours (without use of antipyretics)."
21st April[3]	Cabinet Secretary outlines to Parliament the change to 2 negative tests prior to transfer to a care home
26th April[4]	The need for two negative tests is incorporated into HPS Guidance

4.1 Scope

LAS and several members of the executive team agreed the scope of the internal review and that it would be conducted in two phases as outlined below:

Phase 1

a. Administrative Audit: Administrative staff manually reviewed records where a patient was thought to have been discharged to a care home. The name of the home(s) and any other relevant information was recorded on a template to ensure consistency across auditors.

b. Clinical Audit: Medicine of the Elderly consultants or specialty registrars conducted a clinical review of those patients that were confirmed to have been discharged to a care home. Results were recorded on a template to ensure consistency across auditors and approximately 10% of records were double adjudicated to confirm accuracy.

[1] https://www.hps.scot.nhs.uk/media/1919/covid-19-guidance-for-social-or-community-care-and-residential-settings-v15.pdf

[2] https://www.hps.scot.nhs.uk/media/1987/covid-19-step-down-guidance-v10.pdf

[3] https://www.gov.scot/publications/coronavirus-covid-19-update-health-secretarys-update-tuesday-21-april-2020/

[4] https://www.hps.scot.nhs.uk/media/1988/covid-19-step-down-guidance-v11.pdf

c. PHS Report: LAS to review the PHS report and determine if there are any cases Lothian had not already identified and include them in the internal review (in both Phase 1 and Phase 2).

d. COVID Test History Review: Results from the Administrative and Clinical Audits were reviewed against COVID testing data to determine if there were any cases that could have possibly introduced COVID into a care home.

Phase 2

a. In-depth Administrative Audit: This was a more thorough review of the cases identified in Phase 1 as possibly introducing COVID to a care home. It gathered information on presenting complaint, ward transfers, COVID testing information (e.g. when patient tested positive relative to admission and discharge) and care home information (e.g. care home already had known cases of COVID or agreed to accept the patient knowing they were COVID positive at time of discharge).

b. Infection Control Review: Clinical staff from Infection Control reviewed cases identified as possibly introducing COVID to a care home relative to the status of the related care home and the national guidance in place at time of discharge.

c. Review of Care Home Timelines: LAS reviewed cases identified as possibly introducing COVID to a care home against all care home staff and residents that had tested COVID positive or died due to COVID/suspected COVID in a particular care home. This was to determine if the discharged patient could have introduced COVID to the home or if COVID was already present in the care home.

d. Virology Review: Any cases identified as possibly introducing COVID to a care home would be sequenced to determine if the COVID strain the patient had was the same as the prevalent strain in the care home.

4.2 Methodology/Parameters

Ideally the questions outlined above would be answered using system generated reports from data stored in the patient administration system (Trak). Trak does not currently have specific fields where "admit from" and "discharge to" location can be consistently populated with accurate information. It should be noted that eHealth is currently working on a system solution in conjunction with PHS.

Therefore, a manual audit of patient records had to be undertaken by administrative staff to determine if a patient was admitted from/discharged to a care home, which home and if a patient discharged from hospital could have introduced COVID to the care home.

NHS Lothian was working to a tight timescale in order to be able to quickly respond to the pre-release of the PHS report and to provide information to the NHS Lothian Board. Therefore, it was important that the list of records to be reviewed included those patients that were most likely to have been discharged to a care home in order to maintain a manageable number of records for audit.

The key parameters for the audits/reviews detailed above are highlighted below.

a. Administrative Audit: Generate a list of patients likely to have been discharged to a care home (see Appendix 1 for full methodology report):
   - Age - patients over age 50

- Care Home Type - Older People's homes located in Lothian
- Exclusions:
    - Discharges where patients were readmitted to hospital on the same day
    - Patients who did not stay in hospital overnight

b. Clinical Audit: Review those patients that were confirmed to have been discharged to a care home in the following priority categories:
    - with a positive test result(s) within 14 days of discharge
    - who died with COVID-19 listed on death certification after discharge
    - who were discharged to a care home which already had recorded COVID-19 death(s) or an outbreak

c. COVID Test History Review: These cases were identified by reviewing patients that had a positive COVID test:
    - Within 14 days either side of discharge date or
    - Were discharged to a care home from 22 April 2020 having only tested positive in hospital and without any negative test

5. Phase 1 Findings

The audits/reviews conducted in Phase 1 of the Internal Review were important as they provided a broad understanding of hospital discharges to care homes from March – May 2020. Furthermore, the findings allowed NHS Lothian to respond to the PHS report at the time of pre-release so the final report could include the most accurate information possible. Phase 1 also facilitated planning and narrowed the focus for Phase 2 of the Internal Review.

5.1 Administrative Audit

A report was generated for patients that were likely to have been discharged to a care home. The report was based on discharge date so every discharge episode in the specified time period was pulled which means that a patient may be listed more than once as they could have been admitted and then discharged more than once in the given period.

The table below details the key findings from the Administrative Audit.

Key Administrative Audit Findings

Description	Number of Discharge Episodes
Number of Episodes Audited	**1050**
Number of Discharges to a Care Home (regardless of location or type)	**763**
Number of Discharges to a Lothian Care Home (regardless of type)	**738**
Number of Discharges to a Lothian Older People's Care Home	**724**

5.2 Clinical Audit

Clinical review was undertaken for 570 care home discharges from NHS Lothian hospitals between March and May 2020 following the methodology described above, prioritising those discharges deemed to be of most interest. These reviews were shared amongst 29 reviewers at specialty registrar or consultant level. As judgements include a degree of subjectivity, a proportion of cases were double reviewed (reviewers blinded to each other). Reviewers were primarily assigned cases managed outside of their usual clinical area but were asked to exclude themselves if they subsequently identified a case they were significantly involved with (no such cases occurred).

The report can be found in Appendix 2. Its conclusions included the following:

1. In the early part of the pandemic, assessment of the clinical notes within Trak suggested that there appeared to be excellent communication on the need to isolate when discharging positive patients back to care homes, although this rarely made the formal discharge documentation.
2. Later, the requirement for two negative tests before discharge was universally observed before leaving for the care home.
3. Using multiple methodologies, a very small number (1-2% of this sample, <1% overall) of hospital discharges to care homes in this period were considered 'high-risk', where negative (or no) testing may not have reflected true COVID status.

The review also assessed the likelihood that the patient had COVID on discharge. 12% (69) discharges were identified as probable or possible through clinical review. 26 were recorded as Confirmed with the patient's COVID status communicated to the care home in each instance.

Key Clinical Audit Findings

COVID likelihood at discharge	Overall Clinical Impression	
	Number	%
Unlikely	470	83
Possible	63	11
Probable	6	1
Confirmed	26	5
No notes	5	1

5.3 Public Health Scotland Report

The Scottish Government commissioned Public Health Scotland (PHS) to examine the data around discharges to care homes. This report, published on 28th October, examined both the pattern of testing, in a manner similar to that presented to the private Board meeting in September 2020 and the factors that increased the likelihood of a COVID outbreak in a care home. The latter element concluded that care home size was by far the biggest factor in the likelihood of an outbreak within a home, reinforcing findings from previous studies. It also found that an outbreak was more likely in local authority or NHS run care homes than those under private management control. Whilst both of those conclusions were statistically significant, this was not the case for hospital discharges, where, although the best estimate of risk is 21% higher for homes in the period after receiving a discharge, the uncertainty around this estimate is such that it cannot be stated assuredly that discharges contribute additional risks.

The PHS summary report is in Appendix 3 and the full report is available https://beta.isdscotland.org/find-publications-and-data/population-health/covid-19/discharges-from-nhsscotland-hospitals-to-care-homes/.

PHS asked for Health Boards' assistance in validating some of their data. Given the work undertaken in the Internal Review, NHS Lothian was able to feedback on discharges that had been incorrectly identified by PHS as going to a care home as well as ones that had been additionally identified by NHS Lothian.

Receipt of PHS patient listings also allowed the records identified locally to be checked for completeness. In total, PHS has identified 24 discharges that had not been identified in Lothian's own work. These extra cases had been identified by PHS due to the differences in scope and available data, despite the broad similarities in approach.

The inclusion of these PHS cases allowed the initial work presented to be repeated with this additional data and expanded the analysis beyond Older People's care homes to those supporting other patient groups. It should be noted, despite these additions, that small differences remain between the two sets of discharges identified by PHS and NHS Lothian due to slightly different data collection and analysis methods.

5.4 COVID Test History Review

This section examines the number of discharges to care homes and the tests that were undertaken.

An earlier version of this analysis was shared at September's private Board meeting. This initial work demonstrated that testing had only been undertaken in a minority of discharges initially. The proportion tested increased as time went on with almost all being tested following the Cabinet Secretary's announcement on 21st April setting out the expectation of two negative tests prior to discharge to care home.

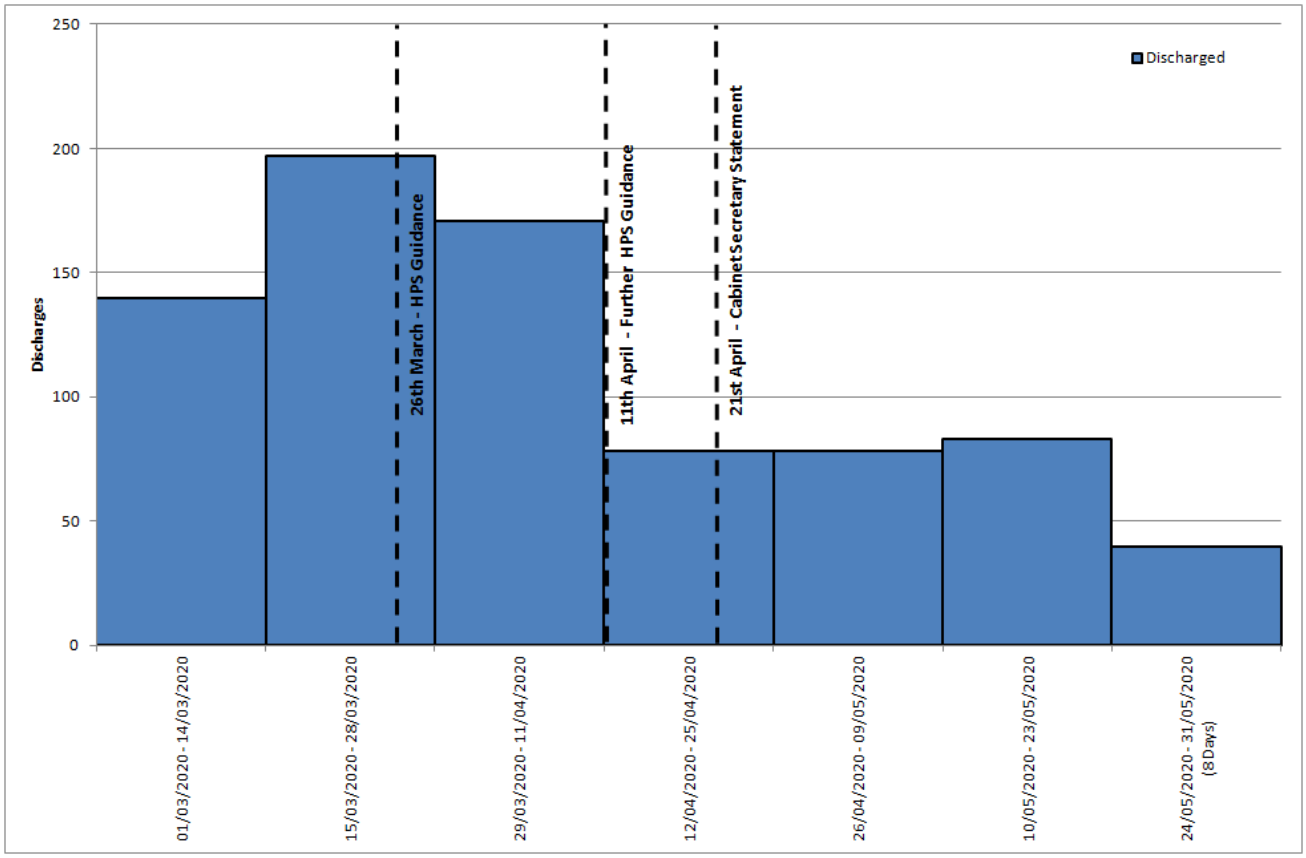
The analysis and figures below have been updated following receipt of the additional 24 cases from PHS which accounts for the differences to the numbers shown above and widen to all care homes and not just those for older people.

Comparisons are made against figures in the national report where appropriate.

Number of Discharges to Care Homes

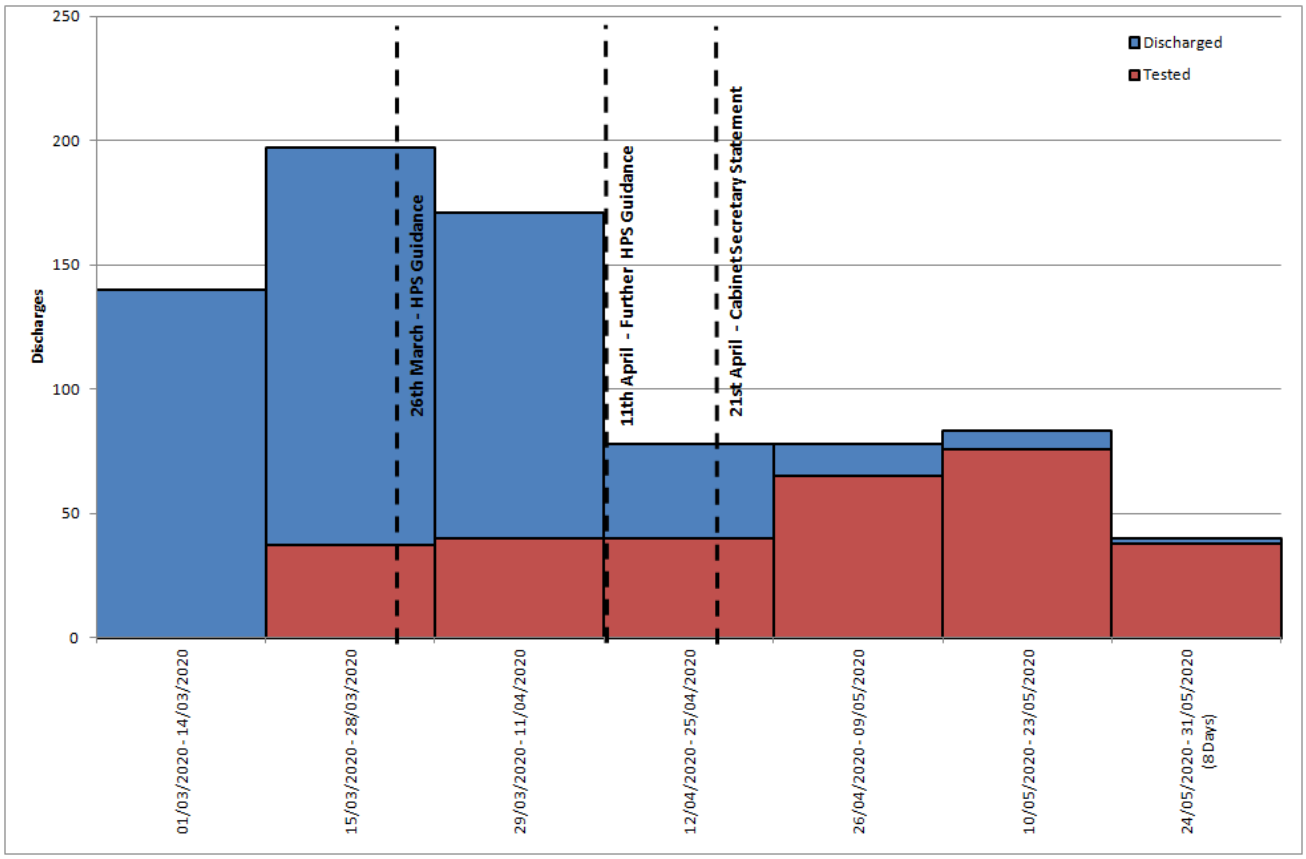
Examination of discharges between 1 March and 31 May 2020 identified 787 discharges to care homes. The pattern is shown in the chart below.

Discharges to Care Homes – March to May 2020



Of these 787 discharges, 296 were tested in hospital prior to discharge, with the proportion tested increasing as time went on and the expectations around tests became firmer. This is set out in the accompanying chart.

Discharge to Care Homes and Those Tested in Hospital – March to May



Of the 296 tested, 256 had a negative result only whilst 15 had a positive result only and 25 had both positive and negative results (as patients can be tested more than once).

At the private Board meeting on 24 September 2020, 9 discharges after 21st April were identified for patients with only a positive test result where guidance required two negative test results. With the addition of the extra discharges identified by PHS, this increased to 11.

Tests whilst in Hospital for Those discharged to Care Homes

Guidance Status	Number of Discharges	Those Tested	Tested %
1. No Care Home Discharge Guidance	315	31	9.8%
2. Testing Not Mandated although isolation should occur	193	46	23.8%
3. Testing on discharge if testing capacity allows but not mandatory	51	22	43.1%
	559	**99**	**17.7%**
4. 2 negative swabs before transfer and 14 days isolation	228	197	86.4%
	228	**197**	**86.4%**
	787	**296**	**37.6%**

The PHS Scotland report identified 3,599 discharges from hospitals in Scotland to a care home between 1 March and 21 April 2020 with 18.1% tested for COVID-19, in-keeping with clinical guidance which restricted testing to those with symptoms of infection. The analysis above places Lothian with a similar rate of 17.7%. The proportion of those testing positive in Lothian during this time (less than 5%) was less that observed by PHS nationally at 12% (78 of 650).

The national report outlined that, for the period from 22 April to 31 May, there were 1,605 discharges from hospital to a care home, with 1,493 (93%) in this later period tested for COVID-19, in line with the changes in clinical guidance. The comparable level in Lothian has been established at 86.4%. Of those tested nationally, 278 (18.6%) tested positive. Local analysis places Lothian's rate at 18.3%.

That the rate of testing is below 100% will be noted. In their report, PHS highlighted that

> *"[i]t is important to note that there are valid clinical reasons for individuals not to be tested prior to discharge, relating to their capacity to consent to testing and appropriateness of testing, e.g. in end of life care situations.*
>
> *PHS sought clarification from Boards for individuals discharged from 22 April onwards who had tested positive and had either no negative tests or only one. There is recognition that changes in policy and guidance require time for implementation in clinical practice and this was reflected in the feedback from NHS Boards. Feedback received provided several reasons for not being able to complete negative testing prior to discharge, including: unable to swab (clinically inappropriate due to end of life care or distress to person), clinical decision based on symptoms and duration since first swab, and that the individual was returning to a care home with a known outbreak"*
>
> p.15

Discharges of Particular Focus

The time between the first positive test result of each discharge and the date that they left hospital can help determine whether the patient was still infectious. Following discussion a window of 14 days either side of a patient's discharge date was set, drawn from isolation guidance (14 days from onset or positive test) and timeframes established by HPS to determine the possibility of the virus being acquired in hospital ("nosocomial").

This step allowed the identification of discharges where further examination was required to establish if the discharge may have initiated an outbreak in a care home. It should be noted that this is a difference in approach to that undertaken by PHS. That study did not look at whether discharges had a positive test result, rather it looked at the increases in probability of an outbreak following any discharge, whether tested positive or not, into a home. The approach taken here considers only those with positive test results and therefore will not include those untested or those with a negative result who may have introduced the virus into a care home.

As mentioned at the private Board meeting and referred to earlier, a small number of further discharges were identified where a patient, discharged after the Cabinet Secretary's announcement, only tested positive in hospital before they left thus contrary to the expectation of two negative tests as required at the time. These added to those potentially infectious or with nosocomial acquisition total 41 discharge episodes (38 patients as some patients had more than one discharge episode) requiring further exploration.

A number of these 41 occasions involved admission to hospital from the care home, having tested positive, or suspected of already having COVID in the home and then returned to the originating care home where an outbreak was ongoing.

The table below sets out how these cases relate to the guidance in place at time of discharge.

Discharges of Particular Focus against Guidance Status

Guidance Status	Number of Discharges	Cases
1. No Care Home Discharge Guidance	315	7
2. Testing Not Mandated although isolation should occur	244	15
3. Testing on discharge if testing capacity allows but not mandatory		
	559	**22**
4. 2 negative swabs before transfer and 14 days isolation	228	19
	228	**19**
	787	**41**

6. Phase 2 Findings

At its private meeting in September, the Board received an update on the work undertaken to date, identifying those for further investigation, that appeared to not have met national guidance in place at the time (i.e. where patients being transferred to a care home required two negative tests prior to discharge).

The Board asked for a report to be provided to the Healthcare Governance Committee in November, although, in the event, it was the focus of a separate Board briefing later that month.

To provide the Healthcare Governance Committee and the Board with assurance that all discharges that could have possibly introduced COVID to a care home were thoroughly evaluated, all 41 cases identified in Phase 1 – including the additional two cases from PHS - underwent an in-depth review.

As outlined above in the Phase 2 – Scope section, the following reviews were conducted on all 41 cases and results were collated with the Administrative and Clinical Audit results from Phase 1:

a. In-depth Administrative Audit: gather information on presenting complaint, ward transfers, COVID testing information (e.g. when patient tested positive relative to admission and discharge) and care home information

b. Infection Control Review: Clinical staff from Infection Control reviewed cases relative to the status of the related care home (e.g. care home already had known cases of COVID or agreed to accept the patient knowing they were COVID positive at time of discharge) and the national guidance in place at time of discharge.

c. Review of Care Home Timelines: LAS reviewed cases against all care home staff and residents that had tested COVID positive or died due to COVID/Suspected COVID in a particular care home

These comprehensive reviews found that, of the 41 discharge episodes, 38 patients were discharged to 21 different Older People's care homes in Lothian. 12 of these homes were in Edinburgh with 9 elsewhere within the Board.

As referred to earlier, in the period examined from 22nd April onwards, several patients were highlighted as apparent variations from national guidance at the Board meeting on 24th September 2020. Despite national guidance setting out the expectation that discharges to a care home should occur following two negative tests, 9 patients were discharged following only a positive test in hospital.

All of these discharges, as well as the further two brought to light via the national exercise, were examined. All fell into the explanations for variance given in the national report and cited earlier in this report, returning to a home where an outbreak had already commenced with instances where distress impeding testing was also noted.

Additionally, the timelines for each of the 21 homes identified was examined to determine whether the discharge could have initially introduced the virus to the home. This narrowed the focus down to 5 homes.

Once those deemed, through separate clinical review by Medicine of Elderly clinicians, as "unlikely" to have had COVID at time of discharge are set aside, less than 5 remain, with discussions in every case documenting the need to ensure isolation of the patient in the care home. Statistical governance disclosure control prevents release of the exact number.

6.1 Virology Review

A review of the 41 episodes noted above as possibly introducing COVID to a care home following discharge from hospital was requested as genome sequencing could help determine if the COVID strain for these cases was indeed the common strain within the care home.

Therefore, such a review is being pursued, focussing upon the 5 homes referred to above.

7. Limitations

The identification of care home residents, those discharged from hospital to care homes and care home staff in hospital records is not straightforward. As highlighted earlier, previous work by Public Health Scotland has identified limitations with the options available to identify care home residents and discharges analytically. Relevant data fields on systems are recognised as suffering from poor data quality and there is no register of either care home residents or staff. It will be understood that the issue of poor data quality led to the delay of the nationally commissioned work.

Therefore in order to explore questions over discharges to care homes from hospital and possible transmission of COVID it was necessary to manually review case notes.

1050 discharges were initially identified as potentially ones that involved a care home between 1 March and 31 May 2020. 763 (73%) were confirmed as such on examination. As had been anticipated in the scoping, this was unlikely to have identified every care home discharge in scope and indeed equivalent work by PHS determined there were a further 24 cases. It remains unlikely that all discharges to care homes in the period have been captured.

The pattern of outbreaks within care homes has been derived from laboratory data. In addition to the challenges highlighted above regarding the identification of those connected to a care home, there are limitations with using laboratory data. In addition to the problem of identifying which tests relate to those associated to a home, tests for COVID are recognised as not 100% effective. This means that those with a negative result may have had the virus. Moreover, it is not assured that everyone connected to a care home and who had COVID had been tested. This may because they were asymptomatic or as a result of the policy/practice initially extant in care homes which was that specimens were only taken from the first cases in an outbreak. Whilst the details of those where COVID has been specified on death certificates, although a positive laboratory result is absent, have been incorporated into the analysis, this does not mitigate for the risk that those with COVID may have been overlooked.

As a consequence of the above issues, it is possible that discharges that were primary cases in care home outbreaks have been incorrectly identified. Furthermore, it will be understood that the virus may have entered a care home through more than one route. As genome sequencing of virus strains from a Virology Review has not been incorporated to date, it is only possible to potentially identify the first entry, not subsequent.

Finally, a number of conclusions in this report hinge on the time between the positive test and the date of discharge from hospital – both in relation to their potential infectiousness and whether the virus was acquired in hospital. Whilst these assumptions are not new – for example the timescale for determining whether the virus was acquired before discharge uses nosocomial timescales drawn up by HPS – they are recognised as imperfect. The clinical review panels deployed during this work will have addressed some of this risk; but not all.

In light of the above, it should be recognised that the conclusions of this report should not be considered definitive, and that greater weight should be placed on the output of the work being progressed on behalf of the Lord Advocate.

Given these limitations it is recommended that the Committee take **moderate assurance** from the review process undertaken, as despite controls applied a moderate amount of residual risk remains.

8. Conclusions

The Internal Review confirmed which patients were discharged to a care home between 1 March – 31 May 2020. Further analysis of these discharged patients provided assurance that national guidance was followed for the majority of discharges.

A comprehensive review of the previously highlighted 41 cases established that, while some had been discharged positive, they had proper instructions to isolate upon discharge and the care home knew the patient was positive before accepting the patients. Additionally, several patients were found to be positive on or within two days of admission (from the same care home where they were later discharged to).

Five discharge episodes were determined to have possibly introduced COVID into a care home following discharge from hospital. It should be noted that all these cases were prior to 22 April 2020 when the national requirement for two negative tests prior to discharge was instituted.

Once those deemed, through separate clinical review by Medicine of Elderly clinicians, as "unlikely" to have had COVID at time of discharge are set aside, less than 5 remain, with discussions in every case documenting the need to ensure isolation of the patient in the care home. Statistical governance disclosure control prevents release of the exact number.

9. Recommendations & Progress to Date

It has not been possible to complete the virology assessment for the discharges and other residents of the 5 care homes identified in the time available. **It is recommended that the Committee note that this aspect of work is currently being undertaken.**

Given the limitations on the approach taken in this study, **it is recommended that the Committee take moderate assurance of the review's process**, given that moderate risk remains that discharges that may have introduced the virus into a care home have not been identified.

It is also recommended that those actions supported at the private Board meeting on 24 September 2020 continue to be progressed.

The status of those recommendations is set out below.

1. Full analyses be shared with Scottish Government, Public Health Scotland, Health Protection Scotland and Lord Advocate's investigation team.
   As identified earlier, data has already been shared with PHS to assist in their own publication. Furthermore, the Lord Advocate's team has been briefed on the initial stages of this work with the later output made available to them,

   Discussions with other identified bodies will occur following incorporation of virology results.

2. Incorporation of learning from the review into clinical practice
   Members will have noted the work undertaken by Medicine of Elderly and their contributions to this paper. Their findings are under consideration by the Directorate's clinical governance leads.

   Wider learning opportunities are currently under consideration by NHS Lothian's Medical Director and the Director of Nursing.

3. Improve data relating to Care Homes
   NHS Lothian is currently working with Intersystems and other Boards to improve the ability to collect information about care home residents in hospital systems. Members will also be aware that there are a number of data recommendations within the PHS report published at the end of October.

   In addition to these steps, the potential for data quality checks are also being explored.

   Additionally, it will be necessary to amend those cases audited where incorrect information has been identified in order to ensure that national records are rectified.

4. That the families and care homes identified are met.
   The work contributing to this report has narrowed the discharges of concern to five.

   It is suggested that contact is made with these families and care homes once virology results have been incorporated into this work in order to reduce the potential for inaccurate conclusions and that the Chief Executive and Interim Chair consider how this contact is made.

10. Appendices

- Appendix 1 – Initial Methodology Document - Discharges to Care Homes during COVID
- Appendix 2 – Clinical review of discharges to care homes during COVID
- Appendix 3 – Public Health Scotland Summary Report

Discharges to Older People Care Homes during COVID

This document sets out the approach that will be taken to examine discharges from NHS Lothian's hospitals into older people's Care Homes between March and May 2020.

Aims of Study

This study aims to determine the following:

- The number of discharges from Lothian hospitals to older people's care homes in the period;
- The specific homes to which the patients were discharged;
- Whether testing was undertaken prior to discharge (including no test) and compliance with guidance in place at that time;
- How many of those discharged from hospital may have acquired Covid whilst an inpatient;
- Whether such patients might subsequently be a primary case in a care home where an outbreak occurred;
- How many deaths occurred from Covid in homes where a potentially primary case may have acquired it in hospital;
- The presence of patients who had been identified as delayed discharges within the above analyses.

Additionally, the study will respond to 2 points requested from the Lord Advocate/CDIT, which are:

- Those patients who were in hospital, who tested positive and who were moved to care homes at some point between 1 March 2020 and 21 May 2020
- Those patients who were not tested and who moved from hospital to care homes between 1 March 2020 to 21 May 2020

This work may however also be of assistance in supporting PHS in their work on behalf of the Cabinet Secretary.

Methodology

There are four stages to the process:

1. Establishing a list of those discharged to older people's care homes, determining to which homes they were transferred and their test history;
2. Identifying the chronology of cases in each care home with an outbreak from test results (reconciled subsequently with HPZone) and, in order to include those with presumed Covid status, death certificates;
3. Synthesising these outputs to:

a. *Identify those discharges who may have been infectious at the time of transfer.* Patients who tested positive in hospital will be assumed to be potentially infectious for the 14 days following their **first** positive test (split by 1-7 days and 8-14 days.) [5]
b. *Identify those discharges subsequently found to be positive in the Care Home, potentially having acquired Covid in Hospital.* - Nosocomial timelines developed by HPS will be used. Thus, a positive test in 1 or 2 days from hospital discharge will be definite hospital acquired, between 3 and 7 probable, 8 to 14 indeterminate, 15 or more non-hospital.
c. *Identify instances where the primary case may have been a hospital discharge, who have acquired Covid in hospital* –This will be achieved using the outputs from 3a and 3b and setting this against the chronology of positive cases in a home identified in 2.
d. *Identify discharges, with no history of a positive test whatsoever, who were discharged into a home between an outbreak occurring and 2 weeks beforehand*– this will be achieved by making use of the test history.
e. *Identify those with no test during their hospital stay* – lacking a record of a sample collected between their admission and discharge dates.

4. Undertaking Clinical Review, recognising limitation to notes held on Trak:
    a. Assessing the testing undertaken during patients' time in hospital and in preparation for their discharge, contrasting it with guidance extant at that time;
    b. Confirming groups identified as discharges in 3a, 3b and 3c, with the review;
    c. Examining cases in 3d, where no positive is recorded, to allow identification of instances where clinical symptoms of Covid were recorded during their hospital stay despite absence of a positive test.

Scope of the Audit

This audit was commissioned as the data quality concerning discharge locations was not sufficient to support a robust analysis. It will therefore require manual assessment of records. Given the timescales available, it is proposed to limit the focus of the audit in a number of ways, set out below.

Timescale – the majority of FOIs received in this area cover a period from February 2020 to June 2020, although one seeks information back to January 2019. Having assessed the number of records requiring potential review, the timescale has been limited to March – May 2020. This coincides with the study commissioned from PHS by the Cabinet Secretary;

Types of Care Home - The concern of Care Home deaths has focussed particularly on homes for Older People. It is proposed that this be the focus of the study, excluding other Care Inspectorate registered establishments for other client groups. NRS also includes some other establishments, such as hospices and police stations, under their definition of care homes. These locations are also to be excluded.

Age - the limitation to older people's homes also allows age to be used to limit those records to be examined (no Covid deaths occurred in other care homes[6]). A minimum age of 50 at discharge is proposed.

[5] Based on HPS stepdown guidance v1.61. https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3012/documents/1_Covid-19-step-down-guidance.pdf
[6] Some were identified at hospices.

Location – Records will be taken from Trak, which includes activity at non-NHS Lothian locations such as hospices, private hospitals and Hospital at Home. It is proposed that the study is limited to discharges from NHS Lothian hospitals. Similarly discharges where patients have been readmitted on the same day will be excluded.

Length of Stay – Particular interest has been expressed over the steps taken to improve the delayed discharge position. However many patients spend only a short time in hospital. It is therefore proposed that those who do not stay overnight are excluded from the analysis. Determining where such individuals were infected is unlikely to be possible through the hospital dataset alone.

Virus Strain – Information on virus strain through whole genome sequencing is not available for patients in this dataset. If this were available, this would allow chains of possible infection to be identified.

Likelihood of Care Home Residence - Although no dataset permits definitive identification of discharges to care homes, there is content that can assist their identification. Whilst the use of these datasets will not deliver assuredly every discharge to care homes in the period, it will – when coupled with manual assessment – provide a more complete result than that available currently. The following will be used to identify potential care home discharges for assessment, where:

1. The relevant Trak episode indicates that admission was from a care home
2. The relevant Trak episode indicates that discharge was to a care home
3. Elements of the patient address matches that of a care home;
4. The GP has identified that the patient is resident in a care home for remuneration purposes – either at time of discharge or at any point;
5. A patient was recorded as a delayed discharge during the relevant hospital admission and that delay was associated with a care home;
6. The death certificate indicates that the patient died in a care home; or
7. Where the Covid lab test undertaken for the patient indicates that they are a care home resident.

Risks

Risks and mitigations are set out below

Risk	Mitigation
That discharges into care homes are incorrectly identified, leading to incorrect conclusion on outbreak homes	Assess outbreak houses against content held by HPT on HPZone
Insufficient time to undertake exercise	Addressed in part through restricting audit dataset to the area of most concern. If the final stage (clinical audit) is not completed in time, an interim report based on analytical results will be provided – with clinical conclusions made available subsequently
Results differ from PHS report and Care Home Death Inquiry work	PHS data will be available during this exercise and will have the potential to be considered. These analyses will inform the Care Home Death Inquiry but the Inquiry will also consider other material. Those receiving the report will need to

	be advised of the potential for differences and reasons for that.
That infection may have entered through other routes despite hospital discharge being identified as possible primary case	Information on staff infections will be incorporated if possible. HPS nosocomial timeframes will be used to inform likelihood of arising from hospital infection.
Unavailability of virus strain information from whole genome sequencing leading to other primary cases in home being overlooked	Consider revisiting study once data available

Timescale

At ELT on 25th August, the timescale of a month was given for this exercise.

Release on 25th September should coincide with pre-release of the PHS study on behalf of the Cabinet Secretary, due on the 30th September.

APPENDIX 2 - CLINICAL REVIEW OF DISCHARGES TO CARE HOMES DURING COVID

Summary of Findings

Clinical review of discharges to care homes during COVID

1. Overview of process

Clinical review was undertaken for 570 care home discharges from NHS Lothian hospitals between March and May 2020. These reviews were shared amongst 29 reviewers at specialty registrar or consultant level.

Cases were selected by LAS based on potential risk of transmission of COVID-19 into care homes. Broadly this included patients discharged from hospital to a care home:

1. with a positive test result(s) within 14 days of transfer
2. who died with COVID-19 listed on death certification after transfer
3. who were transferred to a care home with COVID-19 death(s) and/or an outbreak

This work was intended to support understanding of any potential impact that hospital discharges to care homes may have had on containment or spread of COVID. As not every patient discharged was tested over this period, and because an individual test lacks some sensitivity (i.e. has false negative results), a simple review of test results in relation to hospital discharges and care home outbreaks may not provide full understanding.

Important questions to be address included:

- was there clinical suspicion of COVID-19 at discharge (with or without testing)?
- was advice given for patients to be isolated within their homes following discharge?
- were there symptoms and/or signs of possible COVID at discharge (with or without testing)?
- what was the overall clinician suspicion of COVID at the point of discharge to care homes in this period (unlikely, possible, probable, confirmed)?

As such judgements include a degree of subjectivity, a proportion of cases were double reviewed (reviewers blinded to each other). Reviewers were largely assigned cases managed outside of their usual clinical area, but were asked to exclude themselves if they subsequently identified a case they were significantly involved with (no such cases occurred).

2. Summary of findings

Primacy has deliberately been given to the overall clinical judgement of the reviewer(s) in the likelihood of the patient having COVID-19 at the time of hospital discharge. This was captured using a single question:

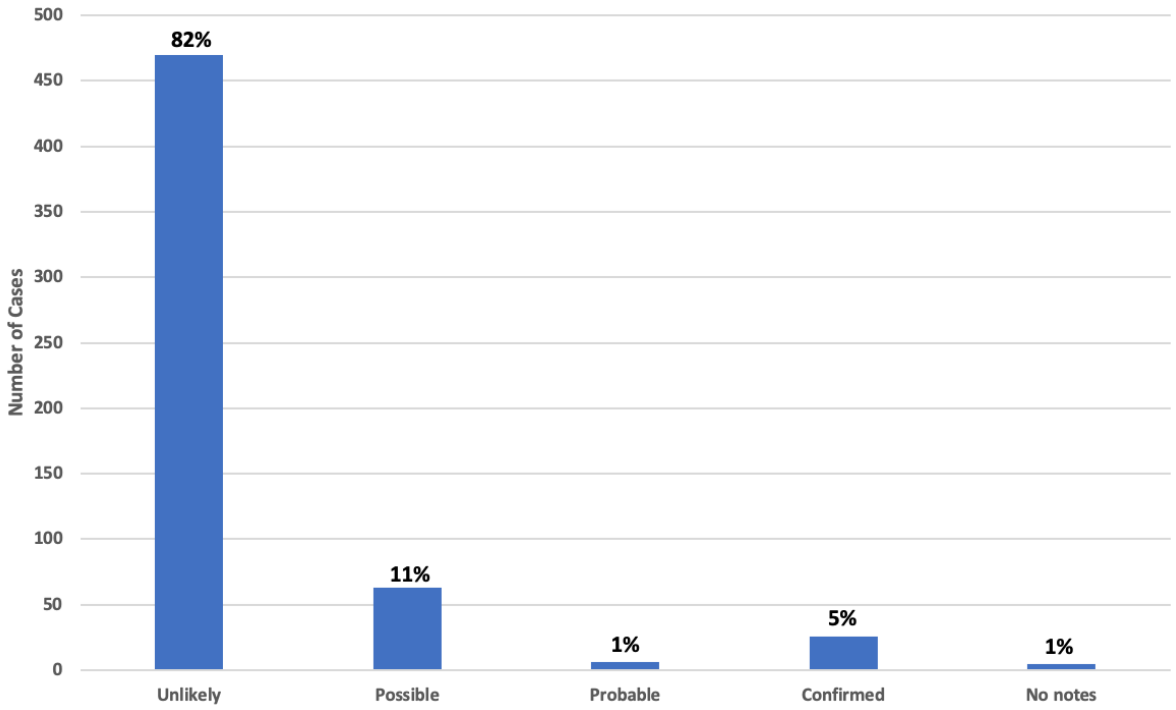
Reviewing all the information available, what is your impression of the likelihood of COVID-19 at the time of hospital discharge?

Select from: 1) Unlikely; 2) Possible; 3) Probable; 4) Confirmed (i.e. swab positive)

5 cases could not be reviewed due to a lack of notes. These all related to stays in HBCCC units in Edinburgh, Midlothian and East Lothian, where regular progress notes are not recorded on Trak. Some of these cases (but not all) had discharge letters, but in these 5 cases, reviewers felt there was insufficient information to make a judgement on COVID-19 status at the point of discharge.

Where cases were double adjudicated and there was disagreement, the potentially more serious likelihood statement was chosen for this initial analysis (e.g. if 'possible' and 'probable' selected, 'probable' taken forward) and the case underwent further narrative review (see below). An objective algorithm was also applied to all cases using potential signs and/or symptoms of COVID-19 (see below).

The breakdown of responses for overall likelihood of COVID-19 at discharge was as follows:



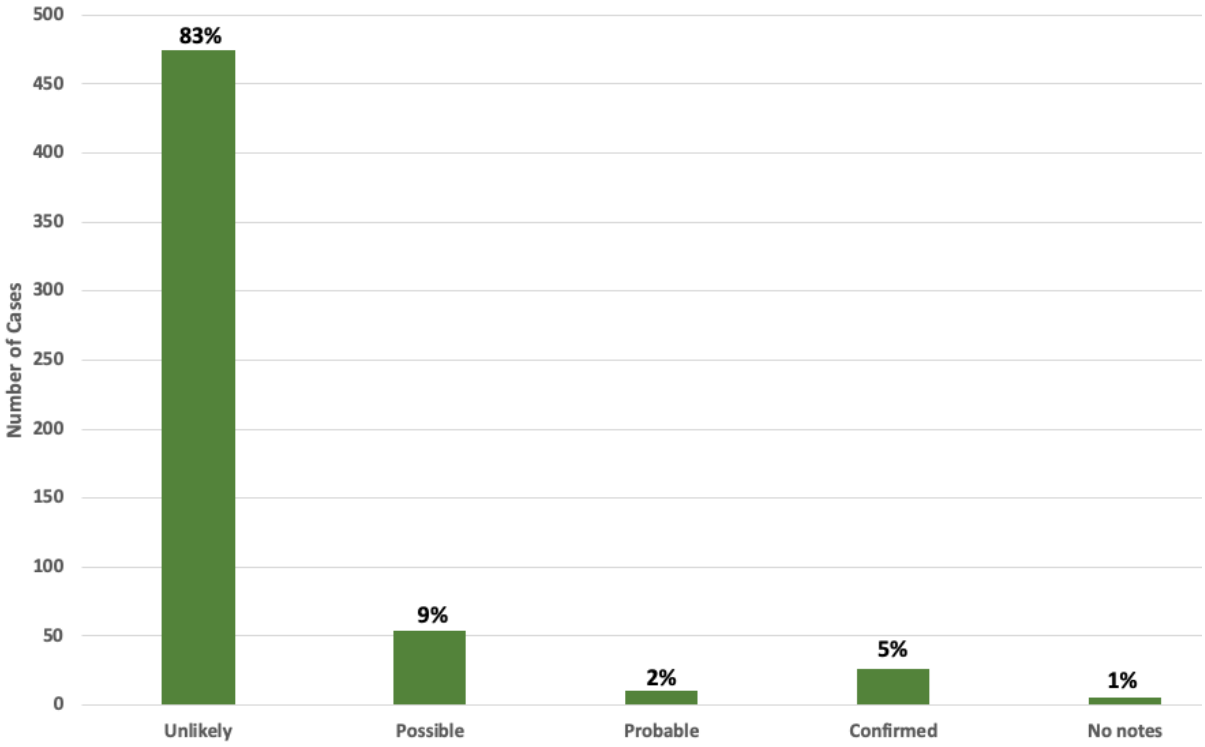
To provide some objectivity to the assessment of COVID-19 at discharge, additional information was collected by reviewers for 6 clinical features that can be suggestive of infection, at the point of hospital discharge. These were as follows:

1. Potential COVID-19 symptoms (cough, SOB, loss of taste/smell) or new geriatric syndrome (e.g. delirium or falls/immobility)
2. Fever >37.8
3. Radiological changes consistent with pneumonia
4. New significant lymphopaenia (<1 x 10^9/L) in the absence of neutrophilia
5. Evidence of a significant inflammatory response (CRP >30)
6. A new or increased oxygen requirement

In addition, if a clear alternative diagnosis to explain changes in the above criteria was present, this was recorded.

Prior to distribution of cases, an algorithm to classify likelihood of COVID-19 transmission using these objective criteria was established (see **Appendix 1**). Using this algorithm, the number of cases in each group

appears very similar, suggesting that objective criteria influenced individual reviewers' assessment of likelihood of infection:



The overall numbers in each group by each method are as follows:

COVID likelihood at discharge	Overall Clinical Impression		Algorithm	
	Number	%	Number	%
Unlikely	470	83	475	83
Possible	63	11	54	9
Probable	6	1	10	2
Confirmed	26	5	26	5
No notes	5	1	5	1

3. Agreement between reviewers

Double review of cases was initially undertaken for a random selection of cases, but this was then supplemented for potential 'high-risk' cases identified by LAS, and any cases judged to be 'probable', or 'possible' with more than 3 suspicious clinical features on the first round of reviews. In total 30 cases were reviewed by 2 clinicians.

For the overall clinical impression of likelihood of COVID at discharge, exact agreement was seen in 24 (80%) of cases. In those with discrepancy, this was by one level only (i.e. unlikely – possible or possible – probable). In view of this reasonable but not perfect agreement, any case where any reviewer flagged 'probable'

likelihood of COVID went forward for more detailed narrative review (see below). This was also required as it transpired that reviewers quite reasonably interpreted "Confirmed" COVID differently – some as *any* positive swab during the admission, and others as only where a positive swab was *not* followed by negative swab(s) before discharge. For this reason, all cases with any selection of "Confirmed" status underwent narrative review.

4. Isolation advice on discharge

As part of the extraction of data, reviewers were asked if specific isolation advice was noted on discharge to care home. This was only found in 20 (4%) of cases, but reviewers frequently reported that they felt it was likely from the overall narrative of the clinical notes that discussions had taken place without formal documentation on discharge documentation (the original criteria defined for this work). The overall impression is that this low number does not therefore reflect clinical communication around isolation of suspected or confirmed cases, although clearly reflects formal documentation practice on discharge letters. More information was therefore gathered by detailed narrative review.

5. Narrative review of specific cases

[Discussion redacted as Potentially Disclosive]

6. Summary

The main conclusions of this work can be summarised as follows:

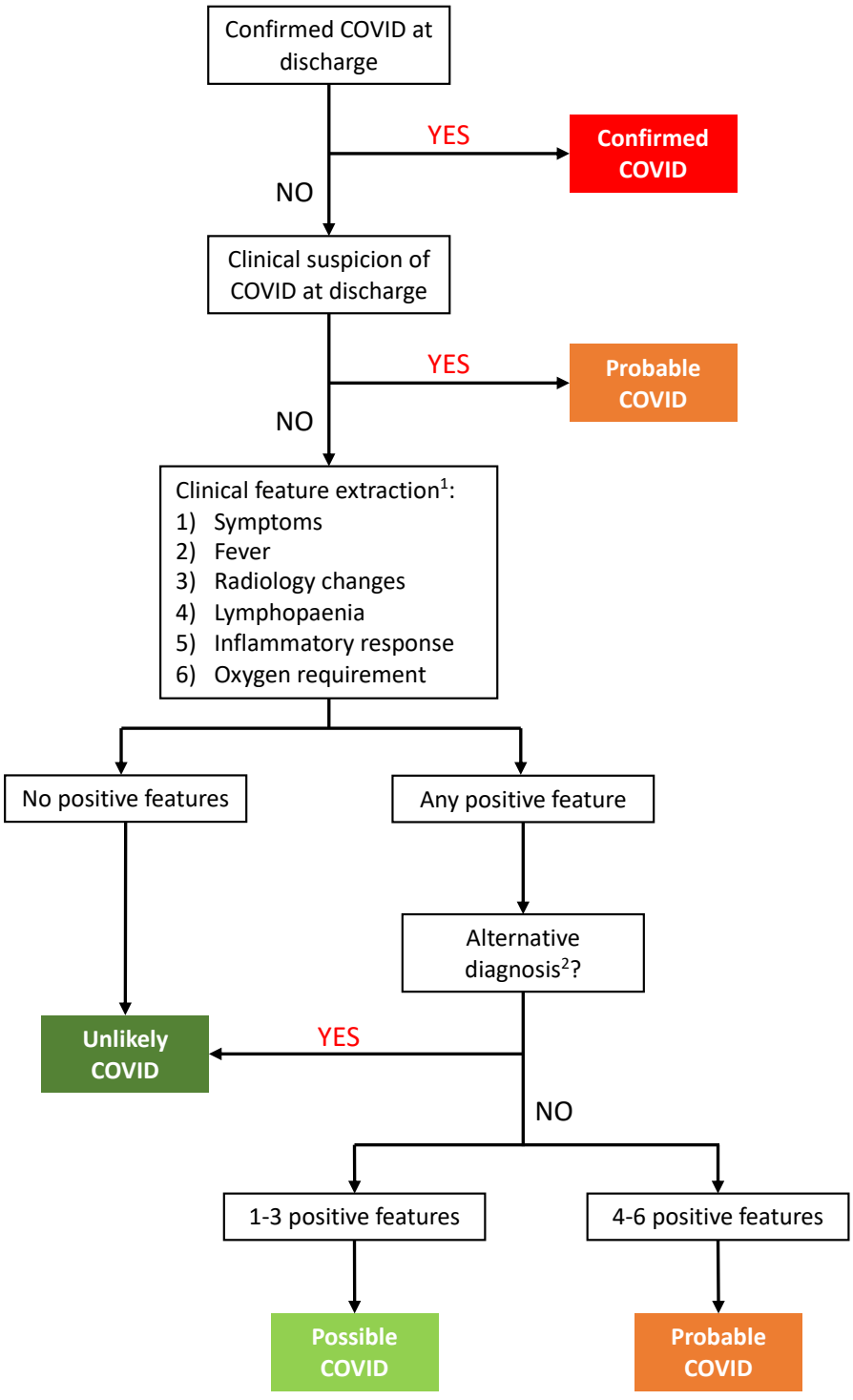
- The number of known COVID positive care home patient admissions with survival to discharge during this period was relatively low (around 1 in 20 of all discharges considered here and around 1 in 40 care home discharges across this period).
- In the early part of the pandemic there appeared to be excellent communication on the need to isolate when discharging positive patients back to care homes, although this rarely made the formal discharge documentation.
- Later, double negative testing was universally observed before care home discharge.
- Using multiple methodologies, a very small number (1-2% of this sample, <1% overall) of hospital discharges to care homes in this period were considered 'high-risk', where negative (or no) testing may not have reflected true COVID status. **[Redacted as Potentially Disclosive]**
- Review of these data will be further enhanced by including community care home testing data.
- This process of retrospective review is limited, particularly in the absence of regular testing in the early part of the pandemic. No conclusions can be classed as absolute.

Report author: Dr Atul Anand (Consultant MoE, RIE)

Analysis supported by Dr Marie-Claire Grounds (ST7, MoE).

Review panel included clinical staff across the RIE, WGH and SJH sites.

7. Appendix 1 – Algorithm for allocation of COVID-19 likelihood from clinical features



[1]See full protocol for definitions
[2]Clear alternative and evidenced diagnosis identified by clinical team

8. Appendix 2 – Brief narrative reviews

[Redacted as potentially disclosure]

Discharges from NHSScotland Hospitals to Care Homes

Public Health Scotland

Between 1 March and 31 May 2020

A Management Information release for Scotland

Publication date: 28 October 2020

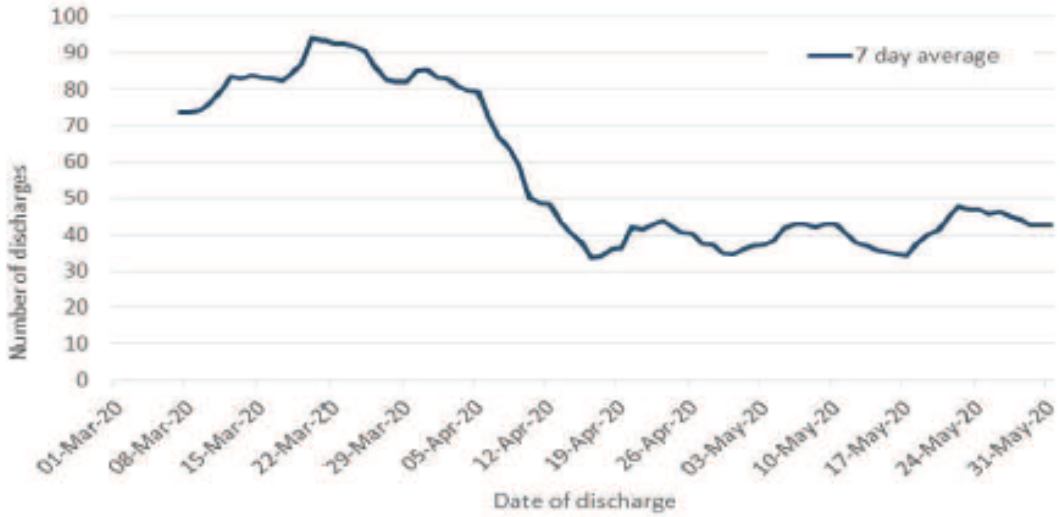
About this release

This publication by Public Health Scotland (PHS) presents management information statistics on people aged 18 and over who were discharged from an NHSScotland hospital to a care home between 1 March and 31 May 2020. The report is presented in two sections. Section one of the report explains the methodology in defining the cohort of patients who were discharged, and describes their demographics and COVID-19 testing status. Section two defines and describes care home outbreaks of COVID-19 with an analysis of the factors associated with those outbreaks, specifically including hospital discharges.

Main Points

- Between 1 March and 31 May 2020, there were 5,204 discharges from NHS hospitals to care homes (4,807 individuals), this accounted for 5.3% of all hospital discharges during the same period.

Seven-day moving average for daily discharges to care homes; Scotland; Discharges between 1 March to 31 May 2020



Source: Validated register of hospital discharges to care homes

- There were 3,599 discharges from hospital to a care home between 1 March and 21 April. The majority (81.9%) of which were not tested for COVID-19, in-keeping with clinical guidance which restricted testing to those with symptoms of infection. Of the 650 who were tested, 78 received a positive result while in hospital.
- There were 1,605 discharges from hospital to a care home between 22 April and 31 May. The majority (1,493, 93%) were tested for COVID-19, in line with the changes in clinical guidance. Of these, 1,215 tested negative and 278 tested positive. Of those who tested positive, 233 had a negative test result prior to discharge.

It is important to note that there are valid clinical reasons for individuals **not** to be tested prior to discharge, relating to their capacity to consent to testing and avoiding causing distress, and to appropriateness of testing, e.g. in end of life care situations.

- 843 of the 1,084 care homes received hospital discharges between 1 March and 31 May.
- Using laboratory confirmed cases, 348 (32%) of care homes in Scotland experienced an outbreak of COVID-19 in the home between 1 March and 21 June.
- In the statistical modelling analysis:
    - Care home size has the strongest association with outbreaks of COVID-19, and this association persists after taking account of other care home characteristics including discharge from hospital. Risk of a care home outbreak increases progressively as the size of care home increases.
    - Hospital discharge is associated with an increased risk of an outbreak when considered on its own. However, after accounting for care home size and other care home characteristics, the estimated risk of an outbreak associated with hospital discharge reduces and is not statistically significant.

Background

On 18 August 2020 the Cabinet Secretary for Health and Sport, commissioned PHS to carry out this work and to publish the findings. Both the University of Edinburgh and the University of Glasgow were partners in the production of this report.

Contact

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For all media enquiries please email phs.comms@phs.scot or call 07500 854 574.

Further Information

Data from this publication are available from the publication page on our website.

PHS and Official Statistics

Public Health Scotland (PHS) is the principal and authoritative source of statistics on health and care services in Scotland. PHS is designated by legislation as a producer of 'Official Statistics'. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Statistics. Further information about our statistics.

NHS LOTHIAN

Board Meeting
9 December 2020

Director of Finance

PROJECT BANK ACCOUNT - ONCOLOGY ENABLING LINAC/ADMIN PROJECT

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the opening of a Project Bank Account for the Oncology Enabling Linac/Admin capital project. The Board's Standing Financial Instructions state:

'The Board shall approve the banking arrangements. No employee or Local Authority Employee may open a bank account for the Board's activities or in the Board's name, unless the Board has given explicit approval.'

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

2 Recommendations

The Board is recommended to:

2.1 Approve the opening of a project bank account for the Oncology Enabling Project at the Western General Hospital.

2.2 Confirm that the five executive members of the Board will provide the required personal information to complete the forms for the Royal Bank of Scotland to carry out the bank's Know Your Customer and Know Your Business regulatory checks.

2.3 Authorise the Director of Finance to be the designated signatory to sign the account application on behalf of the Board.

2.4 Authorise the Director of Finance to be the designated signatory to sign the trust deed on behalf of the Board.

3 Discussion of Key Issues

3.1 The Review of Scottish Public Sector Procurement in Construction noted that the construction sector suffers from endemic late and extended payment terms between businesses. It recommended that the Scottish Government should trial project bank accounts.

3.2 The Scottish Government Procurement and Property Directorate co-ordinated pilot projects and worked with the banking sector to develop project bank account services, including the Scottish Government's Banking Services Framework Agreement.

3.3 A project bank account is a facility which a commercial bank provides. Scottish Government policy requires NHS Boards to open project bank accounts when the value of the project is more than £2m. The NHS Board is required (as the commissioning body) to open the account jointly with the main contractor. A project bank account operates as a legal trust, and the NHS Board and the main contractor will both be named trustees in the trust deed. It allows the commissioning body to pay the main contractor and supply

chain firms which are named as beneficiaries of the trust deed. As a project proceeds, interim certificates determine how much should be paid to each beneficiary. The commissioning body deposits the total amount to be paid into the account, and all the beneficiaries are paid simultaneously.

3.4 This differs from previous practices where the total amount of the interim certificate would have been paid into the main contractor's bank account. The main contractor's payment from the project bank account only reflects the work that it has directly executed, plus the total amount due to supply chain firms which have not joined the project bank account i.e. non-beneficiaries.

3.5 Once the commissioning body has deposited the amount to be paid (as an interim certificate requires) into the project bank account, the amounts due to named beneficiaries are excluded from assets deemed to belong to an insolvent main contractor. This is known as "ring fencing" and protects named beneficiaries by preventing money which has been certified under the main contract from then being held back or reduced by the main contractor. The trust deed will not of itself create any direct works contract between the NHS Board and any of the subcontractor beneficiaries. The NHS Board's only direct relationship with the firms participating in the project bank account is that of being a trustee in relation to the named beneficiaries (main contractor and subcontractors). The trust deed governs that relationship, not the main contract

3.6 For Scottish Government and other public bodies, a trust is created by a trustor (public body) and the trustees (public body and main contractor) signing a trust deed. The deed complies with the law of Scotland and names the beneficiaries to be paid from the project bank account. A trust deed must be agreed for each project which uses a project bank account.

3.7 The law requires all banks to check the credentials of any entity seeking to open an account. These processes, referred to as 'Know Your Business' and Know your Customer, typically take at least 20 working days. All parties who are involved in setting up and operating the project bank account should ensure that form-filling etc, is accurate, complete and uncontested at the first time of asking to avoid unnecessary delays.

3.8 The Full Business Case for the Oncology Enabling project at the Western General Hospital was approved by the Scottish Government Capital Investment Group in September 2020, with the requirement for a project bank account referenced as part of the feedback to NHS Lothian. The new Linac / Admin block is the first part of that project to proceed and will be the first project in NHS Lothian to utilise a project bank account through the process described.

4 Key Risks

4.1 The key risk covered in this process is assurance on the control of the use of the internet banking platform is deployed safely, securely and efficiently. The project bank accounts use the same internet banking platform as for existing Board banking transactions, and the proposal is an extension to existing processes for that.

4.2 The implementation of a project bank account mitigates the the consequences of late payment to sub-contractors, particularly the insolvency of the main contractor, resultant redundancies and wider costs such as a greater draw on state benefits and loss of tax revenue.

5 Risk Register

5.1 There is nothing to add to the Risk Register at this stage.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

7.1 As this particular report does not relate to the planning and development of specific health services, there was no requirement to involve the public in its preparation.

8 Resource Implications

8.1 There are resource issues arising from this paper are minimal – there is no cost of opening the account and small transaction costs <£1. Additional administrative activities can be accommodated within existing resource.

Doreen Howard
Head of Financial Control
19th November 2020
Doreen.howard@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Directors Form

4. Directorship details

Please complete the details (including the current residential addresses) of the directors of the company.

Percentage of total ownership held ☐ %

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ ☐ (please specify)

First name

Middle name(s)

Surname

Address line 1

Address line 2

Address line 3

Address line 4 OR overseas country

Postcode

Position held

Contact telephone number (including extension if applicable)

Fax number

Date of birth (DD/MM/YYYY)

Nationality/ies

Do you hold any citizenships? Yes ☐ No ☐

Citizenship/s

If you have more countries of Nationality or Citizenship, please ask your Relationship Manager/Business Manager Team for a supplementary Customer Taxation Form and tick this box. ☐

Country of birth

Place of birth (town)

Tax residencies

Tax residency United Kingdom ☐ Other ☐

Please select the box(es) where you are resident for income or corporation tax Purposes.

If 'Other' please tell us where you are resident for tax purposes

If 'Other' please enter the tax identification or reference number/social security number or local equivalent Country

Are you resident for tax purposes in any other countries? Yes ☐ No ☐

If 'Yes' please list here and provide your tax number

Country

Tax number

Country

Tax number

Country

Tax number

☐

If you have more than four countries where you are resident for tax purposes, please ask your Relationship Manager for a supplementary Customer Taxation Form and tick this box.

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NHS LOTHIAN

Board
9 December 2020

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on the NHS Lothian's Corporate Risk Register for assurance.

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

2 Recommendations

The Board is recommended to:

2.1 Accept the risk assurance table, as set out in Appendix 1, as a summary of all risks including levels of assurance and grading, as agreed by the relevant committee.

2.2 Note that a high-level review of the risks on the corporate risk register is being undertaken.

3 Discussion of Key Issues

3.1 As part of our systematic review process, the risk registers are updated on Datix on a quarterly basis at a corporate and an operational level. Risks are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used, is based on the same risk scoring matrix, remains unchanged.

3.2 There are currently 22 risks in Quarter 2 on the corporate risk register. The 10 risks at Very High (20) are set out below. A full copy of the corporate risk register is available on request.

1. The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge
2. Patient Safety in Royal Infirmary of Edinburgh Accident & Emergency Department
3. Achieving the 4-Hour Emergency Care standard (organisational)
4. Timely Discharge of Inpatients
5. General Practice Sustainability
6. Access to Treatment (organisational risk)
7. Access to Treatment (patient risk)

8. Delay in providing clinical care for RHCYP and DCN patients in new facility
9. Health of the population and impact on NHS Lothian services from Covid-19
10. Brexit

3.3 The Healthcare Governance committee received a paper on the Winter plan at the November 2020 meeting and accepted moderate assurance. This in turn provides moderate assurance on the following risks:

- Patient Safety in Royal Infirmary of Edinburgh Accident & Emergency Department
- Achieving the 4-Hour Emergency Care standard (organisational)
- Timely Discharge of Inpatients
- Access to Treatment (Organisational Risk)

3.4 Moderate assurance was also accepted on the Clinical prioritisation plan, which provides assurance on the Access to Treatment (patient and organisational risks). The impact of COVID restrictions on access to treatment was acknowledged and this informed the risk grading.

3.5 The Staff Governance committee considered papers on Water Safety (Legionella) and Violence & Aggression at its October 2020 meeting. Limited assurance continues to be accepted for management of the Water Safety risk (Legionella) due to incomplete work around the systems of control, including the development of water safety plans for all buildings. In relation to violence and aggression, moderate assurance was agreed with respect to appropriate policies and procedures being in place though assurance was limited in terms of reliable implementation of required actions.

3.6 The current phase of the pandemic has resulted in closer working through the resilience command structure with a clear log of discussions and decisions kept. This is most pertinent for winter planning, Covid, scheduled and unscheduled care and Brexit, and is a responsive and dynamic system but which has not yet been fully linked to the risk register process

3.7 **Risk Review**

3.7.1 Work continues to conduct a high-level review of risks on the corporate risk register and in scoping work to refresh the risk register, with a particular focus on a clear description of the elements of each risk that are within NHS Lothian's control and those that are not. This will begin with the acute services risk register, included training for risk owners and handlers and will explicitly address the impact on risks form decisions taken as part of the Gold and silver command structure.

3.7.2 Work will also be re-started to engage with Health and Social Care Partnerships Chief Officers and their staff involved in risk management to examine common risks across the system and how they are being managed through health and council risk management processes.

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. It fails to describe adequately measures in

mitigation of risks that could be taken but are not, or conversely, relies on control measures that are not in place reliably.

5 Risk Register

5.1 Not applicable.

6 Impact on Inequality, Including Health Inequalities

6.1 Not applicable.

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

7.1 This paper does not consider developing, planning and/or designing services, policies and strategies.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

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29 November 2020
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List of Appendices

Appendix 1: Risk Assurance Table

Appendix 1

Risk Assurance Table

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
4984	Covid-19 New risk added June 2020 Update provided October 2020	Healthcare Governance & Risk Committee (HCG) July 2020 - HCG accepted limited assurance on this risk overall. A standing item on the HCG Agenda, last discussed November 2020.	Very High 20			Very High 20	Very High 20
4813	Royal Hospital for Children & Young People/Dept of Clinical Neurosciences Update provided July 2020	Finance & Resources Committee (F&R) & Healthcare Governance Committee (HCG) May 2020 - Board accepted: • Significant assurance that the facilities and the service are ready for DCN migration to Little France to commence on 11 May. • Moderate assurance of progress towards the signing of Supplemental Agreement 2 to deliver the required ventilation works in the RHCYP, noting that the timescale for Autumn completion is subject to further discussion. • Moderate assurance that the proposals for contract management of IHSL and their FM partners will be sufficient for the commencement of operations in the new facility. July 2020- F&R agreed risk remains very high.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
3600	Finance Update provided October 2020	Finance & Resources Committee September 2020 – F&R accepted limited assurance on the management of this risk.	High 12	Very High 20	Very High 20	Very High 20	Very High 20
3203	4 Hours Emergency Access Standard (Organisational) Update provided October 2020	Healthcare Governance Committee November 2020 - HCG accepted moderate assurance on the Winter plan which includes 4 hour emergency access performance.	High 10	Very High 20	Very High 20	Very High 20	Very High 20
4688	Patient safety in RIE ED Update provided October 2020	Healthcare Governance Committee November 2020 - HCG accepted moderate assurance on the Winter plan which includes 4 hour performance in RIE ED.	High 15	Very High 20	Very High 20	Very High 20	Very High 20
3726	Timely Discharge of Inpatients (Previously Unscheduled Care: Delayed Discharge). Update provided October 2020	Healthcare Governance Committee September 2020 – delayed discharge was discussed as part of HSCP annual reports, with moderate assurance accepted. November 2020 - HCG accepted moderate assurance on the Winter plan, which includes timely discharge.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3829	GP Sustainability. Update provided January 2020	Healthcare Governance Committee July 2020 – HCG continued to accept limited assurance. Acknowledged that risk needs to be re-evaluated. Agenda item for January 2021.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
3211	Access to Treatment (Organisation Risk) Update provided October 2020	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 Winter plan and Clinical prioritisation plan.	High 12	Very High 20	Very High 20	Very High 20	Very High 20
4191	Access to Treatment (Patient Risk) Update provided October 2020	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.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
4693	Brexit/EU exit Update provided October 2020	Healthcare Governance Committee Agreement to keep under review pending discussions on trade agreements. October 2020 – Board agreed to reinstatement of this risk. Agenda item for January 2021	Very High 20	Very High 20	Very High 20	Closed 9/4/2020	Very High 20
4820	Delivery of level 3 recovery plans	Board	Very High 20	High 12	High 12	High 12	High 12

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
	Update provided October 2020	January 2020 - Board accepted moderate assurance on the management of the risk and agreed to reduction in the risk grading. Process with Scot Gov paused, acknowledgement of need for substantial review of plans/metrics in view of Covid-19					
4921	Bed Capacity in Acute Mental Health Update provided October 2020	Healthcare Governance Committee September 2020 - moderate assurance accepted as part of adult inpatient services	High 15	High 15	High 15	High 15	High 15
4694	Waste Management Update provided October 2020	Staff Governance Committee August 2019 - Health & Safety Committee accepted moderate assurance. July 2020 - moderate assurance continues to be accepted by the Staff Governance Committee.	High 15	High 15	High 15	High 15	High 15
5034	Care Homes New risk –approved by Board, 12 August 2020 Update provided October 2020	Healthcare Governance Committee July 2020 – 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. September 2020 – moderate assurance accepted on oversight of quality in care homes by HSCPs as part of HSCP annual reports. On January agenda	High 12				High 12
5020	Water safety (Legionella)	Staff Governance Committee	High 12				High 12

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
	New risk –approved by Board 12 August 2020	October 2020 – limited assurance accepted.					
3454	Learning from Complaints Update provided October 2020	Healthcare Governance Committee November 2020 – Moderate assurance accepted.	High 12	High 12	High 12	High 16	High 16
3527	Medical Workforce Update provided July 2020	Staff Governance Committee July 2020 - moderate level of assurance accepted that the controls in place mitigate any risks to immediate patient safety and quality of care. October 2020 – verbal update provided, no new level of assurance agreed.	High 16	High 16	High 16	High 16	High 16
3189	Facilities Fit for Purpose Update provided October 2020	Finance & Resources Committee June 2020 - Moderate assurance agreed, reduction in grading from High 16 to high 12 (impact changed from high to moderate) On agenda for further review Jan 2021.	High 15	High 16	High 16	High 12	High 12
3455	Violence & Aggression. (Reported at H&S Committee) Update provided October 2020	Staff Governance Committee October 2020 - moderate assurance accepted on processes in place, limited assurance on implementation of required actions.	Med 9	High 15	High 15	High 15	High 15
3328	Roadways/ Traffic Management (Risk placed back on the	Staff Governance Committee	High 12	High 12	High 12	High 12	High 12

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
	Corporate Risk Register December 2015) (Reported at H&S Committee). Update provided October 2020	October 2020- limited assurance accepted regarding safe traffic management at the acute sites.					
1076	Healthcare Associated Infection Update provided October 2020	<u>Healthcare Governance Committee</u> November 2020 - Moderate assurance accepted. Standing item on HCG agenda.	High 12	Med 9	High 16	High 16	High 16
3828	Nursing Workforce Update provided October 2020	<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.	High 12	Med 6	Med 6	High 12	High 12

NHS LOTHIAN

Board Meeting
9th December 2020

Director of Public Health and Health Policy

NHS LOTHIAN PHARMACEUTICAL CARE SERVICES PLAN

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board consent to publication of the Pharmaceutical Care Services Plan: Provision of Pharmaceutical Services Delivered via Community Pharmacy 2020

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

2 Recommendations

2.1 Note that the Pharmaceutical Care Services Plan: Provision of Pharmaceutical services Delivered via Community Pharmacy 2020 has been supported by the NHS Lothian Corporate Management Team on 24th November 2020.

2.2 Note that IJB Chief Officers and Planning Officers have seen the 2020 plan for information and will be included in future development of the plan

2.3 Provide consent for the plan to be published on The Community Pharmacy Lothian website.

2.4 Provide consent that the plan continue to be reviewed annually and brought to the Board every three years.

2.5 Support the recommendations in the Pharmaceutical Care Services Plan.

3 Discussion of Key Issues

3.1 In March 2011 PCA (P) 7 (2011) The NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 introduced an annual requirement for Boards to produce an annual Pharmaceutical Care Services Plan from 1st April 2011: Boards are obliged to publish Pharmaceutical Care Services Plans; Boards also have to monitor their Pharmaceutical Care Services Plan annually to reflect changes in service provision or patient needs.

3.2 This current version continues to follow previous guidance on the contents of the pharmaceutical care services plan produced by NHS Scotland Directors of Pharmacy group. The national pharmacy strategy document Achieving Excellence in Pharmaceutical Care has provided direction for changes in pharmaceutical services provided nationally. There has been work through Directors of Pharmacy to enable PCSP to meet the needs of Health Boards and further guidance from SG has been in development.

3.3 The PCS Plan is intended to fulfil two main functions, to:

• provide a comprehensive picture of the range, nature and quality of pharmaceutical care provided within the NHS Board area; and

• identify needs and gaps in the provision of pharmaceutical care within the NHS Board area.

3.4 In NHS Lothian, the main users of the plan are the PCCO Pharmacy Practice Committee (PPC) which determines on applications for a new pharmacy to be included in the board list of contractors. The PCSP is one of a range of resources available to the PCC to inform the needs in NHS Lothian.

3.5 Community Pharmacy falls within the IJB scheme of delegation for primary care independent contractors. To strengthen future iterations of the plan it is intended to work with the IJBs to review the plan and develop the recommendations in 2021. The plan and its recommendations will be presented at an IJB meeting in each of the 4 IJBs in 2021.

3.6 There are 13 recommendations in the PCSP but the following are of particular note and it is recommended that:

3.7 The Medication Care and Review service should be further implemented to increase serial prescribing in NHS Lothian. This will enable patients to receive their repeat prescriptions from their local pharmacy for a period of up to one year, without having to go back to the GP practice.

3.8 Community pharmacies in NHS Lothian should be given access to the clinical portal to improve patients care and safe emergency supply of prescribed medication when General Practice are unavailable to provide a repeat prescription.

3.9 NHS Lothian should continue to support and expand the Pharmacy First service. This service enables all patients to access advice and treatment for minor ailments. NHS Lothian funded a pharmacy first service including treatment of uncomplicated UTI and treatment of impetigo,this has now become part of the national contract. NHS Lothian should continue to expand the range of services that could be provided under a Pharmacy first approach e.g. Pharmacy First Plus led by pharmacist independent prescribers for management of minor conditions.

3.10 More work is require to improve smoking cessation services in community pharmacies in NHS Lothian

3.11 Continue work with Drug and Alcohol Partnerships to further increase take home naloxone provision from community pharmacies and development of a package of care model to support holistic care from a community pharmacy setting. Both are desirable to support reducing drug related deaths.

4 Key Risks

4.1 A delay to publication of an updated Pharmaceutical Care Services Plan for NHS Lothian for 2020.

5 Risk Register

5.1 Failure to comply with the requirement to monitor and publish a pharmaceutical care service plan annually

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment was carried out on 19th December 2017. The main findings was access to services for those with communication difficulties. This is addressed by access to interpretation services and ensuring awareness of these services. Loop hearing devices are available in 81% of pharmacies. Health literacy promoted to community pharmacy teams**.**

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

Advice on patient public involvement was sought but limited support was available for this edition. Previous versions of the document involved patients and public and the material issues remain the same.

8 Resource Implications

8.1 The resource implications are support for improvement, investment and service redesign will be required to address unmet need and unwanted variation in the nature, quality, comprehensiveness and equity of provision.

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Consultant in Pharmaceutical Public Health
25th November 2020
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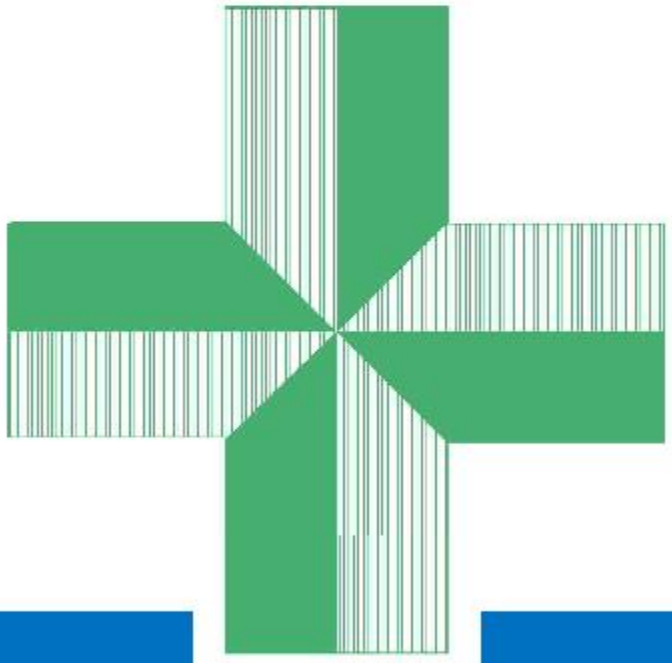
List of Appendices

Appendix 1: Provision of Pharmaceutical Care Service Delivered via Community Pharmacy for 2020 Final Version

NHS
Lothian



Provision of Pharmaceutical Care Services Delivered via Community Pharmacy 2020

CONTENTS PAGE

1 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 by the Board of where it believes there is a lack of adequate provision. Further guidance on the content of a pharmaceutical care services plan has been produced by the NHS Scotland Directors of Pharmacy Group and this has been followed in production of this plan.

1.2 Aim

The primary function of this Pharmaceutical Care Services plan is to describe the unmet need for pharmaceutical services within Lothian Health Board population and the recommendation of 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 professions and planners in the planning of pharmaceutical services. As a descriptor of needs within Boards for new or enhanced community pharmacy services, the Pharmaceutical Care Services plan is a data source that Pharmacy Practices Committees are directed to use in assessing need when considering applications to the Pharmaceutical List.

1.3 Achieving Excellence in Pharmaceutical care

Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland was published in August 2017 and describes how pharmaceutical care will evolve in Scotland and the crucial contribution of pharmacists and pharmacy technicians, working together with other health and social care practitioners, to improve the health of the population and impact on health outcomes, especially for those with multiple long term and complex conditions.

Two main priorities are identified: Improving NHS Pharmaceutical Care and Enabling NHS Pharmaceutical Care Transformation. These priorities are supported by 9 commitments and 29 actions which focus on integrating and enhancing the role of pharmacy across all areas of pharmacy practice, increasing capacity, and offering the best person-centred care. Community pharmacy plays an important role in the provision of NHS Pharmaceutical care by providing highly accessible services for people both in- hours and out- of-hours. Commitment 1 focuses on improved and increased use of community pharmacy services. Included in this commitment is the provision of services such as Minor Ailments Service, Chronic Medication Service and Public Health Services with five actions which NHS Lothian are working to implement. Achieving Excellence in Pharmaceutical Care

The increase in demand for pharmacists and pharmacy technicians has lead to a need to understand and prepare for the expansion of the pharmacy workforce. A shift in the pharmacy workforce across the different sectors and to new roles

within GP practice will challenge the profession in the short term to maintain consistent delivery of existing services in community pharmacy.

Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and eliminate adverse events whenever possible. Patients, regardless of their setting, should receive high quality pharmaceutical care. This is particularly important for patients with complex health issues, including multimorbidities, those in care settings and substance misuse services.

The NHS Lothian Community Development Team undertake to implement new community pharmacy services and changes to existing services to deliver improvements necessary to evolve pharmaceutical care provision as outlined in Achieving Excellence in Pharmaceutical Care.

1.4 Health and Social Care Partnerships

The integration of Health and Social Services under the new Health and Social Care Partnership provide an opportunity for Pharmaceutical Services to more effectively deliver services to support patients in communities. Close working with a range of disciplines and patients within the Health and Social Care Partnership and across the wider health system is required. NHS Boards and Health and Social Care Partnerships should consider opportunities to utilise community pharmacy to meet local needs. 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.

1.5 Primary Care Transformation /nGMS Contract

1.5.1 Pharmacotherapy Services

Work is ongoing to establish the required compliment of clinical pharmacists and pharmacy technicians under the development of pharmacotherapy services. This will see clinical pharmacists and pharmacy technicians recruited from all pharmacy sectors based in GP practices as part of the work towards implementation of the nGMS contract in 2021.

1.5.2 Vaccine Transformation Programme

Provision of routine NHS vaccination services such as childhood vaccinations, influenza and travel vaccines are being redesigned at health board level along with Health and Social Care Partnerships to support the implementation of the new GMS contract by March 2022. Community Pharmacies provide an easily reached location where vaccinations can be accessed. Pilot work was undertaken in 2019 to develop the role of community pharmacy in supporting the delivery of the adult seasonal influenza vaccination programme. This work

will be built on for the 2020/21 influenza season which will see Health and Social Care Partnerships develop different models for delivery of influenza vaccine to their populations.

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

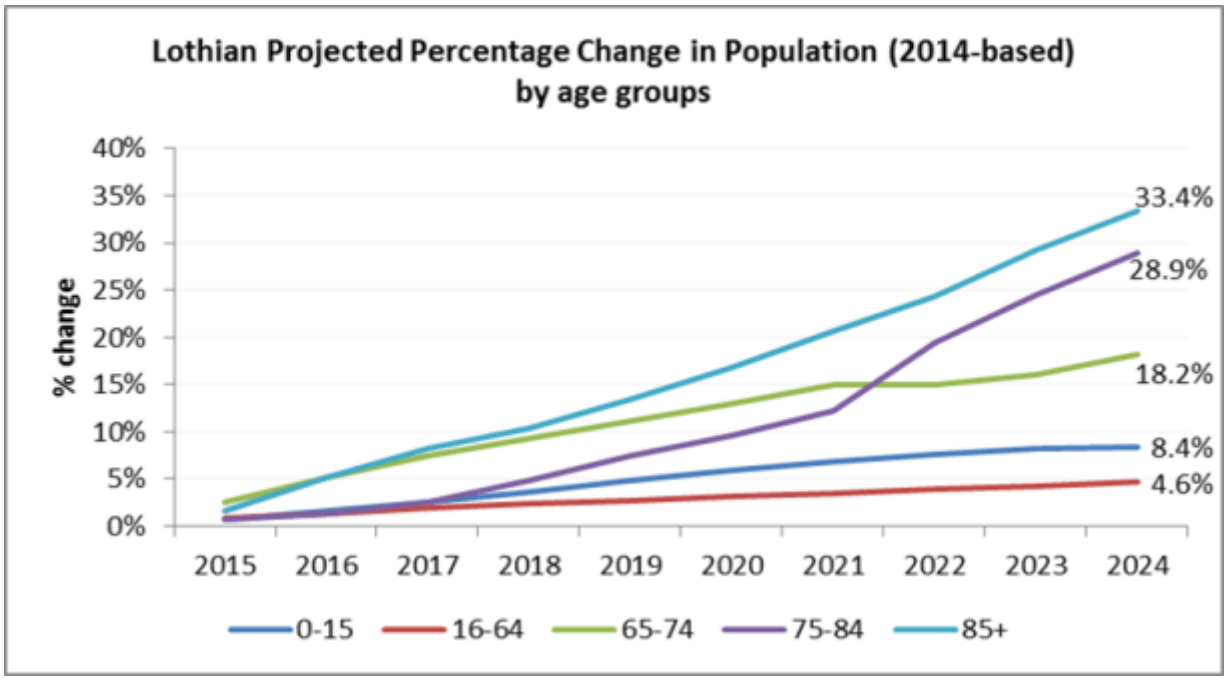
2.1 Age and Population

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 below shows the change projected to 2024 in total and by age group.

Table 1 Projected Population 2018-2024

Age Group	Population	Projected Population
	2018	2024
0-15	150,916	157,821
16-64	590,085	603,274
65-74	81,276	87,859
75-84	46,898	57,652
85+	18,728	22,619
Total	887,903	929,225

Figure 1 Projected population Growth to 2024 across Lothian



This increase will lead to an increase in the total demand for access to primary care services. Large new housing developments in all areas will require establishment of new primary care services and associated facilities.
The changing age profile will bring increased demand to primary care from an older population with multiple conditions who will 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- Lothian Estimated Population Numbers by Age & Council Area, 2015
Source: NRS, January 2017

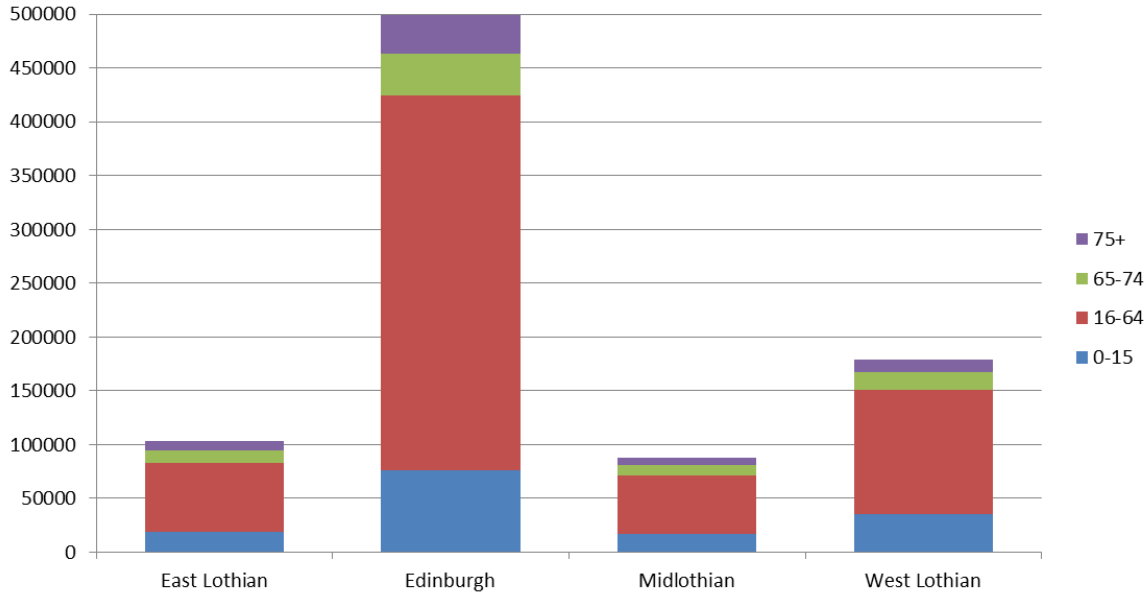
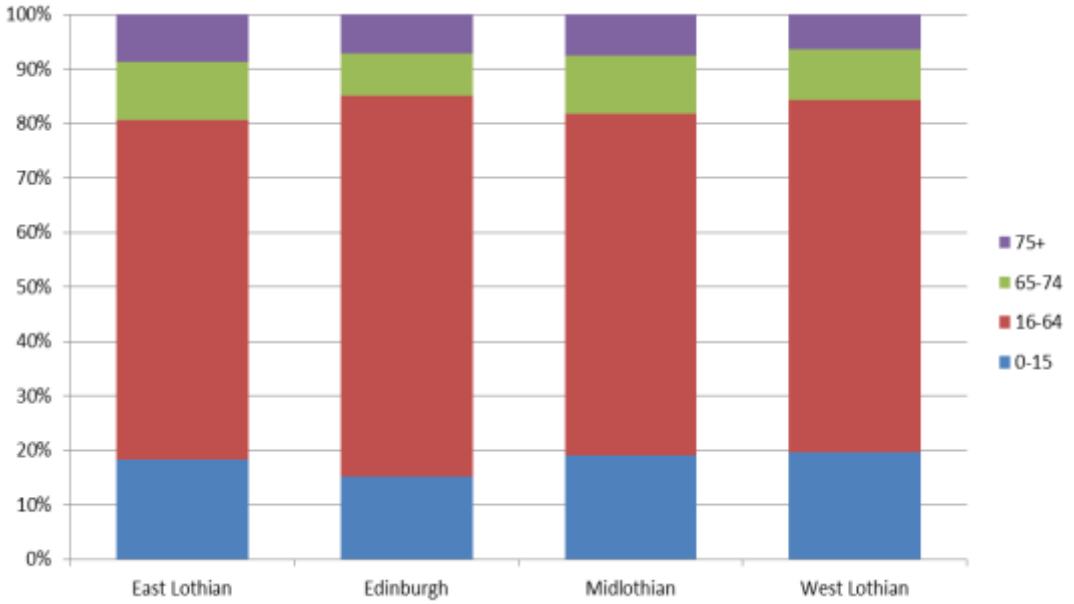


Figure 2 gives a view of comparative populations in the council areas relating to Health and Social Care Partnerships in NHS Lothian. Edinburgh has the largest population of the 4 areas. However to get a better view of the age breakdown of the NHS Lothian population Figure 3 looks at the age groups in terms of percentage of the population.

Figure 3 – Lothian Estimated Population Percentages by Age & Council area, 2015
Source: NRS, January 2017

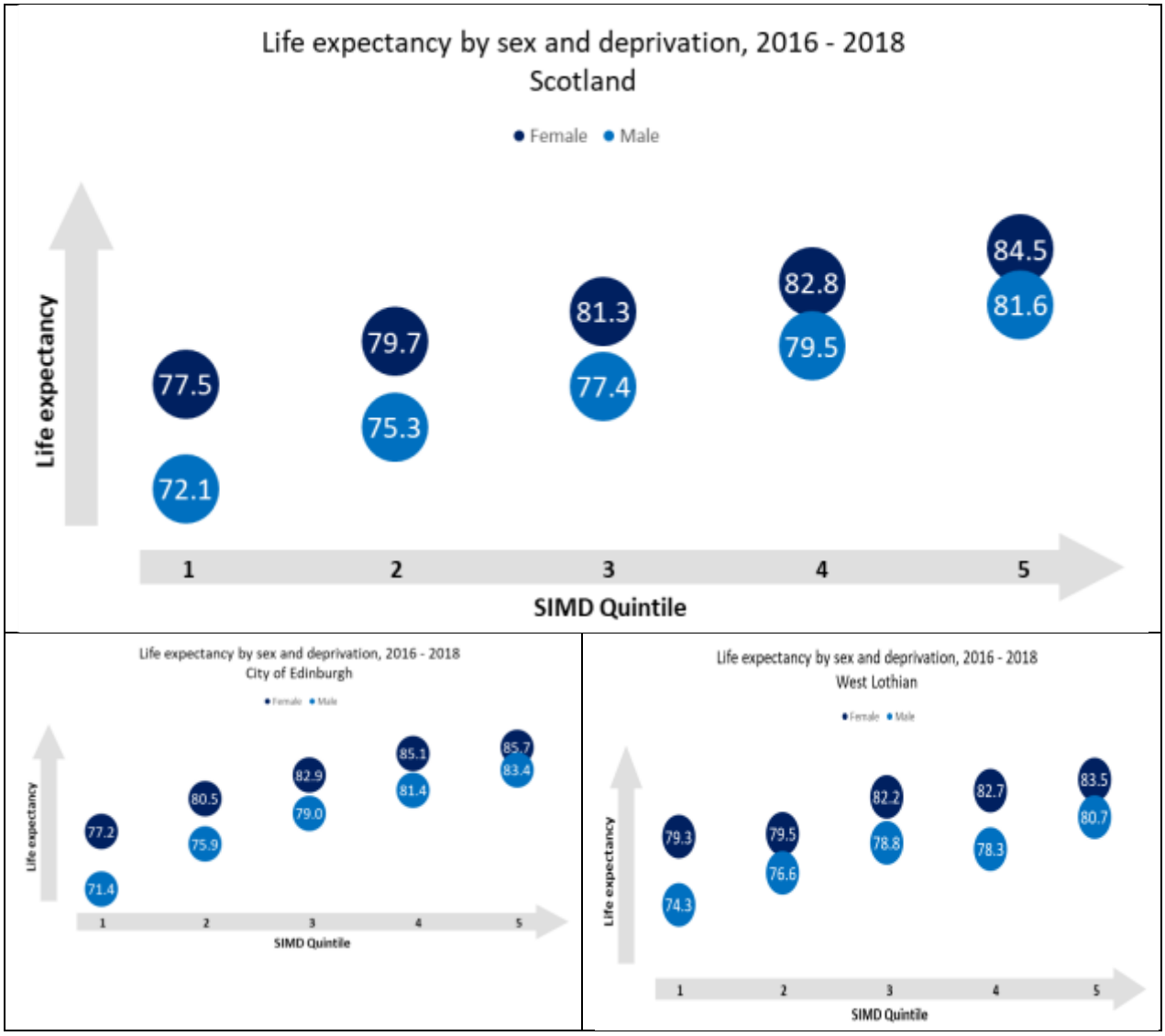


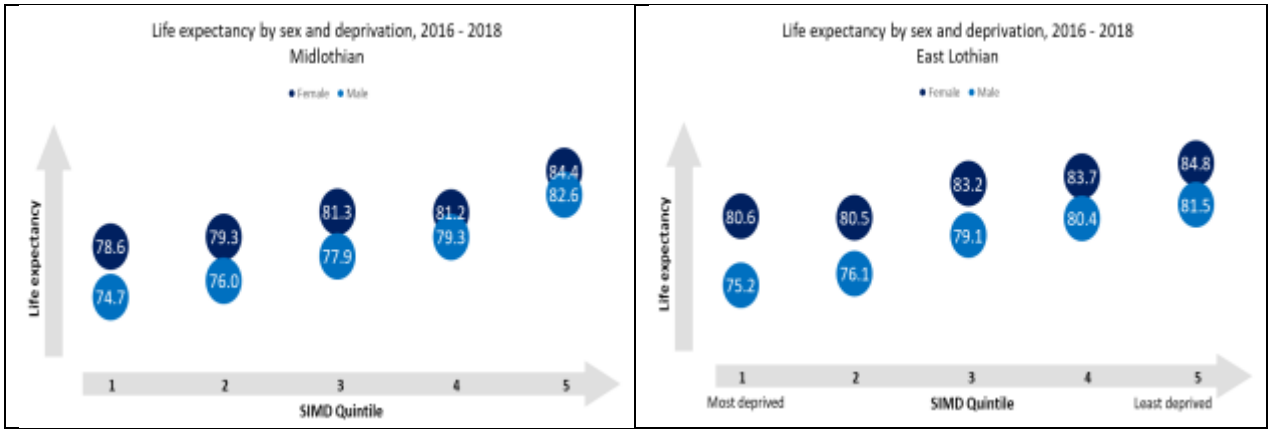
When age is considered in these terms there are not noticeable differences in the extremes of age. In general the extremes of age may have need of additional pharmaceutical care input. Edinburgh whilst having the largest populations of those under 15 and over 65 has a smaller proportion of its population in those groups than the other Health and Social Care Partnership areas. It is therefore reasonable to expect similar pharmaceutical needs in terms of age across NHS Lothian. 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–Life Expectancy at Birth by Sex and deprivation across Scotland and Lothian HSCPs (2013-2018)

Source NRS 2018





Overall life expectancy for the population in NHS Lothian is better than the Scottish average for both males and females with the average for males being 78 years compared with 77.1 years for the Scottish average and for females life expectancy is 81.7 years in Lothian compared with the Scottish average of 81.1 years. Within Lothian there are significant inequalities in life expectancy. Men living in the most deprived communities live 13 years less than their counterparts in less deprived areas. Those health inequalities exist for almost all health indicators.

Ethnicity

In the 2011 Census NHS Lothian had 77% identifying themselves as White Scottish compared with 84% in Scotland as a whole. Other differences to note are that NHS Lothian has 2.1% of their population that identify themselves as white Polish compared with Scotland 1.2 and 3.7% as Asian, Asian Scottish or Asian British compared with 2.7% in Scotland.

Table 2: Lothian 2011 Census Selected Results; ethnic group by Health and Social Care Partnership

	White	White: Scottish	White: Polish	Asian	African, Caribbean or Black
Lothian	787451	648746	17357	31069	7623
East Lothian	98011	85347	811	955	286
Edinburgh	437167	334987	12820	26264	5505
Midlothian	81715	74875	455	910	258
West Lothian	170850	153815	3273	2941	575

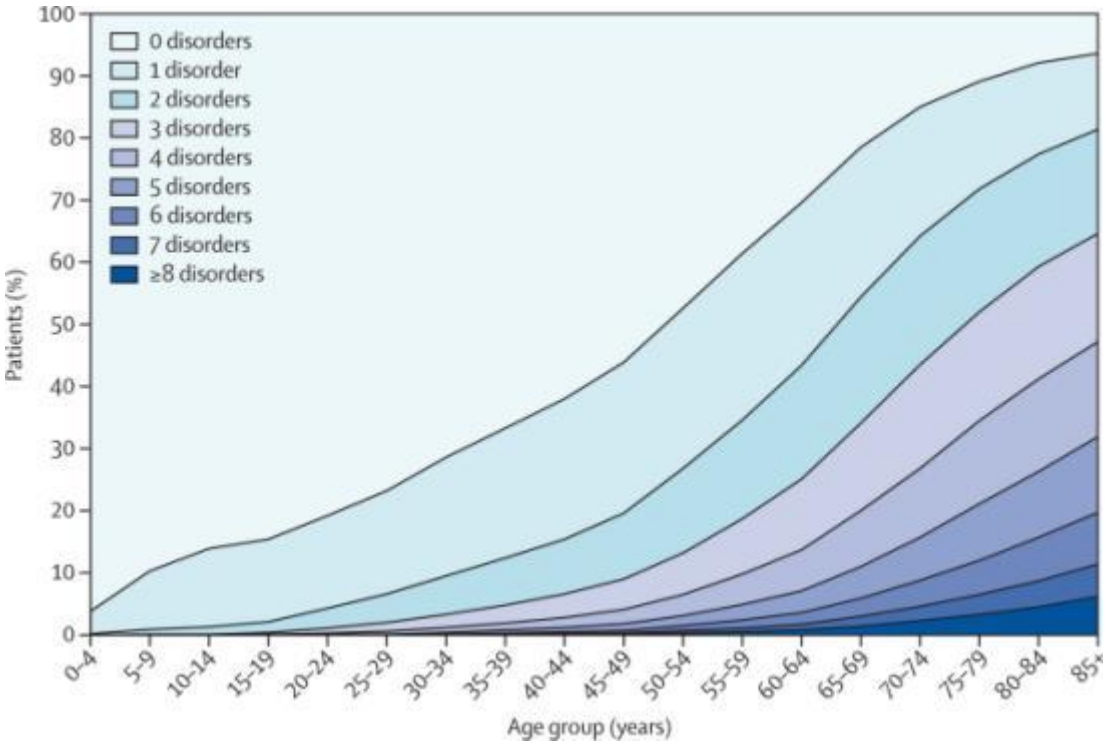
Source: Census Data Explorer

2.2 Disease Burden in NHS Lothian

As people get older they are more likely to experience multimorbidity. While it is possible to describe individual disease states this does not necessarily tell the whole story as many patients will have more than one disease. An illustration for some of the priority health areas is given to show where NHS Lothian sits within the context of time and in Scotland as a whole where relevant. The disease areas have also been chosen because of their potential links to pharmaceutical needs.

Figure 5 – N**umber of Chronic Disorders by Age-Group**

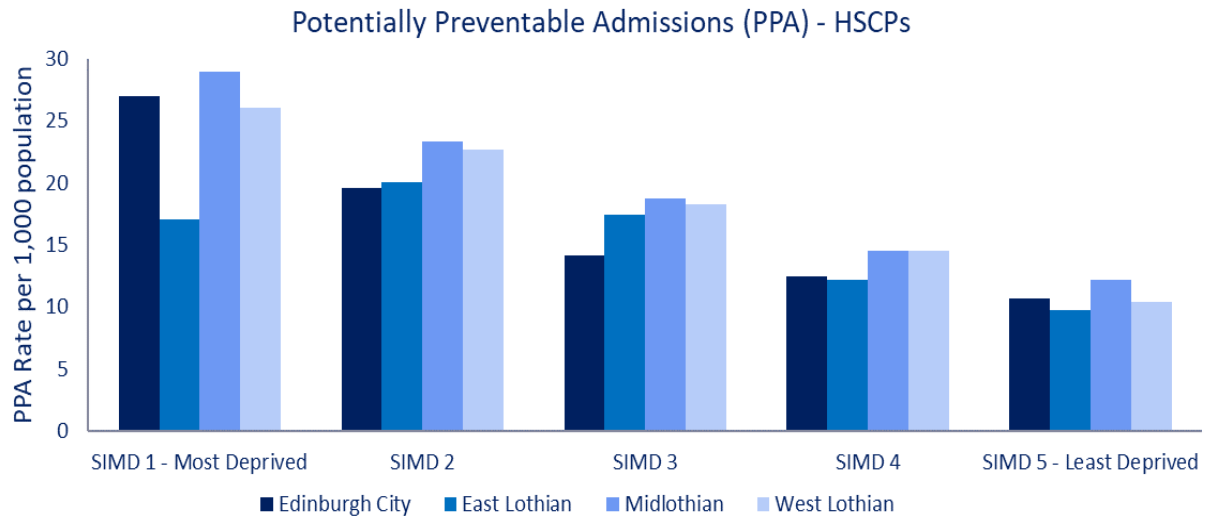
source: Barnet K et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 2012; 380:37-43



2.3 Potentially Preventable Hospital Admissions

Those living in the most deprived communities are more likely to experience potentially preventable admissions as illustrated in figure 6 when all health conditions are measured together.

Figure 6 All Potentially Preventable Admissions Residence Rate per 1,000 population, April 2019 - March 2020
Source: Discovery, ISD



2.4 Coronary Heart Disease

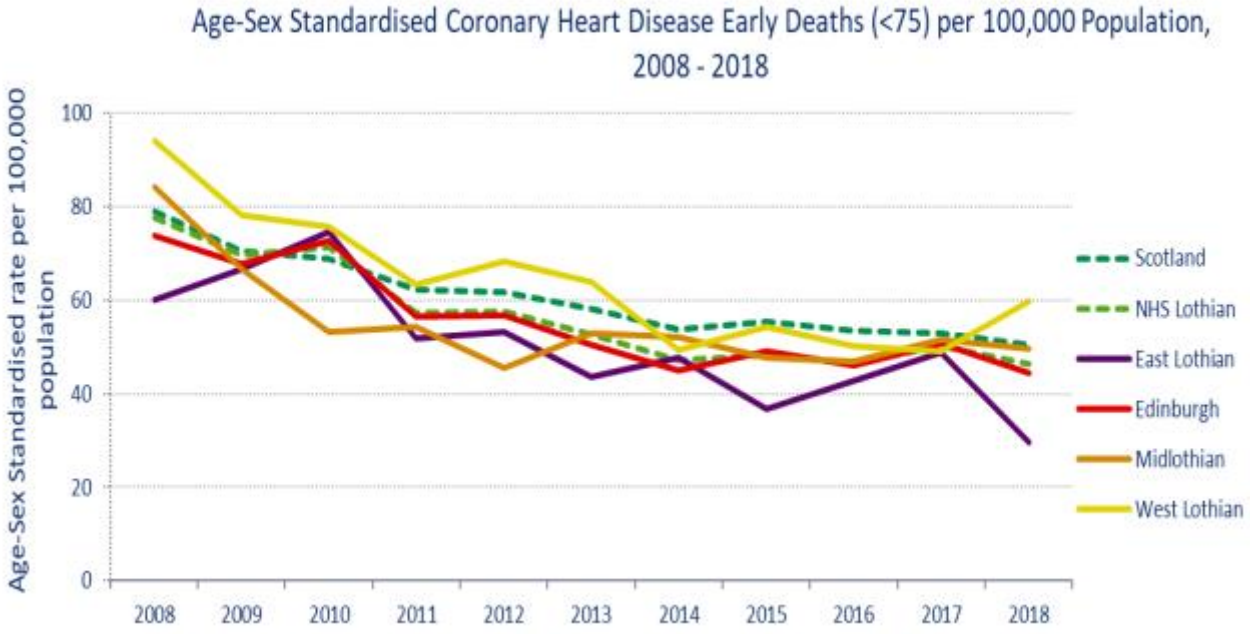
There has been an overall reduction in incidence of coronary heart disease over time. This is due to a large investment in this area and is a combination of legislation and regulation changes, behavioural changes and packages of care, including evidence based treatment. This includes reductions in smoking, which smoking cessation services contribute to alongside other strategies which have had a large impact such as tobacco price increases, restrictions on sales and advertising and the ban on smoking in public places. There has also been large investments in rapid effective treatment, cardiac rehabilitation and medicines for secondary prevention. Patients with a diagnosis of coronary heart disease will often be on multiple medicines and be managed primarily in Primary Care making these patients high users of pharmaceutical services. There is room for improvement in the uptake of safe, effective treatment, in improving our response to the changing nature of coronary heart disease and in reducing the socioeconomic gradient in outcomes. Coronary heart disease risk increases in patients with diabetes and there are increasing numbers of people on the diabetic register with type II diabetes.

Figure 7– NHS Lothian Age-Sex Standardised Coronary Heart Disease Early Deaths (<75) per 100,000 Population

Source: Scottish Heart Disease Statistics ISD, tables MC1 and MC4 published January 2020

Notes

1. Age-sex standardised discharge rates use the European Standard Population (ESP20131), which was first used in 1976, was revised in 2013. Figures using ESP1976 and ESP2013 are not comparable.
2. European Age-Sex Standardised Rate (EASR), calculated using ESP2013 and using 5 year age groups 0-4, 5-9 up to an upper age group of 90+.



NHS Lothian as a whole has fewer coronary heart disease related early deaths than the Scottish average with rates of 46.3 and 50.5 respectively. Figure 7 shows the lowest rate of coronary heart disease early deaths in East Lothian and highest in West Lothian Health and Social Care Partnerships for 2018. All areas show a reduction over time from 2008 - 2018.

2.5 Cancer

The potential role for community pharmacy in promoting healthy behaviours and cancer prevention has already been highlighted in the Better Cancer Care Cancer Action Plan 2008. In April 2011, the Cabinet Secretary announced that the new administration would pursue a programme to achieve earlier diagnosis of cancer. This programme supports a fundamentally new approach to the management of cancer in NHS Scotland, promoting engagement with the Scottish population that embeds mutual partnership, delivers on quality and efficiency and results in better outcomes.

The Scottish Government's new cancer strategy Beating Cancer: Ambition and Action was published in 2016. Community Pharmacy continues to contribute to this via public health campaigns targeting cancer risk factors such as smoking and provision of patient centred care.

Figure 8 - Number and Age-Sex Standardised Cancer Early Deaths (<75) per 100,000 Population

Source: ScotPHO https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do

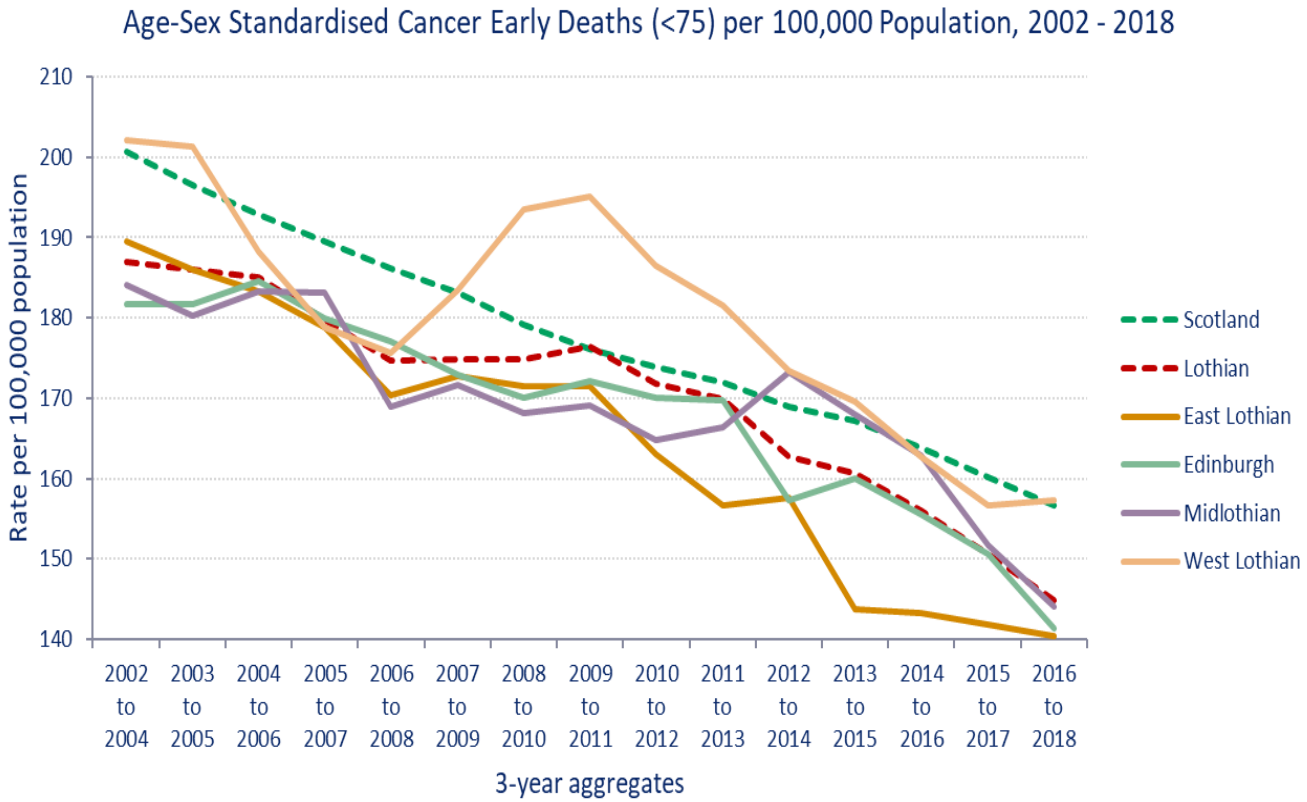
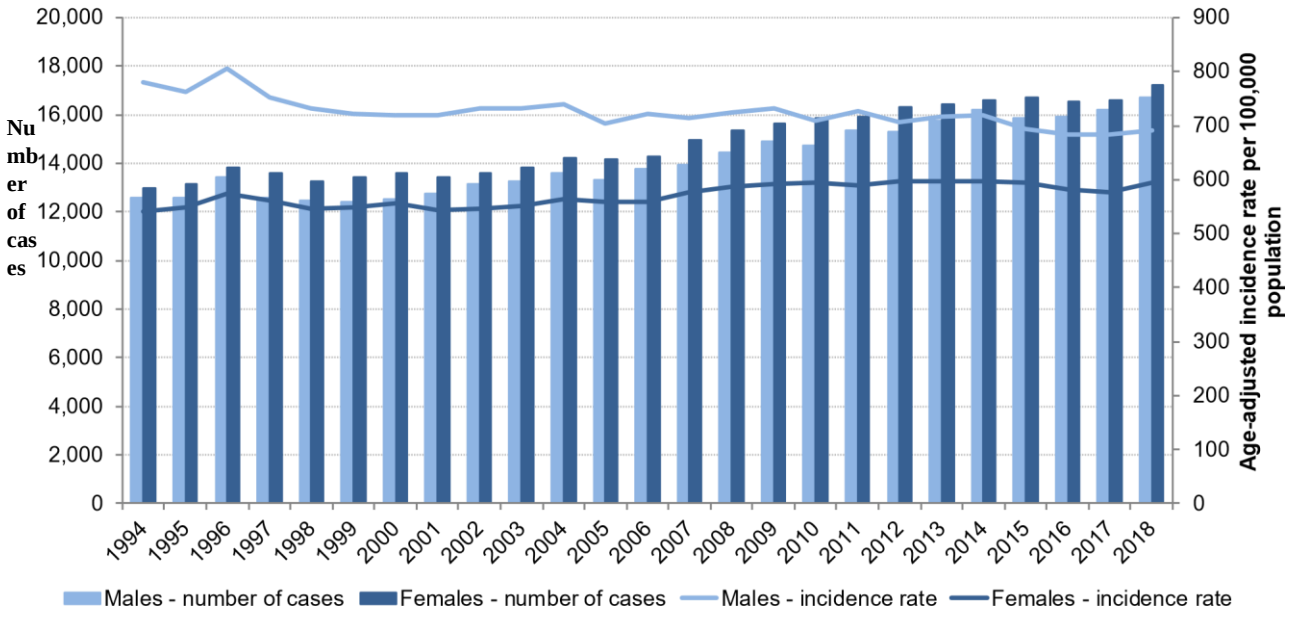


Figure 9 - Cancer incidence in Scotland, 1994-2018. Number of cases and age-adjusted incidence rate by sex

Source: 1.Scottish Cancer Registry
2.ISD publication: Cancer Incidence in Scotland publication date 28 April 2020



Figures 8 and 9 show that over the last decade cancer incidence rose in Scotland, however the mortality rate has fallen. Much of this can be explained by our ageing population and the fact that cancer is a relatively common disease among the elderly. In terms of overall mortality figures for early deaths from cancer, there is a reduction over time and the NHS Lothian rate is lower than the Scottish figure rate. Cancer can be seen as a disease of old age. The proportion of people having common cancers detected early is improving and a greater proportion of people survive to get cancer. Even premature deaths tend to occur at an older age than the causes of death they have replaced. East Lothian has seen the greatest reduction in early cancer deaths. The Detect Cancer Early programme was formally launched by the Scottish government in February 2012.

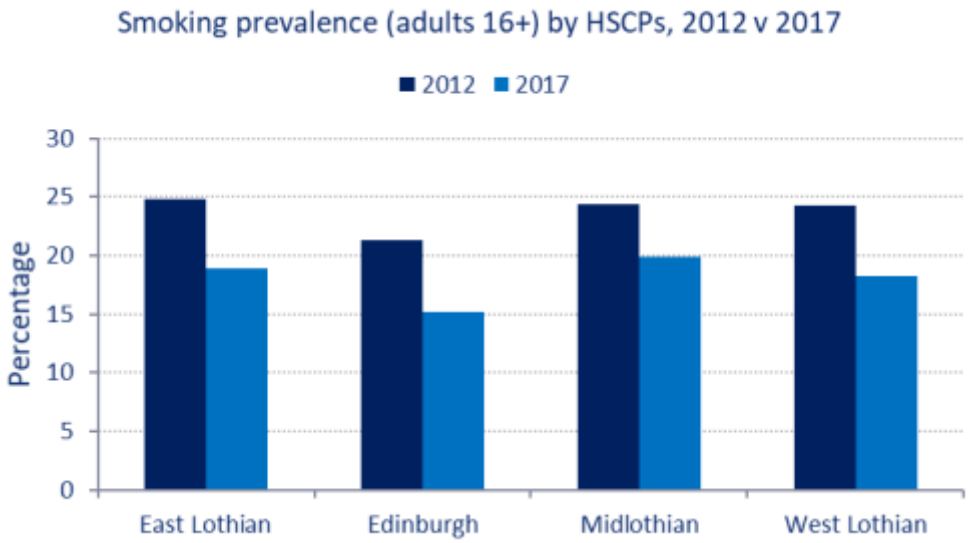
In terms of pharmaceutical care needs, cancer medication is complex. There is also a trend towards oral medication rather than injections and this will not only result in a shift of where treatment may be delivered but also the contribution that pharmacists may make because of those different treatment protocols in community settings.

2.6 Smoking

Smoking is a significant cause of preventable serious ill-health and premature death. It is also the single biggest contributor to the differences in life expectancy between the socioeconomic groups. It kills between a half and two-thirds of long-term smokers with around 25% of smokers dying before reaching retirement age. In general, smokers endure poorer health than non-smokers at all ages.

The benefits of stopping smoking are well known. The smoking cessation service delivered via community pharmacy in NHS Lothian has made a significant contribution to the number of successful quits reported.

Figure 10 – Smoking Prevalence (16 +) for 2012 – 2017
Source: ScotPHO https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do



In 2017, the smoking prevalence among adults (>16years old) was estimated at 16.7%, an 11.3% fall from a baseline of 28% in 2003. There has been 5.9% reduction in smoking prevalence since 2012 across Lothian. Figure 10 compares the prevalence across the HSCPs. Smoking rates remain high in people living in areas of multiple deprivation and vulnerable populations such as people with mental health problems. As part of its commitment to implement the legally binding WHO Framework Convention on Tobacco Control the Scottish Government published its 5 year tobacco control strategy in 2013, Creating a Tobacco-Free Generation. This sets a target to reduce smoking prevalence in Scotland to 5% or less by 2034. There are a series of prescribed interventions required to achieve this.

2.7 Sexual Health

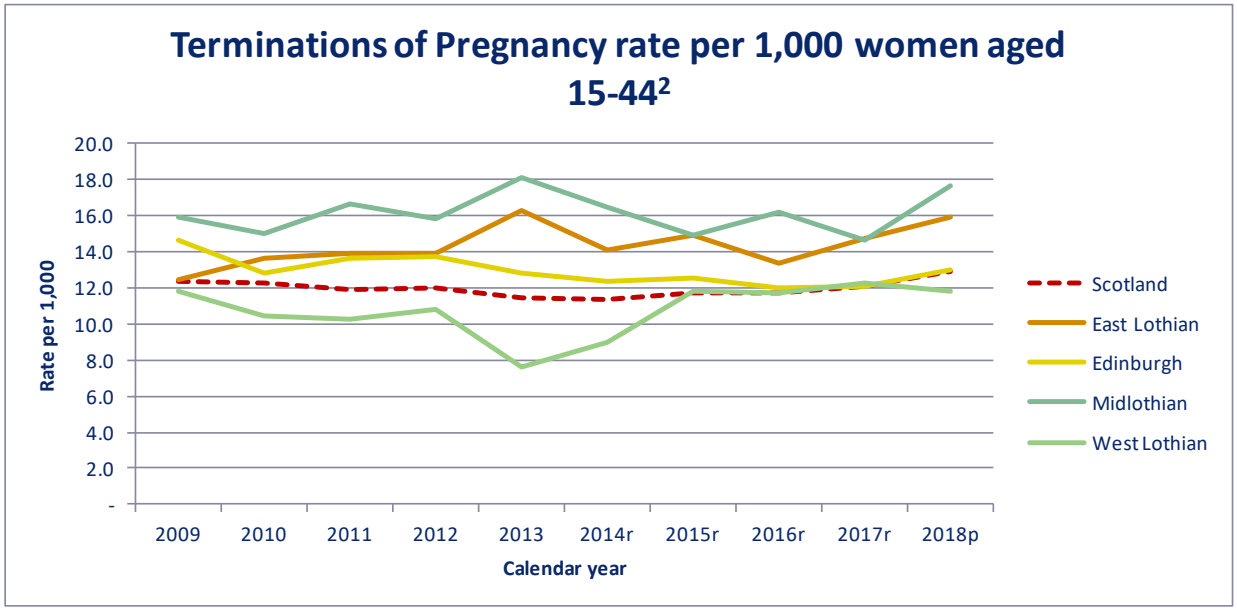
Emergency hormonal contraception has been available to buy from community pharmacy since 2001. Emergency hormonal contraception became available free of charge from community pharmacies in 2008.

Following a fall in the number and rate of abortions in Scotland between 2012 and 2016 per 1000 women aged 15-44 there is a change to this pattern with an increase since 2016. Since the implementation of the 1967 Abortion Act small dips for short periods have been observed before. The rate of terminations increases with increasing deprivation. West Lothian is the only area continuing to show a reduction in the rate of terminations.

Figure 11 – Terminations of pregnancy[1] rate per 1,000 women aged 15-44[2] by local council area of residence

Source : Notifications (to the Chief Medical Officer for Scotland) of abortions performed under the Abortion Act 1967. ISD Scotland

1 Refers to therapeutic abortions notified in accordance with the Abortion Act 1967.
2 Rates per 1,000 women aged 15-44; based on 2017 mid-year population estimates.
3 Patients resident outwith Scotland or Scottish residents who cannot be assigned to a council area.
4 Performed in Scotland
p Provisional.
r Revised.

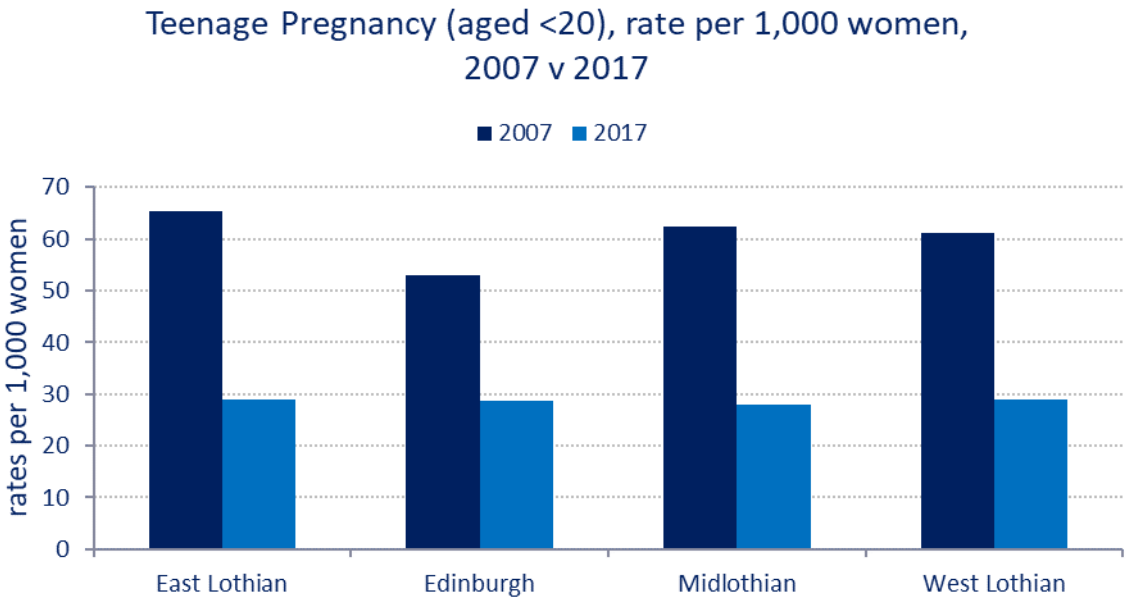


An additional measure of sexual health is teenage pregnancy. With a higher rate of teenage pregnancy than most other western European countries, reducing unintended teenage pregnancy is a national target for the Scottish Government. Teenage pregnancy is also linked to deprivation with the rates of teenage pregnancy in deprived areas more that treble those of the least deprived areas. Teenage pregnancy rates in all age groups, <16 years old; <18 years old; <20 years old, have continued to decline in 2014. The teenage pregnancy rate for under 20s has dropped from the most recent peak of 57.7 in 2007 to 34.1 per 1,000 women in 2014, a decrease of 40.9%. NHS Lothian rate for the < 20 years old age group shows a similar decline to 34.2 per 1,000 women in 2014 from 57.1 in 2007.

There are differences in the reduction between areas for teenage pregnancies as shown in Figure 12 and it could therefore be argued that the provision of emergency hormonal contraception services is not as well met in the rural areas of East Lothian and Midlothian. Factors other than access to community pharmacy will influence this outcome. Low unplanned pregnancy rates and teenage pregnancy rates require easy access to effective contraception services through community pharmacy and other settings.

Figure 12 – NHS Lothian Teenage Pregnancy Rate per 1000 Female Population (15-19)

Source: NRS birth registrations & Notifications of abortions performed under the Abortion (Scotland) Regulations 1991.
1.ISD publication, July 2019: https://www.isdscotland.org/Health-Topics/Sexual-2.Health/Publications/data-tables2017.asp
3.The rate for 'Under 20' is calculated using the female population aged 15-19.



2.8 Mental Health

Mental illness is one of the major health challenges in Scotland. It is estimated more than 1 in 3 people are affected by a mental health problems each year. The most common mental illnesses are depression and anxiety. Severe enduring mental illness due to psychosis affects 1-2% of the population. Mental illness is often linked with other long term conditions and alcohol and substance misuse. Higher rates of mental illness are observed in areas of multiple deprivation. As understanding grows and stigma of mental illness reduces the number of people treated for mental illness issues will rise. The aging population has led to an increase in the number of people living with dementia. More people are treated at home shifting care into the community. Community pharmacy contributes to patient centred care for those prescribed medicines for mental illness. The five main categories of medicines prescribed for mental illness are: antidepressants; hypnotics and anxiolytics; antipsychotics; drugs for dementia; drugs for attention deficit hyperactivity disorder (ADHD). Medicines are just one way that these conditions are treated. Treatment can also involve social, psychological, behavioural or educational interventions or therapy.

The Scottish Governments' Mental Health Strategy 2017 -2027 was published in March 2017.

Figure 13- Depressions Prevalence by HSCP

Source: https://beta.isdscotland.org/find-publications-and-data/health-services/primary-care/general-practice-disease-prevalence-data-visualisation/

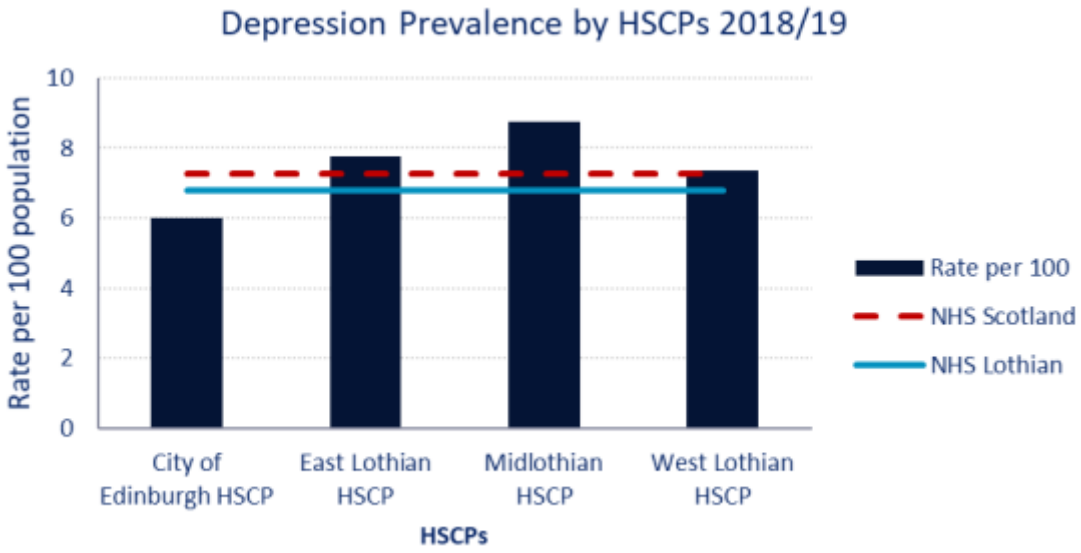
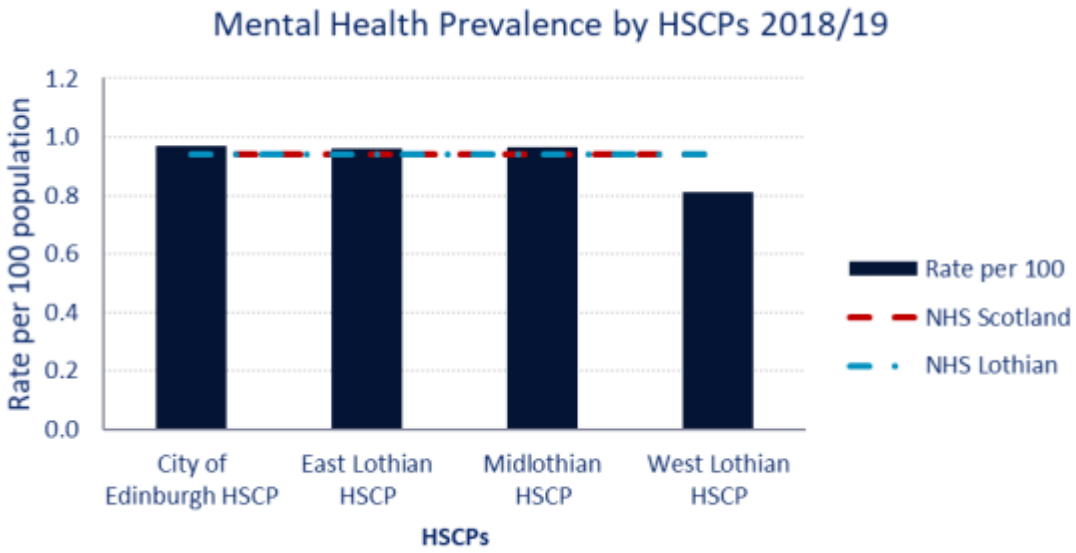


Figure 14 – Mental Health Prevalence by HSCP

Source: https://beta.isdscotland.org/find-publications-and-data/health-services/primary-care/general-practice-disease-prevalence-data-visualisation/



3. Description of Pharmaceutical Services in NHS Lothian

3.1 Background

The community pharmacy contract introduced in 2006 replaced one where NHS pharmacy services mainly related to dispensing of medication. The contract aims to use the skills and knowledge of pharmacists better. Pharmacists now graduate at a Masters level of degree education. This education together with expertise in clinical practice offers the potential for the neighbourhood pharmacists to play a significant role in the assessment and delivery of care. This would enable the locations and facilities of pharmacies to be better utilised to meet the needs of patients and improve access to health services to improve inequalities.

All pharmacies are required to provide all 4 core pharmaceutical care services

- Medication Care and Review (formerly Chronic Medication Service)
- Acute Medication Service
- Pharmacy First (formerly Minor Ailment Service)
- Public Health Services.

These services are described in more detail.

There are also some additional service contracts negotiated for services that are required in addition to the core services. These may not be available in all community pharmacies.

Pharmacies may also provide services which are non NHS commissioned. Not all pharmacies will provide the same non commissioned services.

3.2 Summary of Pharmaceutical Care Services in NHS Lothian

Table 3 Community Pharmacies NHS Lothian

Location	Number of community pharmacies	Population (NRS mid 2019 estimates for council areas)	Population per community pharmacy
NHS Lothian	**182**	**907,580**	**4986**
East Lothian	23	107,090	4656
Edinburgh	107	524,930	4905
Midlothian	19	92,045	4844
West Lothian	33	183,100	5548

There is no standard as to the number of population that should be served by a pharmacy but 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. This compares to other areas of Forth Valley (3,922 patients per Pharmacy),

Fife (4,296 patients per pharmacy),Tayside (4,459 patients per pharmacy) and Scotland (4230 patients per pharmacy).

Pharmacy Provision Across Lothian

Map Showing Pharmacies in NHS Lothian in relation to population density within each Health and Social Care Partnership area illustrates that 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 area, with major conurbations having a pharmacy. This plan uses the 2015 small area population data. This updated information has resulted in a change in population density due to the creation of new housing. There are already pharmacies nearby and their location is nearby GP practices.

There is good co-location near GP practices (***Map Showing GP Practices for each Health and Social Care Partnership area in NHS Lothian***). Under the community pharmacy contract where all 4 core services are required to be provided, co-location with GP practices is not necessarily required. However the nature of both these services means that they tend to be accessible and located in local communities. Several maps also illustrate the pharmacies located within each Health and Social Care Partnership and the surrounding multiple index of deprivation.

See following maps in Appendices

2016 Scottish Index of Multiple Deprivation for Edinburgh- by datazone
2016 Scottish Index of Multiple Deprivation for East Lothian- by datazone
2016 Scottish Index of Multiple Deprivation for Midlothian- by datazone
2016 Scottish Index of Multiple Deprivation for West Lothian- by datazone

There can be a variety of reasons for a community pharmacy location and a mix of accessible pharmacies would appear to exist within NHS Lothian.

3.2.1 Hours 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 week days 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 week day (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.

This effectively means that each contracted pharmacy must open five and a half days per week and the opening hours tend to reflect local GP Practice times. However there are variations to these hours depending upon individual circumstances and applications for slightly 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.

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 Saturdays 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.

3.2.2 Facilities

Most community pharmacies have been developed to provide private areas which can be utilised for the provision of counselling and/or advice. These enable patients to have private conversations and to enable other private service such as emergency hormonal contraception to be provided in a confidential manner. The development of consultation or private areas in many pharmacies has been an enabling factor in the development of these services. These areas can be either fully or partially enclosed, reflecting the needs of different patients. 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.

In recent years there has been significant investment in improving pharmacy premises to ensure that they are fit for purpose. This has been supported by the Scottish Government, The Right Medicine Funding and contractors themselves.

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%)

Results from the 2005/6 community pharmacy customer satisfaction project carried out in NHS Lothian showed that less than 2% of respondents reported any difficulties gaining access to the pharmacy premises, the services it provides or in obtaining information in an appropriate format.

3.2.3 Travel time

Previous national research has indicated that 86% of the population are within 20 minutes travelling time of their pharmacy and 44% are within 10 minutes. This data also showed that 47% of respondents travelled by car and 42% walked. The majority (83%) started and ended their journey at home with only 8% travelling from their place of work. Another UK wide survey showed that 56% of respondents were a short walk away from a pharmacy with an additional 22% further than a short walk but less than one mile. The respondents in this survey reported a mean distance of travel of 0.8 miles to a pharmacy.

The travelling time of 20 minutes for driving, cycling and walking has been shown on an NHS Lothian map and on each Health and Social Care Partnership to show more detail. It can be clearly seen that most city centre pharmacies are within 20 minutes walk for most of the population and more rural areas are within 20 minutes drive from their nearest pharmacy.

Results from the 2005/6 community pharmacy customer satisfaction project carried out in NHS Lothian showed that 59% of customers chose the pharmacy they were visiting because they lived close by, 28% because of the quality of service and only 4% because they worked nearby. This also illustrates a clear link to travelling from home to pharmacy.

See the following maps in Appendices

- **Map showing 20 minute isochrones in East Lothian for driving, cycling and walking.**
- **Map showing 20 minute isochrones in Edinburgh for driving, cycling and walking.**
- **Map showing 20 minute isochrones in Midlothian for driving, cycling and walking.**
- **Map showing 20 minute isochrones in West Lothian for driving, cycling and walking.**

Travel times by public transport across NHS Lothian are more complex 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 as discussed previously aids accessibility.

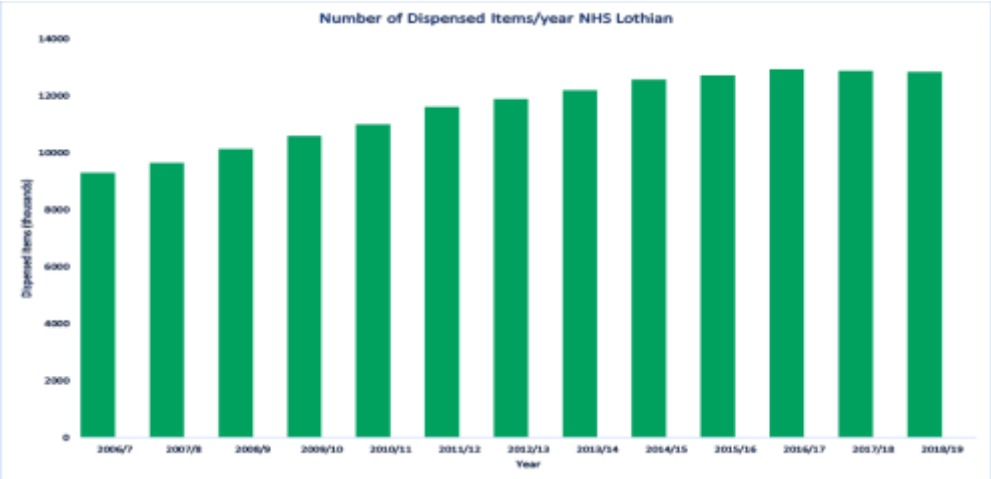
3.3 Essential (Core) Services for Community Pharmacy

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 15.8% from 89.3 million items in 2009/10 to 103.4 million items in 2018/19. In 2018/19 in Scotland, 103,380,000 items were dispensed and 12,847,000 of these were in NHS Lothian. The number of items dispensed in NHS Lothian is 12% of the total for Scotland and NHS Lothian has 15% of the total number of pharmacies in Scotland. In 2015/16 Lothian had 16.3% of the patient population of Scotland based on GP list size. Figure 21 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. Population growth in Lothian, increasing multimorbidity, treatability of disease and polypharmacy will contribute to this demand. Other reasons for this growth include an ageing population, more people living with long-term conditions and the increased use by GPs of evidence-based guidelines that recommend drugs to treat certain conditions.

Figure 21 Dispensed Items in NHS Lothian 2006/07 to 2018/19



3.3.2 Medication Care and Review (MCR) (formerly Chronic Medication Service (CMS))

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

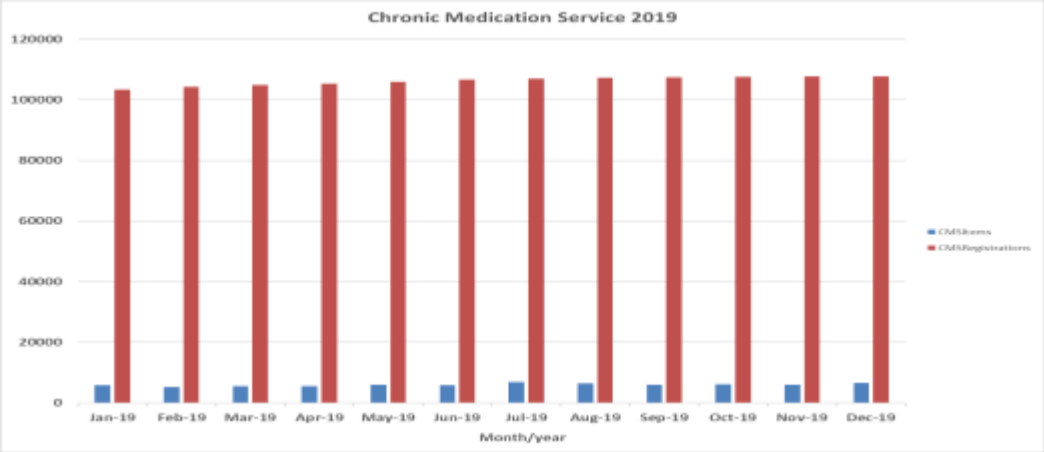
pharmaceutical care in order to improve a patient's understanding of their medicines and to work with the patient to maximise the clinical outcomes from the therapy.

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

As part of commitment 1 in Achieving Excellence in Pharmaceutical Care published in August 2017 the Chronic Medication Service is being refreshed as the Medication Care and Review Service to incorporate a more formalised role for community pharmacy in managing people with long term conditions. The main relaunch of this refresh is expected within 2020/21. Over all the current uptake of the serial prescribing and dispensing element of the MCR service remains low. The Primary Care Pharmacy team will be central to increasing the use of serial prescribing for suitable patients. taking this work forward as part of the pharmacotherapy service and Covid 19 response.

Figure 15 – Chronic Medication Service



Recommendation:
There is clear identified need for acute and medication care and review (formerly chronic medication) services illustrated by dispensing information and prevalence data.

- There is no evidence of patients being unable to source a pharmacy to dispense a prescription which could be taken as evidence that there is no unmet need for the acute prescription service.
- Support changes to the chronic medication service under Achieving Excellence in Pharmaceutical Care commitment 1 as they progress to the Medicine Care and Review service with launch expected in 2020/21. Development of serial prescribing is being taken forward under the pharmacotherapy service.

3.3.3 NHS Pharmacy First Service (formerly Minor Ailment Service)

Minor ailments are common, often self limiting conditions. They can be managed through self-care and the use of appropriate products that are available to purchase without a prescription. Research has indicated that up to 40% of GP consultations are taken up by non-urgent, or minor conditions – most of which could be dealt with in a pharmacy setting.

The Minor Ailment Service aims to support the provision of direct pharmaceutical care within the NHS by community pharmacists. The service allows eligible people to register with the community pharmacy of their choice for the consultation and treatment of common self-limiting conditions. The pharmacists advises, treats or refers the person (or provides a combination of these actions) according to their needs. To be eligible for the minor ailment service a patient must be registered with a Scottish GP practice and in one of the following categories:

- persons who are under 16 years of age or under 19 years of age and in full-time education;
- persons who are aged 60 years or over;
- persons who have a valid maternity exemption certificate, medical exemption certificate, or war pension exemption certificate;
- persons who get Income Support, Income-based Jobseeker's Allowance, Income-related Employment and Support Allowance, or Pension Credit Guarantee Credit; and
- persons who are named on, or are entitled to, an NHS tax credit exemption certificate or a valid HC2 certificate.

In 2017 an average of 8050 eligible patients per month registered with a community pharmacy under the minor ailments scheme. The average number of consultation per month was 20,985. Of these 8% receive advice only and 92% were prescribed treatment. At March 2017 a total of 121,191 eligible patients were registered with a pharmacy in NHS Lothian for minor ailments. (Figure 15)

A recent evaluation undertaken jointly by the Universities of Strathclyde and Robert Gordon's reported that **87% of those surveyed** rated their satisfaction as 10/10 and their consultation experiences were consistently rated as 'Excellent' when using the CARE criteria. This report also shows that this service is an efficient use of NHS resources as **60% of users** said they would have gone to their GP if the MAS service were unavailable to them.

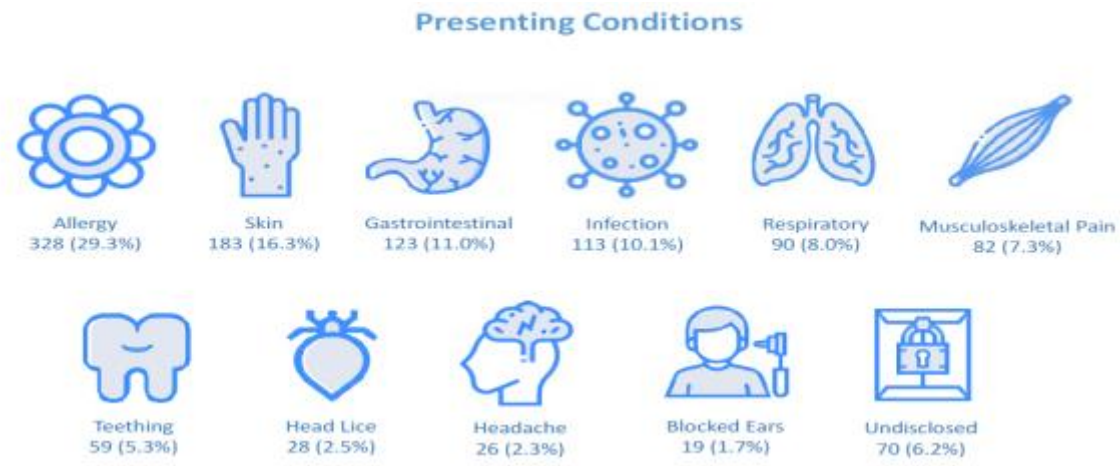
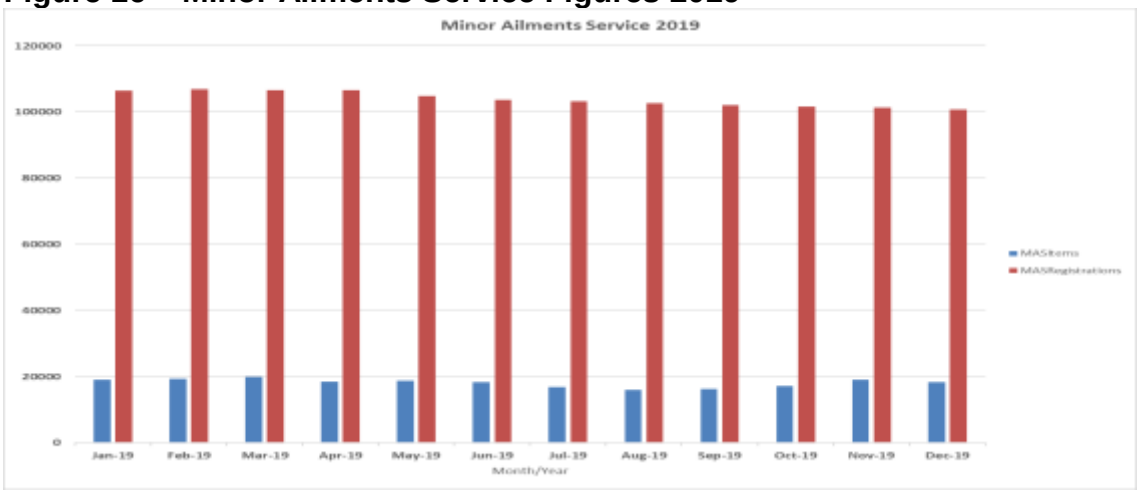


Figure 16 – Minor Ailments Service Figures 2019

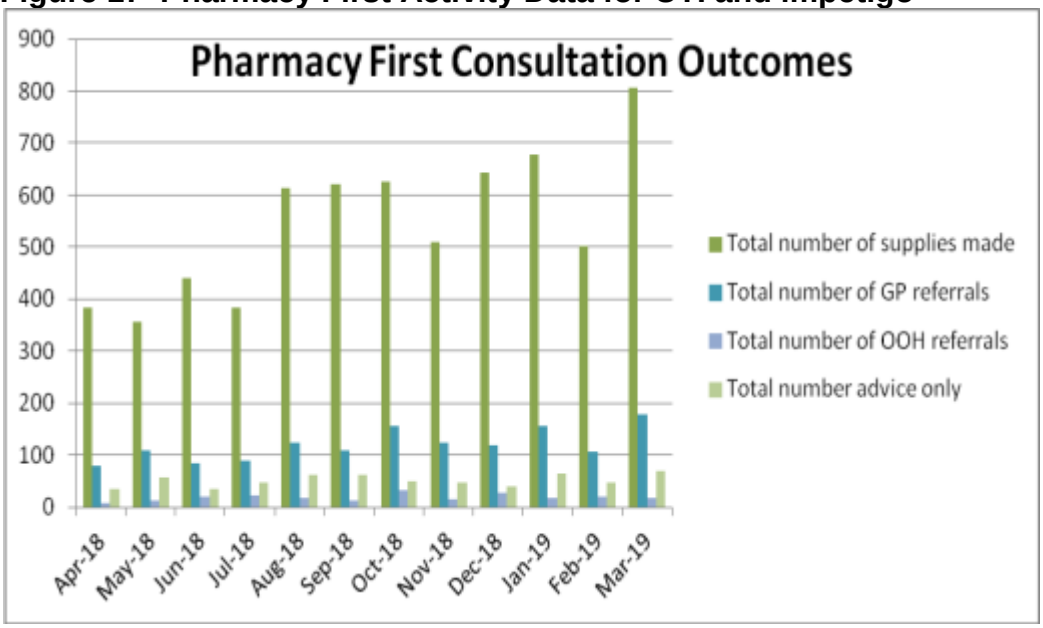


In July 2020 the Minor Ailments Service (MAS) was replaced by the new NHS Pharmacy First service detailed in PCA (P) (2020) 13 available here. The patient eligibility is extended in comparison to the MAS to include all individuals who are registered with a GP practice in Scotland or who live in Scotland although 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.

Pharmacy teams will undertake an NHS Pharmacy First Scotland consultation and provide one of three options- Advice, Treatment or Referral to another healthcare professional if appropriate.

In addition to treating minor conditions it will also provide advice and treatment for specific common clinical conditions starting with uncomplicated UTIs in women and impetigo. Figure 17 shows outcomes of treatment for minor conditions from April 2018. Additional common clinical conditions will be identified for future inclusion under the Pharmacy First Service

Figure 17 Pharmacy First Activity Data for UTI and impetigo



Recommendation:
Patients no longer require to register for Pharmacy First which could be taken to indicate there is no unmet need in this area.

- NHS Lothian should support the Pharmacy First service and increased eligibility to access lifestyle advice and management of minor conditions.

3.3.4. Pharmacy First Plus Service

PCA (P)(2020) 16 outlines the intention to establish a combined National Foundation Programme and Independent Prescriber (IP) career pathway for community pharmacists. It also outlines the terms for a Pharmacist Independent Prescriber-led common clinical conditions service to be known as NHS Pharmacy First Plus for which funding will be made available to 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.

3.3.5 Public Health Service

Community pharmacists are highly accessible primary care practitioners in terms of location and opening hours including extended hours in some pharmacies. An appointment is not 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 the national public health poster campaigns that pharmacies display.

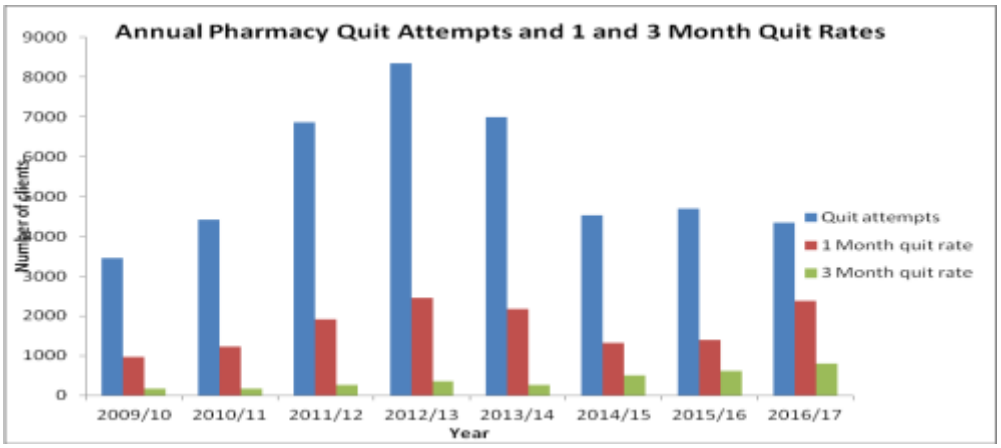
3.3.5.1 Smoking Cessation Services

This 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.

Community pharmacies enrol each patient with the pharmacy and set a quit date. Since the service started in 2008 there has been a clear seasonal pattern for patients wishing to quit smoking. The number of quit attempts recorded has fallen as smoking prevalence reduces in response to the introduction of Smoke Free policies. The increase in use of e-cigarettes and vaping also contribute to this fall in quit attempts which is seen across both community pharmacy and specialist stop smoking services.

Community pharmacy see more clients but have relatively lower percentage quit rates than specialist cessation services. The specialist cessation services can offer more intensive support to complex clients. A shared care model between community pharmacy and specialist services is in development to provide support and an opportunity for pharmacy to be more active in this area and provide increased population coverage and overall improved quit rates.

Figure 18 Annual pharmacy quit attempts and 1 month and 3 month quit rates



There is a national database to record smoking quit attempts and the figures for quits through pharmacy based interventions, specialist services and overall are reported. To fulfil contractual obligations, pharmacists must complete an electronic pharmacy care record which informs the national data base. Community pharmacy co-operation in helping to maximise the accuracy of this data is highly appreciated. 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:

- Develop the community pharmacy smoking cessation service working closely with specialist services and pharmacy champions to support this. This will ensure that the needs of individuals seeking help to quit smoking are being met and that pharmacy continue to contribute positively to the Scottish Government strategic goal to reduce smoking prevalence in Scotland to 5% by 2034.

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.

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).

Figure 19 – Emergency Hormonal Contraception 2019

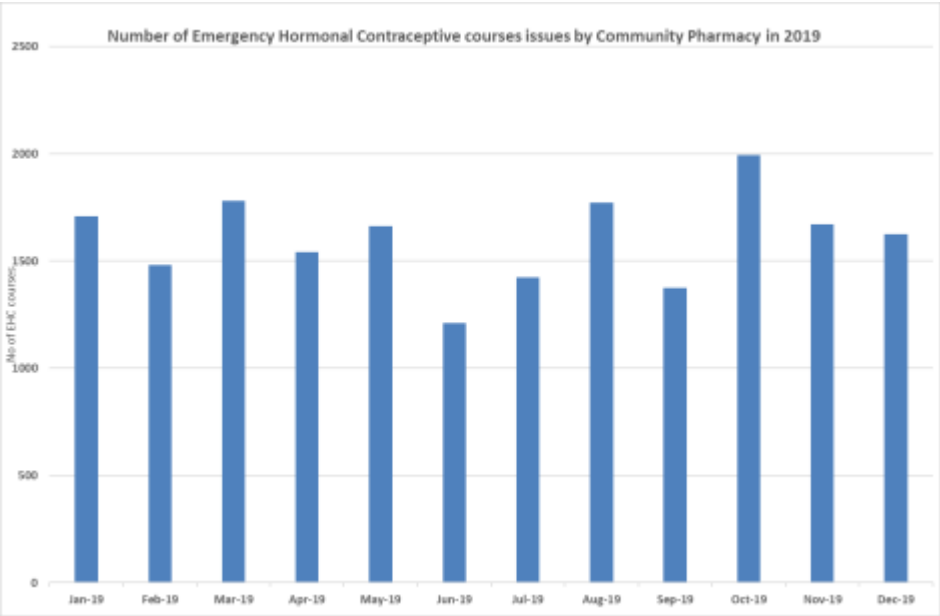
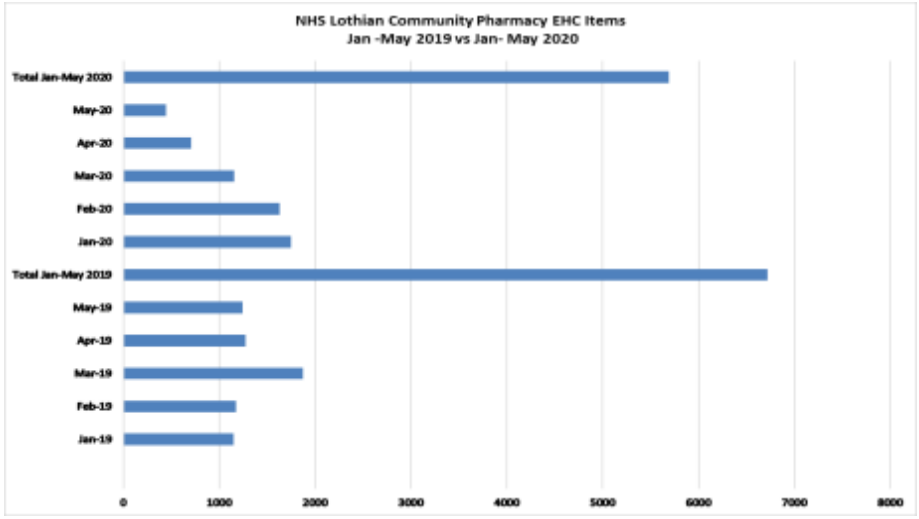


Figure 19 shows that the demand for emergency hormonal contraception, while fluctuating slightly month to month, shows no increasing trend in year. The need for this service would therefore appear to be stable. It is also known from

pharmacy level data that there is capacity within the system to meet any increasing demand. This service has been reviewed locally in response to changes to the faculty of Sexual and Reproductive Health Care guideline for emergency contraception in 2017. The community pharmacy EHC service includes provision of free condoms provided by the C;Card sevice.

Figure 20 shows the impact of Covid 19 pandemic lockdown on the demand and provision of this service from community pharmacy in the first five months of 2020 compared to 2019.

Figure 20 – Emergency Hormonal Contraception Covid 19 Comparison



There is a locally negotiated service 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:
The supply of emergency hormonal contraception is led by patient need.

- Consider new models of delivering wider sexual health services such as bridging contraception in primary care settings including community pharmacy.

3.3.5.3 Prophylactic Antipyretic (Paracetamol)

Pharmacists provide prophylactic antipyretic (paracetamol) in advance of or following childhood meningitis B vaccination and other childhood vaccinations as clinically appropriate.

3.3.6 Unscheduled Care

Community pharmacy is an important access route for people requiring unscheduled 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 medicines that can be provided in this way. To support this pharmacists can now access the Emergency Care Summary for individual patients.

Community Pharmacies can also use Direct Referral to local 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:

- Community pharmacy to have access to clinical portal to help improve patient care and support for pharmacotherapy service element of MCR

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 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

3.4.1.1 Supervised Self Administration of Methadone

Supervised self administration of methadone has become a key component of any methadone treatment programme. The main reason for supervision is clinical safety- to protect patients and the wider public. Supervision is essential in high risk, chaotic patients as it ensures patients receive the correct prescribed dose. It is an essential clinical tool that ensures patients receive only the dose intended and assures prescribers that what they are prescribing is that being taken. Overdose from methadone is a real risk and often those receiving methadone are still using heroin on top. Supervision ensures methadone diversion is limited, and self directed dose top

ups, or rapid dose detoxes are not being undertaken. It also protects patients who may otherwise be coerced into selling or giving away their methadone. It protects the public and children at home that methadone is not circulating uncontrolled in high volumes in a community. The main reason for supervising the dose is to check that the dose is correct for the patient (i.e. neither too high nor too low). However, it also ensures that the patient takes the prescribed dose of methadone and it is not being shared, swapped or sold.

The use of community pharmacists for dispensing methadone allows patients to be treated in their own communities. Community pharmacists are the best placed healthcare professionals to carry out the supervision of methadone. Supervision of methadone ensures that adequate blood and tissue levels of methadone are maintained and helps to prevent diversion for non prescribed use. All pharmacies are available to dispense methadone however a supervised methadone service may not be available in all pharmacies.

The exact number of pharmacies delivering supervision of methadone is not captured in a formal return within NHS Lothian and varies with patient need. The Information and Statistics Division reported that during April 2012 to March 2013 182 pharmacies dispensed methadone and 174 supervised methadone. Clearly there are small variations in number of pharmacies dispensing but this is likely in response to demand and not a pharmacy decision.

Table 6 –Dispensing and supervision of methadone 2015/16 to 2019/20

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

3.4.1.2 Supervised self-administration of buprenorphine

Buprenorphine is also licensed for the treatment of opioid dependence and its use is increasing across the NHS Lothian area, although methadone remains the predominant treatment. The use of either agent is dictated by clinical choice, the two drugs are not interchangeable

Buprenorphine supervision may be requested by a prescriber for the same reasons as methadone and supervision is performed in community pharmacies. Previously, only 15 pharmacies received payment for supervision under a pilot service but payment will now be made to any pharmacy in Lothian where supervision takes place. Similarly to methadone, 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.

Table 7- Supervision of buprenorphine 2015/16 to 2019/20

Year	Total number of supervisions
2015/2016	40642
2016/2017	43844
2017/2018	57377
2018/2019	56140
2019/2020	60540

Recommendation:
The services provided by pharmacies relating to substance misuse 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. This may be challenging in light of budget constraints.

- Key areas to be developed are a package of care model and increasing availability of take home naloxone. Both are desirable to support reducing drug related deaths.

3.4.1.3 Injection Equipment Provision

Injection equipment provision is provided with the aims of reducing the transmission of blood borne viruses by sharing of injecting equipment; to protect the public from discarded equipment; to make contact with drug users who are not in contact with drug treatment services; and to improve access to health and harm reduction advice. Pharmacies providing the service will give limited advice on injecting, dealing with wounds and finding health and drug services. They all provide needles and syringes, other injecting paraphernalia and foil.

The aims of the Pharmacy injection equipment provision service are 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.

The objectives 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.

This is not a pharmacy specific scheme and injecting equipment may be available in other community based settings. A needs assessment of the injection equipment provision service informed the redesign of the Pharmacy injection equipment provision service with a new contract and service specification. The Pharmacy injection equipment provision contract is provided from 19 pharmacies and has been in place since June 2013. Pharmacies input data onto the web-based system called NEO. This supports NHS Lothian to meet national injection equipment provision dataset requirements.

Recommendation:
Needle exchange 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.

3.4.1.4 National and local drivers

Changes announced in the Scottish Government's response (November 2013) to the *Independent Expert Review of Opioid Replacement Therapies in Scotland* included "Improving the care offered by pharmacists through the Scottish Government's *Action Plan for Pharmaceutical Care, Prescription for Excellence*. *The Scottish Government will be working with the profession to develop and implement national standards and specifications for drug and alcohol services"*

It is a long-term goal to move to implementing a new model of delivery of pharmaceutical care in Lothian, which is currently being provided in other Health Boards. The model embraces a patient centred recovery focus where community pharmacy is reimbursed for providing a collection of care components to an individual patient. (i.e. a monthly fee per patient) rather than payment per item of dispensing / supervision service. Key issue post covid is some contractors stopped providing supervision services. This has not been consistent across all contractors leading to an imbalance in where you can access supervisions in different areas. As we remobilise post pandemic supervisions provided by contractors are essential. Before we move forward to a "package of care" post covid supervisions need to be re-established across contractors to ensure equity of services.

In 2017, a needs assessment for people who inject drugs was carried out with input from a range of participants from NHS services, council services, 3rd sector and policing. The report makes several recommendations under 6 main areas with the aim of improving access to services and retaining patients in treatment. There may be scope to develop community pharmacy services as a result of the report and areas for potential development 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.

3.4.1.5 Supervised self-administration of disulfiram

A pilot of supervised consumption of disulfiram was launched in 30 pharmacies across Lothian in May 2010. The purpose of this service, in line with the Scottish Government's national strategy *Changing Scotland's Relationship with Alcohol: A Framework for Action*, is to enhance 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 evaluation of the service provides evidence that the service is cost effective and makes an important contribution to the care of patients in maintaining abstinence from alcohol dependence.

Information gathered from pharmacies in August 2017 regarding the number of patients receiving prescriptions for disulfiram at each pharmacy, suggests that a large number of patients are prescribed disulfiram across the health board area. Many of these patients attend a pharmacy not registered in the disulfiram supervision service and therefore inequalities and gaps may still remain in the disulfiram supervision service from the perspective of patients, prescribers and community pharmacies. Extending the service to include all pharmacies would help to address gaps in service.

This information has informed an option appraisal for the future disulfiram supervision service. Options presented are to continue the service with the current number of pharmacies, expand the service or remove the service and as of yet, no decision has been reached on the future of the service. Substance misuse service budgets were devolved to Integration Joint Boards as of April 2018, therefore each IJB will select the option most appropriate to the needs of the patient population within their area.

3.4.1.6 Covid 19 Substance Misuse Service –Implications

Covid 19 has changed the way all services work and substance misuse services faced vast transformations in service delivery in pharmacy. The biggest issue has been the need to vastly reduce footfall and face to face interactions. This had led to a vast quantity of patients who were normally supervised at the pharmacy for methadone, to have this supervision stopped in order to Covid 19 protect. In Lothian the substance misuse team and GP prescribers clinically assessed and reduced supervisions and reduced pick up days in the majority of patients to help support community pharmacy reduce their footfalls and maintain social distancing. Some supervisions where maintained for a small group of particularly high risk patients and for new patients. Services are working with community pharmacies to remobilise supervision for patients but there is likely to be reduced supervisions maintained and in place longer term to help covid protect against a second wave and to support Test and Protect

The need to have methadone delivered to substance misuse patients during Covid 19 who were self isolating also emerged. This included some patients who did not have a representative to collect on their behalf. Due to the pressure on community pharmacy services this delivery was supported by the third sector substance misuse organisation with support from Drug and Alcohol Partnerships. There may be the need to continue these delivery services to support self isolation and Test and Protect. It is unclear how

long the third sector can support the deliveries or any future role of community pharmacy to support this under Test and Protect.

Although each of the HSCP now has devolved its own substance misuse services, t a constant Lothian approach to the Covid 19 pandemic was maintained from substance misuse services across Lothian in the majority of responses.

3.4.2 Pharmaceutical Advice to Care Homes

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 within their vicinity. Basically, 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.

Payment for this service is made for up to a maximum of five homes per contractor. Payment is made on a sliding scale depending on the number of beds in the care home.

This service would not be expected to be geographically spread but instead correspond to the needs of care homes within their local area. It would not be necessary for a pharmacy to be located in the same Health and Social Care Partnership 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.

It has been agreed that the existing service requires to be comprehensively reviewed to incorporate a greater clinical element as well as a focus on medicines waste. As GP practise based pharmacy progresses there is an example of establishing multidisciplinary medication review for care home residents which won the Scottish Care Home Award for most innovative practice in 2017.

Recommendation:
Currently community pharmacy contractors claim for the locally negotiated service delivered to 64 out of the 110 care homes across Lothian. This would suggest that there is an unmet need in the remaining 46 homes.

- In light of the covid impact in care homes this service should be comprehensively reviewed. This review will aim to increase the pharmaceutical care advice given to homes and in addition, it will have a focus on reducing medicines waste. The enhanced service specification is currently undergoing review.

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. As per the recommendation in 2017 a review taking into account the geographical spread confirmed 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 7 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 people who access the service both in and out of hours to help them remain at home (Figure 22) and by the range of people who access the services (Figure 23).

Figure 22 Palliative Care Network workload

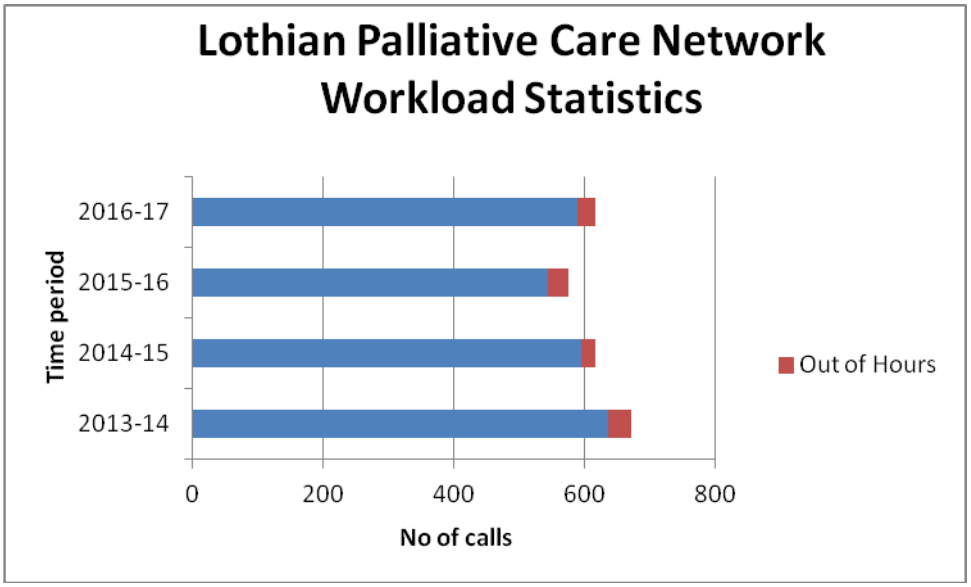
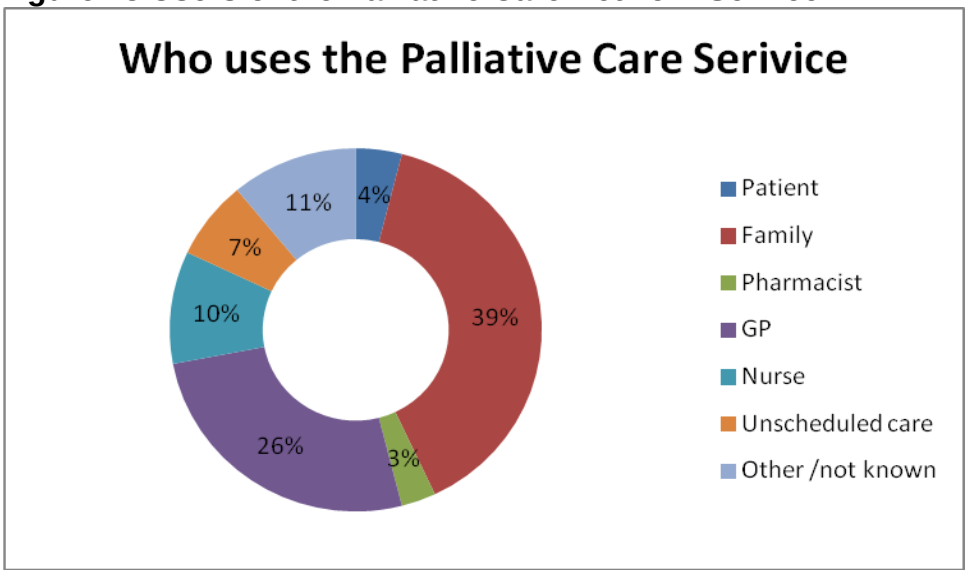


Figure 23 Users of the Palliative Care Network Service



Recommendation:
The Palliative Care Service was reviewed to ensure best coverage for the population of NHS Lothian of a small number of local experts for provision of palliative care medicines and advice both in and out of hours.

- Review post COVID 19 should be undertaken to confirm the continued availability of the palliative care pharmacies for provision of palliative care medicines and to ensure the geographic spread still provides the best coverage and the needs of patients are met.

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.

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

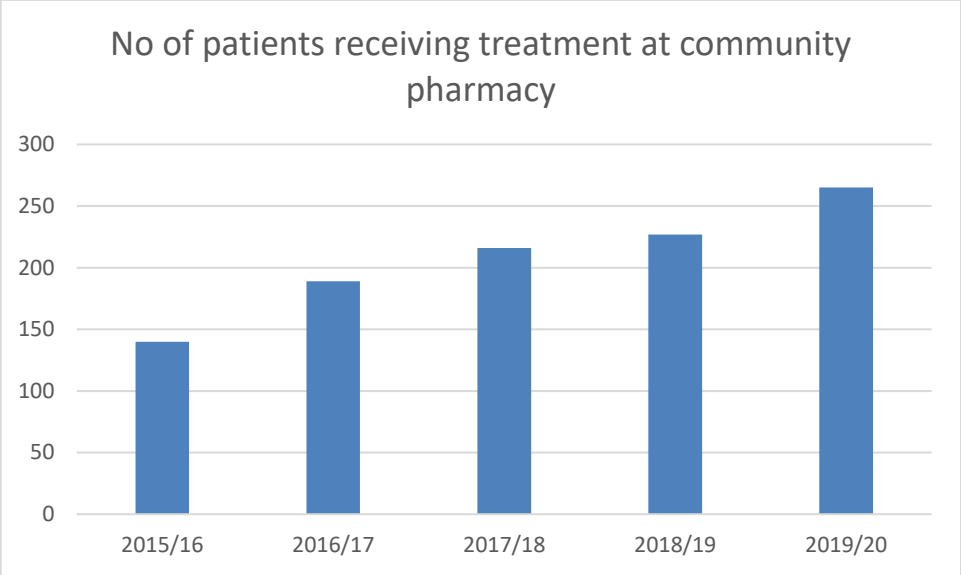
This tier 2 service provides antiviral treatment for hepatitis C.
The specific objectives of the service providing pharmaceutical care to patients receiving treatment for hepatitis C are:

- 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 20 shows the number of patients accessing treatment via community pharmacy. 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 24 Hepatitis C service



3.4.5 Gluten Free Food Service

From August 2015, following a pilot in 2014, patients with a confirmed diagnosis of either Coeliac Disease or Dermatitis Herpetiformis will be able to self-manage their gluten free prescription with the help of community pharmacy rather than General Practice. 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. Patients then select gluten-free food items up to this unit allocation from the local Gluten Free Formulary and take their order directly to their community pharmacy. 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. Each pharmacy will designate a named pharmacist to be responsible for the on-going management and delivery of the scheme. The Community Pharmacy Gluten-Free Food Service forms part of the wider Modernising Patient Pathways for Coeliac Disease Test of Change. GI Collaborative Test of Change Modern Outpatient Programme Coeliac Disease Pathway NHS Lothian Final Report Sept 2019

Recommendation:

- Review uptake of the annual health check offered as part of this service and if unexplained variation is identified consider ways to reduce this recognizing that patient choice will play a role. Covid will have impacted on uptake and provision during 2020

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 Contract. 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. Community pharmacies are expected to complete two quality improvement activities:- undertaking the **Safety Climate Survey** and developing an action plan; and participation in **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Interventions**.

NHS Circular: PCA (P)(2019) 14 issued July 2019 has added two additional requirements for community pharmacy. Improve their delivery of their **smoking cessation service**, applying QI methodology learned in previous years to make small changes and monitor the impact of these changes and prepare for the refreshed **Minor Ailment and Common Clinical Conditions Service** to be launched April 2020.

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 initially for the period of 4 months (December 2019-March 2020) This has been reviewed and has been extended. 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.

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. 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

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 Promoting Health in Leith Walk Area

The Community Pharmacy Project: Promoting Health in Leith is a collaborative project to promote the local services from third sector agencies in community pharmacies and to raise awareness of services available from community pharmacies amongst third sector staff.

The Project hopes to build-up and support relationships between local community pharmacies and third sector agencies in the Leith Walk area to provide greater access for local residents, improve referral to appropriate services in the area and to encourage access to community pharmacies as a first port of call for health and wellbeing.

This is achieved through the third sector agencies providing information to community pharmacy teams and spending time in the community pharmacies talking to local residents.

To date, there have been over 15 third sector organisations and 7 community pharmacies involved in the project with plans to further expand the organisations in the coming year.

4.4 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.net 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.

4.5 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
Flu vaccination
Travel Clinics
Stoma appliance supply
Compliance aid

5. Recommendations Summary

Hours of Service

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.

Essential Core Services

2 There is clear identified need for acute and medication care and review (formerly chronic medication services) illustrated by dispensing information and prevalence data.

3 There is no evidence of patients being unable to source a pharmacy to dispense a prescription which could be taken as evidence that there is no unmet need for the acute prescription service.

4 Support changes to the chronic medication service under Achieving Excellence in Pharmaceutical Care commitment 1 as they progress to the Medicine Care and Review service with launch expected in 2020/21. Development of serial prescribing is being taken forward under the pharmacotherapy service.

5 Patients no longer require to register for Pharmacy First which could be taken to indicate there is no unmet need in this area. NHS Lothian should support the Pharmacy First service and increased eligibility to access lifestyle advice and management of minor conditions.

6 Develop the community pharmacy services for stop smoking services working closely with specialist services and pharmacy champions to support this. This will ensure that the needs of individuals seeking help to quit smoking are being met and that pharmacy continue to contribute positively to the Scottish Government strategic goal to reduce smoking prevalence in Scotland to 5% by 2034.

7. The supply of emergency hormonal contraception is led by patient need. Consider new models of delivering wider sexual health services in primary care settings including community pharmacy

8. Community pharmacy to have access to clinical portal to help improve patient care and support pharmacotherapy service element of MCR

Additional Services

Substance Misuse

9 The services provided by pharmacies relating to substance misuse 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. This may be challenging in light of budget constraints. Key areas are developing a package of care model and increasing availability of take home naloxone which are desirable to support reducing drug related deaths.

10 Needle exchange 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

11 The Palliative Care Service was reviewed to ensure best coverage for the population of NHS Lothian of a small number of local experts for provision of palliative care medicines and advice both in and out of hours. Regular review should be undertaken to confirm the utilisation and availability of these pharmacies in providing palliative care medicines and to ensure the geographic spread still provides the best coverage and the needs of patients are met.

Pharmaceutical Advice to Care Homes

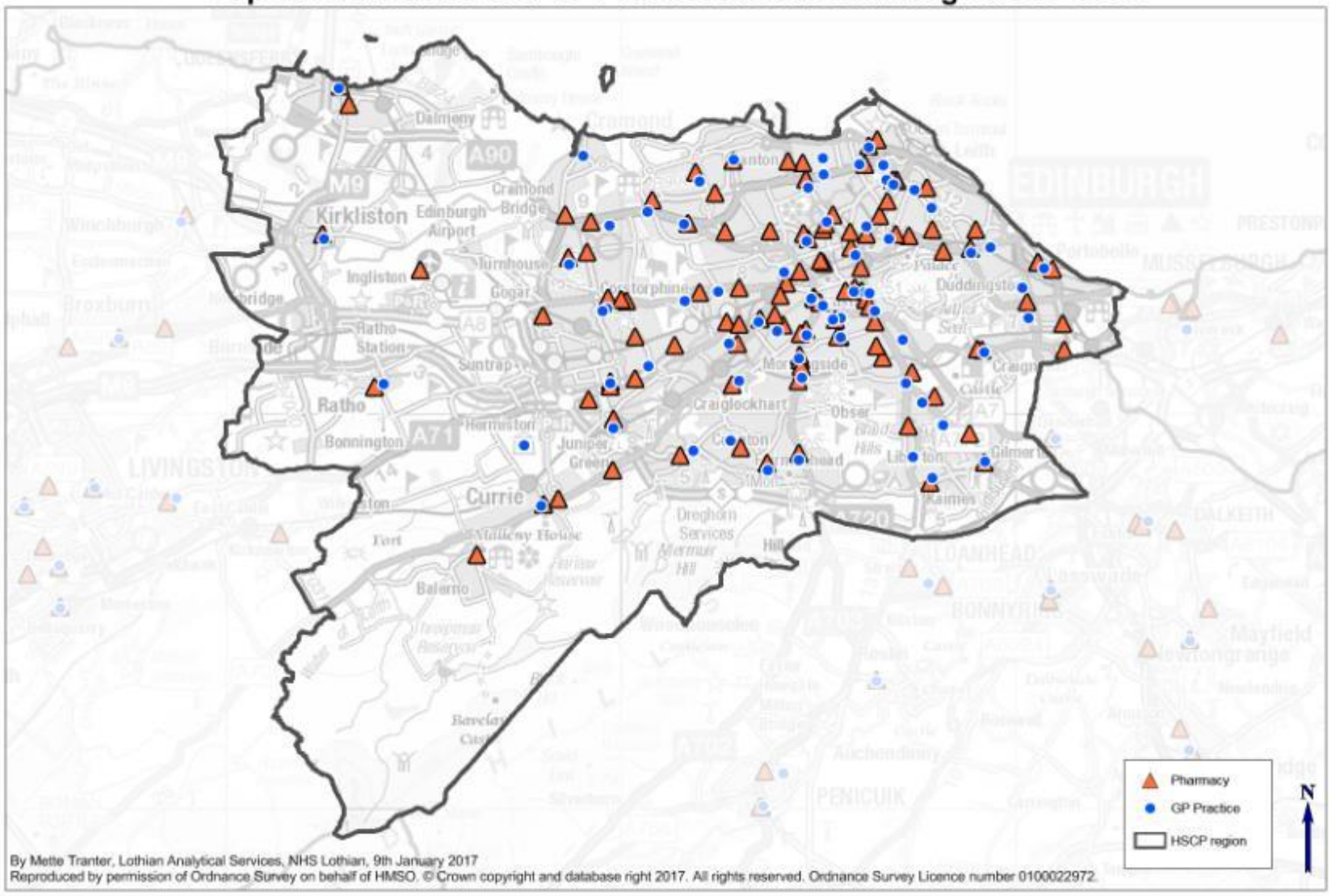
12 Currently community pharmacy contractors claim for the locally negotiated service delivered to 64 out of the 110 care homes across Lothian. This would suggest that there is an unmet need in the remaining 46 homes. In light of the covid impact in care homes this service should be comprehensively reviewed. This review will aim to increase the pharmaceutical care advice given to homes and in addition, it will have a focus on reducing medicines waste. The enhanced service specification is undergoing review

Gluten Free Food Service

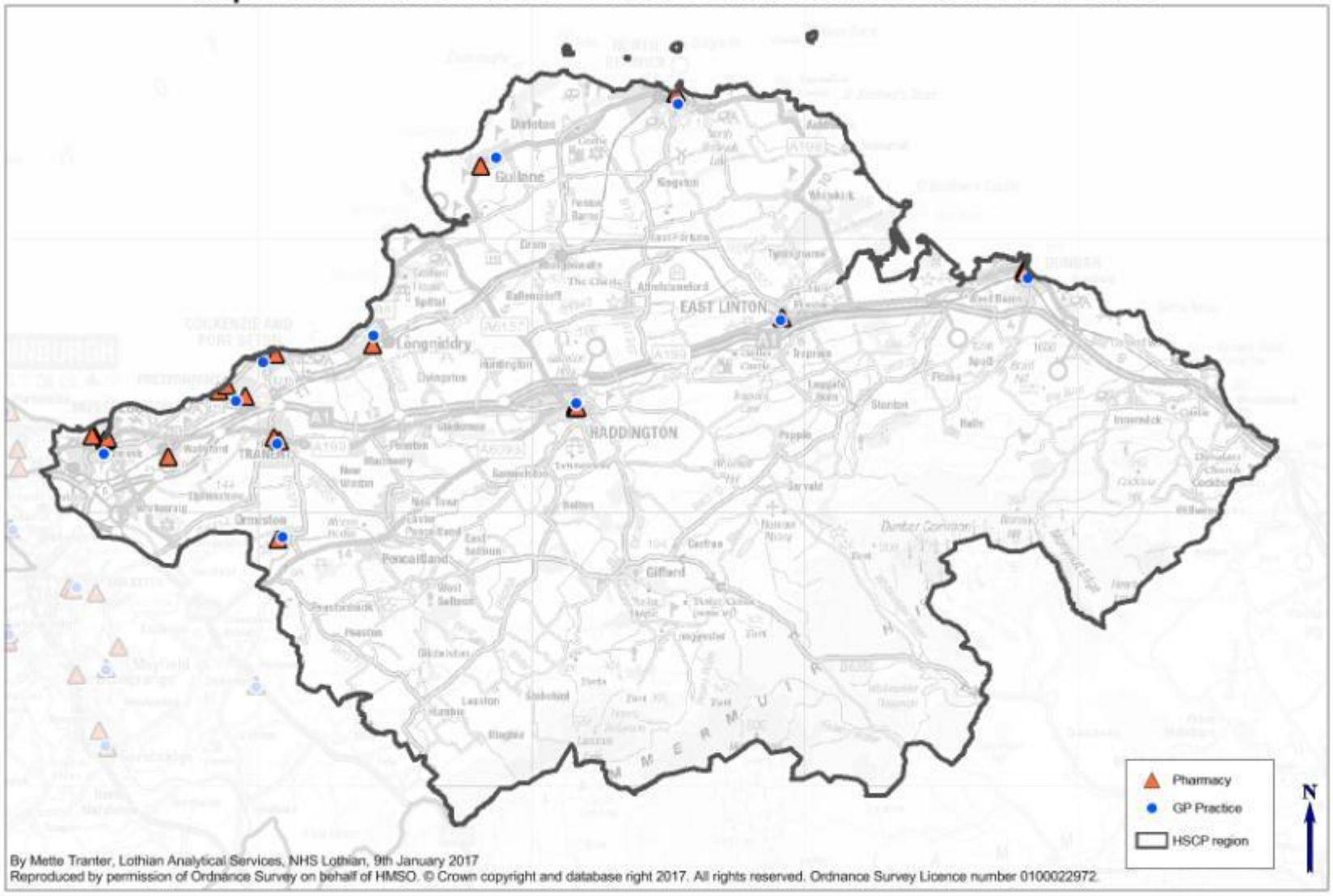
13 Review uptake of the annual health check offered as part of this service and if unexplained variation is identified consider ways to reduce this recognizing that patient choice will play a role. Covid will have impacted on uptake and provision during 2020.

Appendix 1 **Provision of NHS Lothian Community Pharmacy Services**

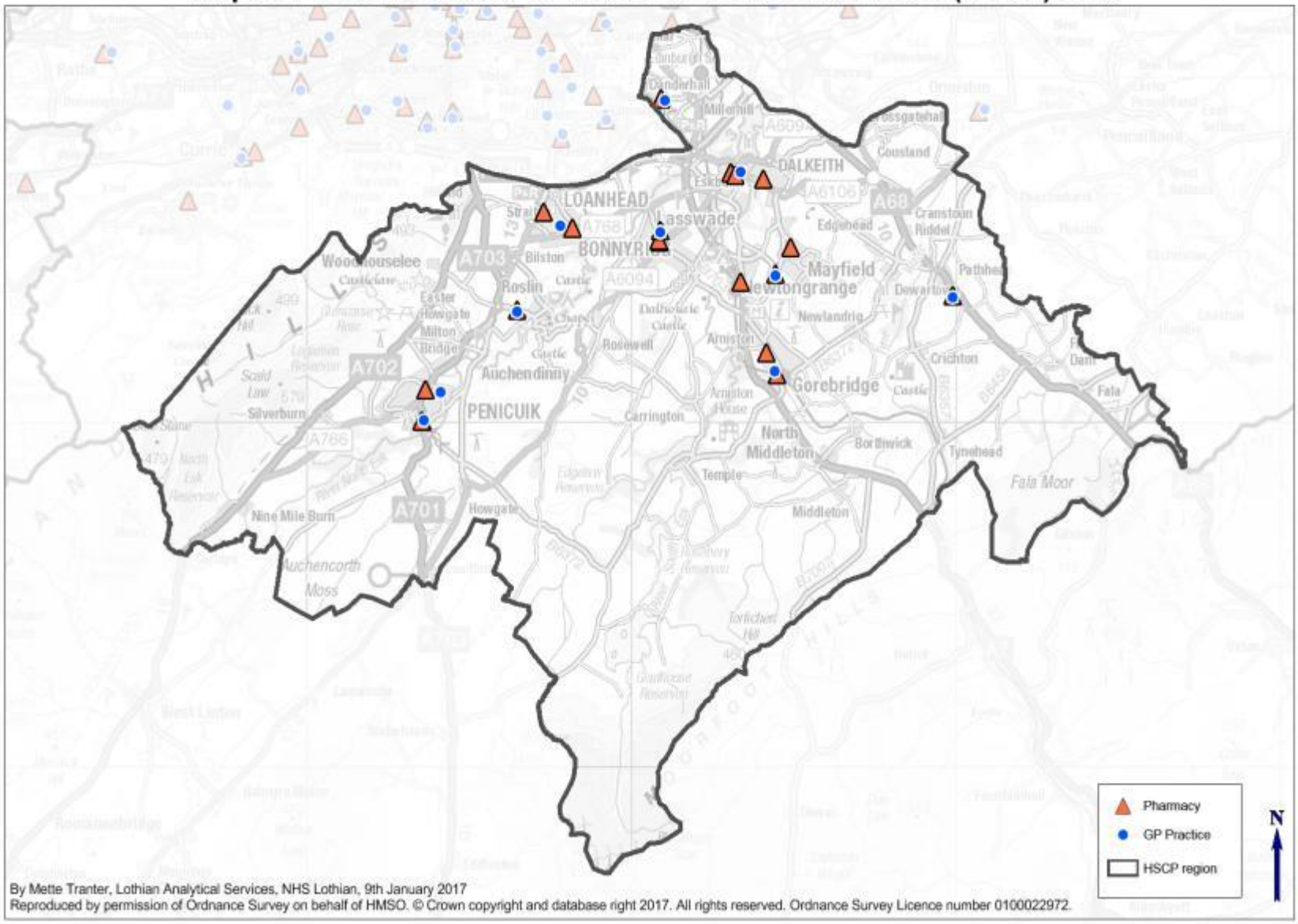
Map of Pharmacies and GP Practices in the Edinburgh HSCP area



Map of Pharmacies and GP Practices in the East Lothian HSCP area

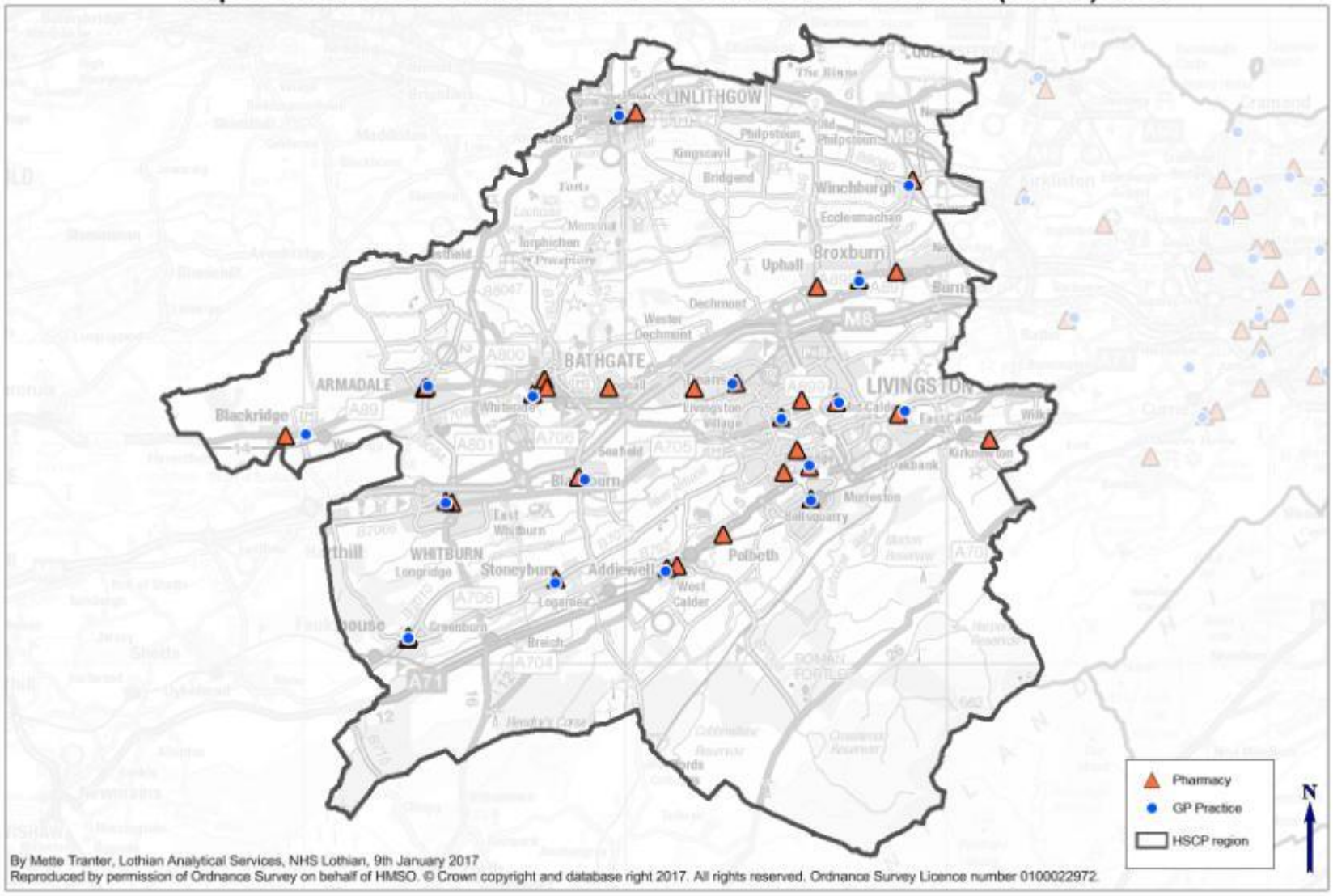


Map of Pharmacies and GP Practices in the Midlothian (HSCP) area

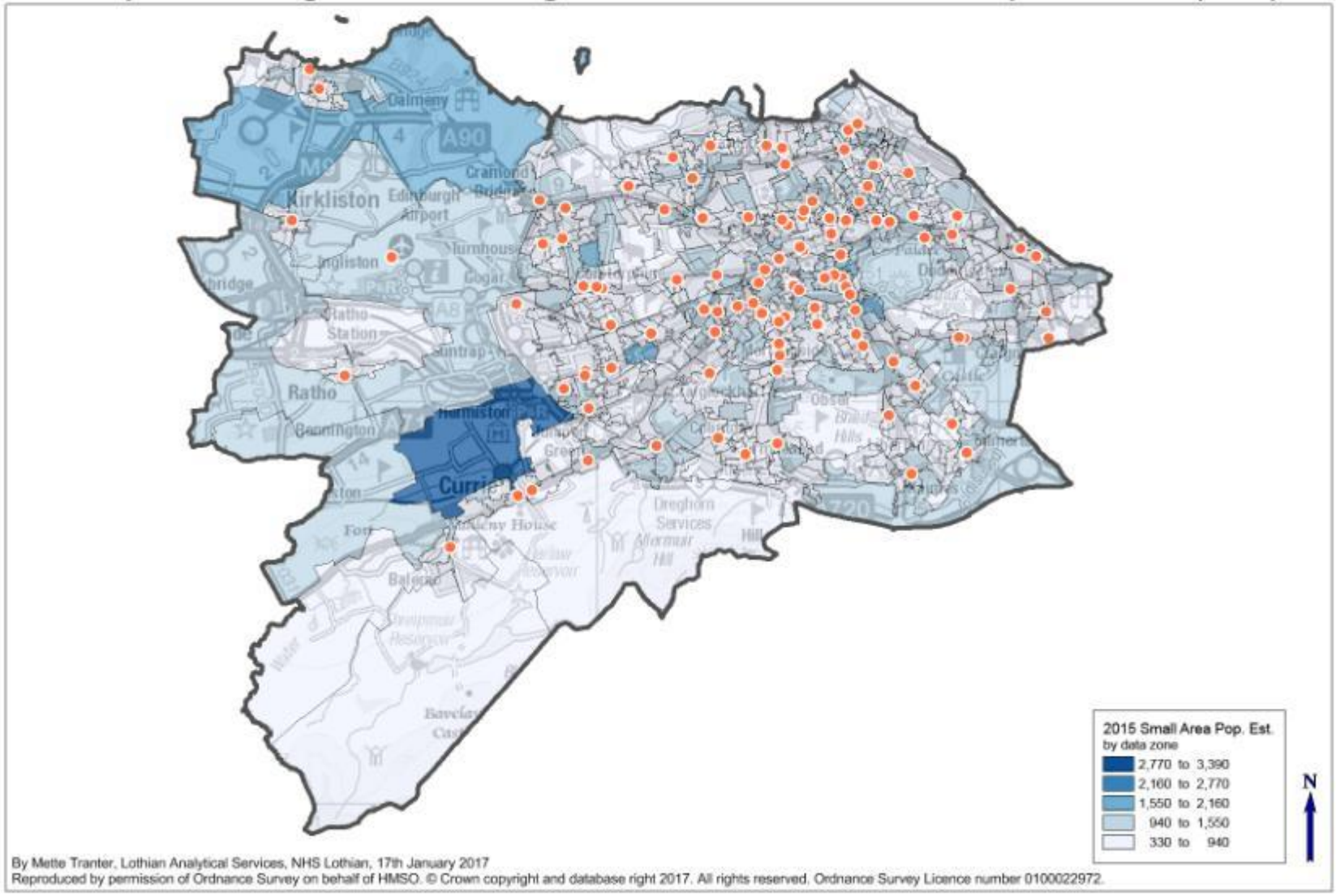


By Mette Tranter, Lothian Analytical Services, NHS Lothian, 9th January 2017

Map of Pharmacies and GP Practices in the West Lothian (HSCP) area

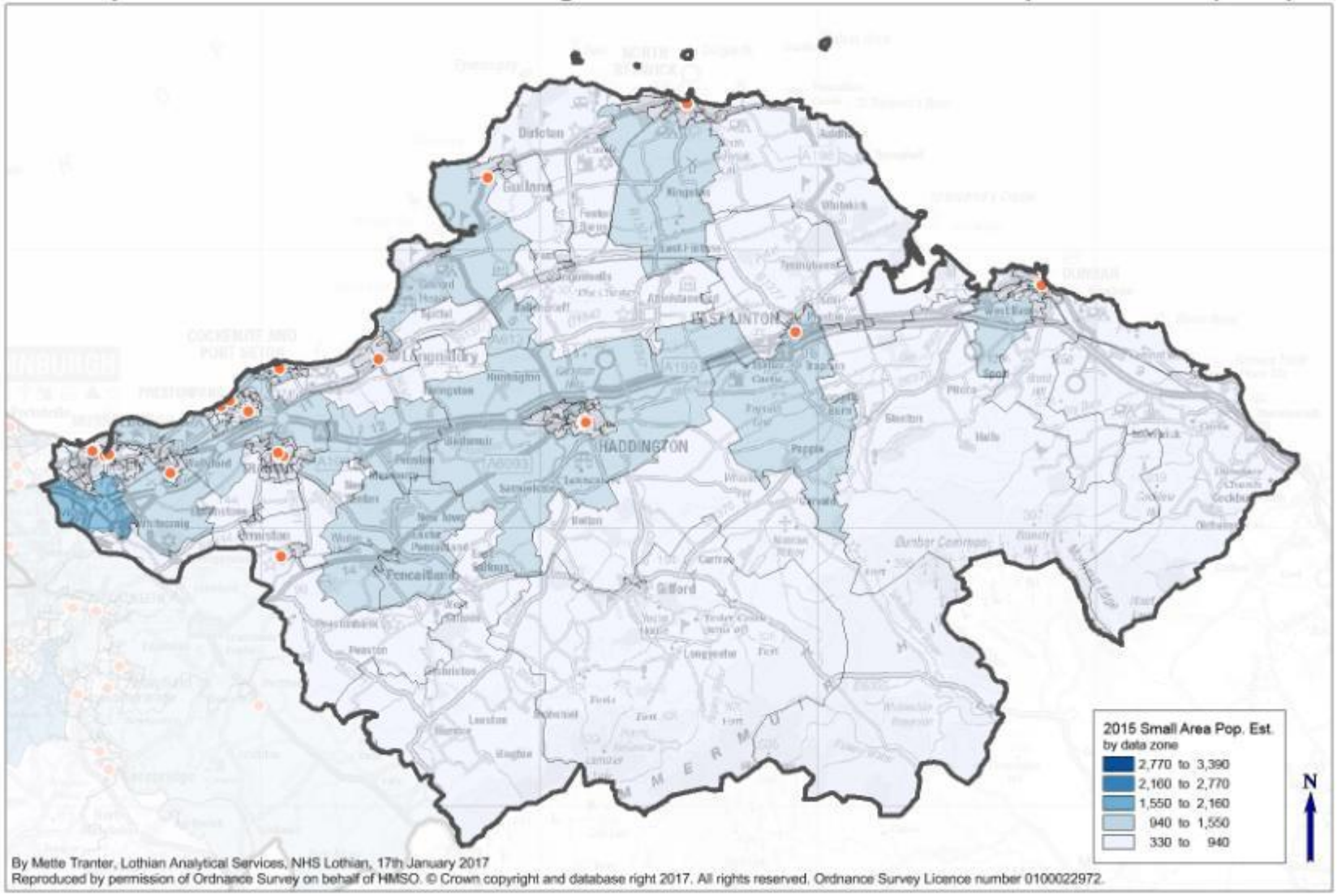


Map of Edinburgh HSCP showing Pharmacies and Small Area Pop. Estimates (2015)



By Mette Tranter, Lothian Analytical Services, NHS Lothian, 17th January 2017

Map of East Lothian HSCP showing Pharmacies and Small Area Pop. Estimates (2015)



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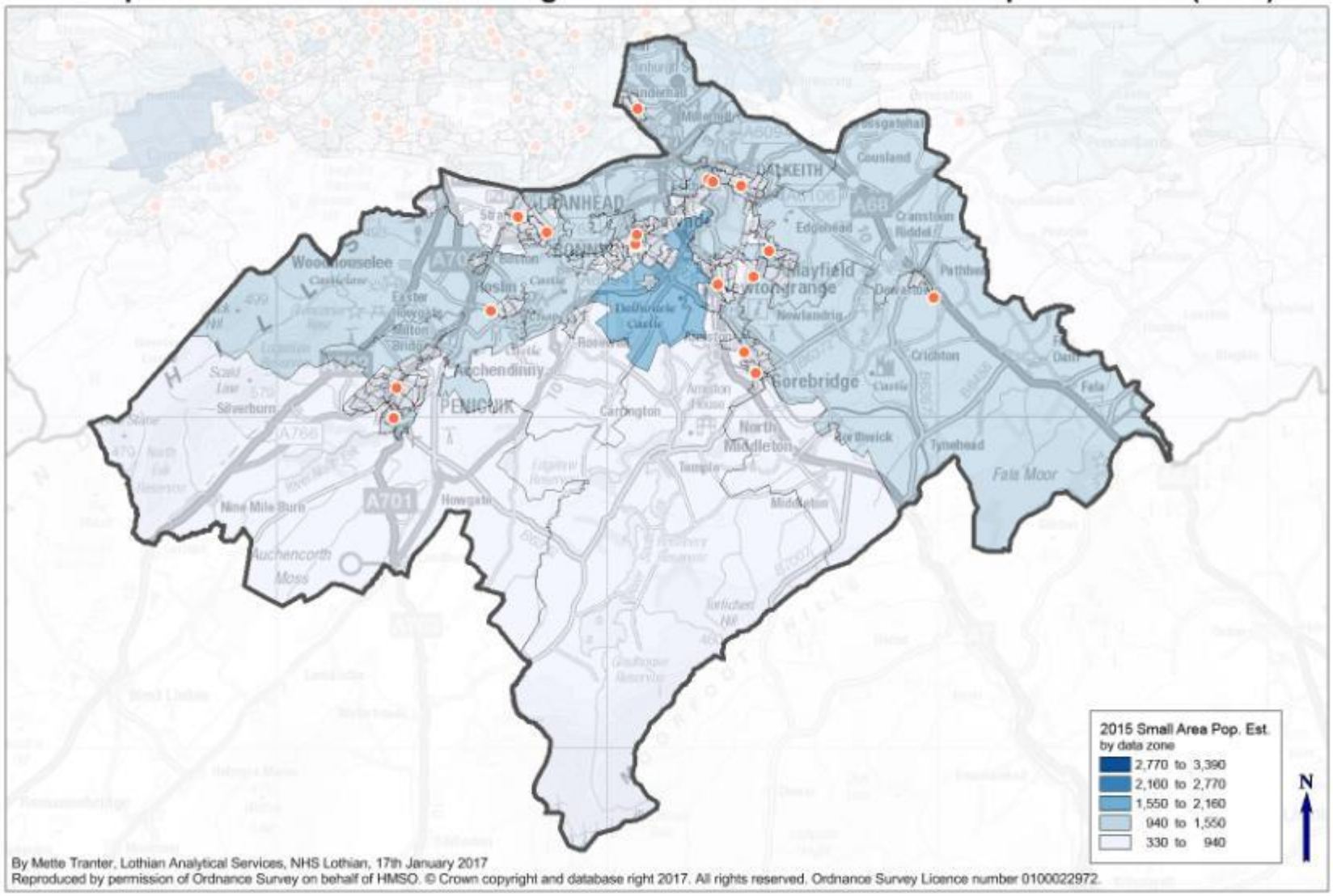

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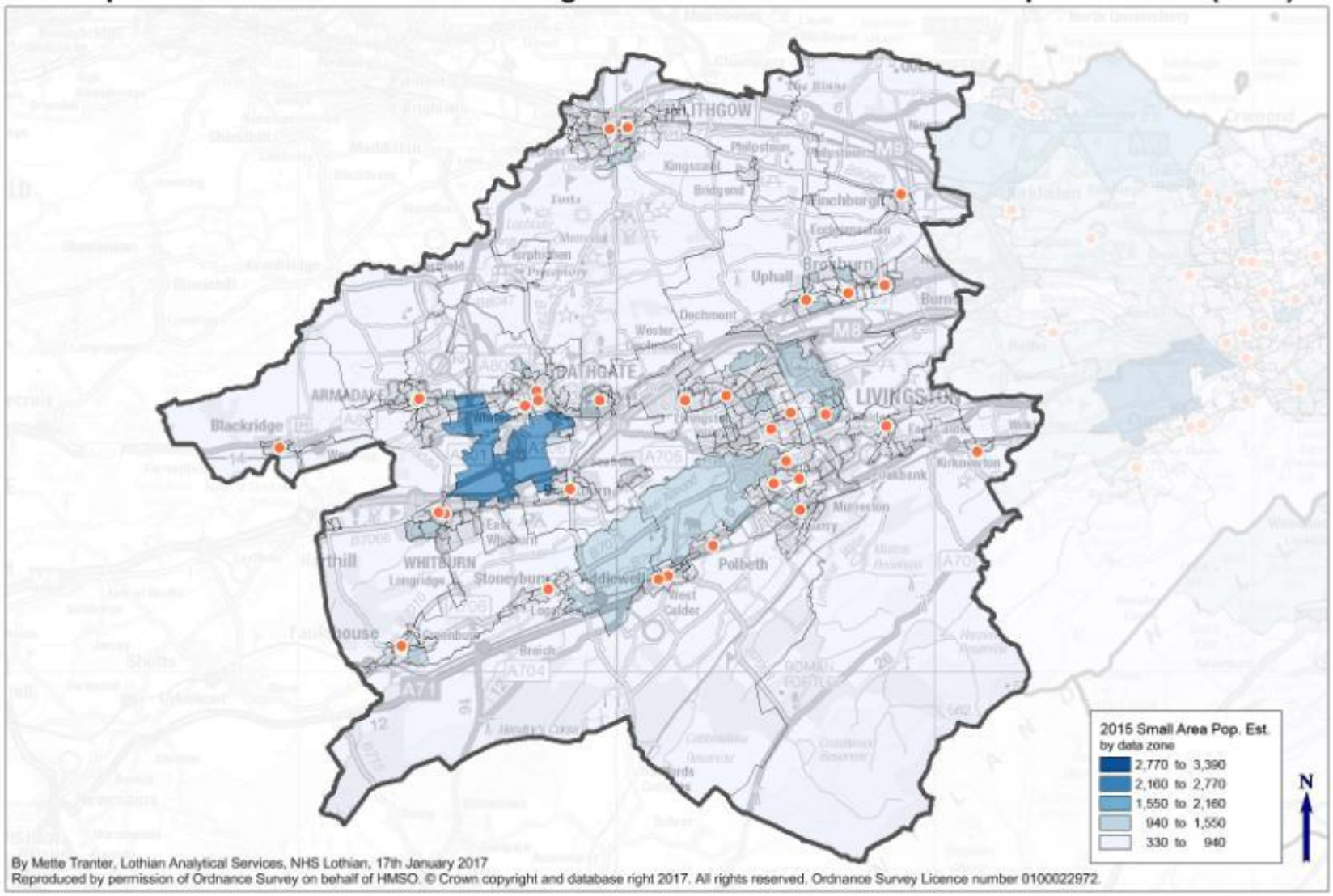

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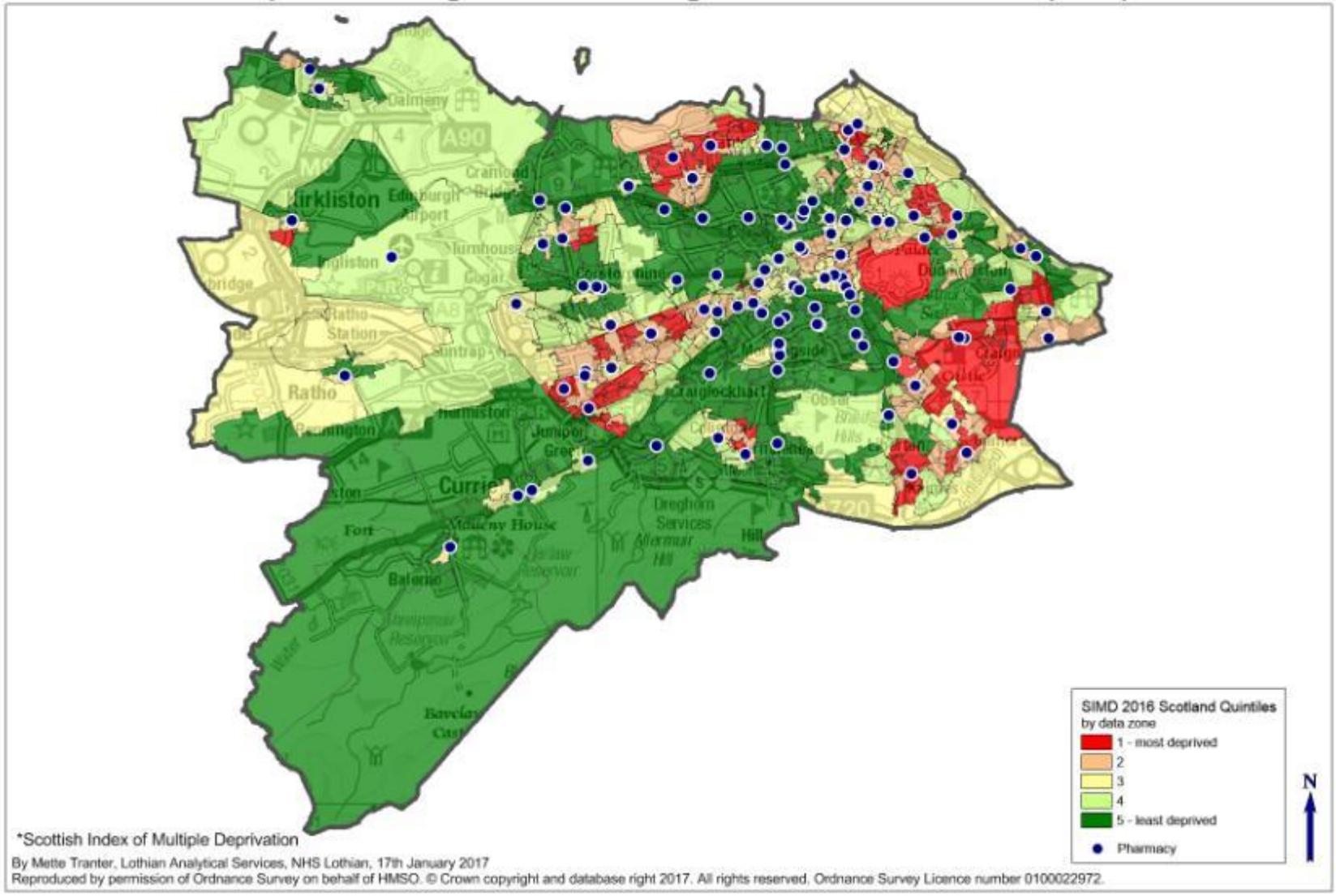
Map of Edinburgh HSCP showing Pharmacies and SIMD* (2016)



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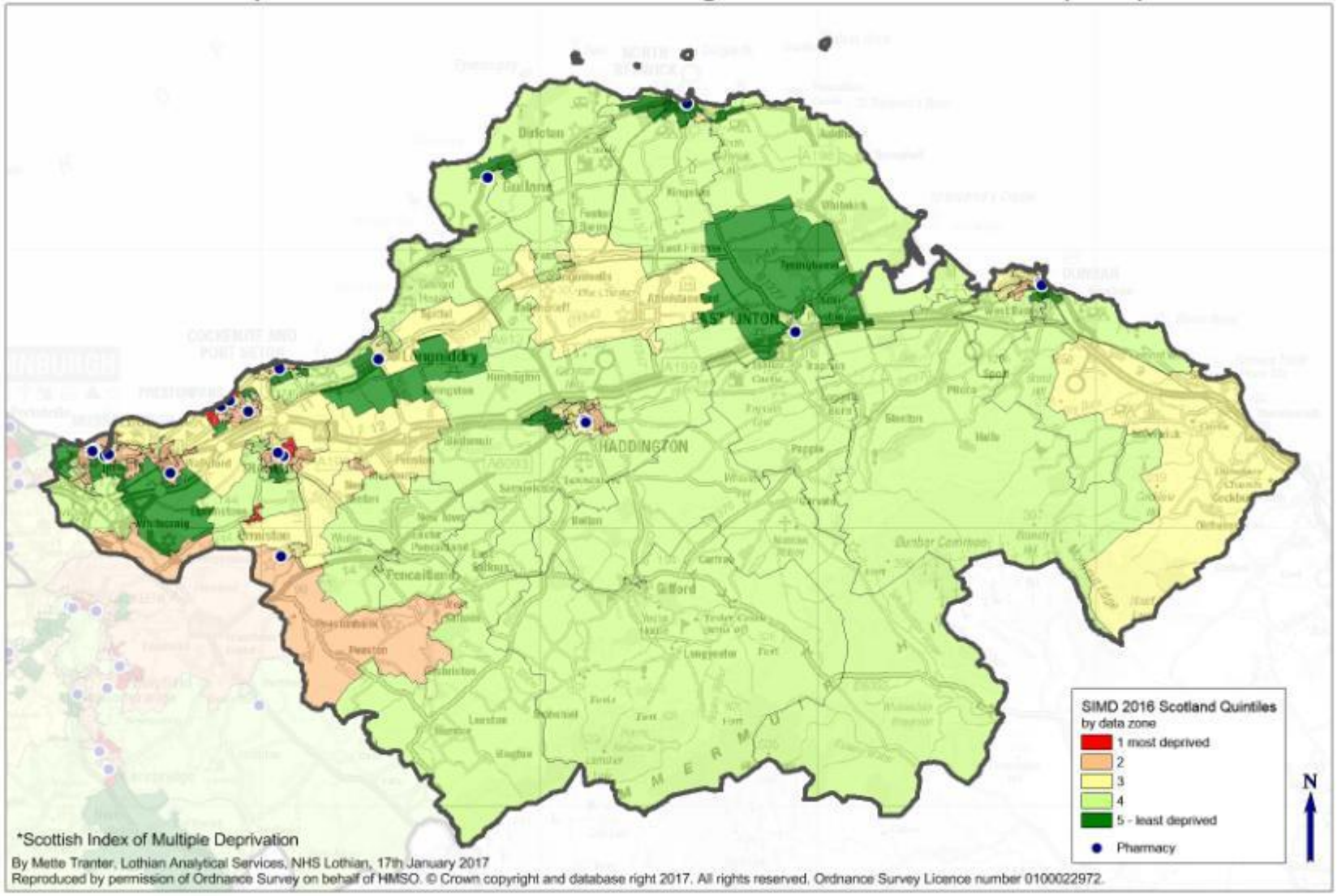

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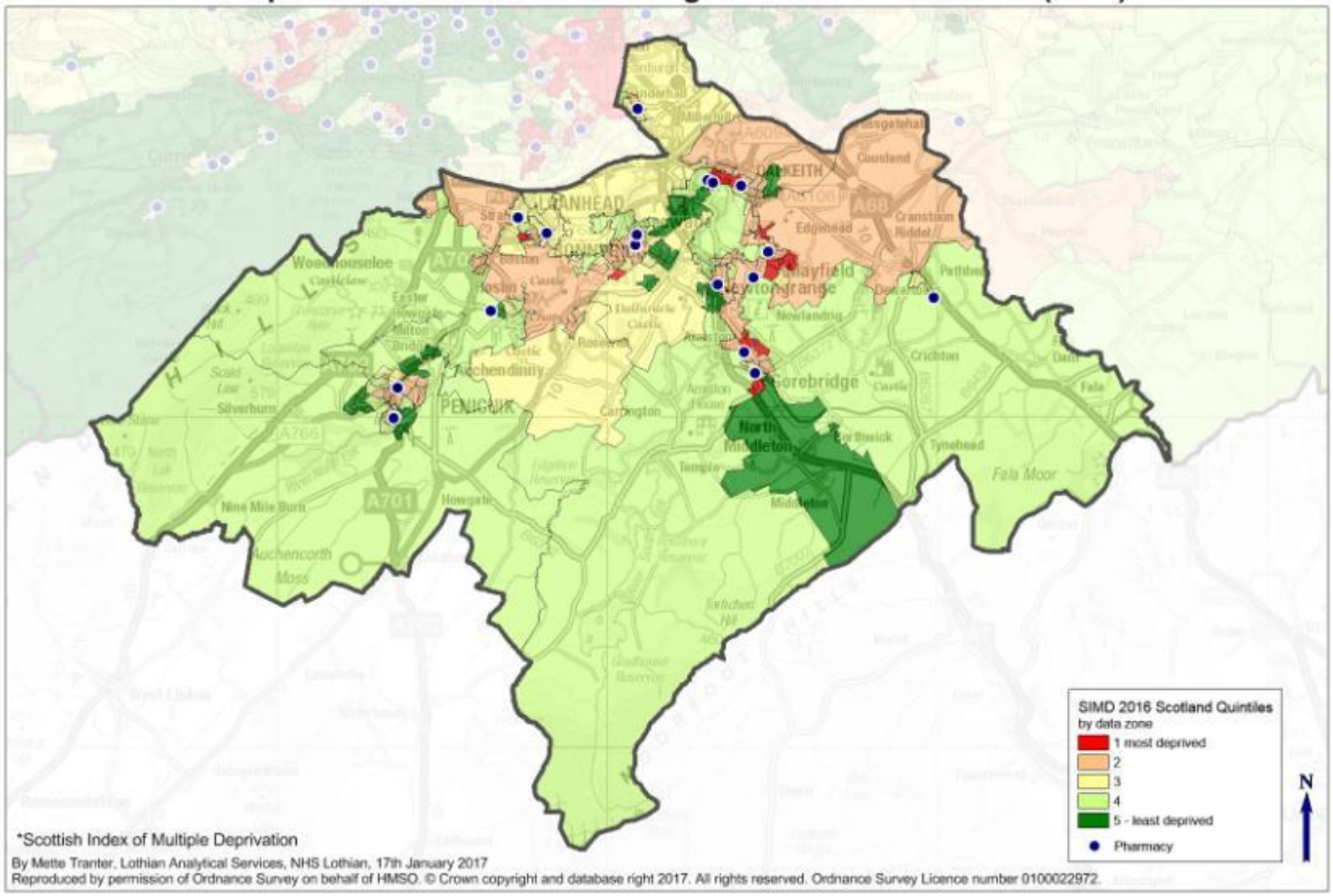

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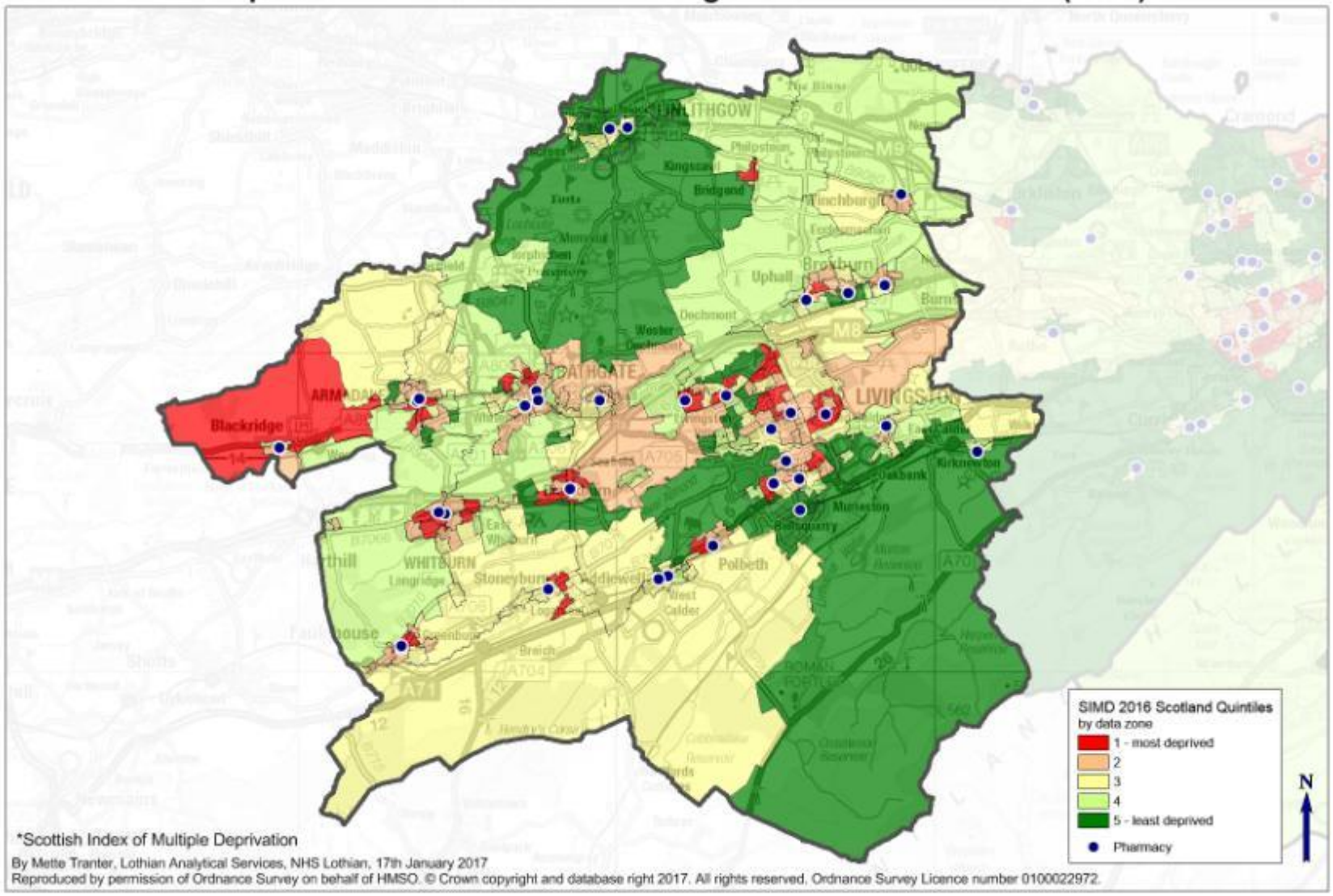
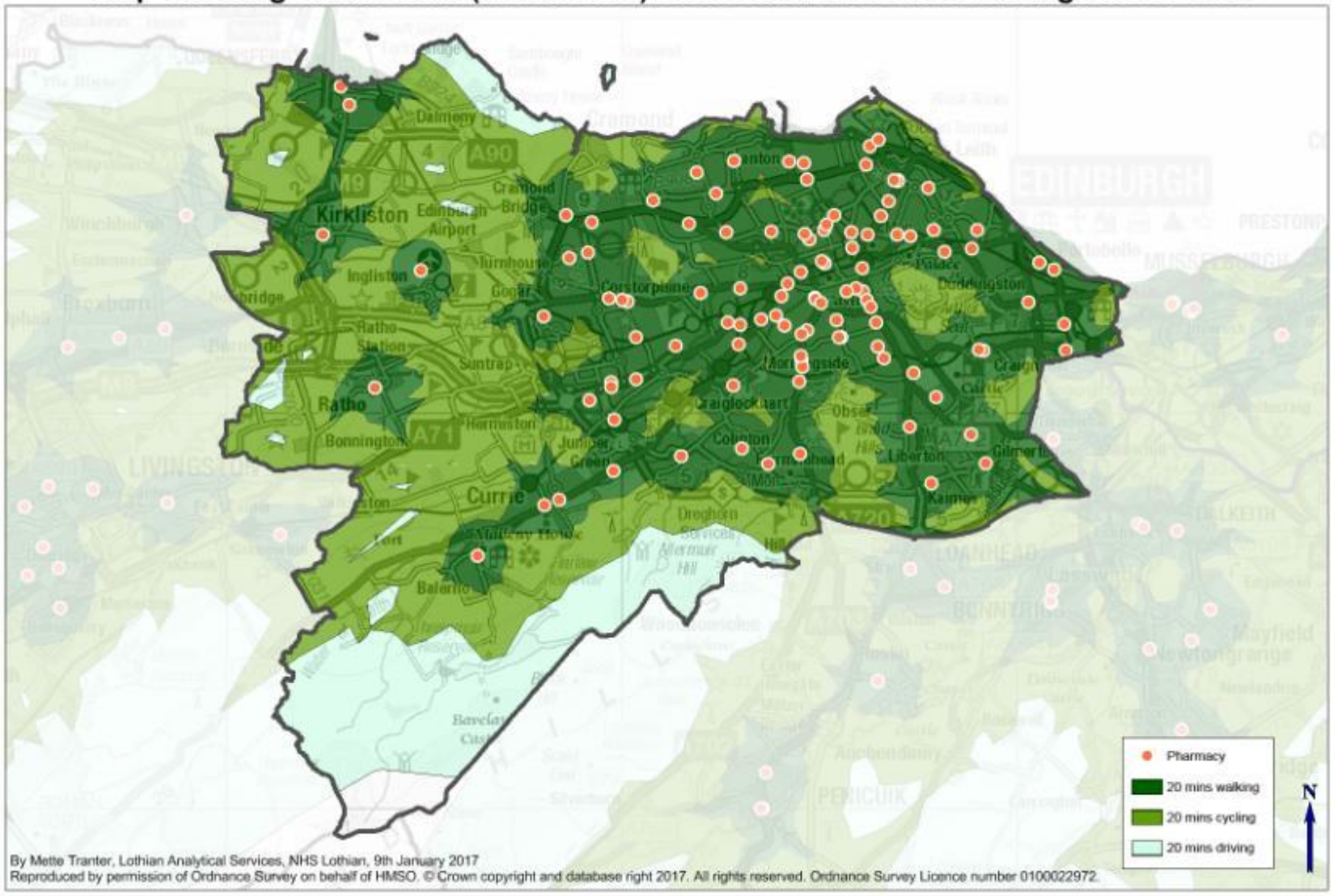
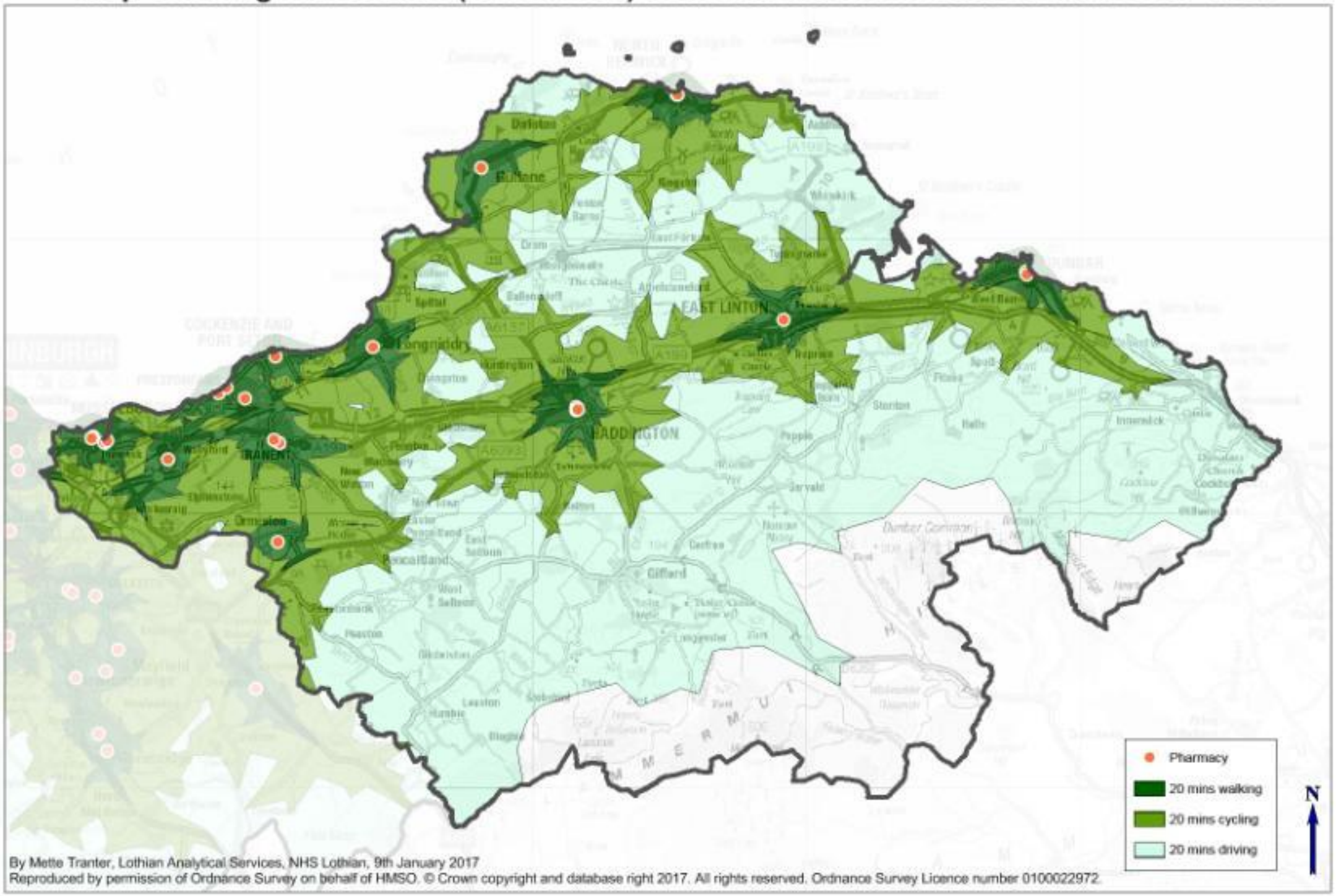


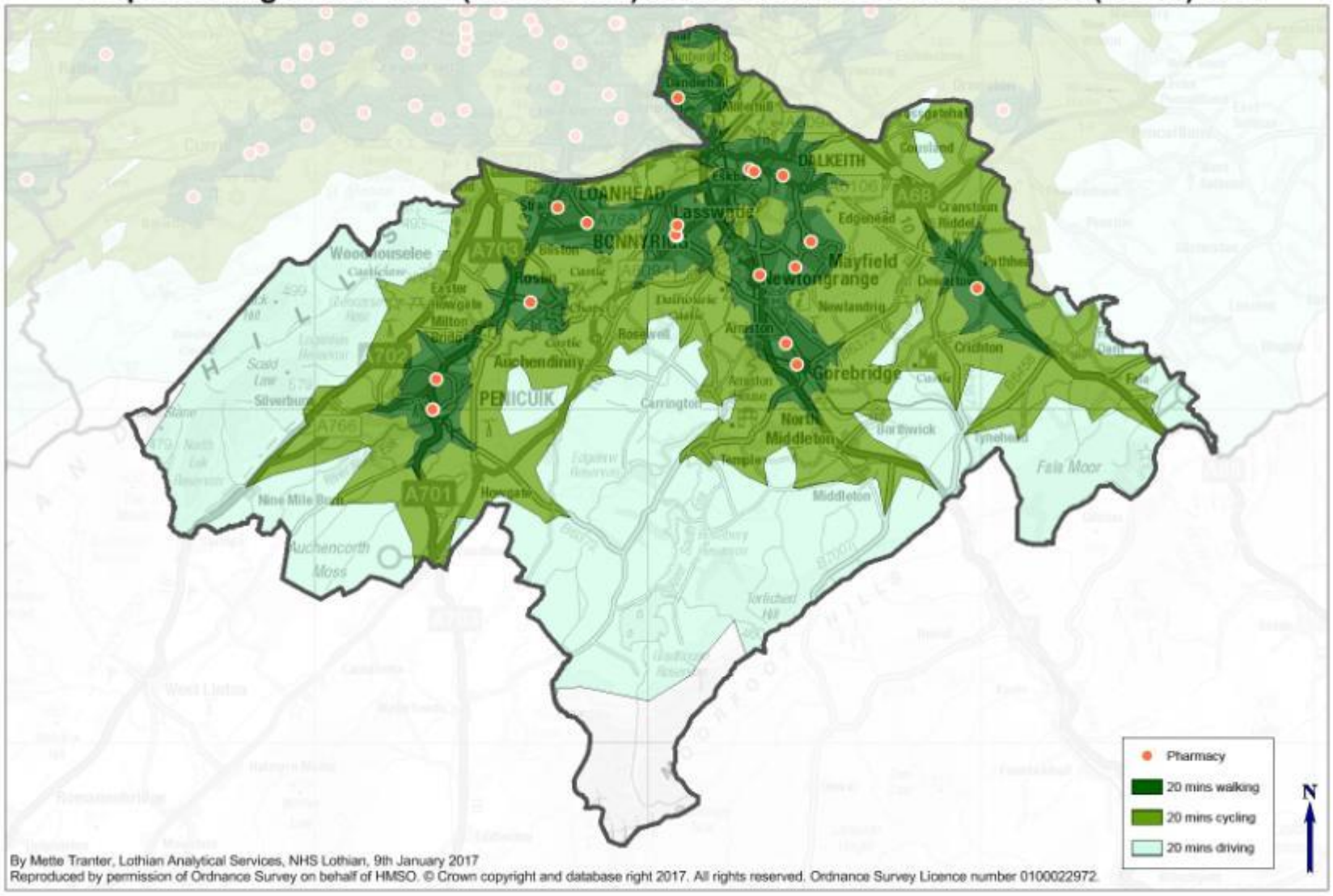
Map Showing Travel Time (isochrones) from Pharmacies in Edinburgh HSCP area



Map Showing Travel Time (isochrones) from Pharmacies in East Lothian HSCP area

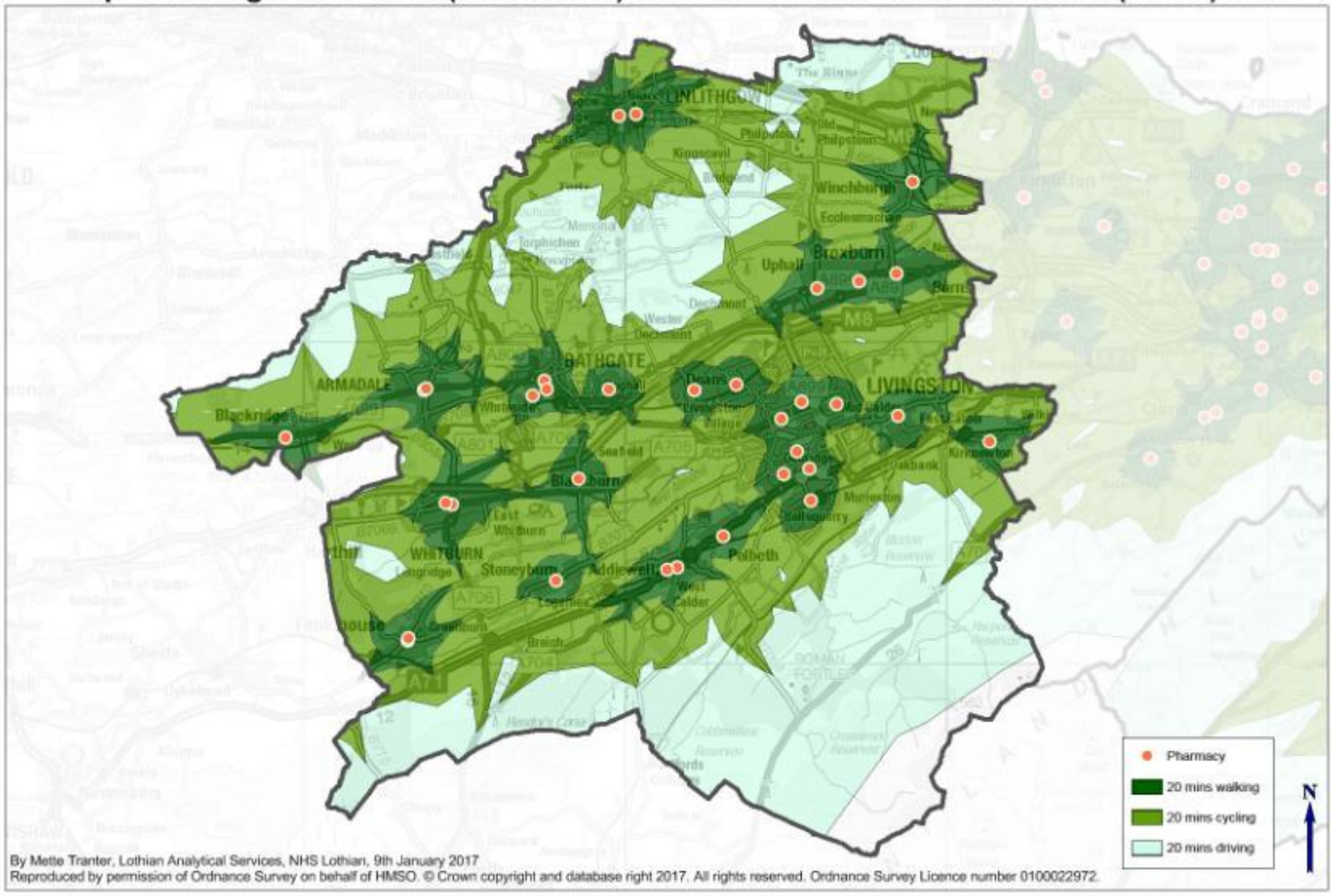


Map Showing Travel Time (isochrones) from Pharmacies in Midlothian (HSCP) area



By Mette Tranter, Lothian Analytical Services, NHS Lothian, 9th January 2017

Map Showing Travel Time (isochrones) from Pharmacies in West Lothian (HSCP) area



NHS LOTHIAN

Board Meeting
9 December, 2020

Director of Finance

RHCYP/DCN/CAMHS PROGRESS UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update Board members on the current status of the project as it approaches final completion.

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

2 Recommendations

Board members are recommended to:

2.1 Accept the contents of the report as an update on the progress to completion of the facility and the planning underway for final migration of services

3 Discussion of Key Issues

Progress to full occupation

3.1 Following the successful migration of all DCN services and 80% of Paediatric Outpatients by July of this year, remedial and enhancement works to Paediatric Critical Care and Haematology and Oncology respectively continue to make good progress with a handover date from the contractor programmed for the end of January, 2021. This continues to be subject to risk from the current Covid circumstances and is being closely monitored by the Executive team. Based on this completion programme services are now planning final migration taking account of winter and Covid.

3.2 Catering outlets, including the shop, are open for staff and visitors to the building. Feedback on the new facility has been overwhelmingly positive from staff, patients and families.

3.3 Enhancement works to the Paediatric Emergency Department to deal with patients presenting with high consequence infectious disease and learning post COVID fit a similar timeline with handover expected in January, 2021.

3.4 The final portion of fire enhancement works has just recently completed and handover of CAMHS achieved from the contractor securing a migration date for this service of 15th January, 2021. These fire enhancements anticipate changes to SHTM guidelines in relation to control of smoke within wards.

3.5 The rooftop helipad has passed all test flights and with the completion of training for the on-site safety team this month, which was postponed due to Covid-19, it will be opened for patient transfers to all services in the RIE and RHCYP + DCN in December 2020.

Oversight and governance

3.6 NHSL Lothian remains under Level 4 for the delivery of this project, with an Executive Steering Group reporting to the Scottish Government Oversight Board. In discussion with Mary Morgan, Senior Programme Director, and the Chair of the Oversight Board it has been confirmed that this arrangement will remain in place until the migration of the remaining services is finalised.

3.7 The pace of the Public Inquiry is now picking up with their infrastructure and physical offices just about in place. The Inquiry team is looking to make progress on a number of key issues in the coming months and the Board have already provided their overview of the project with some supporting documents.

NPD Operational Management

3.8 Significant improvements have been made in terms of the working relationship between BYES, IHSL and NHSL, with the groundwork having been laid for a positive business as usual environment. Programme management arrangements remain in place to provide oversight of the contract management performance, given the current arrangements of both construction and partial occupation. At the same time, NHSL is working to agree the proposed NPD contract management structure and establish this team to move forward with operational management of the full facility.

RHSC at Sciennes Road

3.9 Following the cancellation of moves in July 2019 a review of the existing hospital was undertaken to ensure that services could be sustained until their new home was available. All of the identified repairs and improvements to the fabric of the building were completed, and the move of outpatients in July has allowed for further changes to accommodate Covid-19 measures on the current site.

4 Key Risks

4.1 There remains a risk that there may be an adverse impact on construction materials and labour due to COVID 19. The mitigation factor is that all key materials, systems and components are on site. Nonetheless workforce remains vulnerable.

5 Risk Register

5.1 The Executive Steering group overseeing the completion of the hospital are due to review the Risk in relation to the RHCYP/DCN included in the Corporate Risk register at their next meeting in December.

6 Impact on Health Inequalities

None

7 Impact on Inequalities

None

8 Involving People

8.1 There is ongoing communication and engagement with the Services due to migrate to the hospital.

9 Resource Implications

9.1 An update on the overall resource implications of the works agreed and the maintenance of the existing facilities was considered by the Oversight Board in November. Although the decision making in relation to this rests with Scottish Government a report will be provided to the Finance and Resources Committee on the final resource position.

Susan Goldsmith
Director Finance
24 November, 2020
Susan.Goldsmith@nhslothian.scot.nhs.uk