NHS Lothian Board

12 August 2020, 09:30 to 13:00
TEAMS

Agenda

Declaration of Interests

1. Declaration of Interests

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.

Verbal

Esther Roberton

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 24 June 2020

For Approval

Esther Roberton

24-06-20 Public Board.pdf (20 pages)

2.2. Appointment of Committee Members

For Approval

Esther Roberton

12 August 2020 Board - Committee Appointments (final 240720).pdf (3 pages)

2.3. Finance & Resources Committee Minutes - 20 May 2020

For Noting

Martin Hill

FR 20-05-20 Minutes signed.pdf (5 pages)

2.4. Healthcare Governance Committee Minutes - 12 May 2020

For Noting

Moira Whyte

HGC 12-05-20 Minutes.pdf (6 pages)

2.5. Staff Governance Committee Minutes - 27 May 2020

For Noting

Bill McQueen

SGC 27-05-2020 Minutes FInal.pdf (7 pages)

2.6. Audit and Risk Committee Minutes - 21 May and 22 June 2020

For Noting

Mike Ash

21-05-20 ARC Minutes Approved.pdf (4 pages)

22-06-20 ARC MA approved.pdf (7 pages)

2.7. Edinburgh Integration Joint Board Minutes - 28 April 2020 & 16 June 2020

For Noting

Angus McCann

EIJB Minutes 28-04-2020.pdf (3 pages)

EIJB Minutes 16-06-2020.pdf (2 pages)

2.8. West Lothian Integration Joint Board Minutes - 10 March 2020

For Noting

Bill McQueen

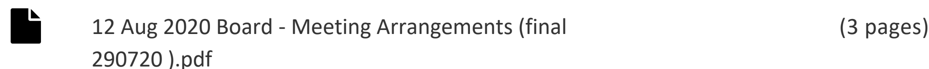
WLIJB Minutes 10-03-2020.pdf (7 pages)

Items for Discussion

3. Approach to Future Board Meetings

Decision

Esther Roberton


12 Aug 2020 Board - Meeting Arrangements (final 290720).pdf (3 pages)

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

Verbal

Esther Roberton

5. Board Executive Team Report - August 2020

Information

Calum Campbell

BET Report August 12-08-20.pdf (11 pages)

6. Covid-19

6.1. Public Health Update

Discussion

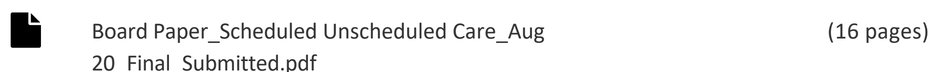
Alison McCallum

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

7. Scheduled and Unscheduled Care Performance

Discussion

Jacquie Campbell


Board Paper_Scheduled Unscheduled Care_Aug 20_Final_Submitted.pdf (16 pages)

8. St John's Hospital Paediatric Services – Follow up to Royal College of Paediatrics and Child Health (RCPCH) 2nd Review Report

Discussion

Jacquie Campbell

Board Paper - sjh ward aug 20.pdf (3 pages)

Appendix 1 - Recommendation Action Plan - RCPCH Second Follow Up Report 2020.pdf (4 pages)

9. Clinical Prioritisation

Discussion

Tracey Gillies

Clinical Prioritisation Board Paper Aug 20final.pdf (4 pages)

10. June 2020 Financial Position

Discussion

Susan Goldsmith

NHS Lothian finance report June 2020.pdf (4 pages)

11. Corporate Risk Register

Discussion

Tracey Gillies

Board Corporate Risk Register Report 12 August 2020 v0.2.pdf (13 pages)

12. Audit & Risk Committee Consideration of the Internal Audit of RHCYP/DCN

Discussion

Mike Ash

ARC report - RHCYPDCNupdate.pdf (4 pages)

13. RHCYP, DCN & CAMHS Project Update

Verbal

Susan Goldsmith

14. Future Board Meetings

- 14 October 2020
- 09 December 2020

Verbal

Esther Roberton

15. Any Other Business

Verbal

Esther Roberton

16. 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 10.15am on Wednesday, 24 June 2020 using Microsoft Teams.

Present:

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

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

In Attendance: Mr C Briggs (Director of Strategic Planning); Mrs J Butler (Director of HR & OD); Dr H Cameron (AHP Director - shadowing Professor McMahon); Mrs J Campbell (Chief Officer, Acute Services); Mr J Crombie (Deputy Chief Executive); Mr P Lock (Director of Improvement); Miss W McMillan (Business Manager, Executive Office); Mr A Payne (Head of Corporate Governance); Mr D Small (Director of Primary Care Transformation); Ms K Taylor (Communications Manager); and Mr D Weir (Business Manager, Interim Chair, Chief Executive and Deputy Chief Executive's Office).

Declaration of Financial and Non-Financial Interest

27. 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.

27.1 Mr McCann declared an interest in respect of the Royal Hospital for Children and Young People commenting that the Public Enquiry terms of reference had been issued and that the enquiry would be chaired by Lord Brodie who was a neighbour.

28. Chair's Introductory Comments

28.1 The Chair welcomed Dr Heather Cameron advising that she was the new AHP Director and was shadowing Professor McMahon at this meeting. She advised that Mr D Small Director of Primary Care Transformation and Ms K Taylor, Communications Manager were also in attendance.

28.2 The Chair commented that it was important to acknowledge that this would be the last Board meeting for both Mr T Davison, Chief Executive and Mr A

Joyce, Employee Director who were both retiring. It was also the first meeting for Mr Campbell the Interim Chief Executive. The Chair advised that at the end of the meeting she would make a few valedictory comments in respect of Mr Davison.

28.3 The Chair invited Mr Crombie to make a few remarks in respect of Mr Joyce advising that she had been unaware that both Mr Crombie and Mr Joyce had started in the service together as Student Nurses.

28.4 Mr Crombie advised that Mr Joyce had started in the service as a Nursing Auxiliary in 1980 in Lanarkshire before coming across to NHS Lothian in1981 to a learning disability facility called Gogarburn Hospital. It was there that he and Mr Crombie had met. Mr Crombie advised that since he had known Mr Joyce he had always been a lively character and had always been a Trade Unionist and a very clear advocate for employees and employee rights. Since these early days he had had a continued focus on striving to make sure that employees have a safe environment to work in and that they were able to advance and move their career forward. Mr Crombie advised that Mr Joyce had always had an intelligent logic to his arguments and this had fuelled many a debate.

28.5 Mr Crombie advised that Mr Joyce had continued to work in NHS Lothian since 1981 and had been a Shop Steward initially with COHSE a UK wide Union. In 1993 that union merged with NUPE and NALGO to create Unison the largest public sector union in the UK. Mr Joyce had been part of the team that orchestrated and supported the closure of Gogarburn Hospital and the transfer of its residents to more appropriate care and independent living which was very impressive.

28.6 Mr Crombie advised that as a union member Mr Joyce had been a long standing member of many national committees. He was appointed as Employee Director to in 2012. He had also been the Chair of the Joint Stewards Committee and the Chair of the NHS Lothian Partnership Forum. In addition since the inception of integration Joint Boards (IJBs) Mr Joyce had served on the East Lothian, Midlothian and West Lothian Boards.

28.7 Mr Crombie advised that Mr Joyce's retirement was well deserved and on behalf of NHS Lothian he wished him good luck and a long and happy retirement. These sentiments were echoed by the Board.

29. Items for Approval

29.1 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.

29.2 Staff Governance Committee Minutes – 19 February 2020 - The Chair advised that Mr McCann wanted to comment on the Staff Governance Committee minutes of the meeting held on 19 February 2020. Mr McCann commented that the minute made reference to the fact that NHS Lothian had subsequently been notified that the Procurator Fiscal may pursue a prosecution against NHS Lothian following an adverse event in 2017. He commented that although the Board Committee was following through on this issue that he did not recall being aware of this and wondered how often prosecutions like this occurred and whether these should be notified to the Board.

29.3 Ms Gillies advised that the Healthcare Governance Committee received a twice yearly report on adverse events including advice on this type of statutory action which was extremely rare. She commented that it was important to point out that the issue referred to by Mr McCann was an intention and that it was not definite at this point that further action would be taken by the Procurator Fiscal. Ms Gillies commented from previous experience discussion on how to handle these cases would be held within the Executive Team followed by a discussion with the Chief Executive and the Chair about what would happen next. The Board were advised that legal advice had been obtained throughout the course of this case.

29.4 Mr McQueen commented that if the organisation was being charged he would have thought there would be a need for some engagement with at least the Chair of the Board. He advised as a Board Member he would like to understand what the proper process was. The Chair commented that if she was consulted in such a process that she would want the Board to be aware albeit it was a very rare occurrence. She suggested that a close eye should be kept on the case referred to and that this should be used as a test bed.

29.5 Mr Ash commented that there was now an opportunity for Committee Chairs to bring items to the attention of the Board. He felt that the current issue was one that he would expect the Executive Team to deal with although the Board should be made aware if a corporate decision was required. Professor Whyte concurred that this would be an appropriate way forward from a Healthcare Governance Committee perspective.

29.6 Cllr Gordon commented in respect of the Healthcare Governance Committee minute 58.1 that it should say on page 28 that it was 2019 and not 2020.

29.7 The Board approved items 2.1 - 2.7 on the agenda without further discussion.

Items for Discussion

30. Opportunities for Committee Chairs or IJB Leads to Highlight Material Items for Awareness

30.1 The Vice-Chair advised that he wanted to raise matters that had come up at the Finance and Resources Committee on 17 June 2020. He advised that the

committee had received and approved the full business case for the oncology enabling works at the Western General Hospital. He advised this would have a huge benefit clinically and in terms of improving the conditions for patients and staff. It was anticipated that an initial business case for the cancer centre would be received later in the year.

30.2 The Vice-Chair commented that his second issue was around discussion held about financial forecasting and the review of risks. This had identified issues of significant uncertainty in respect of unsecured spend around Covid particularly from the Scottish Government. He advised that the committee were keen as the system moved forward that the key drivers of the improvement and transformation agenda should be about service and patient outcomes rather than about money. He felt there would be a need for significant discussion around priorities and suggested the Board might want a development day to consider this. The Chair commented that she was hopeful that the Board could move back to a bi-monthly development session position as she believed there was a whole range of issues that needed to be considered.

30.3 Mr Ash advised that at the Audit and Risk Committee had met earlier in the week and would make recommendations about the annual accounts later in the day.

31. NHS Lothian Covid 19 Response

31.1 Professor McCallum commented that the number of case in Scotland continued to fall as did the rate of positive test results in care homes as one of the closed settings that was affected. The point was made that with the introduction of some easing of lockdown it was important that the system continued to monitor any change in the progress that had been made.

31.2 Professor McCallum advised that Covid had had a significant impact on the health and wellbeing of a large number of people. It would be important to ensure that not just elective services came back to address people who had treatment delayed but also rehabilitation services and ongoing support for mental health and wellbeing. The Board were advised of a wider piece of Scottish Government work looking at the health and wellbeing impacts as a result of shutting down the economy. She commented that if NHS Lothian as a large organisation was not playing in to this then it would be contributing to avoidable health detriment.

31.3 Mr Connor questioned whether there were any indications of why Midlothian was such an outlier. Professor McCallum advised that there was a more detailed piece of work ongoing to look at health and the community transmission in Midlothian. It was noticeable that other parts of the country with a similar socio economic makeup had faced similar patterns. In addition Midlothian had some large care homes that had been significantly affected at the beginning of the pandemic.

31.4 Ms Hirst commented in relation to recommendation 2.6 that there was a need to look at issues from whole system perspective. The Chair advised that to amplify this she had raised at the Board Chairs meeting the need to be clear what was meant by whole NHS system or whole Health and Social Care system.

31.5 Professor McCallum commented in terms of the level of resources in respect of care homes that the level of work being undertaken in these facilities most of which were private for profit organisations was at a level not seen for a good number of years and when systems were structured differently. She felt this was an issue that needed to be looked at as the virus was not going to go away. There would be a requirement to be swift in the management and prevention of outbreaks. There was also a need to embed the learning and support that was going into these facilities often at very intensive levels. It was noted that conversations around this were taking place nationally.

31.6 Professor McMahon commented there was work that needed to be done both from a corporate position and with the 4 Health and Social Care Partnerships (HSCPs) about what the infrastructure needed to be to address the ongoing demand around care homes. Professor McMahon felt that the work being undertaken through the Oversight Group was Lothian-wide.

31.7 Dr Williams commented that the response from Public Health and everyone had been phenomenal and it was important to have this appreciation noted. He advised that at this moment in time the system was well past the peak and it was not known whether there would be a second wave or not. At the moment the Covid numbers were extremely small with there being significant spare capacity in the system. He was concerned that there would be a tsunami of delayed discharges and there was a need to rapidly redesign services in order to get people in to the system and deal with the complications of people who had not been accessing health services. Dr Williams advised that he would like to see the system rapidly using the capacity created correctly. Cllr Gordon advised of discussions held at the Edinburgh IJB and sought advice on the cooperation level with private care homes as there had been a significant number that had declined the training opportunities and were only engaging around PPE and this was concerning. Professor McMahon advised this issue would be a report to be discussed later in the meeting.

31.8 The Chair echoed the points made by Dr Williams that the Board could have no sense of the scale of work that colleagues were having to do both in Lothian and across the country and asked for the Boards appreciation to be passed on to colleagues.

31.9 The Board agreed the recommendations contained in the circulated paper and welcomed the update report.

32. Test and Protect Programme

32.1 Mr Briggs reported that the index cases included residents of care home who had a positive test but would not have had any contacts. Nationally the number of contacts for index cases was very low. It was noted that all of the Older Peoples Care Homes were signed up to the social care portal and had ordered kits to be able to carry out testing for their staff. Mr Briggs referred to an announcement the previous day about the expansion of testing for staff which was targeted in services for older people, long stay mental health and for cancer services.

32.2 Mrs Mitchell commented in respect of testing capacity and intent to migrate to the national process when she read reports and the speed read there appeared to be a lot of cases waiting for testing and she sought assurance around the robustness and efficiency of the laboratory testing capability. She commented if the intention was to expand testing that it currently did not appear that issues were being turned around quickly enough with 100 people waiting for test results in the hospital.

32.3 Mr Briggs commented that the turnaround time within laboratories in NHS Lothian was somewhere between 4 and 24 hours depending on when the test reached the laboratory and this might impact on the 100 number. He advised that the 24 hour limit that was in place for NHS Lothian laboratories was being adhered to and was much closer to being between 4 and 6 hours. The turnaround time for lighthouse laboratories which include, self testing kits was longer than that although they had undertaken a lot of work to reduce the timelines. Mr Briggs commented there was also a possibility of a psychological barrier for some people about admitting to not having adhered to the spirit of the guidance. The tracing team were doing their best to reassure the public that they would not be in trouble and the approach was being undertaken from a public health perspective. Dr Donald clarified that her question related to case swabs and commented that everyone should have access to a test that had symptoms. Mr Briggs advised that home testing kits came with full instructions and there was no requirement that testing needed to be done by a nurse although the issue might be about receiving consent for someone who was suffering from cognitive decline. Professor McCallum advised that the community testing team and GPs would undertake this role.

32.4 The Vice-Chair commented that in the event of any spike or outbreak it would be important to get the results back quickly and this would mean the test being undertaken locally rather than through the UK sponsored laboratories. He questioned whether there was a confidence that there was sufficient local capacity for the quick turnaround in the event of a spike. The Board were advised that NHS Lothian was prudent in the way in which it was using its testing capacity. Mr Briggs commented in terms of its tracing capacity that NHS Lothian currently had 45 staff who had been reallocated from shielding categories who had been provided with training and equipment remotely to be able to support the service nationally.

32.5 Mr McCann commented that people might choose to decline an offer of a test for a variety of reasons or indeed the care home might decline on behalf of

the residents. He questioned whether something needed to be done about this or whether it was seen as a logical response to the test in respect of a person's circumstances. Mr Briggs commented that this was not an unexpected response as the test was not pleasant. It was not possible to require people to undertake a test as this procedure required consent. Professor McCallum advised the test was only part of the contact trace and isolation support process and for a care home resident you would naturally look at the staff looking after that person and put in place additional measures to reduce the risk of them infecting other people. The Chair commented that this was one of the issues raised at the Chair's Group in terms of publishing figures about a number of care home staff as they themselves required to give consent and could not be made to undertake a test.

32.6 Cllr O'Donnell commented given the announcement of the possible return of full-time education on 11 August she questioned what plans were in place and whether discussions had been held with local authorities in terms of how to respond to a position where somebody in a school environment tested positive. Mr Briggs commented that Edinburgh City Council had established a Public Health Advisory Group with NHS Lothian input and the previous day had began conversation not just about the outbreak response that would be led by the Public Health Team but about how to collectively work together to support a prevention suite of measures going forward. This would include a public health messaging system to the public and staff.

32.7 The Chair thanked colleagues for the work that had been undertaken and felt that if progress was maintained then the contact tracing system should be able to cope.

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

33. Enhanced Professional Oversight of Care Homes

33.1 Professor McMahon advised the circulated paper reflected an update in relation to the additional ask put on Executive Nurse Directors and the timeline around this. On 17 May the Cabinet Secretary wrote to Executive Nurse Directors advising them that a variation had been made to their job description effectively from 18 May. Subsequent to that there had been further communication with the Chief Nursing Officer in relation to that letter and further clarity in relation to what was actually meant especially in respect of accountability in care homes and care at home. It was noted that a strategic oversight group had been established on a Pan Lothian basis chaired by Professor McMahon. On a day by day basis the IJB Chief Officers had a daily huddle to provide assurance that everything was being supported as best as could be. As part of the new responsibility it has been agreed that there was a need for a line of sight into the care homes through a process of supported visits. The Chief Nurses had been working on a timeline to develop a process of visits which needed to be seen as process light. The series of visits using an agreed tool to check against aspects like prevention, infection control and the appropriate use of PPE. East, West and Midlothian IJBs had

a plan in place with it being anticipated that one would be available soon for Edinburgh. It was noted that a lot of lessons had been learned from the unannounced inspections that had taken place so far and done in collaboration with the Care Inspectorate, Healthcare Improvement Scotland and NHS Lothian. To date 7 care homes had been visited under this process.

33.2 Professor McMahon advised that a sub group had been established of the Oversight Group looking specifically at education and training. In response to a question about the position where a care home refused entry it was noted that to date no refusal had been experienced. If this were to occur this was where the unannounced inspections with the Care Inspectorate would play a significant role as this would require entry into the homes in order to observe any non compliance with infection prevention control and PPE use.

33.3 Dr Donald advised that she appreciated the collaborative partnership approach that was being taken. She questioned whether any extra resources or people were needed to support the process. Professor McMahon advised that a corporate support function had been established to support the Board around visits and education and training as well as the assurance process. He advised that within each of the four HSCPs area that the ask of Chief Officers and Chief Nurses was to review their current arrangements in terms of care home support teams and to ascertain if this was adequate.

33.4 Professor McMahon advised there was a process around the unannounced visits and these were not led by NHS Lothian but by the Care Inspectorate. At this point because of the Covid position the Care Inspectorate were required to ask the Director of Public Health if they could visit and inspect a care home. This request would be discussed between Professor McCallum and Professor McMahon to ensure that any such visit was appropriate given current circumstances in order not to add complications to a home that might already have Covid cases. The Board were advised that the Care Inspectorate had been asked to produce a fortnightly report to Parliament on the back of these inspections. The expectation was that 10 care homes would be visited each week across Scotland. It had been agreed locally that it would be helpful if one of the senior nurses could accompany the Care Inspectorate around one of those unannounced inspections in order to learn lessons as the Care Inspectorate would look at things in a slightly different way from NHS Lothian staff. The Board was advised that work was underway to choreograph the unannounced visits with the NHS Lothian planned visits that would be done in a supportive manner.

33.5 Dr Williams commented in respect of the shared governance between IJBs and NHS Lothian that one of the issues through the Covid work would relate to general work in particular in respect of staffing numbers and Covid safety and the general quality of care in care homes. It would be important to ensure that tensions around the governance requirements of IJBs and NHS Lothian were addressed. Professor McMahon commented that through the Strategic Oversight Group that all 4 Chief Officers and Chief Nurses were represented on the Group as was a representative of the Chief Social Worker as well as other people across the system. A key piece of work undertaken as a group

the previous week was to develop a Risk Register entry around the risk stratification of this work and to identify who was accountable and responsible for what.

33.6 The Chair commented that Professor McMahon had provided her with assurance and comfort that this did not add to NHS Lothian's governance responsibilities and liabilities as a Board. She commented however that he had access to the usual escalation routes to the IJBs and the Care Inspectorate. There was a need to pick up the issue about the Healthcare Governance Committee responsibility under the new requirements.

33.7 Mrs Hirst felt that it was important that the wording in the paper provided clarity about roles and responsibilities. She advised that she had two different sets of responsibilities as a Board member and a member of an IJB and there was a need for clarity of roles and accountabilities particularly around Chief Officers. She felt that this understanding was beginning to be teased out with there being a better concept of accountabilities and responsibilities. Professor McMahon advised that the risk stratification work and the Corporate Risk Register entry would provide that clarity. In terms of the recommendations the Healthcare Governance Committee had been asked to take a lead in this area and the Audit & Risk Committee would have a role in respect of the Corporate Risk Register entry.

33.8 The Board agreed the recommendations contained in the circulated paper and in particular the delegation of this enhanced oversight process to the Healthcare Governance Committee. The Chair thanked Professor McMahon and his colleagues for developing this work to date.

34. Remobilisation Plan

34.1 Mr Crombie advised that the paper represented a composite remobilisation plan which he suggested would be the first of a series of such plans. He believed that this represented a whole system approach and that the elegance of the whole system interaction was not matured to its final point and subsequent papers would evidence a far greater degree of robust collaboration and engagement. Mr Crombie advised that the paper signalled that the system was not providing the whole suite of services that had previously been provided. Mr Crombie reported that the system would look to provide the best services for those in most need. The paper indicated that elements of routine elective provision had been postponed and it would be important not to underestimate the impact of this for a number of months or perhaps years.

34.2 Mr Crombie advised that the most recent management information had been released the previous day and reported 191,000 people would be waiting more than 12 weeks for an outpatients appointment with more than 71,000 across Scotland waiting for inpatient and day-case treatment. It was anticipated this might be a deteriorating position moving forward.

34.3 Mr Crombie advised that the clinical prioritisation process and attention to staff wellbeing had been key components of the process with work having been undertaken to address anxiety some of which were detailed in the paper. Mr Crombie felt that the paper heralded a transformation although there was a danger that if the service was not vigilant that service models would return to the old way of working and it would be important to ensure this did not happen. Mr Crombie felt that what was being experienced was also a seismic change for the population and patients and he was not clear that there had yet been effective engagement with them. He advised that a Remobilisation 2 plan would be requested and would take the system from September through to the end of March 2021 and would include winter planning and elements like the scheduling of unscheduled care activity.

34.4 Mr McCann commented that his question related to the urgency around dealing with the backlog in demand. He advised by way of context that at the end of the remobilisation plan there was a point about Nurse and Medical Directors needing to manage the expectations of Non Executive Directors and others around the impact of Covid on productivity and ways of working may be less well understood. He commented that he understood that flow would be much reduced due to the use of spacing and PPE etc but that there had been no reference around restarting face to face outpatients or elective care over the next 3 months. He advised that he was less clear about what was needed to get more services restarted and for example did consultants need to review large caseloads.

34.5 Mr Crombie advised that the elements of this were complex and probably best discussed in a workshop session where all of the issues could be gone into in a lot more detail. He commented however there was active and ongoing triage and that those who were waiting continued to be assessed and included a process of continuing to check with people to ensure that their conditions remained stable or was deteriorating or had indeed improved and would be ongoing. He commented that there was an issue that the system would see a decrease in capacity because of issues like PPE, social distancing etc. Ms Campbell advised that a process of active clinical triage of the waiting lists was being undertaken where patients could be clinically triaged for their level of urgency. The criteria had been agreed through the Clinical Prioritisation Group. It was pointed out for people that remained in the routine category they would also have active clinical triage.

34.6 Mrs Hirst commented on the reference in the paper to the likely requirement for extended plans and sought assurance about the involvement of IJBs in this as individual IJBs had been looking at their own recovery plans and that the Chief Officers had been engaged in producing mobilisation plans. She sought further information on the interaction between IJBs and NHS Lothian in producing the whole-system report that needed to go into the Government. Mrs Hirst felt that the quality and nature of the communication and the approach being taken including the ability for people to have a face to face conversation would be important and sought assurance about the plans that were in place to address these issues particularly with the public.

34.7 Mr Crombie assured the Board that in terms of remobilisation that weekly if not daily interactions were underway to discuss how better to engage. He advised that he had seen real evidence of collaboration between teams and Chief Officers and this was a seismic step forward in terms of the sharing of expertise and resource as well as challenges. The Board were reminded that previously a number of recovery forums had been established and all of these would be conduits for working up the process. Mr Crombie commented in terms of communication that he agreed with Mrs Hirst and there was already evidence that the public's patience was starting to wane and letters were now being received in terms of waiting times. He felt that the comprehensiveness of the messaging needed to start with a national focus in order that there was an explicitness of where the NHS was. Mr Crombie advised there was a danger that when people saw a relaxation of the lockdown requirements they would assume that the NHS was back to normal. There was a need to be explicit around clinical risk assessment and not to do harm to patients. The risk of clinical intervention needed to be balanced against the risk of Covid. The Board were advised that communications being sent to inpatients who needed to attend physically contained a significant focus on risk and what this meant for them as an individual. A similar communication was being produced for outpatients where hospital attendance was needed. There was also a need to communicate and educate people who did not meet the attendance criteria and explain to them the reasons for this and this would be an ongoing and significant piece of work. The Chair concurred with these views advising that she and colleagues were pressing for this message at national level as a matter of urgency.

34.8 Mr Murray commented that what was being discussed was the legacy of a recovery process that had been out of balance before the Covid experience. He did not think that it was fair that NHS Lothian should continue to wrestle with recovery whilst it was impossible to recover. He felt that the remobilisation plan was the only way forward and this was the process that needed to take precedence. He felt it would be important for this to be reflected to the Scottish Government in some form of communication. Mr Murray commented that the impact on the Risk Register needed to be captured. Mr Murray commented that if communications was to be a key issue it would be best to consider how to generally communicate across the country. The Chair commented that the Chairs Group had accepted the Cabinet Secretary's point around discussions in respect of scheduling unscheduled care and the importance of starting the early messaging around the scale of the challenge to the public.

34.9 Mr McQueen advised that within the papers there was a template looking at all available physical capacity in relation to the 2 metre social distancing. He questioned what the position would be if it was accepted that social distancing could happen at 1 metre whether this would have an impact on capacity and how quickly could the system readjust to that. He also sought an update on what was happening in respect of shielded NHS Lothian staff and whether there was capacity within the system to individually assess their workplaces to allow a return to work. Mr Crombie advised that a process of review had been started around social distancing. He advised that what had evolved from a

tactical group was a series of risk assessments that were happening in order that individual departments and wards could look at their specific areas. He advised that the reduction of the 2 metre to 1 metre guidance would absolutely support additional capacity provision but again that would be on the basis of where that could be delivered. It was noted that any proposals would require to be supported by clinical risk assessment with the support of the Infection Prevention Control Team. Mr Briggs commented that a number of risk assessments had already been received and the key issue was that the benefit of physically coming to a facility for treatment needed to outweigh the risk and needed to be essential rather than desirable.

34.10 Ms Butler advised that NHS Lothian currently had around 500 staff who either had a shielding letter or who had been risk assessed by occupational health as requiring to work from home. She advised that there was a push for revised guidance around those who were shielding and those in the high risk categories. There was a sense from the occupational health community in Scotland that the current workforce guidance was out of date based on the evidence coming through. If the guidance was changed there might be staff who could return to work. Ms Butler advised that she had a conversation later in the day with colleagues from Scottish Health Workforce and that the NHS Lothian Director of Occupational Health was also engaging through another route. Ms Butler advised that there was a need for revised guidance in order to make a more measured assessment of staff that could be at work. Her view was that the Occupational Health Service would be in a position to do that. The Chair commented in terms of Test and Protect that the 45 staff in that service were all in the shielding category with another 35 standing by.

34.11 Ms Kasper questioned in respect of the reduced capacity as a consequence of changed measures whether there were details about the level of capacity available. She felt that all of these issues required to be factored into the risk assessment process particularly as the capacity constraint would be with the system for so long as the virus continued. She felt that this was the biggest risk on the ability to deliver clinical care for the foreseeable future and the sooner a strategic view was taken around projections of capacity the better. Mr Crombie advised that this work was already underway and the impact had been assessed in some areas as being up to 75% of a reduction and this was why consideration was being given to whether circumstances could be mitigated in some way to allow an increase in capacity. Mr Crombie commented that capacity issues went beyond hospitals and earlier in the meeting there had been discussion about the impact on care homes and on parts of the population who might in the past have considered care home placement as a part of the package of care for family members no longer considering this as an option. Mr Crombie advised that he felt that there would be a need to rapidly look at the alternatives and this would bring constraints around workforce provision. He felt that there would capacity implications across the whole of health and social care and the work described by Ms Kasper needed to be a component part of the way forward.

34.12 The Vice-Chair commented that when he had looked at the principles and assumptions underlying the mobilisation plan he had wondered how to avoid

the understandable pressure to restart where the system had left off to deal with the extant demand. He commented however that the demand across the population would have changed over the past few months and there would be a lot more economic problems for people with more deprivation in certain areas. He questioned how the system started to address this and whether there was scope for some innovative and positive discrimination for certain parts of the community as this was not currently evident.

34.13 Mr Crombie commented that there were some very glaring danger points and that there was an assumption that everyone would have access to IT and android phones that they were comfortable in using as well as a number of other assumptions. He commented that there were a number of assumptions that very quickly would start to disadvantage a cohort of people with evidence already being seen about the impact of lockdown on people's mental health that would reflect in increased demand in services.

34.14 Professor McCallum commented that there was an immediate ask to have a remobilisation plan that allowed the system to move forward in terms of people who would otherwise come to detriment. She advised that a detailed integrated impact assessment would be undertaken and would look at compliance with all of the equalities outcome and with the Fairer Scotland Act. She commented that there would be a need to look at whether the mitigation that was in place routinely around welfare rights and income maximisation services and practical support to individuals and their family was of an adequate volume. Professor McCallum advised that the integrated impact assessment that she was referring to was something that was done very rapidly over a few hours.

34.15 The Chair advised that Mr Small had made a point that referred back to the previous issue around inequalities that no more than 50% of patients would be seen by GPs on a face to face basis and this was a huge issue in terms of inequalities. Mr Briggs commented in respect to previous comments made by Ms Kasper that in mental health tremendous work had been done about providing outpatient and other consultations using technology with potentially significant numbers being able to be covered through this approach. He advised that the other issue was around the scheduling of urgent care and referenced a video based service in minor injuries that was undertaken on an appointment basis and there was a need to expand this approach. He commented that initiatives like this would be a significant feature of future remobilisation plans and IJBs strategic plans. He commented however that this worked on the assumption that everyone had a phone where in fact 30% of the population did not have a smart enabled mobile telephone. The Chair commented that this was not a piece of work that only affected NHS Lothian and that the Cabinet Secretary was keen to move quickly on these issues. This fitted well with the work that was already underway nationally.

34.16 The Chair commented that the Board was very impressed with the amount of work that had gone into preparing the paper. She noted that the paper referred to a timeline of the end of July whereas the Scottish Government tended to refer to the process as being for the next 100 days which would

take the timeline into later in the summer. It was agreed that this was a technicality that could be resolved off-line. The Chair confirmed that there was a clear desire for the Board to have a development session on this subject.

34.17 The Board accepted the moderate level of assurance provided by the plan.

35. Scheduled and Unscheduled Care Performance

35.1 The Chair commented that through previous discussions it had become evident that there was need for the whole performance framework to be revisited and that this was on the agenda nationally.

35.2 Mrs Campbell advised that she planned to build on the discussion that had just been held about remobilisation. She advised that the focus of the paper was on the performance element although she would build on the earlier discussion around Clinical Prioritisation. In terms of outpatients at the beginning of the Covid pandemic there had been a significant reduction in the number of outpatient referrals although now in terms of urgent suspicion of cancer the system was back at 90% of referrals. In terms of urgent referrals the position had moved back to 60%-70% of the pre-Covid referral position and for routines the position was around 50%. The Board noted this represented a cohort of patients that depending on how they manifested through GP referrals that the system was still not seeing.

35.3 In terms of the number of patients waiting more than 12 weeks Mrs Campbell welcomed the view that systems should not be reporting against this although this was still a part of the formal reporting process. In April there had been just over 28,000 patients waiting over 12 weeks for new outpatient appointments and in May that had grown to 36,300 patients waiting more than 12 weeks. In terms of TTG for inpatients and day cases for routine patients the position was at around 25% of the pre-Covid position numbers but for urgent additions the position was at above 90% of the pre-Covid position. At the moment the capacity in Theatres was meeting urgent demand although this was increasing. The Board were advised that the focus was around urgent suspicion of cancer and this was managed plus patients who might have deteriorated. Ms Campbell advised in respect of cancer work that NHS Lothian was using Spire for colorectal and urology and for some breast and neurosurgical urgent work. This has been extremely beneficial and agreement had been reached with the Scottish Government to use Spire for this cancer work until September. There was a view that this capacity would not however be available after September and this needed to be part of the remobilisation plans moving forward.

35.4 The Board were advised in terms of cancer performance that 95% had been achieved for the 31 days standards and for 62 days 82.2% had been achieved. Key changes in the cancer pathway were explained to the Board. Mrs Campbell commented in respect of scheduled care that she would reinforce the risks inherent at the moment around the balance of patient

choice against patient requirement to attend the hospital for an outpatient or inpatient appointment. The Board were advised in terms of scheduled care that the recovery programme had been established and this was still focussed on the principles of demonstrating that capacity was available to manage urgent suspicion of cancer patients and capacity to manage and look at how to look at long-term patients in relation to any detriment to them.

35.5 The Board were advised that for unscheduled care the system was still maintaining over 95% performance. Attendances had dropped significantly during the initial pre-Covid period although increasing attendances were now being seen particularly at the Royal Infirmary of Edinburgh. Mrs Campbell advised that the real focus was now on scheduling unscheduled care with a pilot in place in relation to minor injuries. It was noted that a 6 week pilot would start the following week at the Western General Hospital about scheduling GP scheduled referral the details of which were explained to the Board. It was hoped this would safely reduce the unscheduled care demand at the front door. The Board were advised that the winter plans were being pulled together and these were whole-system and would be risk assessed against the general principle about how to safely reduce demand and safely reduce length of stay for patients.

35.6 Mr McCann commented that he was interested in the concept of scheduling unscheduled care. He advised that NHS Lothian could offer alternative facilities but ultimately people may increasingly choose to attend ED. He questioned to what extent the system could move more rigorously to pre-screening for ED or whether this would benefit from a more national approach. Mr Campbell advised that the approach to scheduling for unscheduled care was absolutely a national one. There was also work underway to optimise the use of NHS 24 with it being noted that Call Mia was a national platform. It was noted that part of the work that the Scottish Government was undertaking around scheduling unscheduled care would be around communication and how to build on the learning from Covid. The Chair advised that NHS 24 were involved in this work on behalf of Chief Executives.

35.7 Mrs Campbell in response to a question from Mr McQueen advised that a specific Team which was clinically led looked at the triaging of patients to identify anybody who it was felt might have a detriment to their care. Ms Gillies advised there was a suggestion that the system was seeing a bit of stage drift with patients presenting at a later stage. This reinforced the need to maintain capacity to move urgent patients through the system as many of these patients would not be presenting through the normal GP referral route. This reinforced the decision to keep sufficient diagnostic capacity in the system in order to treat patients more effectively and move them to treatment swiftly. The Board were advised that the system would also see a number of patients who had been delayed coming through for treatment who might need reassessment particularly if it was cancer as their disease might have progressed. There would be a need to consider a risk benefit assessment discussion with those patients and this reinforced the need to reconsider every decision previously made.

35.8 Mr Murray questioned whether work was being undertaken with the trade unions in terms of resourcing the Louisa Jordan facility in Glasgow. Mr Campbell advised that she could not answer the position about trade unions specifically but her last discussion with the Scottish Government was that they were still looking at how best the Louisa Jordan facility could support Scotland in terms of recovery around elective care.

35.9 Mrs Butler advised in terms of trade union engagement that there had been general discussion but no recent direct engagement about staffing the Louisa Jordan facility. There had been a number of meetings planned which had been stepped down because of the need for the future model to be clarified.

35.10 Dr Williams advised that the Board had heard that the intention was for 50% face to face consultations in general practice. He advised that this position filled him with trepidation and anxiety and questioned where and when assurance would be provided that this was safe and appropriate. He commented that he felt if patients were not getting face to face consultations with their GP they would go to A&E. He felt it would be important therefore to evaluate the unintended consequences of that model. Mr Small advised that the 50% was not a blanket position and would depend on the individual practice and their use of technology. It was noted that there was also ways of ordering prescriptions on line that did not require a direct connection with the practice. He advised there were things that could be done which did not disadvantage anyone and made it easier for people to get access to primary care.

35.11 The Chair thanked colleagues for the useful discussion advising that this was an issue that would have to be revisited over time.

35.12 The Board agreed the recommendations contained in the circulated paper and welcomed the update report.

36. The Royal Hospital for Children and Young People, Department of Clinical Neurosciences and Children and Adult Mental Health Services Project Update

36.1 Mrs Goldsmith referred to an email that she had issued the previous evening confirming that all of the documentation in relation to SA2 (Supplemental Agreement) had been received in an agreed format. The Lenders were in the process of doing their own due diligence. It was anticipated that this would be concluded by the following week. NHS Lothian's own due diligence report had been agreed by the Finance & Resources Committee where it had been agreed it would be shared with the Chair, Vice-Chair and the Chief Executive and Interim Chief Executive. This was also available for any other Board member who wished sight of it. The Board noted that this set out the context of why the system had entered into the structure of contracts that it had and the commercial terms associated with those. Issues around how to actually

sign the contract to reflect differences between English and Scots law would be progressed outwith the meeting.

36.2 Mrs Goldsmith advised that once the document had been signed then NHS Lothian would have a target programme for completion of work and it would be for the Cabinet Secretary to announce this in Parliament. She reminded the Board that this would be a target programme and in certain circumstances the SA gave IHSL and Imtec an opportunity to request an extension albeit this would be in limited circumstances. The Board were advised that work was underway and good progress was being made. She advised that Board members would also have seen the announcement on the move of DCN services and a range of outpatient services for children's services in July.

36.3 The Chair thanked Mrs Goldsmith and her colleagues for the progress that had been made. The Board noted the update report.

37. Corporate Risk Register

37.1 Ms Gillies advised that the Board had discussed many aspects of the risks included in the Corporate risk register earlier in the meeting. The risks in respect of Covid were set out in the appendix with it being noted that it was very difficult to capture these on paper give the fluidity of the position. She felt however that it was important to set out the control measures in detail. She commented however that this made all of the other risks all out of date. Ms Gillies felt the time was now correct to ask the team that managed the risk register to engage with managers to update their risks. This would be undertaken over the next few months.

37.2 Mr Ash advised that the risk register was a regular item for discussion at the Audit & Risk Committee. He advised that one or two members of the Audit & Risk Committee would work with lead officers on this with a more detailed discussion being scheduled for the August Audit & Risk Committee meeting. After this point it was hoped to be able to come back to the Board having gone through the risk register in some detail. He advised that there was also a desire to look at some new processes that would link the assurance levels and mitigation action with the description of the risks.

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

38. Financial Update at April 2020

38.1 Mrs Goldsmith advised that she felt the paper was self-explanatory. She apologised that it only covered month 1 financial position. She advised that as a consequence of the complexity of analysing the monthly results and trying to set out Covid costs from the baseline this meant it had not been possible to finalise the month 2 results in time for the Board report. She advised that month 2 had been concluded and updated Board members that the position was close to mirroring month 1 which took the system to an

overspend of £11m. She advised that within that there were costs of £17m in relation to Covid which were offset by reduced costs of £9m. There was therefore a slight reduction in the monthly cost of Covid in month 2 which would be expected. She advised that until a detailed quarter 1 review had been undertaken it was difficult to predict what the financial position would look like for the Board. This was the same for the Scottish Government and NHS Lothian was working closely to undertake a quarter 1 review that allowed the Scottish Government to come to a view about what they could and should allocate. She advised that one of the issues that had been discussed was about the share of activity in terms of Covid impact across Scotland. Mrs Goldsmith advised that once the quarter 1 review position had been received there would be a need to take stock about what this meant for the Board's financial position although more information was becoming available about the cost profile.

38.2 The Vice-Chair drew the Board's attention to the point in the paper that stated that the Finance and Resources Committee did not have any level of assurance at the present time about the ability to breakeven and the work referred to by Mrs Goldsmith would inform the Committee on this position.

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

39. Future Board Meetings

39.1 The Chair advised that the next formal Board meeting would be held on 12 August 2020. She advised that she was still working to the premise to step back to bi-monthly Board meetings and therefore make the September session a development one. There might be a need to consider how to do this virtually.

40. Any Other Competent Business

40.1 Chief Executive Retiral – The Chair advised that she had known of Tim for a long time and since her days in NHS Fife. She had not realised that he had started as a Management Trainee in Stirling before coming to Edinburgh in 1986. He had then gone back to Glasgow and had worked in Primary Care and Mental Health acute services which provided him with a complete overview of the whole health service. It was noted that he had done 37 years in the service with more than 20 of those as a Chief Executive in 5 different roles, 3 of which were in NHS Trusts and then as Chief Executive of NHS Lanarkshire before coming to NHS Lothian. The Chair commented that the other thing that it was important to pay tribute to the fact that on top of all of those things that Tim had been a major player on the national scene and had been involved in all sorts of national groups in terms of Health and Community Care but also in the reshaping of the Medical Workforce. The Chair commented that it would be easy to forget what a visible leader Tim had been locally, regionally and nationally. She advised that the thing she most wanted to pay tribute to was the previous difficulties that NHS Lothian had

experienced in terms of its culture and the huge transformation in culture over the years. She commented that even in her short time at NHS Lothian a number of people had commented on this. The Chair reflected on Tim's distinguished career and paid a big thank you to him on behalf of her and the Board.

40.2 The Vice-Chair advised that when he had retired from the NHS 2007 he retired from the position of Deputy Chief Executive of Lanarkshire and it was Tim that spoke at his retiral. The Vice-Chair advised that he had first met Tim in the early 1990s at the Management Centre at Stirling University as part of a development programme for Unit General Managers. Tim had been the Unit General Manager in the Glasgow Mental Health Unit with the Vice-Chair being the Unit General Manager in the R H in Paisley. The programme had been designed to establish and develop a cadre of leaders of whom Tim was a standout in the Vice-Chair's eyes as he was the only one to sport a bowtie and that became his USP. The Vice-Chair commented that he knew then that Tim had big ambitions. The Vice-Chair advised that Tim had had an outstanding and influential career in the Scottish NHS. He had transformed mental health services in Glasgow and developed a coherent strategy in Lanarkshire.

40.3 The Vice-Chair commented that Tim had led many national working groups and was instrumental in designing models of health and social care and integration as well as developing effective approaches to the rising demand for unscheduled care across Scotland. The Vice-Chair commented that Tim was a people person and commented that those people who had been here under the old regime when Tim first came to Lothian would recognise and be forever grateful that together with Brian Houston he achieved what all leaders said they would do but very few achieved. He had changed the corporate culture for the better and then the wider organisation to a more open, confident and engaging one which encouraged staff to a level of commitment and loyalty that fed through to better and higher quality for both staff and patients. The Vice-Chair commented that Tim was an inspirational leader and would be sorely missed not just by NHS Lothian but by the wider Scottish public sector. The Vice-Chair commented that Tim had much still to give and he was sure many opportunities would come his way. The Vice-Chair thanked Tim and wished him good luck in whatever he done next.

40.4 The Chair invited the Interim Chief Executive to say a few words of introduction to himself and also to give a message to Tim. The Interim Chief Executive introduced himself and advised that he would have an opportunity to meet with people over the coming weeks. He commented that he had had the pleasure since he came back to Scotland over the last 10 to 11 years of working with Tim in the Board Chief Executives Group. He advised that Tim was massively respected by all the Board Chief Executives. He advised that he was probably the best known Board Chief Executive in Scotland right across the service. The Interim Chief Executive commented the thing he would miss from Tim most was his ability to see both sides and communicate difficult messages especially sometimes to Scottish Government colleagues in a nice balanced manner.

40.5 Tim advised that these were very kind and humbling words and he was very grateful to everyone for that. He advised that he had said at the Chief Executive's Group that when he reflected on his career he felt that his happiest and most enjoyable was the decade or so that he was able to lead the development of community mental health disability services in Glasgow that allowed the closure of the old institution. Tim thanked the Board in its current guise and in its previous guises over the previous 8 years. He had worked for 3 Chairs and a whole plethora of Non Executive Board members and Executive colleagues some of whom who had played major roles in the achievements that had been reflected upon himself. Tim also thanked his Executive Leadership Team that had been tremendous and commented that it was only in adversity that the quality of a team shone through. He advised that the last few years had been excruciating for many colleagues and for him personally but that the Team had pulled together extremely well. Tim commented that organisations were all about the people and that he left Lothian in good heart and led by some fantastic people. He thanked colleagues for all their support in the past.

41. Standing Order 5.23

41.1 The Board agreed to invoke Standing Order 5.23 to allow a meeting of Lothian NHS Board to be held in Private. The reasons for this was based on the commercial and confidential nature of the business.

Chair's Signature ………………………………………………………………………………

Date ………………………………………………………………………………………………

Mrs Esther Roberton
Interim Chair – Lothian NHS Board

NHS LOTHIAN

Board
12 August 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 Homologate the appointment of Jacqui Macrae as a non-voting member of Edinburgh Integration Joint Board for the period from 12 August 2019 to 11 August 2021.

2.2 Appoint Alison Mitchell as a voting member of Edinburgh Integration Joint Board for the period from 12 August 2020 to 30 April 2021.

2.3 Appoint Tom Waterson as a member of both the Staff Governance Committee and the Remuneration Committee with immediate effect.

2.4 Appoint Mike Ash as a voting member of Midlothian Integration Joint Board for the period from 12 August 2020 to 30 April 2021.

2.5 Appoint Dr Richard Williams as a voting member of East Lothian Integration Joint Board for the period from 12 August 2020 to 11 August 2023.

2.6 Appoint Katharina Kasper as a voting member of West Lothian Integration Joint Board for the period from 12 August 2020 to 11 August 2023.

2.7 Appoint Cllr. George Gordon as a member of the Healthcare Governance Committee with immediate effect.

3 Discussion of Key Issues

Edinburgh Integration Joint Board

3.1 On 12 August 2019 the Edinburgh Integration Joint Board appointed Jacqui Macrae to the non-voting position on the integration joint board for a registered nurse. Jacqui is the Interim Chief Nurse, and the NHS Lothian Executive Director for Nursing, Midwifery and Allied Health Professionals has confirmed that she is the appropriate person to appoint to this position. The NHS Board should have made this appointment in the first instance, and it is recommended that the Board homologate

the appointment for the period from 12 August 2019 to 11 August 2021.

3.2 Mike Ash's term of appointment as a voting member ended on 31 July 2020. It is recommended that the Board appoints Alison Mitchell to replace him, for the period from 12 August 2020 to 30 April 2021. Alison will also continue to be a member of the Staff Governance Committee.

Employee Director

3.3 The Cabinet Secretary has appointed Tom Waterson as a Board member from 1 August 2020 to 31 July 2024, recognising that he is the new Employee Director. The terms of reference of both the Staff Governance Committee and the Remuneration Committee state that the Employee Director is to be a member. It is recommended that the Board appoint Tom to both of these committees.

3.4 Alex Joyce, the previous Employee Director, was also a member of other committees and integration joint boards. In light of his retirement the Board has to make other appointments to fill the vacancies that his departure creates.

Midlothian Integration Joint Board

3.5 It is recommended that the Board appoints Mike Ash as a voting member of Midlothian Integration Joint Board for the period from 12 August 2020 to 30 April 2021.

East Lothian Integration Joint Board

3.6 It is recommended that the Board appoints Dr Richard Williams as a voting member of East Lothian Integration Joint Board for the period from 12 August 2020 to 11 August 2023.

West Lothian Integration Joint Board

3.7 It is recommended that the Board appoints Katharina Kasper as a voting member of West Lothian Integration Joint Board for the period from 12 August 2020 to 11 August 2023.

Healthcare Governance Committee

3.8 It is recommended that the Board appoints Cllr. George Gordon as a member of the Committee with immediate effect.

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
24 July 2020
alan.payne@nhslothian.scot.nhs.uk

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 20 May 2020 by videoconference.

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

In Attendance: Ms J. Campbell, Chief Officer, Acute Services; Mr I. Graham, Director of Capital Planning and Projects; Dr J. Hopton, Programme Director, Facilities (item 10.2); Mr A. McCreadie, Head of Management Accounts; Mr D. Mill, Senior Project Manager, Facilities (item 10.2); Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes).

Apologies: Mr J. Crombie, Deputy Chief Executive; Professor A. McMahon, Executive Nurse Director.

Chair's Welcome and Introductions

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

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

8. Committee Business

8.1 Minutes and Actions from Previous Meeting (22 April 2020)

8.1.1 The minutes from the meeting held on 22 April 2020 were approved as a correct record.

8.1.2 The updated cumulative action note had been previously circulated.

9. Capital

9.1 Property and Asset Management Investment Programme

9.1.1 Mr Graham presented the previously circulated paper. It was noted that in appendix 2 of the report £1 million expenditure was recorded for the upgrade of GP IT systems in 2021/22. Ms Goldsmith confirmed that this was a placemarker for the project and that David Small was working on a more detailed business case.

9.1.2 Mr Graham advised that the restrictions in place due to COVID-19 meant that some projects were being delayed due to a number of factors including time for risk assessments to be carried out by contractors, programming and supply due to suppliers having furloughed staff, and some manufacturers of supplies having

temporarily stopped producing. There may be cost increases related to delays. Actions were in progress to mitigate risks and support projects so that they could continue.

9.1.3 Ms Goldsmith explained that the clinical trials project was originally to be funded by the Health Foundation as clinical trials were not considered to be core business for NHS Lothian. This was presented as a separate business case to the oncology enabling works although the two were related. However, due to the benefit for patients of this project NHS Lothian would have funded this project if the Health Foundation had been unable to.

9.1.4 Professor Whyte explained that although not core business, clinical trials in cancer treatment were beneficial for patients and brought cost savings on new treatments. The Scottish Government provided funding for research infrastructure but that to carry out a clinical trial an academic or commercial sponsor was needed. There were major research centres in both Edinburgh and Glasgow. All proposed trials were prioritised according to value to patients. It was agreed that a short paper on resourcing of research and development would be submitted to the Committee at a future meeting. **SG**

9.1.5 Members accepted the recommendations laid out in the paper and accepted moderate assurance on the delivery of the programme in 2020/21 following supportive statements from the Scottish Government on the economy.

9.2 Royal Hospital for Children and Young People and Department for Clinical Neurosciences Update

9.2.1 Ms Goldsmith gave a verbal update. Negotiations continued with IHSL on the supplemental agreement 2, which had not yet been signed. NHS Lothian had now had sight of contracts between IHSL their subcontractors Imtech and Bouygues and relevant documents and they had agreed that comments would be taken into account. IHSL continued to raise issues concerning their commercial position but discussions were continuing between lawyers.

9.2.2 An indemnity period of 5 years on the ventilation system had been agreed early on so that if the system failed once NHS Lothian was in the building no cost could be deducted from IHSL, Imtech or Bouygues and Bouygues would carry out the rectification. Bouygues have recently suggested passing the responsibility for rectification to Imtech. This moved away from the original project agreement and pushed the responsibility further from NHS Lothian's control adding further risk. This had been discussed with the Scottish Futures Trust who had agreed to support NHS Lothian in resolving this.

9.2.3 It was noted that the delay was costing resources and £1.4 million per month for building lifecycle maintenance plus legal costs. Mr Graham advised that if the supplemental agreement was not signed the original contract would remain in place for lifecycle and maintenance of the building, but ongoing maintenance of the new ventilation system would not be covered. It was expected that all parties would sign the agreement but this was taking time.

9.2.4 As negotiations continued, work on the site was in progress and the agreed programme remained on track. Members noted the situation.

9.3 Laboratory Information Management System (LIMS) Consortium Project Initial Agreement

9.3.1 Ms Campbell presented the previously circulated paper. The existing management system had been developed alongside generic sequencing over the last 25 years and a more robust less person dependent system was needed. Members agreed that a professional service was required to ensure the system was kept up to date and secure. It was noted that regional services should work together on procurement so that the same version of the chosen system was used by different health boards.

9.3.2 Ms Campbell advised that any risk of consortium failure would be mitigated by the option for local purchase. This risk would be added to the full risk profile.

9.3.3 It was confirmed that the purchase of the equipment for the project was expected to be cost neutral with no additional revenue required, but members noted that there could be efficiency savings by reducing the number of tests run as laid out in the paper. The possible benefits of using the new system locally and regionally in looking at variation and efficiency needed to be clearly articulated.

9.3.4 Members accepted the recommendations laid out in the report and approved the Initial Agreement submitted.

10. Revenue

10.1 2019/20 Financial Position

10.1.1 Mr McCreadie presented the previously circulated paper. Some of the implications of the COVID-19 response were becoming apparent in month one of the new financial year and this would be reported fully at the next meeting. A summary of the national work around COVID recovery 'mobilisation plans' was included in the report.

10.1.2 The Scottish Government had indicated that any costs incurred as part of the COVID-19 response would be reimbursed. The funding would not be allocated using NRAC as the effect of COVID will not have been equal across the population. A methodology for measuring the costs was being developed nationally so that each Board was using the same criteria. The mobilisation plan included all health boards and Integration Joint Boards. Costs had increased for GP community hubs, equipment and eHealth as well as acute services.

10.1.3 The risk of the costs incurred not being covered was being evaluated but would not be clear until data on spend for a longer time period was available. Available off sets would also be evaluated as some costs had reduced in the past two months and some programmes where money had been committed had not gone ahead.

10.1.4 The update of the financial plan agreed last year was in discussion. The updates would include the strategy for 2021/22 and future years as well as more immediate plans for 2020/21. It was agreed that a draft of early thoughts on the new financial plan would be submitted to the next meeting but noted that the first proper iteration of

the plan could not be produced until after quarter one of the financial year and that it would still need further development following this. **SG**

10.1.5 Members accepted the recommendations laid out in the paper.

10.2 Sustainability and Climate Change Carbon Emissions Report 2019/20

10.2.1 Dr Hopton and Mr Mill presented the previously circulated paper. It was noted that the report covered 20-30% of NHS Lothian's emissions; other contributors were mainly procurement and some patient transport but data was not currently available on this. Actions to gather this data were on the draft sustainability plan starting with data on pharmaceutical procurement with the possibility of a secondment from the Analytical Services team to do some analytical work on pharmaceutical data and other procurement data currently available in different datasets.

10.2.2 Work was in the first phase for an energy centre at the Western General Hospital such as the one being developed at St John's Hospital. The infrastructure needed to be replaced and this was an opportunity to take steps towards better efficiency. The possibility of being involved in a district energy scheme was being considered so that equipment purchased would be compatible with any future projects, although it was recognised that NHS Lothian may need to move faster than this to ensure the infrastructure is replaced in a timely way. Work was needed nationally on infrastructure, legislation and procurement models to make the most of this and this was the direction being developed by the Scottish Government.

10.2.3 Similar carbon pathways also needed to be considered for other sites including the Royal Infirmary and the Royal Edinburgh Hospital, looking at what opportunities there were at each site for reducing carbon.

10.2.4 Members accepted the recommendations laid out in the report.

11. Committee Business

11.1 Reflection on the meeting

11.1.1 It was agreed that the need for collaborative working with the Integration Joint Boards to be improved should be raised to the Board. There was a need to show that there was strategic oversight and that IJB remits were covered. This applied to resources but also to the remits of all Board Committees. **MH**

11.1.2 It would be noted at the next Board meeting that the Committee had asked for a revised 2020/21 financial plan to be presented. **MH**

12. Date of Next Meeting

12.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 17 June 2020**.

13. Meeting Dates in 2020

13.1 Further meetings would take place on the following dates in 2020:

- 22 July 2020;
- 26 August 2020;
- 23 September 2020;
- 28 October 2020;
- 25 November 2020.

Signed by the Chair on 29-06-2020

Original kept in file.

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 12 May 2020 by videoconference.

Present: Professor M. Whyte, Non Executive Board Member (chair); Dr P. Donald, Non Executive Board Member; Ms C. Hirst, Non Executive Board Member; Ms F. Ireland, Non Executive Board Member; Mr A. Joyce, Employee Director, Non Executive Board Member; Ms L. Rumbles, Partnership Representative;

In attendance: Ms S. Gibbs, Quality and Safety Assurance Lead; Ms T. Gillies, Medical Director; Ms M. Hughes, Chief Nurse, West Lothian Health and Social Care Partnership; Ms T. McKigen, Services Director, Royal Edinburgh Hospital (item 6.1); Professor A. McMahon, Executive Nurse Director; Ms J. Morrison, Head of Patient Experience; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Professor A. Timoney, Director of Pharmacy; Dr A. Watson, Associate Medical Director, Royal Edinburgh Hospital (item 5.3); Dr C. Whitworth, Medical Director, Acute Services.

Apologies: 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.

1. Minutes from Previous Meeting (10 March 2020)

1.1 The minutes from the meeting held on 10 March 2020 were approved as a correct record subject to a minor correction to the attendees list.

1.2 The updated cumulative action note had been previously circulated.

2. Emerging Issues

2.1 Coronavirus update

2.1.1 Ms Gillies presented the previously circulated paper. In addition, Professor McMahon advised that governance responsibility for care homes was with the Health and Social Care Partnerships and relevant updates would be through them. NHS Lothian was trying to support care homes with training as well as workforce and student nurses, bank nurses and care of the elderly nurses had been identified to work in care homes for 6-8 weeks. Support of care homes was important for NHS Lothian's patient flow and functionality.

2.1.2 NHS Lothian's Health Protection Team was leading on testing and managing outbreaks in care homes, both testing of symptomatic cases and contact tracing and testing. Results from test results carried out by the Health Protection Team were reported direct to the Board; those carried out at the UK Government testing centre at Edinburgh airport were reported by a different route. The actions taken on receiving a positive result were the same as with other outbreaks: to isolate the patient and any contacts. Some national work was ongoing on population testing and actions to take following positive results; this was expected to be published.

2.1.3 Ms Gillies advised that post intensive care rehabilitation arrangements had been made for patients who had been in intensive care for some time with COVID with provision of care at the Astley Ainslie Hospital. A report on statistics for outcomes of patients admitted to ICU was due to be released the next day and would be circulated to members. **TG**

2.1.4 It was noted that the COVID hubs rapidly set up had been very effective in triaging patients and some of this model may be kept in the future. Staff were thanked for their work in establishing these at short notice.

2.1.5 In relation to the rapidly changing guidance around COVID, the importance of documenting decisions made and what current guidance was being referred to was noted; this would allow any review to take into account the prevailing conditions at the time.

2.1.6 A patient information leaflet on safe attendance at hospital was discussed. It was noted that this information was available online on the NHS Inform website which was a centralised information point for all Scottish health boards. There could be benefit in also providing local information on NHS Lothian's website, but due to rapidly changing guidance this would have to be done carefully and with national discussion to ensure a clear message. Ms Gillies agreed to discuss this with colleagues nationally. **TG**

2.1.7 An internal intranet page was available for staff with all updated guidance from Health Protection Scotland. The guidance had been rapidly changing and it was the responsibility of Health Protection Scotland to review available evidence and advice on what health boards should do. Following this guidance therefore provided security and a level of authority.

2.1.8 Professor Whyte praised the hard work and resourcefulness of all involved and noted that Edinburgh was the first medical school to graduate medical students early with training made available. A Massive Open Online Course (MOOC) in intensive care had been developed by NHS Lothian and the University of Edinburgh based on an existing course and had provided training to 60,000 participants world wide.

2.1.9 The impact of COVID for non COVID patients was discussed. Ms Gillies advised that a digital approach had been taken for patient contact and consultations in mental health services which had worked well. Most cancer services had continued to operate with the Spire hospital used for procedures where suitable, and 'green' areas being kept open in hospitals for cancer pathways. Some procedures had been deferred but for no more than three months. This was often based on patient choice and patient perception of safety when attending hospital. There had been an increase in cancer

mortality risk in the past two months. Risks are being explained to patients so that they could make their own choice on the risk they were prepared to accept.

2.1.10 For the next report members requested more information on outcomes for non COVID patients including mental health and cancer diagnosis and treatment indicators, future capacity requirements, more information about the effect on prisons and care homes for the disabled, and a further update on care homes. **TG**

2.1.11 Members accepted the recommendations laid out in the paper and accepted limited assurance overall against the COVID-19 risk.

3. Committee Effectiveness

3.1 Healthcare Governance Committee Annual Report and Assurance Need

3.1.1 Professor Whyte presented the previously circulated annual report which had been revised following discussion at the previous meeting. Three areas for improvement had been highlighted from the members' survey and these would be taken forward.

3.1.2 Members accepted the recommendations laid out in the paper and approved the report.

4. Person Centred Care

4.1 Complaints Performance Assurance

4.1.1 Professor McMahon and Ms Morrison presented the previously circulated paper. Ms Hirst commented that there was assurance that complaints management was improving, but that more needed to be done to demonstrate this. The uphold rate was one important indicator as it showed whether clinical areas were learning from the feedback received and sharing the learning throughout the organisation. It was suggested that each paper to the Committee could focus on a particular indicator to give more in depth assurance, with a focus on 'patient opinion' at the next meeting. **AMcM**

4.1.2 It was noted that there had not been an increase in complaints related to the COVID restrictions to visiting, which reflected the work done on alternative means to facilitate patient communication with families and staff including rainbow boxes, iPads and digital stories. The benefits of some of these initiatives could continue after the COVID response period.

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

5. Safe Care

5.1 Healthcare Associated Infection Update

5.1.1 Professor McMahon presented the previously circulated paper. A COVID advice line set up for staff by the Infection Prevention and Control Team had received around 160

calls per day initially but was now receiving around 10 calls per day, indicating staff were more confident on following the guidance.

5.1.2 Appropriate use of PPE had been the biggest anxiety for staff, particularly with changes in guidance; following Health Protection Scotland guidance allowed for standardisation. Further work on supply of PPE had been done with some shortages in visors and gowns resulting in face fit testing needing to be done for new brands of mask, including in primary care and social care as well as acute settings. A better system was now in place for training and supply of PPE for care homes.

5.1.3 Members accepted the recommendations laid out in the paper and recognised the efforts of all involved to provide this service for the safety of patients and staff.

5.2 Management and Learning from Significant Adverse Events

5.2.1 Ms Gillies presented the previously circulated paper. Ms Morrison advised that the patient representatives group had discussed this paper before the meeting and had supported the internal audit described in the paper, stressing the importance of good communication with patients and family.

5.2.2 There was a backlog in cases of unexpected deaths to be investigated, particularly mental health and substance misuse deaths. Delays were due to complexity of cases, staff availability and in some cases a legal element. All unexpected deaths were reported in datix and investigated as significant adverse events, but many investigations brought up the same themes. Review of shared themes and learning was being done in the acute setting but was more difficult in the community setting where services were dispersed. A group had been set up earlier this year to review REAS investigations to consider case in depth where necessary and develop shared actions in response to themes identified. More work was needed for community and delegated services.

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

5.3 Review of the Report on Mental Health Services in Tayside

5.3.1 Dr Watson presented the previously circulated paper. Professor McMahon noted that, in response to the results of a patient survey the previous year, work had been done on occupancy and introducing therapeutic professionals to the wards.

5.3.2 It was requested that further information about monitoring and evaluation frameworks be included in the next report.

5.3.3 Recruitment in mental health services was a problem across Scotland in psychiatry, mental health nursing and in the third sector; this had been a significant problem in Tayside. Lothian was in a slightly better position than the Scottish average but had been considering ways to improve recruitment to training and to posts. It was noted that staff shortages made those remaining feel pressured and unsupported and more likely to leave.

5.3.4 It was noted that the health ombudsman in England had made recommendations on learning disabilities services which could be useful in Lothian. Dr Watson noted that there had been recent scrutiny of learning disabilities services as part of the redevelopment of the Royal Edinburgh Hospital.

5.3.5 Members accepted the recommendations laid out in the paper and accepted significant assurance. A further paper would be brought to the Committee once the Programme Board's work was in progress.

6. Effective Care

6.1 Royal Edinburgh Hospital and Associated Services Governance

6.1.1 Ms McKigen presented the previously circulated paper which laid out a plan for the presentation of different aspects of the service: specialist regional services at the meeting in July 2020; inpatient adult services at the meeting in September 2020; psychological therapies at the meeting in November 2020. **AMcM**

6.1.2 Members accepted the recommendations in the paper and accepted the timetable for reporting.

7. Exception Reporting

Members noted the following previously circulated papers for information:

7.1 Diabetes Managed Clinical Network Annual Report;
7.2 Out of Area Placements Monitoring Team Annual Update.

8. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

8.1 Clinical Management Group, January and March 2020;
8.2 Lothian Infection Control Advisory Committee, 10 December 2019;
8.3 Policy Approval Group, 28 January 2020;

9. Corporate Risk Register

9.1 Ms Gillies presented the previously circulated paper. Members accepted the recommendations laid out.

10. Any other business

10.1 Royal Hospital for Children and Young People and Department of Clinical Neurosciences Compliance Reviews

10.1.1 Ms Gillies presented the previously circulated paper. Members agreed that significant assurance was provided by the National Services Scotland (NSS) report on compliance with the required processes for redevelopment and that no further work would be done on the Callidus review.

10.1.2 Members accepted the recommendations laid out in the paper subject to provision of an excerpt from the minutes of the Oversight Board where this was discussed. This would be circulated and updated in the action note. **BP**

11. Date of Next Meeting

11.1 The next meeting of the Healthcare Governance Committee would take place at **9.00am** on **Tuesday 14 July 2020** in **Meeting Room 8**, Fifth Floor, and Waverley Gate.

12. Further Meeting Dates

12.1 Further meetings would take place on the following dates in 2020:
- 8 September 2020;
- 10 November 2020.

Chair's Signature……………………………………………………………………………

Date……………04/07/2020……………………………………………………………………
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NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 9.30 on Wednesday 27 May 2020 via Microsoft Teams

Present: Ms A. Mitchell, Non-Executive Board Member (Chair); Mr W. McQueen, Non-Executive Board Member; Ms C. Hirst, Non-Executive Board Member; Councillor J. McGinty, Non-Executive Board Member; Mrs Katharina Kasper, Non-Executive Board Member (Whistleblowing Champion); Mr A. Joyce, Non-Executive Board Member; Mr S. McLauchlan, Partnership Representative; Ms H. Fitzgerald, Partnership Representative; Ms J. Butler, Director of Human Resources; Miss T. Gillies, Medical Director 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; Dr A. Leckie, Director NHS Lothian Occupational Health & Safety Service; Mr T. Waterson, Union Chair, NHS Lothian (shadowing Alex Joyce) and Mr C Graham, Secretariat Manager.

Apologies: Councillor D. Milligan, Non-Executive Board Member; Ms J. Campbell, Chief Officer, Acute Services and Mr J. Crombie, Deputy Chief Executive.

Chair's Welcome and Introductions

The Chair welcomed members to the meeting, this was the Committee's first meeting on MS Teams and as such the Chair reminded members of the expected Teams etiquette. The Chair welcomed Mrs Kasper and Mr McQueen to their first meeting as members and also welcomed Mr Waterston who was shadowing Mr Joyce ahead of taking on the role of Employee Director.

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.

1. Minutes and Action Note of the Previous Meeting of the Staff Governance Committee held on 19 February 2020

1.1 The minutes from the meeting held on 19 February 2020 were approved as a correct record.

1.2 The Committee noted the updated cumulative action note and that due to the revised agenda for this meeting some items would be carried forward to the next meeting and reviewed again as necessary at that point.

2. Matters Arising

2.1 None.

3. Items for Discussion

3.1 Changes to the Staff Governance Workplan

3.1.1 Mrs Butler presented the Committee with information on the impact of Covid19 on the Staff Governance work-plan and the governance processes surrounding this.

3.1.2 There was discussion around local and national initiatives that had been paused around workforce and staff governance as a result of the COVID19 pandemic. It was noted that the Board had responded quickly to address the impact of the pandemic on the organisation in terms of Partnership, HR and OD arrangements. The Board had also been able to influence and shape the national pandemic response for staff terms and conditions and workforce policy through participation in the daily Scottish Government Workforce calls and also the regular Staff Terms and Conditions Group meetings .

3.1.3 The Committee also noted that there was a Covid19 space on the Board's intranet for staff and guidance was available here with updates on any changes for staff being included within the daily Speed Read document. HR Enquiries service had also continued throughout the pandemic and had seen an increased level of calls initially.

3.1.4 There was discussion on local and national governance arrangements and getting back to business as usual. Any potential staff governance implications or corporate liability for the Board of the new role and responsibilities of the Executive Nurse Director in relation to care home staff was also discussed. It was noted that the staff in these areas were employed by either the local authority or the private company owning the home and therefore the governance route was likely to be through Healthcare Governance in terms of clinical matters. The Committee also noted that further clarification around the care at home element of the new responsibilities had been sought from the Scottish Government Chief Nursing Officer.

3.1.5 Professor McMahon explained that there were not many registered nurses working within these care home environments and that his responsibility is only for key clinical elements such as PPE and Infection Prevention and Control. At this stage it was not clear what the new processes will be and these will be worked through over the next couple of weeks with the likely establishment of a Pan Lothian Strategic Oversight Group to include representation from Staff Side, HSCPs, Chief Nurses and Social Work. The area of Board accountabilities would also have to be considered and it would be vital that this work progresses in genuine partnership.

3.1.6 The Committee agreed to note the position on key Staff Governance workstreams and requested that updates to come back to future meetings. The Committee also supported the extension of timelines where necessary where actions had been impacted by the Covid19 response.

3.2 Staff Health and Safety

3.2.1 Miss Gillies provide an update to the Committee on the key staff health and safety issues which have emerged and been managed over the course of the pandemic to date; the governance around these issues and the any risk mitigation strategies.

3.2.2 The Committee welcomed the well set out paper and thanked Miss Gillies and Professor McMahon for their hard work against the huge challenges around staff testing, PPE and RIDDOR Reporting:

PPE

- Noted that supply remains settled but is reviewed on a week to week basis. There remains anxiety with staff around the products being supplied especially when these change. The PPE group is now meeting three times per week and the Staff Side support is being provided by Caroline McDowall.
- In relation to the Executive Nurse Director's extra responsibilities for care homes and care at home, Professor McMahon confirmed that he was confident the level of PPE volumes needed going forward and the rhythm of supply were in place. The supply of social care and health supplies through partnership hubs continued and work was underway to look at predicting PPE consumption and developing a greater understanding of this. There were also any future changes to government policy to factor in. The Committee noted that the NHS Lothian developed Framework would be circulated after the meeting.

AMcM/CG

Staff Testing

- Miss Gillies explained that a large number of staff accessing testing were outside the time window for effective interpretation and that slicker referrals to testing slots on the right days were being progressed. Taxis to drive through testing sites were being provided and there was now an additional testing site in West Lothian.
- Work was underway to now incorporate Test and Protect into the Staff Testing procedures
- There was discussion on testing of care home staff; provision of test slots to local authorities and other providers; asymptomatic testing; issues around UK Gov test results returning to staff members records and the speed of results coming back

RIDDOR Reporting

- Noted that Covid-19 had led to an update from the HSE with specific guidance for reporting
- Not many RIDDORs recorded; there was awareness of the impact of some aspects of behaviours in non-clinical areas, remaining appropriately social distanced and staff to staff transmission. Reminder guidance has been issued to staff
- Discussion on implications for staff working from home and risk assessments in relation to infection control. Noted that at this stage no risk assessments had taken place and that an approach from returning to corporate offices was being carefully developed but it was likely that home working would be around for some time.

3.2.3 The Committee agreed to take moderate assurance on the management actions and mechanisms in place for robust and effective staff PPE, RIDDOR reporting, staff testing and general staff safety arrangements.

3.3 Resourcing Update

3.3.1 Mrs Kelly updated members on the additional resourcing that has been put in place in response to the Covid19 Pandemic and some of the changes to recruitment practices and induction that have been implemented in light of the restrictions.

3.3.2 There was discussion on staffing levels; national and local recruitment and revised recruitment processes; use of staff bank; links with universities; medical and nursing students; returning staff through the NES portal; volunteer recruitment; use of shielding staff for contact tracing; the possible request for the Board to staff beds at the NHS Louisa Jordan Hospital and remobilisation work moving forward whilst looking at things

that have been done differently and how this can also be carried forward and learned from.

3.3.3 The Committee agreed to note the current position with resourcing and the actions that were taken. The Committee also took comfort that there were systems in place to respond flexibly to staffing requirements if required.

3.4 Staff Wellbeing During Covid19

3.4.1 Ms Langsley reported on the staff wellbeing response to Covid19 which included plans for both the recovery and renewal phase. The Committee noted the range of wellbeing services and tools that had been established to help staff and the ongoing work to take the opportunity to learn from this work during the pandemic.

3.4.2 There had been positive feedback from Staff Side on these wellbeing initiatives and the airport lounge arrangement at the RIE had been particularly well received. There was the question of how these initiatives would be sustained as we move on from the pandemic. It was noted that through the EHLF and NHS Charities significant funds have been raised and work was ongoing to retain, where appropriate, these initiatives for staff wellbeing and support.

3.4.3 There was discussion on the 'hub in a tub' initiative which had also been well received by community services; initiatives for non-clinical staff and support for the senior management team. Ms Langsley stated that the 'hub in a tub' was accessible for all staff across health and social care and that senior staff support was through Organisational Development teams; this included access to online coaching and the ability to access facilitated coaching out with NHS Lothian.

3.4.4 The Chair congratulated Ms Langsley and her team for the work being undertaken to support staff across the organisation and the work now being developed to sustain this approach.

3.4.5 The Committee noted the actions in place to support staff wellbeing in response to Covid19 and plans to continue this work in a structured manner through the reactive, recovery and renewal phased of our response to the pandemic. The Committee agreed to accept a significant level of assurance that NHS Lothian had placed staff wellbeing at the forefront of activity and had robust plans in place to progress this work in the transition to the next phases of the pandemic.

3.5 Staff Absence over COVID-19 Period

3.5.1 Mrs Butler updated the Committee on the change to staff absence levels since the start of the Covid19 global pandemic. It was noted that monitoring of absence at the moment was being undertaken daily and weekly where normally this would be monthly. The challenge of receiving timely information was noted except for nurse staffing where there was real time e-rostering data available through the eRoster system.

3.5.2 Mrs Butler pointed out that Covid19 related absences appeared to have now peaked and had plateaued in terms of absences. Non Covid19 related absences were now below where they were for the same period last year.

3.5.3 Mrs Butler asked the Committee to note that there was no Covid 19 related staff absence in Critical Care until 12 May, which should provide the Committee with

assurance in terms of availability and correct use of PPE. Critical Care and Covid19 wards continue to be closely monitored.

3.5.4 There was discussion around staff within the shielding category. It was noted that there were around 500 NHS Lothian staff in the highest risk category and this had been challenging as staff had received shielding letters from GPs over a period of weeks. The Occupational Health team had been working hard to undertake the required risk assessments in relation to staff in the high risk category too. In addition, the guidance from the Scottish Government around pregnant workers had initially been unclear and took a long time to be finalised but it now advises that staff over 28 week gestation should remain at home.

3.5.5 The Committee also noted that although some staff were shielding they were able to work at home and an example of this was around contact tracing. Further policy guidance was expected from the First Minister before 18 June and this should give a clearer position for staff who fall within the first shielding period. Should shielding not continue, risk assessments for staff coming back into the workplace would continue.

3.5.6 There was further discussion on the staff absence data and how this compared to other health boards. It was noted that at the moment for Covid19 related absences it was not possible to compare this but such a comparison would be helpful at some point. In relation to non Covid19 absences Lothian continues to fair well against the other large teaching Boards.

3.5.7 It was noted that data and learning from the Covi19 experience would be important moving forward, looking at impacts of the virus on certain staff groups e.g. BAME staff. There was also ongoing issues around staff health and wellbeing to be considered. It was recognised that a lot of this work would be done for the general population through Public Health Scotland work and that it would not be possible to get the data needed to allow NHS Lothian to undertake this specifically for staff. Dr Leckie advised that data showed that the single biggest risk factor for Covid 19 was age.

3.5.8 The Committee accepted the recommednations within the report, namely to:

- note the extraordinary level of absences that have resulted from the Covid 19 pandemic and support the range of measures that have been taken to monitor levels within the workforce.
- support the measures that have been taken to protect vulnerable staff that face disproportionate risks through age or underlying health conditions and that further national advice is awaited on our BAME staff
- recognise the determination and hard work of all areas of the workforce who have acted responsibly in self isolating where necessary reducing clinical risk whilst maintaining a level of absence that is substantially below the reasonable worst case assumption for pandemic modelling
- note the wide range of measures that are being taken to support staff resilience and mental health in this exceptionally challenging time set out separately in the staff support and wellbeing paper
- acknowledge that as measures are introduced to gradually unlock society the level of staff absence is likely to rise once again and this may remain the case until there is either an effective vaccine or treatments to eradicate or control Covid 19.

3.6 Whistleblowing Monitoring Report

3.6.1 Mrs Kelly introduced the report outlining the monitoring data for the Whistleblowing and Speak Up cases that had been raised within NHS Lothian. Mrs Kelly advised that since the last meeting of the Committee on 19 February 2020, 2 new cases had been raised and these were included in Appendix 1. Mrs Kelly also indicated that since the paper was prepared for the meeting a further whistleblowing case had been raised and the details of this case will be included in the whistleblowing report for the next meeting of the Committee. The paper also provided an update on the arrangements for the new National Whistleblowing Standards which had now been paused by Scottish Government but confirmed that background work in preparation for their introduction continues.

3.6.2 There was discussion on the cases and summaries outlined; the trend information now provided and the number of anonymous cases. The Committee noted that the Speak Up Ambassadors would be attending the July meeting. During the COVID19 Pandemic there had been about 5 or 6 Covid19 related enquires being received per week through Speak Up and further information on this would be provided at the next meeting.

3.6.3 The Committee agreed to take moderate assurance based on the information contained in the paper that systems and processes were in place to help to create a climate in NHS Lothian which ensures employees had 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.

3.6.4 The Committee also noted the number and types of cases raised through the Speak Up Initiative from January to March 2020 and noted the current position with the implementation of the new National Whistleblowing Standards.

3.7 Staff Governance Committee Annual Report

3.7.1 Mrs Kelly presented the Annual Report for Committee member's approval so that the report could then be submitted for inclusion with the Board's Annual report and accounts.

3.7.2 The Committee noted that the format of the report was the same as prescribed for all board governance committees and this format had not changed from the previous year.

3.7.3 It was also noted that the statement of assurance is updated on a continuous basis following each meeting throughout the year to provide any identified issues around assurance to the Board through the annual report. Another part of the report was the input from members through a short standardised questionnaire. It was noted that the questionnaires received had not identified any significant issues but had highlighted that induction for new members could be better developed and this would be picked up.

3.7.4 Mrs Kelly explained how areas identified as having limited assurance would come to the Committee throughout the year and have background plans in place to address the low level of assurance. In the main the only items on the current Assurance Register are those that are already on the Corporate Risk Register. Mrs Butler added that that the achievement of the 4% Sickness Absence Rate Heat Target was something that no territorial board had ever attained in the time the standard had existed and Lothian were no different in this context.

3.7.5 The Committee agreed to approve the Annual report of the Chair of the Staff Governance Committee for inclusion in the Board's Annual Report and Accounts.

4. Chair's Closing Remarks

4.1 Agenda Focus – The Committee felt that the agenda focus had been appropriate and that there had been a high quality of papers submitted.

4.2 Chair of Committee – The Chair stated that this would be her last meeting as Committee Chair and thanked Members, Mrs Butler and Mrs Kelly for their professionalism, engagement and support during her chairship.

4.2.1 Mrs Butler thanked Ms Mitchell for her leadership and support over the last couple of years in moving the committee forward and transforming how it worked.

4.2.2 The Chair of the Committee would now move over to Mr McQueen

5. Any Other Competent Business

5.1 None.

6. Date of Next Meeting

6.1 The next meeting of the Staff Governance Committee would take place at **9.30** on **Wednesday 29 July 2020**.

7. Further Meeting Dates in 2020

7.1 Further meetings would take place on the following dates in 2020:
- 29 July 2020;
- 21 October 2020;
- 16 November 2020.

Chair Approved 29/07/2020
Original held on file

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee Meeting held at 2.00 p.m. on Monday, 21 May 2020 via MS Teams.

Present: Mr M Ash (Chair), Non-Executive Board Member; Mr M Connor Non-Executive Board Member; Ms K Kasper, Non-Executive Board Member; Mr B McQueen, Non-Executive Board Member; Mr P Murray, Non-Executive Board Member; Councillor John McGinty, Non-Executive Board Member and Dr R Williams, Non-Executive Board Member.

In Attendance: Mr T Davison, Chief Executive; Ms J Brown, Chief Internal Auditor; Mr C Brown, Scott Moncrieff; Mr C Marriott, Deputy Director of Finance; Ms S Goldsmith, Director of Finance; Mr A Payne, Head of Corporate Governance; Ms S Gibbs, Quality & Safety Assurance Lead; Ms L Baird, Committee Administrator (minutes).

There were no apologies for absence.

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

1. Minutes of the previous meeting held on 24 February 2020

1.1 The minutes of the meeting held on 24 February 2020 were accepted as an accurate record.

2. Running Action Note

2.1 The committee noted the actions marked complete. Those marked ongoing would be updated in advance of the June Audit and Risk Committee.

3. Internal Audit

3.1 Internal Audit Progress Report - May 2020 - Ms Brown presented the paper providing a summary of internal audit activity since the February 2020 meeting and the ongoing progress in delivering the 2019/20 Internal Audit plan.

3.1.1 It was noted that 3 internal audit reviews had been delayed due to the potential impact of the audits on clinical teams. Ms Brown would consider whether the audits would be brought forward into the 2020/21 and if they remained in line with the priorities of the Board. **JBr**

3.1.2 It was recognised that due to Covid-19 services had been paused and as a consequence there would be a large impact on those patients waiting over 12 weeks. Prior to Covid-19 65,000 outpatients were waiting over 12 weeks for treatment in Lothian. Following the suspension of routine service in Lothian the number of outpatients waiting over 12 weeks for treatment in Lothian had increased to 120,000. Members agreed that the context of the audit on waiting times would need to take into account Covid-19. Ms Brown would liaise with Miss Gillies and Ms Campbell to reflect on the changes to waiting times and bring forward a proposal to the Audit and Risk Committee in August 2020. **JBr**

3.1.3 The committee discussed whether the delay to the Royal Hospital for Children and Young People internal audit would impact the internal audit opinion that supports the annual accounts. Ms Brown advised that the Internal Audit on the Royal Hospital for Children and Young People had been commissioned independent of the internal audit 2019/20 plan. She would take a view on the position of the audit at the time of providing her opinion to the Audit and Risk Committee in June 2020.

3.1.4 The Committee discussed the current hybrid model employed by NHS Lothian for the provision of the internal audit team. There were plans to move to a regional model that would see the provision of internal audit services across NHS Lothian and NHS Borders. Due to Covid-19 this had been put on hold and the current contact with Grant Thornton had been extended for another six months.

3.1.5 Mr Davison advised that he Board had no intention of switching to a full in house model for the provision of internal audit services. The current hybrid model would be retained at this time. Mr Marriott agreed to circulate the rationale for this outlined in the strategy document to the Committee. Members were invited to pitch ideas to Mr Ash and Mr Connor if they thought the model needed to be refreshed. **CM/ALL**

3.1.6 The Committee accepted the internal audit progress report – May 2020.

3.2 Update paper on the timeline for the completed RHCYP Internal Audit review of governance and internal control – the Committee received the update on the internal audit report on the review of the internal controls and governance in respect of the Royal Hospital for Children and Young People (RHCYP). The review focused on determining why the ventilation issue arose within critical care and what steps NHS Lothian took to enhance controls and governance. The internal audit report would support NHS Lothian's submission to the public inquiry.

3.2.1 Members recognised that once in the public domain the report would be open to scrutiny and many would only read the highlights within the executive summary. It was important that key messages and findings were brought to their attention within the summary. It was noted that if management felt that areas had been missed or required clarification these could be picked up within their management response. It was also important that where issues and faults had been identified it was clear what action had been taken to address them.

3.2.2 Ms Brown reflected on Mr McQueen's comments and agreed that if the report specifically identified an individual to be at fault, they should be given the opportunity to respond to comments made within the report. She noted that adding this step to the process could potentially push back the date for publication and would require further thought.

3.2.3 Mr Brown would continue to work on the internal audit report with key stakeholders and co-sponsors with a view to bring the final report back to 22nd June 2020 Audit and Risk Committee meeting. **JBr**

3.3 Internal Audit Report - East Lothian Integration Joint Board (IJB): Strategic Change Priorities and Delivery at HSCP Level – Ms Brown spoke to the previously circulated report. She concluded that since the introduction of the

Change Boards in 2018, the Governance Framework operated reasonably and effectively with projects introduced that contribute to the delivery of the East Lothian IJB strategic priorities. However some improvement opportunities have been identified and recommendations made to enhance the governance arrangements already in place.

3.3.1 There was agreement that the paper would be of interest to other integration joint boards. Mr Payne would draw the report to the attention of the Chief Officers noting that the Audit and Risk Committee thought that reviewing the report would be valuable to all IJBs. **AP**

3.3.2 The committee accepted the report.

3.4 Internal Audit Review: Board Governance Arrangements during COVID 19 – Ms Brown spoke to the previously circulated report. Following the internal audit review of the revised governance arrangements in response to COVID-19, it can be concluded that the arrangements were reasonable and appropriate for the circumstances NHS Lothian was currently facing. Ms Brown concluded that the revised arrangements were in line with relevant legislation and Scottish Government principles.

3.4.1 The committee accepted the report.

4. Corporate Governance

4.1 2019/20 Risk Management Annual Report – Ms Gibbs spoke to the previously circulated report. Key areas of focus related to the compliance of the Health Improvement Scotland review and the Board's compliance to the adverse event management framework. NHS Lothian was currently complying with 13 of the required 15 elements. Work was ongoing in respect of a consistent approach to seeking patient and family feedback and evidencing the sharing of final significant adverse event reports with staff.

4.1.1 The committee discussed the process for notification to Health Improvement Scotland (HIS) of all level 1 reviews for category 1 adverse events. It was noted that given the significant demands on the service due to Covid-19 from March, HIS have suspended the national notification requirement. During this time it was essential that local governance around reporting, managing and communicating about adverse events is maintained to ensure patient and staff safety.

4.1.2 NHS Lothian published an annual report covering the first year of implementation of statutory organisational Duty of Candour for the period 1 April 2018 – 31 March 2019. To date no feedback has been received on the report. It was noted that preparatory work for the 2019/2020 report had commenced.

4.1.3 Ms Kasper questioned what evidence had been presented to the Audit and Risk Committee over the year to support the recommendation of moderate assurance with respect to systems in place to manage risk across NHS Lothian beyond the standing corporate risk register paper. If the committee only received assurance through the standing paper presented each month how did the board assure itself on risk that fell out with its remit. Ms Gibbs and Mr Payne took an action to bring forward a paper on risk detailing how the organisation looks at risk across the Board, the processes and methodology in place, and whether this provided appropriate assurance to the Board. Ms Kasper, Mr McQueen and Dr Williams

agreed to feed all relevant concerns and points to Mr Payne and Ms Gibbs out with the meeting. **AP/SG/KK/BM/RW**

4.1.4 The Audit & Risk Committee accepted the recommendations in the report, and that it was a source or assurance to inform the NHS Lothian Governance Statement.

4.2 Accounting Policies – Ms Goldsmith spoke to the previously circulated report, drawing the Committee's. She noted that there were no changes to the accounting policies this year.

4.2.1 The Audit & Risk Committee approved the accounting policies and confirmed that they were appropriate for the Board at the present time for the purpose of giving a true and fair view

5. Any Other Competence Business

5.1 Date and Time of Next Meeting – The Group discussed the timing of the meeting proposed for 22 June 2020. It was agreed that the meeting would start at 9.30 a.m. 30 minutes later than the previously advertised time.

6. Reflection on Meeting

6.1 The Members of the committee reflected on the meeting.

7 Date of Next Meeting

7.1 The next meeting of the Audit and Risk Committee will take place at **9.30** on **Monday 22 June 2020** via MS Teams.

8. Future Meetings
24 August 2020
23 November 2020

Chair Signed 22/06/2020

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee Meeting held at 9.30 am on Monday, 22 June 2020 via MS Teams.

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

In Attendance:
Ms J. Brown, Chief Internal Auditor; Mr C. Brown, Scott Moncrieff; Mr C. Campbell, Interim Chief Executive; Mr J. Crombie, Deputy Chief Executive; Mr G. Curley, Director of Estates; Mr T. Davison, Chief Executive; Mr D. Eardley, Scott Moncrieff; Ms S. Gibbs (Deputising for Ms J Bennett); Ms S. Goldsmith, Director of Finance; Ms D. Howard, Head of Financial Services; Ms P. Irving, Head of Finance; Mr C. Marriott, Deputy Director of Finance; Ms O. Notman, Assistant Finance Manager; Mr J. Old, Financial Controller; Mr A. Payne, Head of Corporate Governance; and Miss L. Baird, Committee Administrator.

Apologies:
None

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

9. Minutes of the previous meeting held on 21 May 2020

9.1 The minutes of the meeting held on 21 May 2020 were accepted as an accurate record and approved.

10. Running Action Note

10.1 The committee noted the actions marked complete and those that were not due for consideration detailed within the report. Mr Murray commented that the action relating to the lines of communication between the audit & risk committee and the integration joint board should be brought forward.

10.2 Internal Audit Team Contract – The committee discussed the provision of the internal audit team, recognising the benefits associated with the mixed model employed in NHS Lothian. Mr Murray proposed investigating the structure of services utilised within other Boards to inform future discussions around the contract. Mr Connor and Mr Marriott would oversee discussions around the provision of the internal audit team contract going forward. **MC/CM**

10.3 The committee accepted the running action note.

11. Corporate Risk Register

11.1 Ms Gibbs spoke to the previously circulated report. She highlighted the addition of a new risk associated with Covid-19 and removal of the Brexit risk, as agreed by the Board in April.

11.2 Ms Gibbs, working with Ms Kasper, would bring back a fuller report on risk across the organisation to the August Audit and Risk Committee meeting. The proposal brought forward would outline the strategy to be recommended to the Board in November 2020. **SGi**

11.3 The committee discussed the impact of Brexit. Members recognised that the United Kingdom had left the European Union, however there would be consequences that would impact the organisation going forward. Members agreed it was important that the Board remained aware of risk emerging from Brexit. .

11.4 The committee accepted the report.

12. Internal Audit (Assurance)

12.1 Update on the RHCYP Internal Audit review of governance and internal control- The Committee received an update on progress of the RHCYP internal audit.

12.1.1 Ms Brown advised that since the Audit and Risk Committee in May, initial comments had been received from the independent tester and updated where relevant. Comments had been received from Mott MacDonald and further discussions were required with the NHS Lothian Project Director and the Director of Planning. In light of additional information received the recommendations within the internal audit report were being reviewed. Work to finalise the report was ongoing.

12.1.2 Ms Brown assured the committee that the report would be submitted to the Audit and Risk Committee for consideration in advance of formal submission to Scottish Government.

12.1.3 It was noted that formal feedback from third parties had related to interpretation rather than material changes or disputed facts. Ms Brown was confident that the final internal audit report would be supported by the evidence collated.

12.1.4 Ms Brown anticipated that the finalised report would be shared with NHS Lothian management for their response in light of the third party comments and subsequent adjustments made by 3rd July 2020. Mr Ash, Mr Connor, Mr Marriott and Ms Brown would review the progress of the report in the next 10 days identify a timeline for the finalised report. **MA/MC/CM/JB**

12.1.5 The Committee accepted the report.

12.2 Internal audit reports with significant assurance for all control objectives – The committee accepted the report with significant assurance for all control objectives for Early Careers and Apprenticeships (June 2020) and Acute Prescribing (June 2020).

12.2.1 The Committee discussed expanding the current early careers programme to maximise intake of applicants to the scheme. The recruitment of carer workers within the health and social care partnerships has historically been an issue due

to low levels of unemployment. As part of the consideration of the programme for early careers the Board would look to work with the partnerships to promote careers within the partnership. Mr McQueen agreed to keep discussion around early careers on the Staff Governance Committee agenda.

12.3 Internal Audit Final Report - Consort Parking Review (June 2020) – The committee noted the previously circulated report. The report found that there was limited assurance that all costs associated with the operation of the car parking facilities at the Royal Infirmary of Edinburgh were accurate, reasonable and in line with the contractual agreement between Consort Healthcare and NHS Lothian.

12.3.1 It was noted that from the sample considered there were errors identified for the period covering 2015 to 2019 totalling £143,107 resulting in an understatement of the NHS Lothian revenue share of £71, 533. Ms Brown noted that this may not be the full extent of the potential understatement as it only reflected errors identified from the sample tested.

12.3.2 There was a requirement for more robust governance of the financial aspects of the contract between NHS Lothian and Consort due to the volume of inconsistent entries within the profit and loss statements since 2012. From the sample of minutes from the Performance Review Committee throughout 2017 and 2018 tested, it was noted that the committee was imbalanced with a large focus on performance but little on the financial aspect of car parking operations.

12.3.3 Members welcomed the proactive approach taken by line management in employing the Internal Audit team to investigate their concerns around contract with Consort in respect of parking.

12.3.4 The Committee discussed the commercial approach taken by consort in the running of the car park at the Royal Infirmary site. Ms Goldsmith acknowledged that cost of parking had remained steady over the years and the funds received by NHS Lothian were to offset the cost of having car parking at the site.

12.3.5 The action taken to establish a shadow team to oversee the contract managements was welcomed by the committee. The shadow team would have the financial, legal and technical skills required to oversee the work. The Corporate Management Team is going to review the management of public private partnership contracts. Mr Ash asked for a report to be provided to the August Audit & Risk Committee meeting to provide assurance that action is being taken on the internal audit recommendations. **SG**

12.3.6 The committee accepted the report.

12.4 Internal Audit Annual Report 2019/20 (June 2020) and Internal Audit Opinion – Ms Brown drew attention to the audit opinion detailed within the report. Noting that during the course of the review the Internal Audit Team concluded that overall, Internal Audit's work indicated that NHS Lothian has a framework of controls in place that provides reasonable assurance regarding the effective and efficient achievement of the organisation's objectives and the management of key risks.

12.4.1 The committee accepted the Internal Audit Annual Report 2019/20 and the internal audit opinion.

12.5 Internal Audit Planning 2020/21 – Ms Brown spoke to the previously circulated report. She noted that the internal audit plan for 2020/21 would be a fluid process going forward in preparation for a potential second wave of covid-19 and impact on services. Following review of the early plan shared with the Audit and Risk Committee in February 2020 (pre-Covid), the plan areas of focus for internal audit between July 2020 and September 2020. Approval of these areas would allow the internal audit activity to be continued, and ensure internal audit were focused on providing assurance, aligned to risk. The Committee agreed to support focussing on key internal controls (including IT controls), and Recovery plans. .

12.5.1 Ms Brown would take the plan to the Corporate Management Team to ensure that the areas identified were appropriate and aligned to the correct areas and identify suitable scopes to underpin the audits.

12.5.2 Mr Murray drew attention to the proposed audits for mental health and the health and social care partnerships. He requested that Ms Brown consider the perspective of the health and social care partnerships within the scope of the audits, recognising the importance of the partnerships contribution to delivering delegated services.

12.5.4 Members agreed the internal audit plan for 2020/21, subject to the plan being reviewed throughout the year as and when required.

13. Counter Fraud

13.1 Counter Fraud Activity for the year to 31 March 2020 – Mr Old spoke to the previously circulated Counter Fraud Activity report for the period to 31 March 2020. He drew the committee's attention to the delays to the impact assessment due to covid-19, work to develop an e-learning module with NHS Education Scotland and the promotion of CFS work across the organisation as a whole.

13.1.1 The Committee reflected on the cases in the report, and agreed that it needed assurance that lessons from these cases are learned and that the Board's systems of control are strengthened by that learning. Ms Goldsmith would follow the committee's concerns up with management and provide assurance at the August Audit and Risk Committee. **SG**

13.1.3 The Committee accepted the report.

14. Corporate Governance

14.1 National Services Audit Reports – the committee accept these reports from the service auditor as a source of significant assurance that there were adequate and effective systems of internal control relating to the National Single Instance financial ledger, and a source of moderate assurance with respect to Practitioner and Counter Fraud Services and National IT Services.

14.2 SFR 18.0 – summary of losses and payments for the year ended 31 March 2020 – Ms Howard introduced the previously circulated paper. She drew the committees attention to the summary of claims abandoned , highlighting that the claims had reduced following the implementation of new guidance. Under new rules there would be no invoice issued to overseas patients if an agreement to pay had not been reached in advance of receiving treatment.

14.2.1 Members welcomed the decrease of debt relating to English, Welsh and Irish NHS Bodies. They noted that debt has decreased significantly from £716k in 2018/19 to £267k. The previously reported ongoing dispute which resulted in NHS Lothian taking NHS England to court accounts for the majority of the reduction. There was still a small amount, £12k with debt collection agencies with the remaining balance being actively pursued by the team.

14.2.2 The Committee discussed an outstanding debt relating to the Scottish Orthopaedic Research Trust into Orthopaedic Trauma. Ms Goldsmith confirmed that action was being taken to resolve this. . **SG**

14.2.3 The Committee accepted the report as a source of significant assurance that the Board has adequate and effective systems of control relating to losses and special payments, and that management are continually reviewing and evaluating changes to improve those systems.

14.3 Edinburgh & Lothian's Health Foundation Annual Report and Accounts 2019/20 - The committee noted that there had been a review of the charitable funds and that they were found to be a clean set of accounts, and there had been no issues raised.

14.3.1 The Committee accepted this report as a source of significant assurance that management have prepared the Annual Report and Financial Statements of the Foundation for 2017/18, Scott-Moncrieff had carried out an external audit of the accounts, and had provided an unqualified audit opinion.

15. Annual Accounts (decision)

15.1 Governance Statement

15.1.1 The Committee accepted this report as a source of significant assurance that the process to develop the Governance Statement was consistent with the associated instructions and good practice.

15.1.2 The Committee reviewed the Governance Statement, did not identify any further required disclosures, and agreed it should be included in the annual accounts.

15.2. Management Representation Letter

15.2.1 The Committee reviewed the draft Representation Letter to the external auditors confirmed that the statements represented confirmation to the external auditors on matters arising during the course of their audit of the accounts for the year ended 31 March 2020, and agreed to recommend that the letter be signed by the Chief Executive of NHS Lothian.

15.3 NHS Lothian Draft Audit Management Report for the year ended 31 March 2020

15.3.1 Mr Brown gave an overview of the report highlighting how the report was collated, key findings and the audit certificate. They noted that they were submitting a draft management report following the impact of Covid-19 on the process. He advised the committee that the audit of the annual accounts had been separated from the wider scope of the audit to ensure the sign off of the annual accounts by the June 2020 deadline.

15.3.2 Mr Brown drew the committee's to the emphasis of matter in the independent auditor's report to note 1 accounting policies 30' key sources of judgement and estimation uncertainty' of the financial statements. He noted that this section described the effects of a material uncertainty, caused by COVID-19, on the property valuation report. He advised that the statement would not modify the unqualified opinion.

15.3.3 Mr Eardley advised that outstanding evidence and been received and the wider audit of NHS Lothian's process would move to final stages in due course. Work to cross reference and double check following transposing the excel accounts to word would commence shortly.

15.3.4 Mr Brown confirmed that the annual report process would reflect on the section 22 notice.

15.3.5 The Committee accepted the report as a source of assurance to inform its review of the annual accounts.

15.4 NHS Lothian Annual Accounts for Year End 31 March 2020

15.4.1 The Committee agreed to recommend to the Board that they adopt the Annual Accounts for the year ended 31st March 2020 and recommend to the Board to authorise the designated signatories to sign the Accounts on behalf of the Board.

15.5 Audit Committee Annual Report and Assurance Statement 2019/20

15.5.1 The Committee approved the annual report and assurance statement 2019/20.

16. Any Other Competent Business

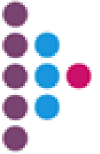
16.1 Chair of Audit and Risk Committee – It was noted that Mr Connor would be take on the role of Chair of the Audit and Risk Committee from August 2020. Members thanked Mr Ash for his contributions as Chair of the Audit and Risk Committee over the years. Mr Ash expressed his thanks to members for their work and support in running the committee during his term as Chair of the Audit and Risk Committee. He wished Mr Connor well in his new role as Chair of the Audit and Risk Committee.

17. Date of Next Meeting

17.1 Ms Goldsmith would liaise with Mr Marriott, Mr Connor and Ms Brown to consider whether there would be an additional meeting of the Audit and Risk Committee in July 2020 to discuss the final Internal Audit report on the Royal Hospital of Children, Young People and the Department of Clinical Neurosciences.

17.2 The date of the next meeting would be confirmed in due course.

Chair Signed 31/07/2020

Edinburgh Integration Joint Board 

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 28 April 2020

Held remotely by video conference

Present:

Board Members:

Angus McCann (Chair), Councillor Ricky Henderson (Vice-Chair), Councillor Robert Aldridge, Mike Ash, Colin Beck, Carl Bickler, Councillor Phil Doggart, Helen FitzGerald, Councillor George Gordon, Kirsten Hey, Councillor Melanie Main, Moira Pringle, Judith Proctor, Ella Simpson and Richard Williams.

Officers: Ann Duff, Rachel Gentleman, Lauren Howie, Gavin King, Jenny McCann, Angela Ritchie and David White.

Apologies: Andrew Coull, Christine Farquhar, Martin Hill, Jackie Irvine, Ian McKay and Peter Murray.

1. Minutes

Decision

1) To approve the minute of the meeting of the Edinburgh Integration Joint Board of 4 February 2020 as a correct record.

2) To approve the minute of the meeting of the Edinburgh Integration Joint Board of 14 April 2020 as a correct record.

3) To note the minute of the meeting of the Futures Committee of 21 October 2019.

4) To note the minute of the meeting of the Audit and Assurance Committee of 8 November 2019.

5) To note the minute of the meeting of the Clinical and Care Governance Committee of 14 November 2019.

6) To note the minute of the meeting of the Performance and Delivery Committee of 20 November 2019.

7) To note the minute of the meeting of the Strategic Planning Group of 14 January 2020.

8) To note that the Chair would arrange a meeting of the committee chairs to discuss the approach to reporting of committees to the Board.

2. Rolling Actions Log

The Rolling Actions Log for April 2020 was presented.

Decision

1) To close the following actions:

- Action 2 (point 1) - Primary Care Transformation Programme
- Action 3 – Evaluation of 2018/19 Winter Plan
- Action 6 – Rolling Actions Log re. NHS Lothian Board Escalation
- Action 10 - Rolling Actions Log – Integrated Older People's Service
- Action 12 – Finance Update

2) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted.)

3. 2020/21 Financial Plan

The report provided information on the financial plan for 2020/21 and the progress towards a balanced position for the year. It was noted that a number of workshops had been held with members to discuss the plan and the savings and recovery programme, but that the response to the Covid-19 pandemic had impacted progress and the level of certainty in relation to costs.

Details of the proposed savings and recovery programme required to support the balanced budget were attached to the report. A further update would be provided at the next meeting.

Decision

1) To note the budget offers from the City of Edinburgh Council and NHS Lothian.

2) To note the resultant financial plan based on the revised delegated budgets and expenditure forecasts.

3) To agree savings proposal 6 (external supported accommodation for older people) and to agree that a session would be arranged to allow members to fully scrutinise the proposal.

4) To agree that officers would further develop the other schemes in the proposed savings and recovery programme, including information on the risks and impact of additional costs, before being brought back to the IJB for approval prior to implementation.

5) To agree to receive an update on progress made towards balancing the financial plan at the next meeting.

6) To note that the Chair would discuss the governance processes relating to financial planning with officers with a potential review of these in autumn 2020.

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

4. Provision of General Medical Services – Edinburgh South

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

Approval was sought for the re-provision of Dalkeith Road and Boroughloch Medical Practices in fit for purpose accommodation. If approved, the Initial Agreement, attached to the report, would progress to NHS Lothian's Finance and Resources Committee for consideration.

During discussion, it was noted that the proposal had been previously considered by the Chair and Vice-Chair in terms of Standing Order 15.

Decision

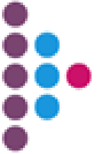
1) To agree the proposal to re-provide Dalkeith Road Medical Practice and Boroughloch Medical Practice in fit for purpose accommodation.

2) To note that NHS Lothian invited Edinburgh Health and Social Care Partnership (EHSCP) to submit an Initial Agreement for this proposal following the conclusion of the 2019-20 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 further information on how the renovation of the buildings could be carried out in line with the sustainability aims of the City Plan 2030.

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

Edinburgh Integration Joint Board 

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 16 June 2020
Held remotely by video conference

Present:

Board Members:

Angus McCann (Chair), Councillor Ricky Henderson (Vice-Chair), Councillor Robert Aldridge, Mike Ash, Eddie Balfour, Colin Beck, Carl Bickler, Andrew Coull, Councillor Phil Doggart, Christine Farquhar, Helen FitzGerald, Councillor George Gordon, Kirsten Hey, Martin Hill, Councillor Melanie Main, Ian McKay, Peter Murray, Moira Pringle, Judith Proctor, Ella Simpson and Richard Williams.

Apologies: Jackie Irvine and Jacqui Macrae

1. Ongoing Procurement Exercises

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

The Board considered a report which sought approval to defer a decision on the award of contracts for Carers and Thrive to the Board meeting on 21 July 2020. If approved, the investments would be able to be considered in the context of the overall financial position which remained unbalanced and required significant measures to deliver further savings to address the gap.

Decision

To agree to postpone the awarding of new Carer and Mental Health (Thrive) contracts associated with new investment. This would allow them to be considered in the wider context of the financial plan which would be presented to the EIJB on 21 July 2020.

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

Declarations of interest

Ella Simpson declared an interest in the above item as EVOC worked with organisations affected by procurement decisions.

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within BLACKBURN PARTNERSHIP CENTRE, ASHGROVE, BLACKBURN, EH47 7LL , on 10 MARCH 2020.

Present

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

Non-Voting Members – Allister Short, David Huddlestone, Mairead Hughes, Jo MacPherson, Alan McCloskey, Caroline McDowall, Martin Murray and Patrick Welsh

Apologies – Harry Cartmill, Alex Joyce, Ann Pike and Rohana Wright

Absent – Elaine Duncan

In attendance – Yvonne Lawton (Head of Strategic Planning and Performance), Pamela Main (Senior Manager, Assessment and Prevention) and James Millar (Standards Officer)

1 DECLARATIONS OF INTEREST

There were no declarations of interest made.

2 MINUTE

The Board approved the minute of its meeting held on 21 January 2020. The minute was thereafter signed by the Chair.

Matters arising:

Item 5 Strategic Commissioning Plans

A Community Wellbeing Hubs data collection update was provided and it was noted that the IT system was being upgraded and would be tested at the end of April.

Item 9 Communication and Engagement Strategy

Engagement with stakeholders was ongoing. It was agreed that a report would be brought to the Board within the next six months providing a summary of engagement with stakeholders and assessing success of the strategy.

Brand identifiers from other HSCPs would be circulated to members, and members were asked to consider them and provide comment at the next meeting.

3 MINUTES FOR NOTING

The Board noted the minutes of the following meetings:

- West Lothian Integration Joint Board Audit, Risk and Governance Committee held on Wednesday 11 December 2019.
- West Lothian Integration Joint Board Strategic Planning Group held on 12 December 2019.
- West Lothian Integration Joint Board Strategic Planning Group held on 20 February 2020.

4 MEMBERSHIP & MEETING CHANGES

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

5 STYLE OF MINUTES

The Board considered a report (copies of which had been circulated) by the Standards Officer proposing a new approach to the preparation of minutes of the Integration Joint Board and its committees, which was presented to the Board for approval.

It was clarified during discussion that minutes were intended primarily for recording decisions; however, members were assured that any significant advice would continue to be recorded in minutes.

It was recommended that the Board agree the new approach to the preparation of minutes of the Integration Joint Board and its committees as outlined in the report.

Decision

To approve the recommendation in the report.

6 WEST LOTHIAN IJB 2020/21 BUDGET - FINANCIAL ASSURANCE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer setting out the outcome of the financial assurance process on the budget contributions West Lothian Council and NHS Lothian had identified to be delegated to the IJB for 2020/21, and seeking approval for the issue of Directions to partner bodies for delivery of 2020/21 delegated functions in advance of 1 April 2020.

Comparable figures to the previous financial year were requested, while it was clarified that the budget contributions were intended to support delivery of the Commissioning Plans and matching demand to budget. To this end, the Chief Finance Officer undertook to provide the previous year's figures to members.

Discussion then highlighted the overspend observed at the end of each financial year and the need for strategic ways to address it. Variables such as the current issues of Brexit and the coronavirus threat might have significant impact on services and should be monitored on an ongoing basis. Finally, the substantial level of savings required was noted.

It was recommended that the Board:

1. Note the financial assurance work undertaken to date on Partner budget contributions;

2. Agree that council and NHS Lothian 2020/21 budget contributions be used to allocate funding to Partners to operationally deliver and financially manage IJB delegated functions from 1 April 2020;

3. Agree that the Directions attached in Appendix 5 to this report be issued to West Lothian Council and NHS Lothian respectively;

4. Agree that an updated IJB medium term financial plan should be provided to the Board on 30 June 2020 covering the three-year period to 2022/23; and

5. Agree the updated IJB Annual Financial Statement attached in Appendix 6.

Decision

To approve the recommendations in the report and to include and agree an additional recommendation as follows: Comparison figures from the same stage in the previous financial year with commentary to be provided to members before the next meeting of the Board.

7 MEMBERSHIP REVIEW

The Board considered a report (copies of which had been circulated) by the Chief Officer reviewing membership of the Integration Joint Board, its Audit Risk and Governance Committee, its Health and Care Governance Group and the Strategic Planning Group.

The Standards Officer referred members to legislation relating to IJBs, which only allows IJB members to sit on its committees, and advised that the Audit Risk and Governance Committee membership could be expanded from existing IJB members. It was then agreed that ways to include co-opted members in the Audit Risk and Governance Committee membership were to be further discussed and determined.

It was recommended that the Board note the outcome of the membership review, specifically:

1. Note that three council voting-members were coming to the end of

their three-year terms and the council would consider appointments before their terms expired;

2. Agree the IJB membership remained appropriate at this time;

3. Agree to appoint an independent member to the Audit Risk and Governance Committee;

4. Agree the Health & Care Governance Group membership remained appropriate at this time;

5. Note that the Strategic Planning Group was seeking to fill vacant positions for up to four service users;

6. Agree to an amendment of the SPG Terms of Reference that reflected the decision of the Board in March 2017 giving status to the third sector interface as a member in their own right; and

7. Note that the membership review would be repeated in one year.

Decision

1. To approve the recommendations in the report, with the exception of recommendation 3, which was to be further discussed.

2. To determine a way to include co-opted members in the Audit, Risk and Governance Committee membership.

8 TIMETABLE OF MEETINGS 2020/21

A proposed timetable of meetings for 2020/21 session, including development session dates, as well as a proposed timetable of meetings for the Strategic Planning Group had been circulated for approval.

Decision

To approve the 2020/21 timetable for IJB, including development sessions; and to approve the 2020/21 timetable for SPG, subject to correcting '31 July' to '30 July'.

9 CHIEF OFFICER REPORT

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

In response to a relevant question, the Chief Officer advised that the delayed discharge position remained a priority and acknowledged the need for its improvement as a matter of urgency. Discussions with Hospital officers in relation to St John’s Hospital front door were also ongoing.

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 contents of the report.

10 SCOTTISH DRAFT BUDGET REPORT

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update in relation to the Scottish Draft Budget presented to the Scottish Parliament on 6 February 2020.

It was recommended that the Board:

1. Note the issue of the Scottish Draft Budget 2020, which included departmental spending plans for 2020/21;
2. Note the key economic and financial implications at a Scottish public sector wide level resulting from the Draft Budget;
3. Note the funding implications for Local Government and Health Boards resulting from the draft 2020/21 Scottish budget;
4. Note that the IJB Chief Officer and Chief Finance Officer had worked with NHS Lothian and West Lothian Council to assess the impact of the Scottish Budget and the funding related to the 2020/21 financial contribution to the IJB from partner bodies; and
5. Note that taking account of the draft Scottish Budget, the IJB Chief Finance Officer had provided a financial assurance report to this meeting of the Board setting out the current 2020/21 IJB budget position.

Decision

To note the recommendations in the report.

11 IJB FINANCE UPDATE AND QUARTER 3 FORECAST

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2019/20 budget forecast position for the IJB delegated health and social care functions based on the outcome of the Quarter 3 monitoring.

It was recommended that the Board:

1. Note the forecast outturn for 2019/20 in respect of IJB Delegated functions taking account of saving assumptions; and

2. Note the current position in terms of year end management of partner overspends and underspends, consistent with the approved Integration Scheme, to allow the IJB to achieve a breakeven position in 2019/20.

Decision

To note the recommendations in the report.

12 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 implementation of the Care at Home contract awarded on 1 October 2019.

During discussion, it was noted that the current model and level of investment in care at home were considered appropriate but were continually monitored and reviewed. Recruitment remained a major challenge and consideration was given to exploring a range of options that would encourage increased recruitment to social care posts. A meeting with senior officers had also been arranged to discuss Unison's Ethical Care Charter. The Board requested a further update in six months.

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

Decision

1. To note the recommendation of the report.

2. A further update to be brought to the Board in six months' time.

13 SELF-EVALUATION ACTION PLAN - PROGRESS UPDATE

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

It was noted that progress shown against the action plan might be amended depending on the recommendations of the strategic inspection that the West Lothian Health and Social Care Partnership was currently undergoing. The new Health and Care Transformation Board was also discussed, as well as ways to identify and apply good practice.

It is recommended that the Board:

1. Note that the Ministerial Strategic Group for Health and Community Care had requested that every Health Board, Local Authority and Integration Joint Board jointly submit a self-evaluation of progress

with integration to the Scottish Government and an associated plan for improvement;

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

3. Note the progress made against the agreed actions.

Decision

To note the recommendations in the report.

14 WORKPLAN

A workplan had been circulated for information.

Decision

To note the workplan.

NHS LOTHIAN

Board
12 August 2020

Chair

APPROACH TO FUTURE BOARD MEETINGS

1 Purpose of the Report

1.1 This report sets out proposals to maintain the Board's approach to governance while the organisation is dealing with the COVID-19 pandemic. The aims of this are:

- The organisation can effectively respond to COVID-19, and discharge its governance responsibilities.
- The organisation maximises the time available for management and operational staff to deal with COVID-19.
- The organisation minimises the need for people to travel to and physically attend meetings.

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

2 Recommendations

The Board is recommended to:

2.1 Agree that the Board will continue not to convene its Board meetings in public up to and including its meeting on 9 December 2020, for the 'special reason' of protecting public health, and the health and wellbeing of anyone who would have otherwise attended the meeting.

2.2 Agree that for the duration, all Board and committee meetings will be carried out by TEAMS or in any other manner which does not require the members and staff to physically meet.

2.3 Agree to delegate authority to the Chair to review the situation and determine whether or not Board meetings should be convened in public after 9 December 2020, or earlier if circumstances materially change.

2.4 Agree to revert to bi-monthly Board meetings from August 2020, with the slots in the intervening months being used for development/ planning/performance.

2.5 Agree the dates for Board meetings and development/ planning/performance sessions in 2021.

3 Discussion of Key Issues

3.1 The Public Bodies (Admissions to Meetings) Act 1960 requires NHS Board meetings to be held in public. However Section 1(2) of that Act states:

‘2)A body may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Act shall not require the meeting to be open to the public during proceedings to which the resolution applies.

3.2 NHS boards also have other legal duties to protect public health. In light of the preventative measures put in place across the country, including social distancing, it is not appropriate to convene public meetings. The Board agreed in April 2020 to stop holding public Board meetings up to its June 2020 meeting, and then review the situation after that point.

3.3 The Scottish Government maintains guidance on its website, and the following is drawn from the guidance as at 15 July 2020:

- There are regulations which stop certain gatherings in place for the next 6 months.
- People are required to wear face coverings in closed spaces.
- Physical distancing, hand hygiene, and respiratory hygiene are the most effective things we can do to control the spread of the virus.
- Public gatherings are prohibited apart from a few specified exceptions. People should try to minimise physical meetings for work purposes.
- Working at home should remain the default position for those who can do so.

3.4 Taking into account the above, it is recommended that the Board does not reconvene public meetings at this point. The experience of the past few months has shown that the Board can conduct its business by virtual meetings. It is proposed that the Board reviews the situation again after its meeting on 9 December 2020. The Chair will monitor the situation and review this earlier if circumstances materially change.

3.5 The Board members have been considering the need to continue with monthly Board meetings, recognising that the time slots could be used in different ways. It is proposed that the Board revert to bi-monthly Board meetings (August, October, December 2020), and to use the September and November slots to hold sessions on development/planning/performance. All Board members are encouraged to attend these sessions.

3.6 The following dates are proposed for 2021 meetings of the Board and development/planning/performance sessions (all starting at 0930):

Board Meetings	Development/ Planning/ Performance Sessions
Wednesday 3 February 2021	Wednesday 6 January 2021
Wednesday 7 April 2021	Wednesday 3 March 2021
Wednesday 23 June 2021	Wednesday 5 May 2021
Wednesday 4 August 2021	Wednesday 1 September 2021
Wednesday 6 October 2021	Wednesday 3 November 2021
Wednesday 1 December 2021	

3.7 The Corporate Governance Team is working with colleagues to develop the timetable for committee meetings, and this will be presented to a future Board meeting for

approval.

4 Key Risks

4.1 Executive Board members and other managers cannot attend governance meetings due to the need to attend to operational matters, or are absent due to illness.

4.2 Meetings do not achieve their quorum due to illness within the membership.

4.3 The organisation convenes meetings in a manner which is contrary to current guidance on COVID-19, which increases the risk of spreading the virus.

5 Risk Register

5.1 This report relates to how the whole system of governance operates, and so is relevant to all risks on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

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

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

7.1 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. However the organisation has already communicated the change of practice for Board meetings to the public. The Board has continued to publish its public meeting papers on its website in advance of the meetings, and will continue to do so.

7.2 The Scottish Government's Health Finance, Corporate Governance and Value Director wrote to Board chairs on 28 July 2020. The letter recognises the desire to return to giving the public and media reasonable access to Board meetings as soon as possible. However there is a need to respect physical distancing, and a desire to take forward a 'Once for Scotland' approach in all Boards. The national Corporate Governance Steering Group is considering this issue, and Boards have been asked to wait until a consistent approach has been agreed before making any changes. NHS Lothian will consider the national approach once it has been issued.

8 Resource Implications

8.1 There are no new resource implications from continuing to meet virtually.

Alan Payne
Head of Corporate Governance
28 July 2020
alan.payne@nhslothian.scot.nhs.uk

LOTHIAN NHS BOARD

Board
12 August 2020

BOARD EXECUTIVE TEAM REPORT

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. 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

Unscheduled Care: NHS Lothian's Chief Executive and the Chief Executive of NHS 24 with The Scottish Government's Unscheduled Care Director are in discussions regarding the practical implications of implementing the Conceptual Framework for Urgent Care – *Appendix 1*. The conceptual framework proposes a process that aims to increasingly schedule demands of unscheduled care. This requires the adoption of new models to support urgent and emergency care across the wider healthcare system, encouraging joined up pathways and models of response to unscheduled care, involving GP In-hours, NHS24, GP Out of Hours, Emergency Departments and the Scottish Ambulance Service (SAS). The potential safety gains of a more controlled approach to unscheduled care attendance to any healthcare setting will be significant. It would help reduce overcrowding and minimise unnecessary face to face contact and would be an important factor in reducing winter pressures, and any additional COVID 19 pressures that emerge in the future.

Ministerial Review: The Ministerial Review will take place on Monday 16 November 2020 by video link.

The Annual Review remains an important part of the accountability process for the NHS, and Ministers hold appropriate sessions with each Board during autumn.

Each session will last up to 90 minutes long, which will be chaired by a Minister, and held with the Chair and Chief Executive of each Board.

2. Deputy Chief Executive

System Wide Performance Framework: I am currently evolving our system wide (Corporate) Performance Framework which will include; aligning the performance approach with our Board missions and objectives, developing standardised agendas, renewing system performance cycles and refreshing the content within Board Performance Reports. We are currently engaging key stakeholders in the development of this and recently held our first performance review in this draft format with Acute services. I am using our learning from this meeting/review to strengthen and streamline

the process moving forwards. We expect the whole system performance programme to be launched in August.

Princess Alexandra Eye Pavilion: NHSL submitted an OBC for the proposed re-provision of Eye Services to EBQ, with an estimated capital cost of £86m including £3m 'collaboration space'. Although CIG accepted the clear need for change, to date the OBC has not been approved due to:

- Ongoing clarifications on the support at the SG for the proposed service model;
- The lack of a funding source at SG level, and uncertainty over the medium term capital funding position.

We are currently exploring options to update the proposal for changes in the service model, recognising the impact of COVID19 on service delivery, and the potential for other funding routes out with traditional public capital. Proposals when matured will be brought through Board Governance.

Short Stay Elective Centre: The Business Case has been approved by Scottish Government and NHSL have been invited to work towards submission of the Full Business Case. The Finance and Resources Committee have agreed to fund a feasibility study to review building design. Accordingly, work is underway to review the geometric arrangement of the design to ascertain if NHS Scotland Review Design Process (NDAP) queries can be addressed and certain design compromises improved. High level design concepts have been reviewed and are in the process of being consulted upon with clinical and service colleagues. The options will be weighted and scored for assessment of suitability and affordability. A considerable amount of engagement has been undertaken already, including; a public survey, Integrated Impact Assessment, Stakeholder Events, design workshops and the establishment of a collaborative working group with representatives from patients, the public and 3rd sector organisations. To assist in the design feasibility, review a Clinical brief and Technical Design Brief are in preparation, this will be completed prior to instruction on commencement of Stage 3 design work. I am keen to ensure the recommendations of the Internal Audit Report; Governance & Internal Controls, RHCYP & DCN are a central component to the progress of this important initiative and will evolve thinking on this for future discussions at relevant committees.

Edinburgh Cancer Centre (ECC): Through a series of workshops and meetings, a vision for the future of cancer services was developed and agreed: “To develop a world class specialist cancer centre and service on behalf of the region – and nation. To be recognised as a world leading centre for cancer research, innovation and clinical academic opportunities”.

The ECC presents the opportunity to transform the pathway for cancer patients from across the South East Region by delivering a robust, sustainable Regional Service Delivery Model which addresses the rising demand for cancer services across the Region. The planning horizon of five to seven years for the centre provides an adequate timeframe to develop services, workforce and technology plans in order to gain short and medium term benefits as well as ensure that when the new centre opens its doors the necessary infrastructure is already in place.

There are areas for further development within this, including; proximity and access to essential services (Critical Care, Pharmacy, Laboratories, Imaging) and accessing diagnostic testing in a timely manner through a Rapid Diagnostic Centre. In the knowledge that development of a new Edinburgh Cancer Centre would take several years, three capital programmes of work are currently underway in order to sustain Cancer Services until 2025.These projects are; the Haematology Capital Programme (£13m), the Oncology Enabling Capital Programme (£20.6m) and the Clinical Trials Capital Programme (£1m).

RIE Temporary Parking Expansion: Prior to the COVID-19 pandemic, work was already ongoing to review the parking situation across the three acute NHS Lothian sites. In 2018, demand was increasingly rising for spaces across these major sites and as a result a refreshed permit allocation system was initiated across all sites; permits are chargeable for staff at the RIE due to the PFI status. In March, it was announced by the Scottish Health Secretary Jeane Freeman that NHS boards will no longer have to pay for parking from Monday 30 March, something which is likely to be extended until the end of the year and potentially beyond. Many of the capacity issues at the RIE are created by more staff bringing cars to the campus than the 60% of spaces pre-agreed with the local authority. The permit system was originally intended to manage the number of staff parking on site, however some staff still chose to pay the full daily parking tariff and fill up the public spaces to the point where the public cannot get access to the car parks and gridlock is the result. With free onsite parking, reduced public transport (capacity and usage) and a relaxed permit system, staff bringing cars on site has increased. In addition, both the Department of Clinical Neuroscience (DCN) and Children's Hospital staff have gradually started to move onto the RIE site, potentially bringing an additional 200 staff and 220+ outpatients on site per day. The preferred option is to extend an existing car parking plot, with a minimum of 250 spaces for an estimated lifespan of three years. The Business Case will be reviewed at August's LCIG, with a view to then begin the procurement process. From the date of receiving planning permission, the estimated timeline for completion (first car on the car park) is 15-24 weeks. ScotGov are supportive of this project and subject to local NHS Lothian Governance have agreed to fund this project (costs estimated £770k). The key risk to delivery at present is the approval of planning permission (through a temporary route) from local authority colleagues.

3. Executive Director of Nursing, Midwifery, & AHPs

Work in relation to supporting care homes continues to progress. Almost all 109 older people's homes have had a supportive visit. PPE and infection prevention control continue to be the main themes that are being identified. We will be exploring nationally and locally what support is required from Nurse Directors in this space beyond 30 November given this was the initial ask.

Work continues across NHS Lothian in relation to the provision and safe use of personal protective equipment (PPE). We are now planning with winter in mind as well as some potential constraints nationally in relation to some FFP3 masks.

We have had a very successful round of student nurse recruitment which means that our current vacancy levels will be below 5%, almost 4%. This is positive from a staffing

and a patent safety perspective and means our dependency of Agency and Bank spend should reduce.

Our new AHP Director, Dr Heather Cameron and I are progressing the development of the strategic plans for the development of the AHP workforce and will align this with the development of our clinical model.

We have appointed two new senior nurses Caroline Craig as Head of Nursing to support our work on Standards and Quality of Care and Jenni Macdonald, Lead Nurse for Tissue Viability. We will be recruiting to our Director of Midwifery post imminently due to retirement.

4. Medical Director

- Participation in discussion at national and local level about mechanisms to redesign urgent care and visit to the Same Day Emergency Centre pilot at WGH.
- Action to progress chronic disease monitoring as part of primary care remobilisation by circulation of guidance developed by the Quality team and discussions about opportunities for telemonitoring.
- Support of clinical prioritisation.
- Recommencement of robotic surgery programme in colorectal surgery.
- Next steps discussion for the ethics support group convened during Covid.
- Visit to DCN and RHCYP following the move of services, with clinical discussion about the necessary conditions to commence thrombectomy.
- Go live for HEPMA in Orchard Clinic in REAS and on site to visit to team.

5. Director of Finance

Inevitably the completion of the RHSCYP/DCN remains a significant focus and preparing for full occupation a priority. A catch up with some of the Project team as DCN fully migrated was a very positive way to end a week. Although the original team is much depleted there are some members who have been involved in the Project for over 12 years, and their relief and pleasure of seeing Clinical staff in the building was evident.

A number of us also met with IHSL and Bouygues to review progress with the changes in the building, and to ensure that as the hospital is slowly occupied, clinical staff are clear about the process for raising any concerns about the building.

With many of the Finance team working on remobilisation and a complex Quarter 1 review, it is a busy time. That said the Finance team continues to progress their work on the departmental modernisation programme. The change programme is broadly split into two themes:

- Process and Product Improvement – Within this, a number of areas have been prioritised to simplify and streamline processes (such as Income collation and Forecasting), as well as deliver enhancements to the finance products available (including the ongoing development of Patient level costing (PLICS), Finance Online, dashboard visualisation of financial performance and IJB reporting). So far, the dashboard visualisation work has now concluded, with improvements to forecasting processes nearing completion. PLICS has kick-started again with a new contract and supplier arrangement just recently agreed;

- Transformational Change – This is a fundamental review of the finance function and the service it delivers. A significant programme of work which is assessing the function of the department now, the plan for the future, and the arrangements necessary to move to this future state. This will likely require changes to working practices and additional training for finance staff, and Partnership and the wider finance team are fully engaged with the process.

I also met with South East Directors of Finance, with the Regional Director of Planning, following a lull in meetings. This was productive and we plan to meet routinely again in support of the wider Regional agenda

6. Director of Human Resources and Organisational

Our 5 point action plan in response to issues raised by our Black and Minority Ethnic (BME) Staff Network has been well received to date. Our commitment to advancing our race equality programme, listening to the lived experience of our staff and the importance of working with and through our staff network will be explored further when the Chief Executive and myself attend BME staff network sessions later in August.

The Scottish Public Services Ombudsman has confirmed to NHS Boards that the implementation of the National Whistleblowing Standards and the introduction of the Independent National Whistleblowing Officer will not take place in July 2020 and that a revised implementation date will be announced soon. Meantime the Boards extant Whistleblowing Policy will remain in place.

At the July Staff Governance Committee meeting we received a positive update from the Boards Speak Up Ambassadors on the successes of our Speak Up Service since it launched in July 2019.

As we remobilise our services we are paying particular attention to supporting our staff wellbeing. A key component to staff wellbeing in the coming months will continue to be psychological support in response to potential accumulative burnout related to Covid-19. In addition to this it is recognised that there is likely to be a high prevalence of non-Covid 19 related trauma in health and social care staff. A proposal has been developed to augment our core Occupational Health provision to include a psychological support service. We are also working in partnership with the Edinburgh and Lothian Health Foundation regarding the development of a Strategic Staff Wellbeing Framework.

In line with Scottish Government policy and to protect vulnerable patient groups from 8th July we commenced a programme of testing asymptomatic staff in the following areas: cancer services, long stay care of the elderly and long stay old age psychiatry & learning disabilities.

7. Director of Public Health and Health Policy

The Public Health update on COVID-19 outlines the directorate's focus over the past month and includes a detailed report on shielding. Several other, serious infections are also starting to be reported again and investigated. Despite COVID-19, the response to the MMR summer catch up for children and young people who have missed out on being fully vaccinated has been excellent. So far, of 3000 people identified, 735 have had

appointments offered, with only 21 cancellations. Prior experience tells us that others have been immunised but that the information is missing from their record and the catch-up letter provides the opportunity to update it.

Our other public health programmes and the services with which we work closely are increasing again. We are examining how to work effectively in a COVID secure way to address our other priorities for improving health and reducing inequalities.

In terms of research and development, a small, expert team has been given delegated Caldicott authority to approve research proposals on a risk assessed basis. The NHS Lothian/University of Edinburgh dataloch partnership has undertaken analysis and provided advice to the Scottish Scientific Advisory Committee. We have participated in vaccine trials and in the study of the acute and longer-term health consequences of COVID. There are regular, accessible seminars and discussion on social media of key findings and work in progress. A separate report will be available at a future meeting.

8. Chief Officer Acute Services

Remobilising services on a phased clinically prioritised basis is a key focus for acute. This includes restarting routine activity where the service has met their urgent demand. The impact of physical distancing, PPE and cleaning regimens has had a significant impact on capacity and activity and services are looking at risk assessed mitigating actions to increase activity, including building on the use of technology enabled care.

A programme to 'Scheduling unscheduled' care to safely reduce demand at the front doors is a national strategy and locally will build upon the success of Covid hub and flow centre processes. This will be a key strategy to cope with winter unscheduled demand

The move into the new RHCYP/DCN have been really positive for patients and staff. All of DCN services have been relocated, following a phased move of Outpatients on 12th May and remaining services in week beginning 13th July.
Paediatric Outpatients starting moving into the new hospital week beginning 20th July and by week beginning 17th August 70% of all out-patient clinics will have relocated . The remaining 30% will move when inpatient service and hospital move takes place.

9. Director of Improvement

Work on the recovery and renew agenda is continuing with a focus on locking in positive change in the light of Covid-19.

I commissioned a survey of senior leaders from the OD and QI team to understand learnings from Covid-19, with 28 leaders contributing, findings are being synthesised to inform our future strategic direction. In tandem, we have been developing initial plans for a broader engagement programme with the public, patients and staff.

Work progresses on the digital first agenda. I supported our Mental Health team to develop their digital vision and secure initial funding to build on their rapid progress at switching to NearMe and virtual clinics. This approach is being rolled out across other divisions in Lothian, with over 300 staff participating in MS Team workshops I chaired on the future of outpatients. Following this I have been leading a team to support

digitally enabled outpatient redesign, this commenced in earnest in late July with initials visit to specialty teams at the WGH.

Jenny Long, our Unscheduled Care Programme Director and I have been re-establishing the unscheduled care programme post Covid with a number of proposals developed to support the scheduling of unscheduled care. This will be a priority going forward to Winter 20/21.

10. Director of Strategic Planning

The focus in June and July has been:

- Supporting COVID-19 activities locally and nationally – leading the implementation of Test and Protect locally and the transition to the national call centre in particular; care home testing; involved in multiple national groups giving oversight and trouble-shooting expertise; leading on NHSL physical distancing work; heavy involvement in national modelling work.
- Strategic – leading preparation of Remobilisation Plan 2, both locally and chairing the national working group on the production of these, ensuring "joined-up" thinking between territorial boards and national boards; preparing for revision process for NHSL strategy.
- The broader team have delivered the critical care surge plan, supported the implementation of NearMe, continued to develop the Major Trauma Centre, supported the establishment and running of the community COVID hub, developed the business cases for the Short-Stay Elective Centre and the Centre for Forensic and Laboratory Services, managed the establishment of the TTIS system locally, supported PPE management, and various other activities.

11. Director of Primary Care Transformation

Primary Care remobilisation plans have been completed. There is a separate plan for each service. The key parts will be included in the Board's overall remobilisation plan.

One key component is the flu vaccination plan for winter 20/21. An increase of around 63% in volume is expected through increased demand from existing cohorts and new cohorts to be added. This is c 163k additional vaccinations and will cost c £3m in addition to existing budgets. Since vaccinations were part of the activity to be removed from general practice under the new contract, each HSCP has developed a plan and there is a Lothian level plan under development to bring all the components together. There is still work to be completed on the details of delivery.

Activity in the Community Covid Pathway established on 23rd March has settled at low levels with a moving 7 day average of 44 patients being triaged and 1 being seen face to face. Activity is particularly low out of hours. The pathway will remain in place till end March 2021, but it is planned to merge with the GP Out of Hours Service (LUCS) in the out of hours period. The pathway can be stepped up as required if covid levels rise.

Information has been collected from all GP Practices on premises and IT implications of Covid 19. This will be used to develop immediate and longer terms plans for change and investment in general practice.

Work is underway following national announcements on reintroducing routine eye care (including eye examinations) to Community Optometry, no date has been set at the time of writing

There has also been a national decision to reintroduce urgent "aerosol generating procedures" into General Dental Services (where possible) for NHS patients from 17th August. Work has begun to develop a plan for this.

Community Pharmacies began to provide a new service "Pharmacy First" from 29th July. This enables pharmacists to see patients with a wider range of conditions and prescribe a range of medications for them. This enhances the role of community pharmacy and will play a significant part in enabling patients to access the right care quickly.

12. Director of Communications, Engagement and Public Affairs

Key media activity

We worked with the Evening News and Scotsman to create a wonderful memento piece for staff and teams at the Department of Clinical Neurosciences at the Western General Hospital before they moved to their new home at Little France. The photo stories featured theatres and staff and were used on the front page and in a double page spread. Photos and dedications were also used across social media, sparking touching engagement with staff and patients. A follow-up piece introducing their new home is in the pipeline.

Similarly, we worked with local TV, media and social to mark the move of children's outpatient services. A photographer was installed for moving days to capture their last days at Sciennes before they moved to Little France. A follow-up piece is being arranged for the next few weeks.

We have been working with TV, print and online media to promote remobilisation across NHS Lothian, including general and dental services and cancer trials. Coverage is being designed to show that while services are beginning to switch back on, it will be a careful process to ensure the safety of patients, staff and visitors.

Midlothian Health and Social Care Partnership featured in the BBC Disclosure documentary around care homes in Scotland during COVID-19, which required intense communications involvement.

New faces in the Comms team

The Communications team will say a fond farewell to two well known faces when Communications managers Clifford Burden and Alexis Burnett retire in August and September. Senior Communications Officer Nikki Lowry, who joined NHS Lothian last year and brought with her a wealth of experience from private and voluntary sector communications, has been promoted to fill one of the roles. She will be joined by another new team member later in the month, who also brings an impressive range of experience gained in public and private sector communications. The team is currently recruiting a new Senior Communications Officer.

Media monitoring

A media monitoring system is now in place for all board members. The daily service is also accompanied by a more detailed monthly analysis which will be provided shortly.

The Board is asked to note 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
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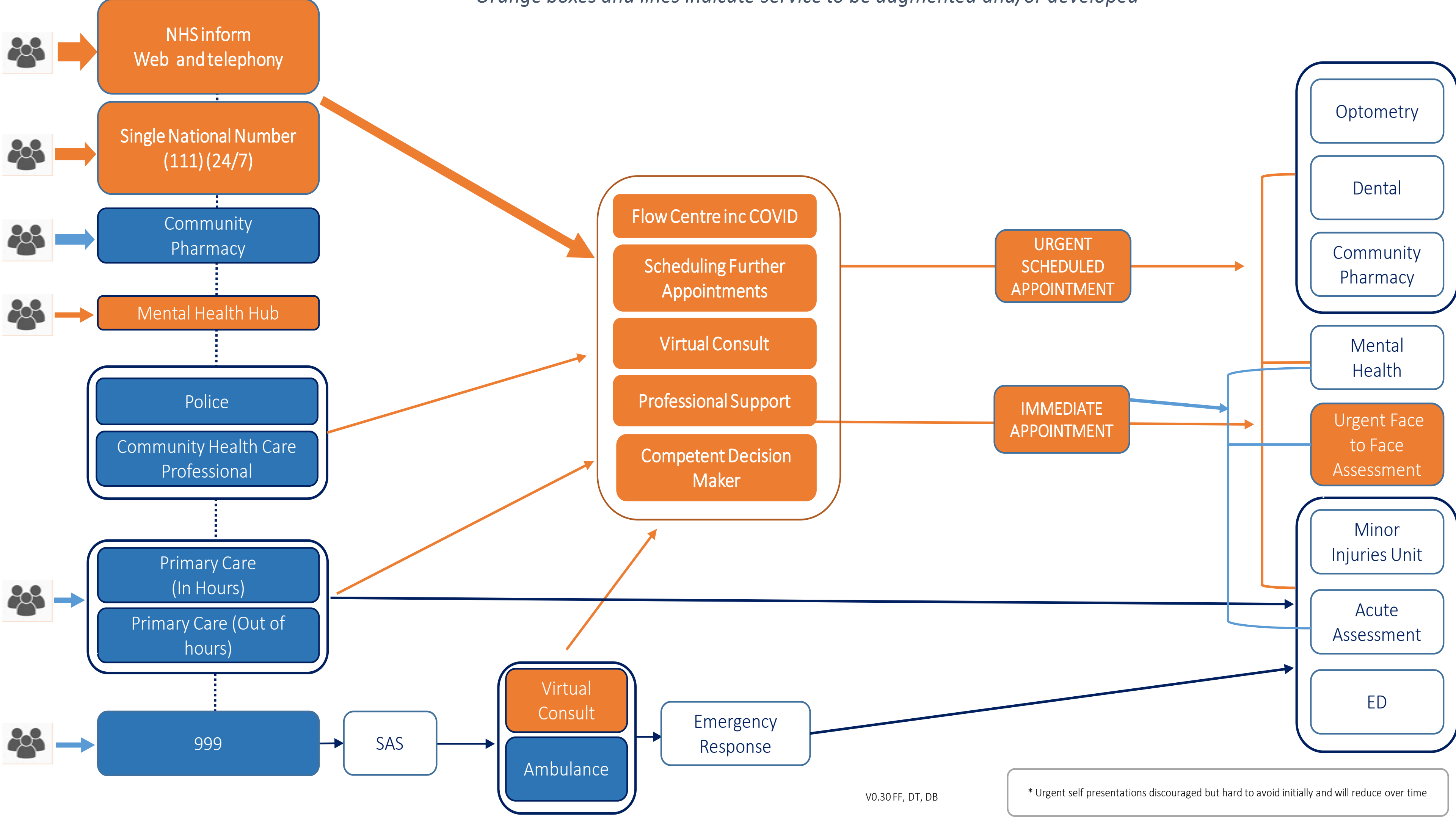


Appendix 1: Conceptual Framework for Urgent Care

NHS LOTHIAN

Board Meeting
August 12, 2020

Director of Public Health and Health Policy

COVID-19 PUBLIC HEALTH UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on the impact of the COVID-19 pandemic in Lothian.

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

2 Recommendations

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

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

2.3 To support the work required to develop an effective response to the Scottish Government route map, informed by the work of the Scottish Scientific Advisory and Public Health Advisory Structures that, together, aim to eliminate circulation of SARS-CoV-2, minimise the burden of COVID-19 on the Scottish population and reduce the risk of future large outbreaks.

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

2.5 To institute a plan to protect black and minority ethnic staff from avoidable exposure to risk from COVID-19.

2.6 To continue and intensify efforts to reduce the unintended consequences of the social distancing measures on individuals and families (e.g. income protection, improved access to food, wrap around services etc.) and to ensure that these remain available to all who need to self-isolate.

2.7 To support the ongoing, rapid redesign of existing programmes designed to improve health and address the wider determinants of health so that they anticipate and address the specific challenges that emerge as communities, local and national organisations respond to changes in the way we live, work and learn together in a world with COVID.

3 Discussion of Key Issues

Background

The pandemic continues to affect individuals and communities across the world. The table below shows cases and deaths associated with COVID-19 reported globally, in the UK and in Scotland from 31st December 2019.to 26th July 2020.

	Global	UK	Scotland
Cases to date	16,300,000	299,426	18,551
Deaths to date	649,000	45,752	2,491
Cases in past 28 days		17,330	315
Deaths in past 28 days		2,202	9

Table 1: Scotland, UK and global COVID-19 cases and deaths (Data sources: World: Google. UK: UK Govt. Scotland: Scottish Govt. 27 July 2020).

4 The pandemic in Scotland

4.1 In Scotland as of 27-Jul-20 numbers of persons tested, positive, proportion positive and deaths is shown in the table below.

	Persons tested	Tested positive	% positive
March	15,895	1993	12.5%
April	38,744	9360	24.2%
May	59,683	4047	6.8%
June	146,014	2851	2.0%
July*	85,919	303	0.4%

* Data incomplete

Table 2: COVID-19 testing and mortality in Scotland (Data source: Scottish Govt. 27 July 2020)

4.2 Public Health Scotland data has produced a new dashboard [https://www.publichealthscotland.scot/our-areas-of-work/sharing-our-data-and-intelligence/coronavirus-covid-19-data-and-guidance/] Together with Scottish Government, National Records of Scotland and local data, these provide a picture of the pandemic as it affects Scotland and Lothian.

4.3 Across Scotland as a whole, as of 26th July 2020, 342 people per 100,000 population have tested positive for COVID-19. By comparison the NHS Lothian cumulative cases per 100,000 is 350.

Scotland	Cases per 100,000 to date (cumulative)	342
	Cases per 100,000 in past 28 days (cumulative)	6
	Current cases per 100,000 (7 day rolling ave)	0.3
NHS Lothian	Cases per 100,000 to date (cumulative)	350
	Cases per 100,000 in the past 28 days (cumulative)	4
	Current cases per 100,000 (7 day rolling ave)	0.2

Table 3: Lothian and Scotland COVID-19 cases (Data source: Scottish Govt. 27 July 2020)

The graph below shows the cases per million in Scotland and NHS Lothian over the period of the epidemic to date.

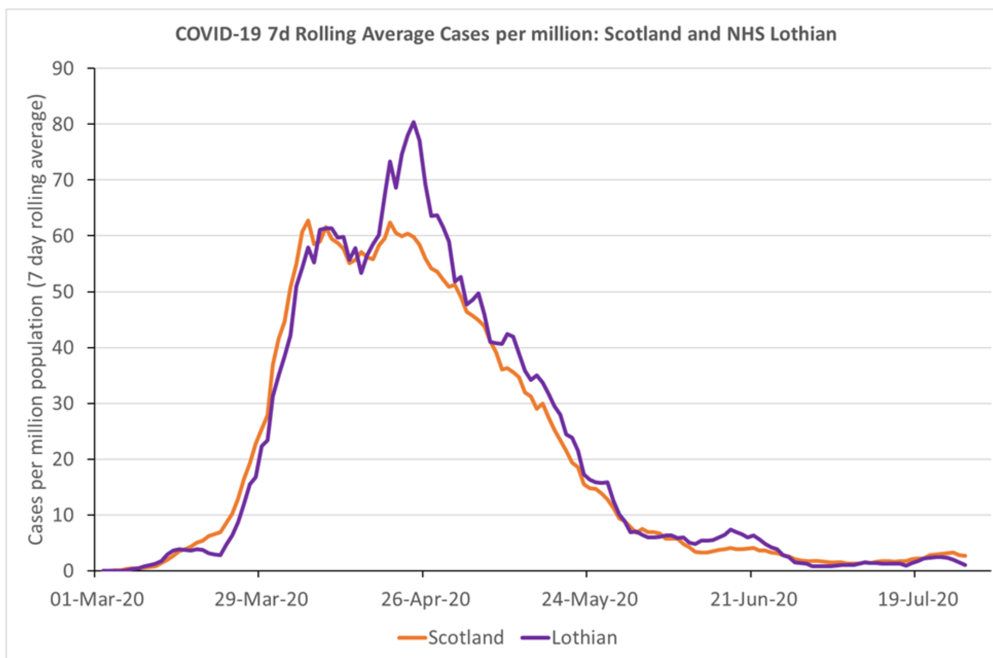
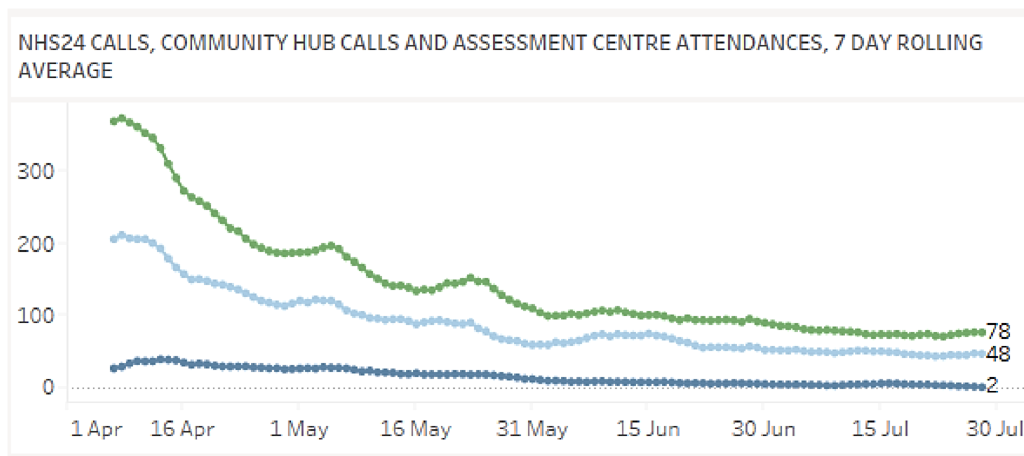


Figure 1: cases per million in Scotland and NHS Lothian over the period of the epidemic to date (Data source: Scottish Govt. data 27 July 2020).

4.4 The current impact of COVID-19 can be estimated by calls to the NHS24 COVID-19 advice helpline, which is receiving [insert number] calls per day. In Lothian, the 7 day rolling average is 78 calls per day compared with100 and 48 community hub calls compared with 72 in June.

Figure 2 Change over time in the 7 day rolling average of COVID-19 related calls to NHS 24, Community Hub and Assessment Centre Attendances.



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(Data source: Covid-19 Epidemiology dashboard 30 July 2020)

4.5 Number of confirmed cases over time

The daily number of confirmed cases illustrates the course of the outbreak to and identifies the number of cases per day that require follow up, tracing of contacts, advice and support to self-isolate, including formal restriction under the Public Health Act

(Scotland) 2008 where this is required. Table 4 illustrates the number of cases by sector and week from Monday to Sunday.

Table 4: Cases by sector 8 June- 26 July 2020(Data source: Covid-19 epidemiology dashboard 27 July 2020)

	All	Health and care workers and families	Care home residents	General Population
08-Jun to 14-Jun	57	23	<5	31
15-Jun to 21-Jun	38	10	<5	25
22-Jun to 28-Jun	10	*	0	*
29-Jun to 05-Jul	5	0	0	5
06-Jul to 12-Jul	<5	*	0	*
13-Jul to 19-Jul	15	8	0	7
20-Jul to 26-Jul**	6	*	0	*

**not full week

4.6 Variation by Local Authority

There is variation in the number of confirmed cases by local authority area across Lothian. The reasons for this variation are being explored. It is known that more deprived communities are disproportionately affected by COVID-19 as are areas with larger numbers of care homes for older people and lower paid key workers who are unable to work from home so are more exposed to the virus in the community and in workplaces where physical distancing may be more difficult.

A more detailed analysis has been undertaken for Midlothian which indicates that the higher mortality reflects the higher case rate in Midlothian compared to other parts of Lothian. Compared to the other areas, the case rate is higher in the general population, key workers and their families and care home residents. Understanding the reasons behind this will need more detailed local investigation.

Table 5: Variation in cumulative confirmed cases by local authority to 26 July 2020

Local Authority/HSCP	Number of confirmed cases	Rate per 1,000
East Lothian	274	2.6
Edinburgh	1761	3.4
Midlothian	531	5.8
West Lothian	469	2.6
NHS Lothian	3063	3.4

(Data source: Covid-19 Epidemiology dashboard, 27 July 2020)

4.6.1. Age and sex distribution of cases and deaths

Of 3,019 positive results recorded on the laboratory results dashboard, 1110 are male and 1909 are female. Significantly more people tested were female (28,281 compared to 19,769). There is a case ascertainment bias because the predominantly female health and social care work force and female residents of care homes have been prioritised for testing. Positive results by age decade are shown in the table below

Table 6: Lothian COVID-19 positive results (Data source: Lab results dashboard 27 July 2020)

	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70+	Unknown
Positive	7	24	237	279	277	381	251	1242	363
Tested	1829	889	2491	3044	3019	3811	2798	9953	23732
%Positive	0.4%	2.7%	9.5%	9.2%	9.2%	10.0%	9.0%	12.5%	1.5%

Deaths data is obtained weekly from the National Register of Scotland. A COVID-19 death is defined as a death in anyone who had either tested positive for COVID-19 or who had suspected COVID-19 indicated anywhere on death certificate. Deaths in which COVID-19 is mentioned currently comprise 1% of total deaths per week in Scotland.

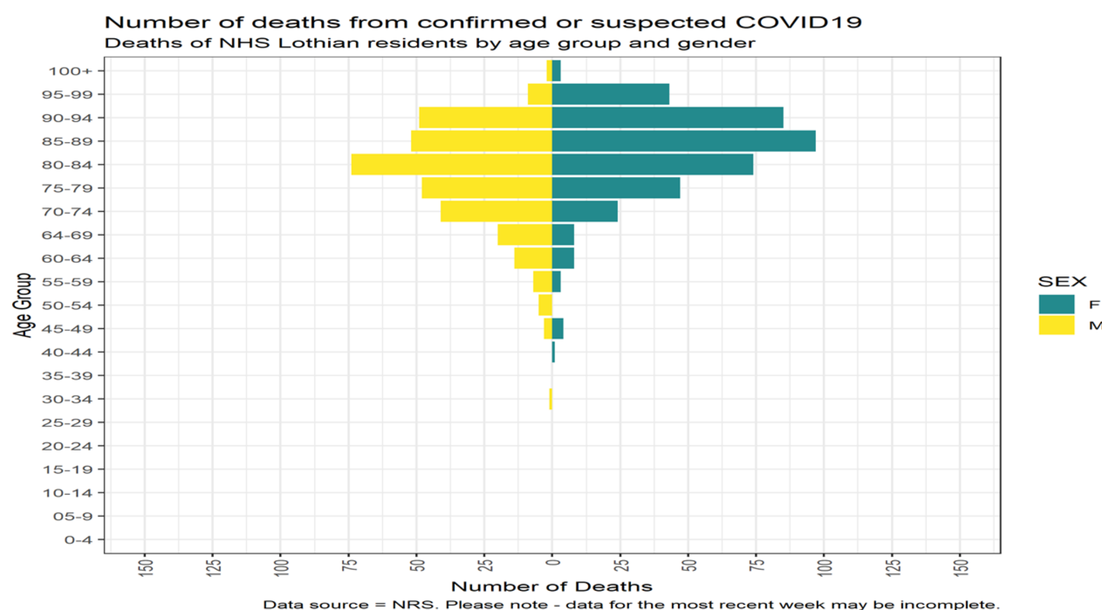
There has been a total of 727 deaths in Lothian where COVID-19 was mentioned on the death certificate (up to 26th July). Most of these deaths occurred between April and mid-May 2020. Only 38 COVID-related deaths occurred at home or outside of a care home or hospital setting.

Increasing age is a risk factor for dying of COVID-19. For COVID-19 related deaths in Lothian residents, 88% were over the age of 70 years and 55% were female. There was no clear relationship between death from COVID and deprivation group in Lothian level data.

Table 7: Lothian COVID-19 deaths by age group (Data source: Covid Deaths dashboard 27 July 2020)

	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
Male	0	0	0	*	*	*	34	89	186
Female	0	0	0	0	*	*	16	70	304
Total	0	0	0	<5	8	14	50	159	490

Figure 3 Deaths from confirmed or suspected COVID-19



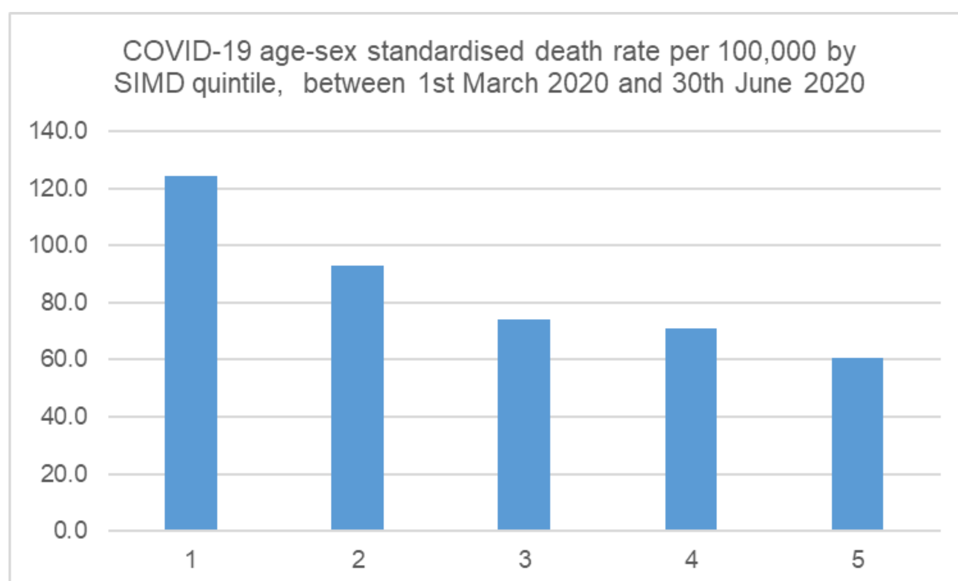
4.6.2. Ethnicity

UK data show a clear relationship between ethnicity and COVID-19 mortality. People from South Asian backgrounds, particularly the Bangladeshi population, have a significantly higher risk of death. In Scotland, Public Health Scotland is leading investigations into morbidity and mortality by ethnic background. The overall numbers of cases and deaths in black and minority ethnic residents of Scotland makes analysis challenging but National Records of Scotland analysis of deaths on or after March 12 and registered by June 14, 2020 indicates that the odds ratio that death involved COVID-19 was 1.9 (95% confidence interval 1,3-2.9). There is also emerging evidence of increased risks of serious illness due to COVID-19 in people of South Asian ethnicity.

4.6.3. Socioeconomic inequalities

Analysis of COVID-19 deaths by National Records of Scotland shows that people from communities with the highest levels of multiple deprivation (SIMD 1) have been twice as likely to die as people from the areas with the lowest levels. (Inequalities are explored further in the discussion about occupational risk in 4.6.7 and section 8 about wider impacts.)

Figure 4 COVID-19 age-sex standardised death rate for Scotland (Source: NRS Deaths involving coronavirus (COVID-19) in Scotland, Week 28, 2020 Additional Analysis)



4.6.4. Occupational risk

The most comprehensive information on occupational risk is from UK wide data. The number of COVID-19 deaths in Scotland among the working population was 230 to the end of June. Analysis of COVID-19 deaths in Scotland shows that the standardised death rate for all occupations is 10.2 per 100,000. But there is a clear gradient with more senior occupations experiencing lower death rates albeit numbers in each category are relatively small. Health and social care workers have the highest risk of exposure to COVID-19 but protective measures for health care workers have reduced risk for this group. But social care workers have experienced a higher mortality rate. For health care workers, the death rate is 6.4 per 100,000 whereas social care workers the death rate is 14.4 per 100,000. The data also shows that security guards, cleaners, bus and taxi drivers, process, plant and machine operatives have had the highest death rates from COVID-19. These are relatively low paid jobs, deemed essential services and with the potential for higher rates of exposure to work-related and community

transmission unless measures to reduce the exposure risk were in place. These findings are consistent with the University of Oxford Centre for Evidence Based Medicine review of factors influencing the high rate of SARS-CoV-2 transmission in meat and poultry processing facilities. Here the physical working environment - metallic surfaces, low temperatures, relative humidity favours persistence of the virus; the social working environment – crowded workplace, shared transport, production of aerosols, droplets etc. and working conditions including low pay may lead to pressure to keep working despite symptoms. [https://www.cebm.net/covid-19/what-explains-the-high-rate-of-sars-cov-2-transmission-in-meat-and-poultry-facilities-2/]

Table 8: Deaths from COVID-19 by occupation (Source: NRS Deaths involving coronavirus (COVID-19) in Scotland, Week 28, 2020 Additional Analysis)

Standard Occupational Classification Major Group	Number of deaths	Age-standardised rate per 100,000 population
1 - Managers, Directors and Senior Officials	22	9.1
2 - Professional Occupations	8	*.
3 - Associate Professional and Technical Occupations	18	6.6
4 - Administrative and Secretarial Occupations	17	7.0
5 - Skilled Trades Occupations	35	13.2
6 - Caring, Leisure and Other Service Occupations	30	13.0
7 - Sales and Customer Service Occupations	21	16.2
8 - Process, Plant and Machine Operatives	43	25.1
9 - Elementary Occupations	36	16.3

4.6.5. COVID-19 related disability/secondary illness

The risk of serious illness or death from COVID-19 is higher for people with pre-existing health conditions. Most people who have died from COVID-19 in Scotland have had underlying health issues. The most common main pre-existing condition among those who died with COVID-19 was dementia and Alzheimer's disease (31%), followed by ischaemic heart disease (13%). Respiratory conditions, and cancer were also frequently recorded as the underlying cause of death between 16th March to 30th June 2020; most excess deaths have occurred in older people, most of these deaths in care homes. Obesity has also been identified as a major risk factor.

It is becoming increasingly clear that recovery from COVID-19 illness is long and complicated even for people who may not have been admitted to hospital. Further work is underway to examine the frequency and severity of ongoing symptoms and disability.

4.7. Prevention and management of outbreaks

4.7.1. National and Local Surveillance

The programme of enhanced surveillance of COVID-19 in Scotland gathers data from various sources to identify how and where COVID is spreading in communities across Scotland. This builds on the established systems for finding flu; other data sources have been added as knowledge of how and where SARS -2-CoV spreads grows. NHS 24 respiratory calls and sentinel swabbing have been identified as the sources of surveillance most likely to act as sources of early warning of community transmission.

The EAVE-II study (early assessment of vaccine and anti-viral effectiveness) collects information about use of health services that may indicate a change in the levels of COVID-19 in the population, including those categories of patient at greater risk of serious disease. This includes random sampling of blood tests taken for other purposes (e.g. blood donors) for antibodies. These antibody tests are not yet ready for clinical use but are suitable for assessing current levels of immunity in populations.[https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/current-applied-health-service-research-to-inform-the-public-health-response/]

4.7.2. Test and protect programme

As part of the gradual relaxation of lockdown measures, an enhanced contact tracing service has been implemented. This is intended to enable a sustained reduction in new cases, outbreaks and to reduce transmission. In Scotland, this is being achieved through a programme of community testing, contact tracing, isolation and practical support, called 'Test and Protect' (TaP). Contact tracing is undertaken for COVID-19 cases confirmed by a positive polymerase chain reaction test. Where positive cases or their contacts are identified in high-risk or complex settings, specialist services including Health Protection, Infection Prevention and Control, and Occupational Health undertake additional risk assessment and rapid response as required. This includes establishment of Incident Management Teams where required.

4.7.3. Contact tracing approach

TaP Contact tracing has been undertaken by NHS Lothian since 28th May 2020. From 16 July 2020, NHS Lothian joined the two tier Scottish national contact tracing system which includes a clinical database and software based telephone system.

Cases are initially assigned to the National Contact Tracing Centre (NCTC) who conduct any straightforward contact tracing and escalate any more complex or specialist work on to the NHS Lothian TaP Contact Tracing Team. This team receives referrals from the NCTC, conducts contact tracing interviews with cases and/or their contacts (as appropriate) and escalates issues for specialist review as appropriate.

The TaP Contact Tracing Team was developed in partnership between the Public Health and Health Policy and Strategic Planning Departments under the governance of the Test, Treat, Isolate and Support Tactical Group. The service operates 7 days a week from 8am-8pm. The team has quickly moved to a position where it is now overseen by a Clinical Lead and a Service Lead with various supporting roles that deliver and support the contact tracing function. The TaP Contact Tracing Team has been developed from staff made available from a combination of service roles that are not currently active; and the Shielded staff group with additional support and expertise from Local Authority Environmental Health Officers.

TaP contact tracing processes have been developed to deliver a dedicated, scalable function, which ensures a safe, efficient and effective contact tracing service operates

in NHS Lothian. As of 16 July 2020, the TaP contact tracing team sits under the Department of Public Health and Health Policy's Health Protection Team. The service is conscious of the impact of remobilisation plans and the relaxation of national Shielding policy on staff availability. All Boards are required to include Test and Protect in their remobilisation plans.

4.7.4. Test and Protect Text Message Notification Service

Since 15th July 2020, the TaP Contact Tracing team have also had the facility to provide COVID-19 test results by text message for patients whose test is processed in NHS Lothian labs. This is only possible if the test has been ordered on TRAK and a mobile phone number is recorded on TRAK. The Test and Protect text notification service is intended as an additional facility. A reminder has been sent to all staff in the 'Speed Read' that the responsibility for informing a patient of their test result continues to rest with the service ordering the test. This is because, for various process/technical reasons, the Test and Protect notification service will not be able to send notifications in certain situations.

4.7.5. Contact Tracing Coverage and Performance

The framework for evaluating contact tracing in the context of COVID is being developed and tested. To break chains of transmission, the process must be engaging, timely, ensure coverage of cases, completeness of contact tracing and identification of potential sources of exposure. From 28 May 2020 until 15 July 2020, NHS Lothian completed 336 cases and recorded 417 contacts. From 16 July 2020 until 24 July 2020, 21 cases have been traced using the new CMS system and 44 contacts identified. These initial figures should be viewed with caution as they include duplicate entries, and some cases arising in complex settings where standard contact tracing is not appropriate.

4.7.6. Isolate and Support

If everyone who is infectious self-isolates effectively, transmission dies out. To self-isolate effectively, practical support is essential. This is provided as standard for other notifiable diseases as required under the Public Health (Scotland) Act 2008. There is a national Covid-19 helpline contact number already in place to support shielded individuals and those who need additional support. This number currently puts people in contact with their local authority who can provide practical help for those who do not have a network of support. Whilst a nationally coordinated service may be helpful there is a risk that for our most vulnerable this is not the most direct or efficient way to direct a request for support. While numbers of cases are small, the arrangements for providing support are being developed further with partners, based on the lessons learned from shielding and support for other groups at increased risk of COVID-19

5 Shielding

5.1 Shielding was introduced in late March 2020 by the Chief Medical Officer as a key public health measure to reduce risk of morbidity and mortality from COVID-19 in individuals thought to be most vulnerable due to existing clinical status. There are seven groups of patients assessed as being at very high risk. Shielding involves strict social isolation. Once identified as needing to shield, patients can access support from primary care, specialist clinical teams and Local Resilience Partnerships. There is a separate programme to support patients who are at increased risk of COVID-19 but who do not meet the clinical criteria for shielding.

5.2 The shielding programme has been a partnership between Public Health, clinical colleagues in Primary and Secondary Care, Analytical, eHealth services Health and

Social Care Partnerships, Local Authority, Third Sector and Scottish Government partners. This has exercised the Assistance Centres, Care for People Groups and arrangements for Community Volunteering established under integrated emergency planning guidance established as part of Preparing Scotland [https://www.readyscotland.org/ready-government/preparing-scotland/].

5.3 Public Health coordinates work streams to:

i. Maintain an up-to-date master list of patients, liaising closely with Public Health Scotland and Primary and Secondary Care to facilitate timely and accurate removal and additions, enabling healthcare records to be kept up to date with the patient's shielding status.

ii. Provide advice to clinicians, teams and groups on application of national guidance. This includes clinical risk assessment, patient level information and actions to mitigate risk.

iii. Support partner organisations to provide practical community services to enable patients to self-isolate successfully.

5.4 The shielding population

Patients, adults and children, have been added and where appropriate removed from the list in accordance with Scottish Government guidance. Scottish Government guidance on the benefits of shielding remains under review and subject to change as new evidence of risk from COVID-19 becomes available.

As of 24th July, 25,272 people, 2.8% of Lothian's population were shielding. This is equivalent to the proportion of the overall Scottish population that is shielding (3.3%) once differences in the populations are taken into account. The requirement to shield is not evenly spread across the population: 54% are female, 53% are aged 65 years or older and 42% are resident in SIMD 1 and 2, the areas with higher levels of multiple deprivation (SIMD 2020). Group three, people with severe respiratory conditions, is the largest of the seven shielding groups; 43% of Lothian's shielding patients are in this group (**Table 9**).

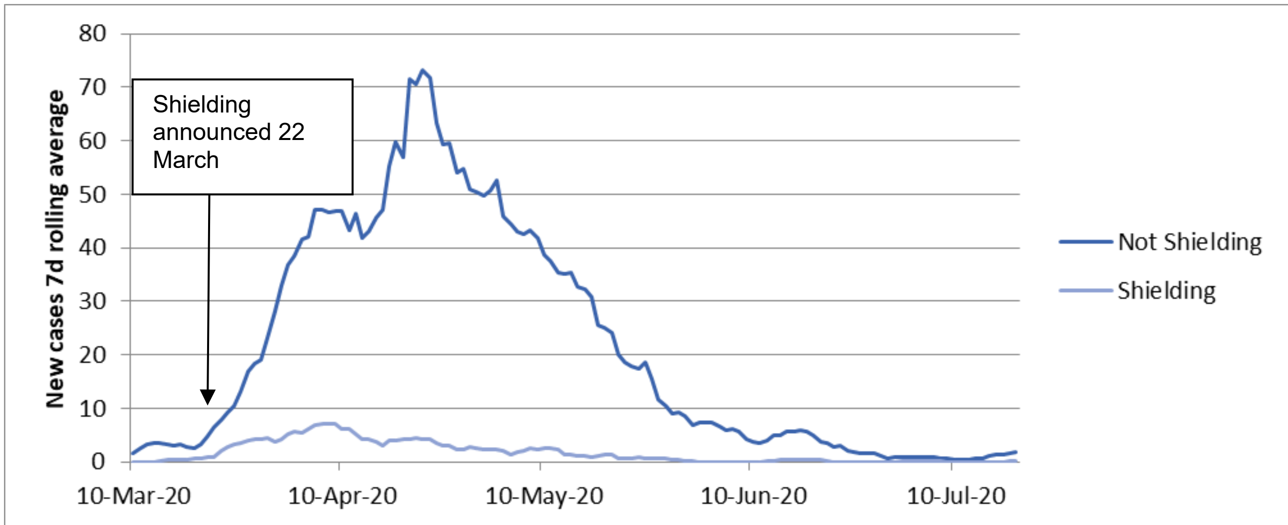
Table 9: NHS Lothian shielding list by Shielding Group (PHS data: 22 June 2020).

Group	Description	Number (%)
1	Solid organ transplants	1184 (4.7%)
2	Specific cancers	3741 (14.8%)
3	Severe respiratory disease	10774 (42.6%)
4	Rare disease	1625 (6.4%)
5	Immuno-suppression	4460 (17.6%)
6	Pregnant with significant heart disease	<10 (0.03%)
7	Clinician identified	5751 (22.7%)

5.5 Cases of Covid19 among the shielding population

Since the start of the epidemic 221 individuals on the shielding list have tested positive for COVID-19 (data checked on 24 July 2020.) Cases in the shielding population peaked on the 6th April (Figure 8). Of those affected, 57% of the cases were female, 70% were aged 65 years or older and 40% were resident in SIMD 1 and 2.

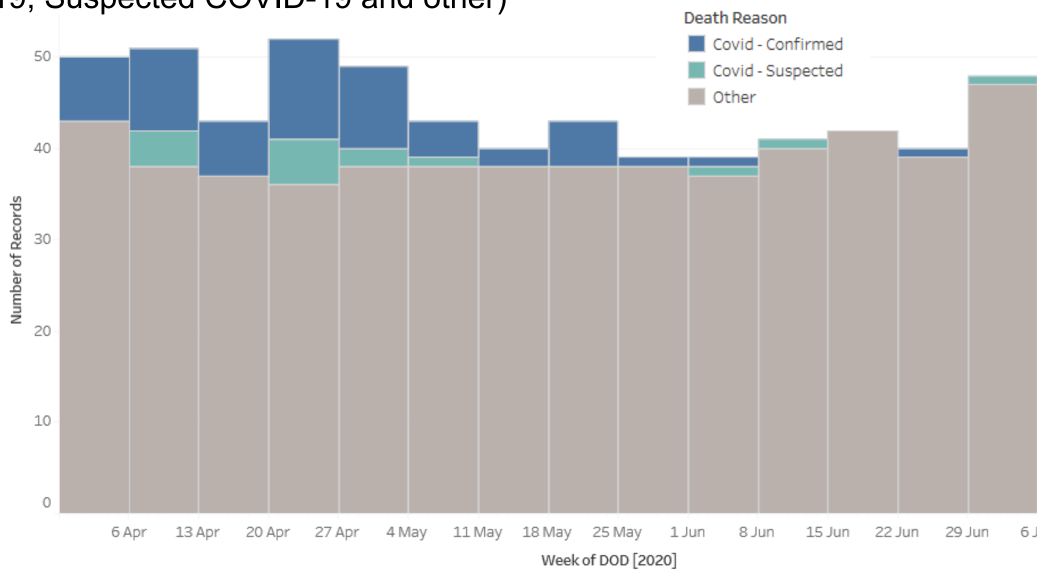
Figure 8: 7 day rolling average of new cases of COVID 19 in individuals on shielding list and individuals not shielding (Source: NRS)



5.6 Deaths

There have been 56 confirmed deaths and 15 suspected deaths from COVID-19 in individuals on the shielding list from 30 March to 05 July 2020 (NRS data). In this same time period there have been 549 deaths from other causes (Figure 9).

Figure 9: Deaths in individuals on shielding list by cause of death (Confirmed COVID-19, Suspected COVID-19 and other)



5.7 Community support

Local Authorities have worked in partnership with national and local organisations to support those clinically at the highest risk of severe illness from COVID-19 including patients shielding and the most vulnerable people in our communities.

The additional support provided included:

- Grocery supplies: working with the food industry to deliver basic weekly food and household essentials directly to doorsteps.
- Medicines: working with local community pharmacies' to support the delivery of prescription medicines. Local guidance was developed to support the safe delivery of medicines.
- Supermarket online priority delivery slots: individuals who are shielding have the option of registering for access to online supermarket delivery slots.

At local level, Local authorities set up telephone support lines to coordinate request for support and were involved in proactively telephoning shielding individuals

collaboratively with other primary care colleagues in General Practice. Organisations worked with third sector organisations using established arrangements for information sharing and working with volunteers to deliver practical support, cater for special dietary needs and provide tailored support for people with particular disabilities or communication needs.

The confidential creation and secure transfer and storage of information required to deliver essential services provided evidence that a Persons At Risk Database can be created and maintained. The lessons learned will enable this function to be refined in anticipation of future emergencies.

Relationships with local councils, health and social care partnerships and public health have been tested and found to be effective and robust. It has not been possible to gauge the experience of those shielding formally yet but Public Health Scotland and academic research is underway to examine this.

5.8 Future Changes to Shielding Policy

From the 1st of August the advice to shield will be paused. Health Boards are required to maintain lists and submit returns to Public Health Scotland in accordance with data processes outlined by the Chief Medical Officer. These arrangements will allow for prompt reactivation of shielding in a situation of increased prevalence of COVID19. Since shielding was introduced in April, clinicians have had to adjust to changing shielding guidance. Clinicians will continue to play a key role in adding newly diagnosed patients and removing those who no longer meet the shielding criteria after discussion and agreement with the patient.

The current clinical criteria for shielding are based on expert consensus across the UK at the start of the COVID19 pandemic. Boards have been advised that a risk stratification model (currently being developed by Oxford University) to support clinical decision making for patients on the shielding lists and to provide more person centred advice will be available from September. Further guidance is awaited on the mechanisms to be established by Boards to coordinate and assure these processes.

6 Deaths in Care Homes

There are 188 care homes in Lothian of which 109 provide services for older people. Deaths in care homes are those reported by the National Register for Scotland where the place of death is coded as a care home. This does not include care home residents who died in hospital or elsewhere.

The majority of all COVID-19 related deaths in Lothian occurred in care home residents. There has been a total of 424 COVID-19 related deaths in care homes up to 26th July. Of these nearly all were in care homes for older people. The first recorded COVID-19 related death in a care home was 28th March 2020 and the most recent was 8th July 2020.The average age of care home residents with a COVID-19 related death was 85 years.

The excess mortality in care homes caused by COVID-19 is clearly illustrated in the figure below. Research undertaken as part of the NHS Lothian University of Edinburgh COVID19 rapid research partnership concluded that care home size was strongly related to COVID-19 outbreaks, with larger care homes more likely to have an outbreak. This has implications for care home design and future outbreak prevention planning https://www.medrxiv.org/content/10.1101/2020.07.09.20149583v1.

The Lord Advocate is gathering information on all deaths of care home residents and staff in whom COVID-19 was confirmed or suspected as a cause of death. All Boards are working with Public Health Scotland and partners to provide this information.

Figure 10: Lothian COVID-19 deaths in Care Homes and other settings

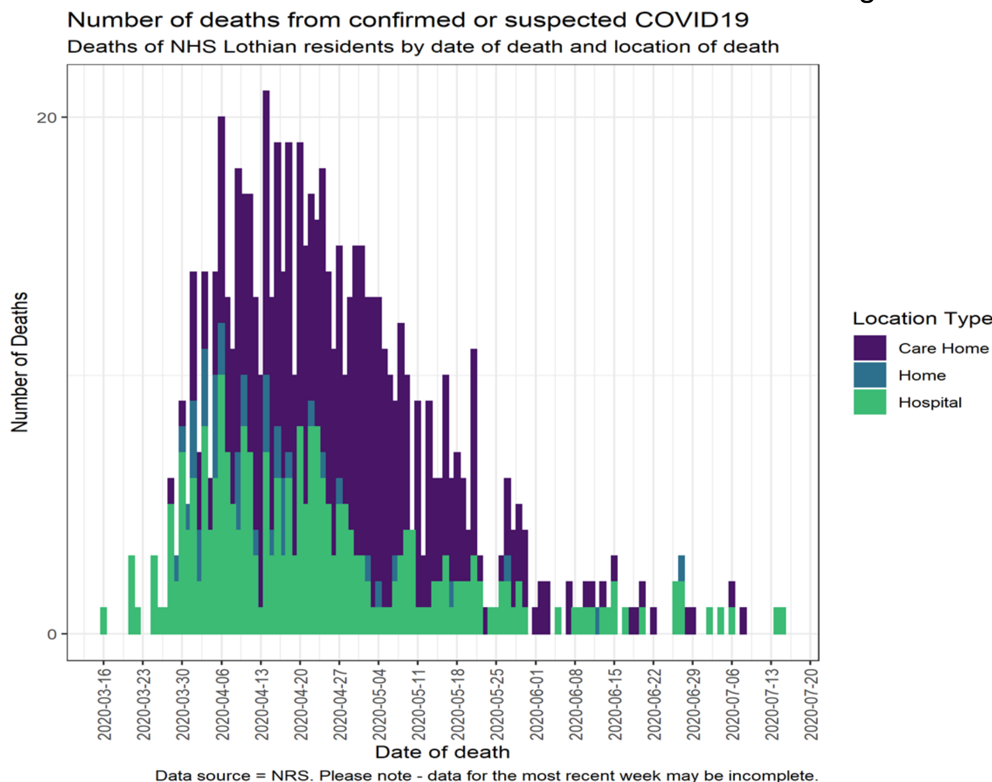
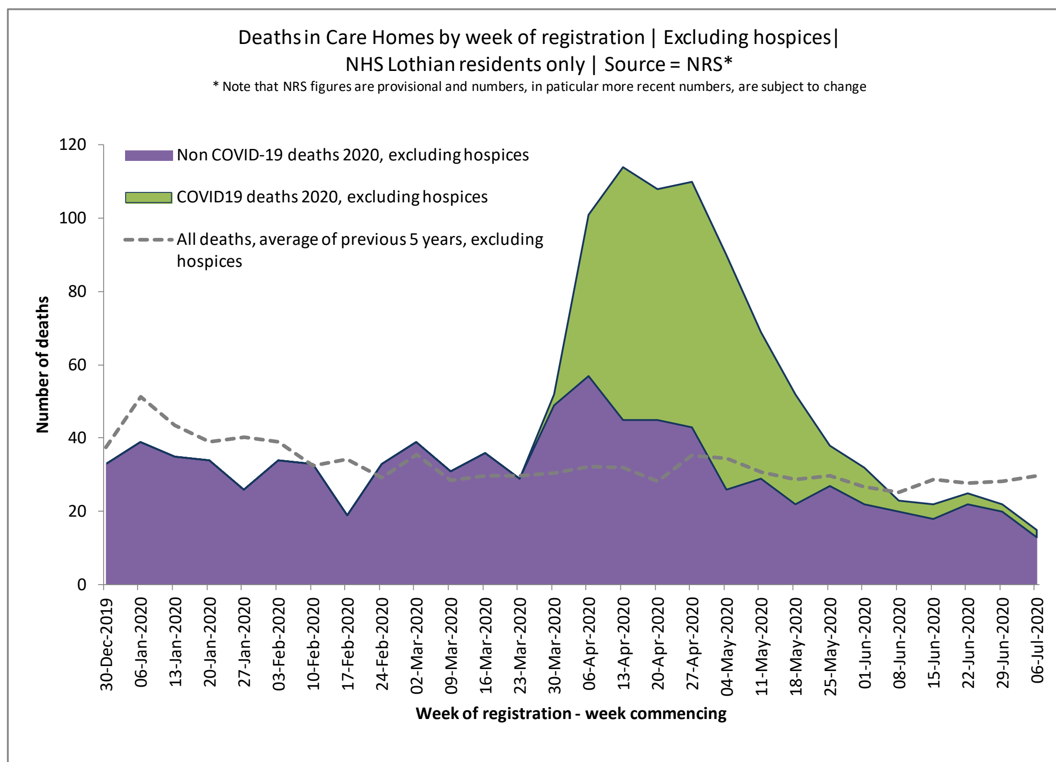


Figure 11: COVID-19 care home deaths as a contribution to excess mortality in 2020



6. Priorities for the next phase of the pandemic

6.1 WHO have set out six key criteria to minimise the risk of significant community transmission and large outbreaks as social restrictions are lifted, workplaces and shops

etc begin to re-open. In summary, this means that COVID-19 transmission must be restricted to sporadic cases and clusters from known contacts or importations; that the health system and public health capacity must be in place to find, detect, isolate and support all cases and their contacts; that the risk of outbreaks is minimised by identifying and addressing the main causes and amplifiers of transmission and ensuring that preventive measures are in place in health, care and closed settings; that workplaces and other settings are redesigned to enable physical distancing, handwashing, respiratory etiquette and, where appropriate temperature/ symptom monitoring; that the risk of imported cases is reduced by having detailed information about people entering and leaving the country and measures in place to rapidly detect and manage cases among travellers (including the capacity to quarantine individuals arriving from areas with community transmission).

6.2 For these measures to be successful, they must be undertaken in partnership with communities. There should be clear communication about what finding, detecting, isolating and supporting all cases and contacts means, how the system will work for individuals, employers and wider communities and the ongoing behavioural change and wider system changes required.

6.6. Outbreak prevention plans

At present, rates of community transmission appear low but the development of outbreaks in various areas of the country requires that outbreak prevention and rapid response plans are in place. These are part of the broader public health programme of COVID preparedness to March 2021.

6.7. Swabbing and testing capacity

Other winter viruses, for example, influenza, will present with similar symptoms to Covid-19 so rapid swabbing and testing will be key to limiting outbreaks of such viruses. However, we need to ensure we are able to scale up our outreach testing team appropriately as original members return to their original posts. National services were established for mass swabbing and are not designed for easy access by people with multiple and complex needs, no mobile or internet access. The outreach testing service has provided a rapid response service for this population to date and it is essential that it is maintained throughout the pandemic and accessible to all settings. The testing strategy is being published separately and it is anticipated that NHS and partner laboratories capacity will be able to scale up as required to cope with an increased number of tests.

6.8. Educational settings

Prevention and preparedness for Covid 19 outbreaks in education settings, nurseries, schools (254 primary and 75 secondary), further and higher education (over 60,000 students). Outreach swabbing/testing capacity will be particularly important along with rehearsed local outbreak plans. Schools guidance has just been published and exercises are underway with universities.

6.9. Workplaces

Experience from other countries is that workplace outbreaks disproportionately affect low income workers in areas of deprivation, often where health literacy in English is limited. The NHS Lothian Health Protection Team have met with Environmental Health Officers to look at workplaces, especially vegetable picking where migrant workers are employed, other employments where contracts are temporary and workplace types in which outbreaks have been reported elsewhere in the UK and in other countries.

6.10. Closed settings

During this phase of the pandemic, while care homes for older people were affected badly, it was possible to limit the number of cases in the criminal justice system and there were no outbreaks in services for people who are homeless. The services that were successful need to be maintained and improvements made where appropriate. There is some urgency as the availability of the funding required to maintain services delivered by partners is not yet clear. Specifically, it is essential that protective housing, self-isolation and quarantine facilities are maintained in line with international outbreak prevention and control guidance.

6.11. Port health

The Directorate of Public Health and Health Policy provides the port health response for the airport and seaports across Lothian. Prior to the establishment of national quarantine arrangements, arrangements were in place for clinical assessment, testing and provision of accommodation appropriate for self-isolation. With the releasing of lockdown these arrangements are being revisited and retested.

6.12. Care homes

Prevention and preparedness for future outbreaks in care homes continues. It is anticipated that outbreak prevention and rapid response will be complemented by practical support provided by Health and Social Care Partnerships will continue alongside community infection control for care homes, care at home teams & carers.

6.13. Community outbreaks

Ongoing surveillance, risk assessment and rapid response are required to limit community transmission and thus outbreaks size. Community outbreak prevention

plans are being tested in line with the updated guidance on Management of Public Health Incidents https://hpspubsrepo.blob.core.windows.net/hps-website/nss/1673/documents/1_shpn-12-management-public-health-incidents.pdf

6.14. Immunisation

In addition to preparing for the expanded influenza vaccine programme, Boards have been asked to prepare for an initial Covid-19 vaccine programme to be ready from October 2020 onwards, including identification of priority groups.

6.15. Communication

Key population control measures are covered by the "FACTS" messages to the general public ,as well as business and other organisations following guidelines on prevention of Covid-19 workplaces and other settings. Face coverings; Avoid crowded places; Clean your hands regularly; Two metre distance; Self-isolate and book a test
If people do not adhere to this advice, outbreaks are more likely.
Flu and Covid 19 prevention measures will include ongoing public messaging on mask wearing, handwashing, cleaning, ventilation, avoiding crowds, social distancing.

7. Mitigating the wider impact of COVID-19 related disease

7.6. The pandemic has affected the population in line with existing inequalities. It has exposed fault lines in society but the strength of the provision of local community support has highlighted the potential for renewal.

7.7. It is also apparent that delaying preventative and non-urgent care and planned surgery as well as suspension of some screening and immunisation services (and reductions in other public services) during the lockdown have potentially caused significant health harm. Furthermore, individuals' reluctance to use health services because they do not want to burden the NHS or are anxious about the risk of infection may have contributed to avoidable mortality. Remobilisation is a vital component of the effort to address some of these potentially negative health impacts.

To protect population health, Public Health Scotland has recommended five priority areas in its draft strategic plan

- COVID-19: response, renewal and recovery (discussed above)
- Children and poverty
- Mental Health
- Place
- Public Health Priorities

6.3 Although the risk of serious COVID-19 related illness is low in children, evidence suggests that children are effective transmitters of the virus. Children have still been significantly negatively affected by the virus. Household reductions in income mean that it is likely there has been an increase in the more than one in five of Lothian children who lived in poverty during 2019. Scottish research suggests that children's mental health may have worsened during the lockdown period. There is also concern about digital and educational exclusion as a result of lockdown. The proposed return to school will be an important opportunity to try to halt these inequalities. But there are risks of increased community transmission of the virus as a result of school return and teachers, especially older teachers, will be at risk of increased health harm as a result of increased exposure unless hygiene and distancing protocols are implemented.

6.4 Social isolation

The impacts of the lockdown have yet to be fully explored. But early research highlights that social isolation, and lockdown in particular, may have had negative health impacts. Preliminary data from the survey of the clinically shielding population highlighted that

- 86% of respondents report a negative impact on their quality of life
- 76% report a negative impact on their mental health
- 83% of young people in education report negative impacts on their education.

6.5 Mental and physical health

There is strong evidence from large population surveys of a negative impact on mental health as a result of COVID-19. The Institute for Fiscal Studies estimate an 8% reduction in mental health across the population with particularly large drops for young people and women. Those people who have experienced job loss, loss of income or had children younger than 15 in the household have experienced poor mental health. There is evidence that Near Me consultations for mental health services have been among the busiest specialties nationally. In addition to the remobilisation of mental health services, supporting public mental health efforts will be an important part of recover; referral and treatment will not always be necessary but there is a need to work with community and voluntary sector partners to develop community prevention and promotion of good mental health and wellbeing.

7.8. Mitigating the impact of loss of income and support

Wider impacts of COVID-19 are driven by unemployment and loss of household income; as the UK Government furlough scheme is withdrawn, there is particular concern about further job losses. There was an increase in Universal Credit claims in March and April. A new population has started to claim Universal Credit to maintain income and unemployment rates have doubled already. And a second wave of increased social security applications is anticipated as more people lose their jobs after furloughing ends. Government funding for community support is ending, which will have an impact on local resilience arrangements as well as other financial support schemes such as free school meals and school uniform grants. Economic activity has slowed down and there is concern about longer-lasting effects of a recession.

7.9. The public health response must balance COVID-19 health protection capacity with work that mitigates and prevents the inequalities and poverty that are being exacerbated by the pandemic. COVID-19 mortality is highest among the poorest members of society because pre-existing health is worse and people in lower paid jobs were less protected from exposure and needed to work to survive. The focus on addressing poverty, a preventative focus on mental health and wellbeing and a response rooted in localities is imperative. Effective mitigation as well as recovery efforts to support people to (return to) work safely are a paramount public health priority.

7.10. For NHS Boards, this means work to consider how NHS agencies function as anchor institutions and contribute to community wealth building. Existing NHS Lothian programmes to support recruitment and retention of staff from more deprived communities or disadvantaged backgrounds should continue to be supported. Income maximisation services based at acute sites may need to be mainstreamed to ensure consistency of service especially for people who may face a long period recovering from COVID-19.

7.11. In the short term, action to strengthen NHS Lothian employability programmes, achieving Living Wage accreditation and refining procurement targets to target local

economic gain should be an integral part of our remobilisation plans and ongoing response.

8. Key Risks

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

9. Risk Register

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

10. Impact on Inequality, Including Health Inequalities

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

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

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

12. Resource Implications

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

Professor Alison McCallum
Director of Public Health and Health Policy
July 30, 2020
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This paper draws on the work of Christine Evans, Martin Higgins, Naomi Honhold, Leonie Hunter, Sue Payne, Fiona Shanks, Janet Stevenson, Lothian Analytical Services, Bhav Joshi, the wider public health and health policy directorate and colleagues in Public Health Scotland.

NHS LOTHIAN

Board Meeting
12th August 2020

Chief Officer, Acute Services

SCHEDULED & UNSCHEDULED CARE PERFORMANCE

1 Purpose of the Report

1.1 To update the Board on the impact of Covid-19 on performance for Scheduled Care standards: New Outpatient (OP), Treatment Time Guarantee (TTG), Diagnostic key test and 31 and 62 Day Pathway Cancer pathways; and the Unscheduled Care 4EAS and Delayed Discharge Standards (please see Appendix 1). Any member wishing additional information should contact the Executive Lead;

2 Recommendations

Board Members are recommended to:

2.1 **Acknowledge** the adverse impact of Covid on OP, TTG and Diagnostic performance, with impact on 31 and 62 Day pathways to be fully understood – please see Appendices 1 & 5;

2.2 **Acknowledge** that management information indicates that 76.6% of patients seen, were seen within the TTG in June 20. This is a similar rate to pre-Covid but activity has dropped to just over a third of pre-Covid levels. Focus remains on managing the most urgent patients. **10,233** patients were waiting longer than 12 weeks in June.

2.3 **Acknowledge** that the second phase of Remobilisation plans has been submitted to the Scottish Government in line with the Remobilise, Recover and Redesign framework, with projected activity to end of March 2021. Plans focus on safely and incrementally resuming clinically prioritised services, targeting Urgent Suspicion of Cancer and urgent activity, whilst maintaining Covid & non-Covid pathways. They also cover winter plans.

2.4 **Take limited assurance** that Remobilisation plans will reduce high volumes of long waiting patients for scheduled care and cancer services;

2.5 **Acknowledge** that 4 hour Emergency Access Standard performance is 94.7% for June 20. Front door demand is increasing but remains lower than pre-Covid. See Appendix 6;

2.6 **Recognise** that the pandemic response from Health and Social Care Partnerships was to increase community capacity along with a focus on Home First, resulting in a significant reduction in the number of delayed discharges. Although there has been an increase in the number of delayed discharge patients, bed occupancy remains low. See Appendix 6;

3 Discussion of Key Issues

3.1 A Scheduled Care Board has been established to oversee Remobilisation. For outpatients, though demand remains lower than pre-Covid capacity has also reduced, caused by physical distancing and infection prevention and control measures. Mitigating actions to increase activity include optimising virtual care for example telephone and video

consultations, and demand management initiatives include active clinical referral triage, patient initiated follow up, email correspondence, patient-focussed booking and RefHelp. Performance focus is on clinical priority management, activity and long waits.

3.2 Surgical and diagnostics capacity is focussed on Cancer and priority 2 patients i.e. those requiring surgery within 4 weeks. Remobilisation of inpatient and daycase surgical services is underway with modelling of theatre sessions/ operating capacity across sites, aligned to critical care and elective bed capacity. We are operating 70% of pre-Covid sessions with an aim to increase to 81% by end of August. Activity is constrained by staff availability, PPE and infection prevention control requirements and there is a focus on maximising this within current guidance.

3.3 Cancer performance remains an area of significant focus however there has been a reduction in performance in June. Urology breaches for Bladder and Prostate constituted over 60% of breaches for both 31 and 62 days. Laprascopic prostatectomy activity undertaken at SPiRE has accounted for a 5% reduction in 31 day performance, as is it not subject to non-standard procedure adjustment. Prostatectomy activity has increased during Covid-19 with the waiting list reducing from ~100 to ~80 with additional capacity secured at SPiRE. Additional clinic capacity has been identified for August to support the 62 day pathway. Balancing risk has increased use of non-surgical pathways including hormone therapy and watchful wait monitoring. Additional urgent SPiRE theatre capacity is secured for Colorectal, Urology, Breast and Neurosurgery until 30th September.

3.4 Endoscopy diagnostics lists have reduced to <5 patients per session, due to physical distancing measures, PPE and increased turnaround time due to infection prevention control ventilation guidance. Access to Leith Community Treatment Centre will become available in August, which will increase high risk and Urgent/ Urgent Suspicion of Cancer post-Covid capacity from 31% to 44%. The Faecal Immunochemical Test (qFIT) is being used to prioritise patients appropriately with high risk patients being expedited for investigation. Enhanced triage criteria have been introduced for upper endoscopy. Keeping in Touch letters are being sent to all delayed planned repeat patients.

3.5 Core capacity to clear Radiology backlog and resume pre-Covid diagnostic and interventional activity is affected by the need to maintain physical distancing in waiting areas and PPE, to a reduction of approximately 20%. Remobilisation is underway, including full analysis of current service provision to modernise care models, maximise efficiency and optimise opportunities from outpatient clinic reduction. Additional MRI and CT capacity from Edinburgh Clinic and University of Edinburgh scanners and 10 MRI slots per week at Golden Jubilee National Hospital are being used. There are proposals to extend existing core scanner capacity through increased workforce and rota redesign. Final migration of DCN imaging and interventional services to Little France has increased CT, MRI and Neuro-Interventional Suite capacity. As the backlog is cleared this additional capacity will be utilised in meeting the expected surge in outpatient clinic and GP demand.

3.6 Unscheduled care plans have focussed on establishing and monitoring Covid and non-Covid pathways to safely cohort patients, and on safely reducing demand, for example through ‘Call MIA’. Work is underway on winter interventions to support system flow and implementing processes to ‘schedule unscheduled demand’ by 31 October 20. The Programme Board considered proposals on 20 July to further develop the Flow Centre to support signposting to alternatives to front door attendance, and the business case for the Same Day Emergency Care (SDEC) service, currently piloting at the Western General Hospital. SDEC aims to minimise pathway delays allowing services to assess, diagnose

and treat emergency patients same day as an alternative to hospital admission, and to 'schedule' their attendance through the working day. In the first two weeks of the pilot (Jun 22nd - Jul 5th) the service provided 216 appointments, 173 of which were new, with an admission rate of 7%. Average time in SDEC was 2 hours 50 mins compared to 4 hours 10 minutes in the traditional front door model. Without SDEC, 52% of patients would have had an Emergency Care attendance (48% from ambulatory care pathways).

4 Key Risks

4.1 There is an unknown risk in terms of patient outcomes due to increasing waiting times, reduced referral rates, delayed diagnosis/ treatment and patient choice in not attending for planned appointments, particularly where suitable virtual care cannot be provided.

4.2 Risks to scheduled care performance include focus on clinically prioritised care resulting in extended waits for lower priority routine demand. Opportunity to increase capacity is limited with access to our annual Golden Jubilee National Hospital allocation not available this year, and limited independent sector capacity. The current requirement for designated Covid and non-Covid pathways, and physical distancing measures, combined with requirements for PPE and cleaning regimens, are reducing productivity.

4.3 Ability to manage increasing unscheduled care demand whilst maintaining Covid and non-Covid pathways, balanced with increasing elective activity. Peaks in winter demand.

5 Risk Register

5.1 Corporate risk IDs 4191 (Risk that patients will wait longer than described in the relevant national standard & associated clinical risk); 3211 (That NHS Lothian will fail to achieve waiting times targets for inpatient/ day case and outpatient appointments); 3203 (4-hour Target (Organisational)), and 4688 (4 Hour Emergency Access Standard (Patient)), have all been updated to reflect risks arising from Covid.

6 Impact on Inequality, Including Health Inequalities

6.1 Capacity restrictions and waiting list delays may impact patient groups differentially. The health impact of Covid will be looked at within future public health work. The move to virtual healthcare could increase the 'digital care divide' for vulnerable groups with limited technology access, and an equality impact assessment is being undertaken to look at this.

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

7.1 Public communication and engagement is planned as part of Remobilisation. Events have commenced with a young persons' group and will feed into new models developed.

8 Resource Implications

8.1 Covid recovery brings significant resource implications which Finance is fully collating.

Jacquie Campbell
Chief Officer, Acute Services
30th July 2020

Appendix 1 – Covid Impact on Performance

In line with Scottish Government requirements NHS Lothian ceased all non-urgent elective activity from 16th March this year. Since then 72,000 outpatient appointments and 3,000 inpatient & day case procedures have been cancelled, resulting in 40,671 outpatients waiting longer than 12 weeks in Jun 20. This is a 93% increase from March 20, when Covid cancellations began – please see Appendix 2. 10,233 inpatients were also waiting longer than 12 weeks as a result of Covid in Jun 20 - an increase of 201% from Mar 20 – please see Appendix 3.

Cancellations have significantly increased waits for key diagnostic tests including Endoscopy (the largest portion of Gastroenterology Diagnostics); for Urology Diagnostics (Cystoscopy); and for Radiology. Cancer activity remains a priority for NHS Lothian, balancing risks of efficacy and vulnerability. Please see Appendices 4 & 5 for performance.

In terms of unscheduled care and further to the improved 4EAS standard performance, all cause health & social care delays have fallen significantly though are beginning to increase – please see Appendix 6.

The table below illustrates current performance for key unscheduled and scheduled care metrics:-

Metric		Jun 2020	May 2020	Apr 2020	Target
Delayed Discharges	**Standard	92	73	63	200
	**Standard & Complex	136	106	74	-
4 Hour ED Waiting Time		94.7%	95.5%	95.4%	95%
Outpatient >12 week waiting time [M]		40,671	37,758	28,312	-
Treatment Time Guarantee [M]		10,233	8,638	5,750	-
Cancer Waiting Times (31 day target) [M]		96.8%	90.8%	95.0%	95%
Cancer Waiting Times (62 day target) [M]		83.9%	82.9%	82.2%	95%

[M] Management information

** Standard (excl. code 9s and code 100s), Standard and Complex (incl. code 9s and code 100s

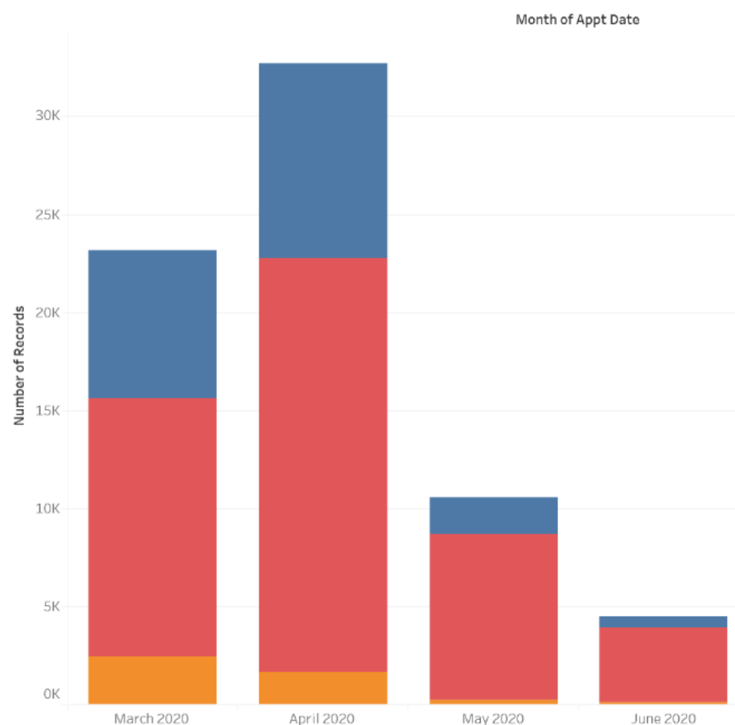
Appendix 2 - Outpatients

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
NHSL OP >12 Wk Performance	**24,307**	**25,529**	**23,274**	**21,098**	**28,312**	**37,758**	**40,671**
OP Trajectory	26,269	25,051	20,393	18,100	19,139	19,390	19,720
Difference	-1,962	478	2,881	2,998	9,173	18,368	20,951

Please note that data provided above is management information and so may differ from published statistics

Outpatient Covid Cancellations Mar – Jun 20, using Covid-19 Cancellation Code:-

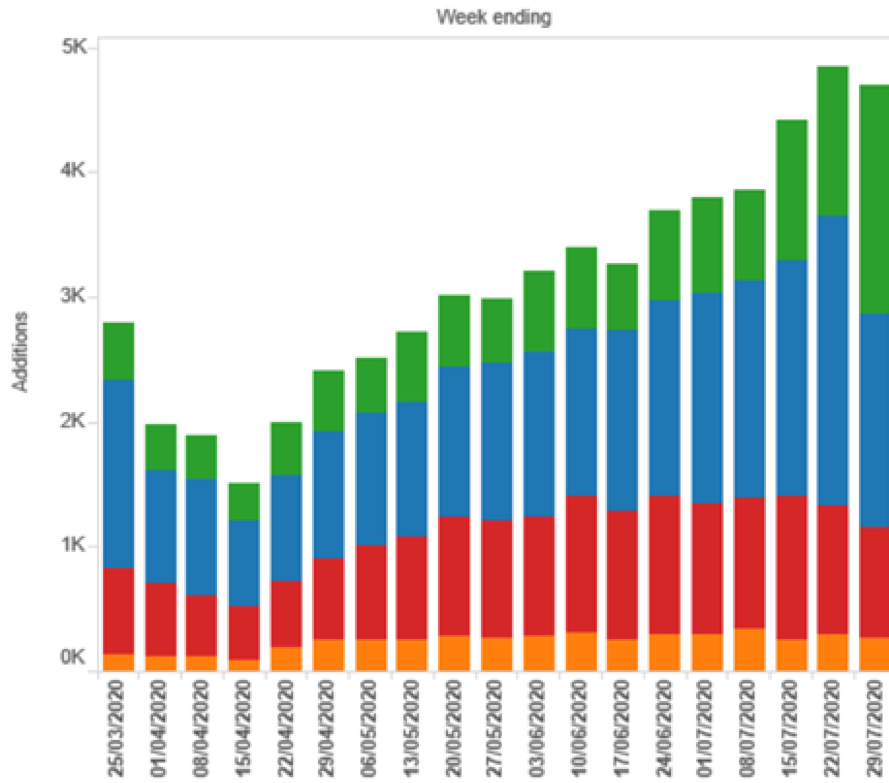


Key:- Blue – New OP; Red – Return OP; Orange – Radiology OP

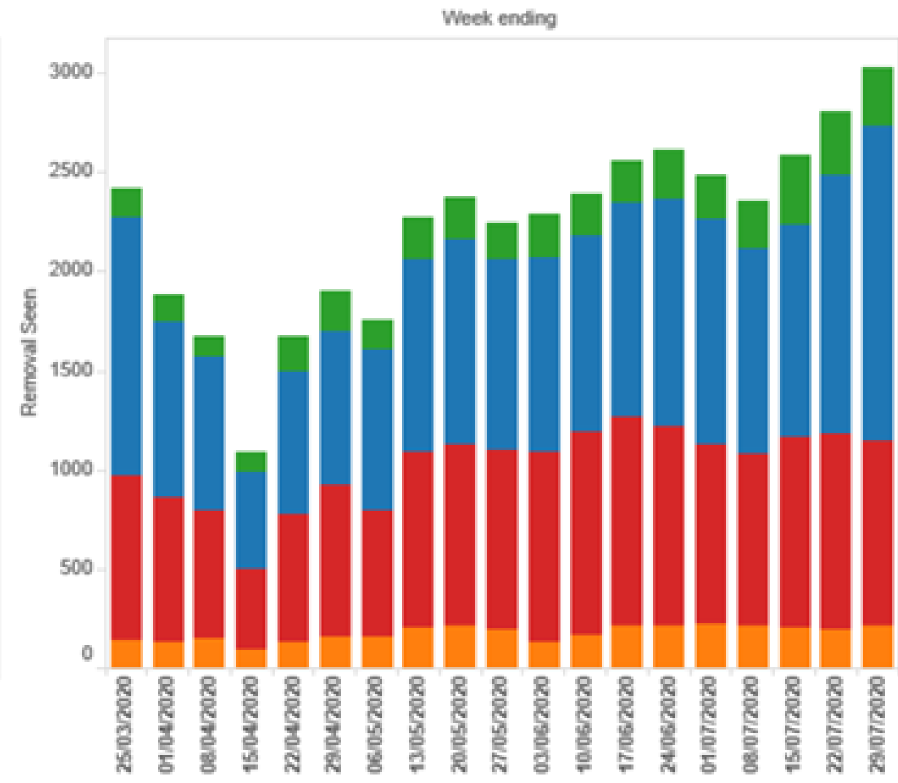
Impact of Covid on Outpatient Waits:-

	Pre-Covid – Early March 20	Jun 20	% Change
Waiting List Size – Urgent & Urgent Suspicion of Cancer	7,618	6,895	-9.5%
Waiting List Size – Routine	52,051	46,127	-11.4%
Referrals	6,303	3,794	-39.8%
>26 Week Breaches	6,886	15,461	+125.0%
>52 Week Breaches	334	1,378	+312.6%

Outpatient Weekly Additions by Priority:-



Outpatient Weekly Removals Seen (Activity) by Priority:-



Key:-

Orange – Urgent Suspicion of Cancer
Red – Urgent
Blue – Routine
Green – Other

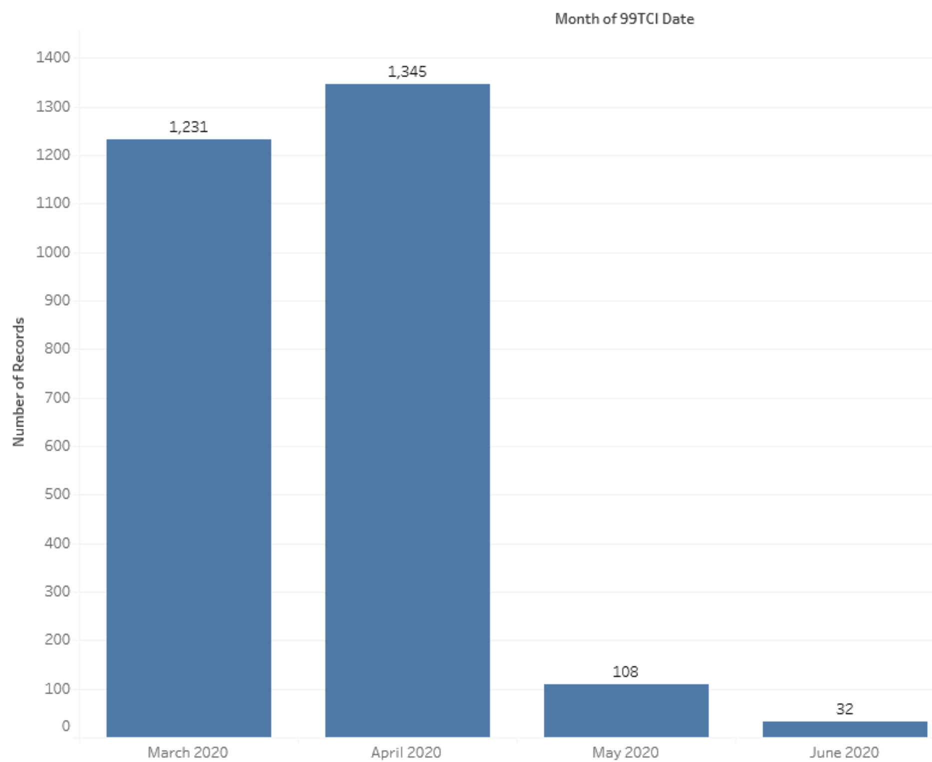
Appendix 3 – Inpatients/ Day cases (TTG)

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
NHSL TTG (IPDC) >12 Wk Performance	**2,622**	**2,788**	**2,753**	**3,404**	**5,750**	**8,638**	**10,233**
TTG (IPDC) Trajectory	2,839	3,190	2,922	3,100	3,141	3,028	2,900
Difference	-217	-402	-169	304	2,609	5,610	7,333
% of all patients seen, seen within the Treatment Time Guarantee	74.7%	74.2%	77.3%	80.2%	95.2%	89.2%	76.6%

Please note that data provided above is management information and so may differ from published statistics
Performance figures are *Ongoing* Waits

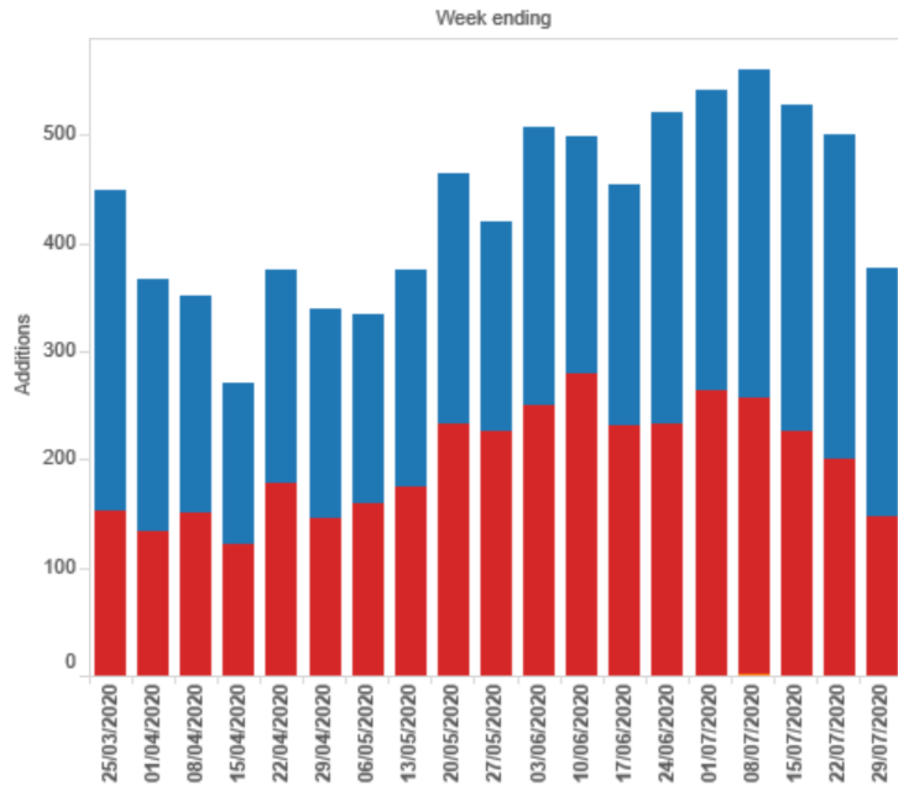
Inpatient Covid Cancellations Mar – Jun 20, using Covid-19 Cancellation Code:-



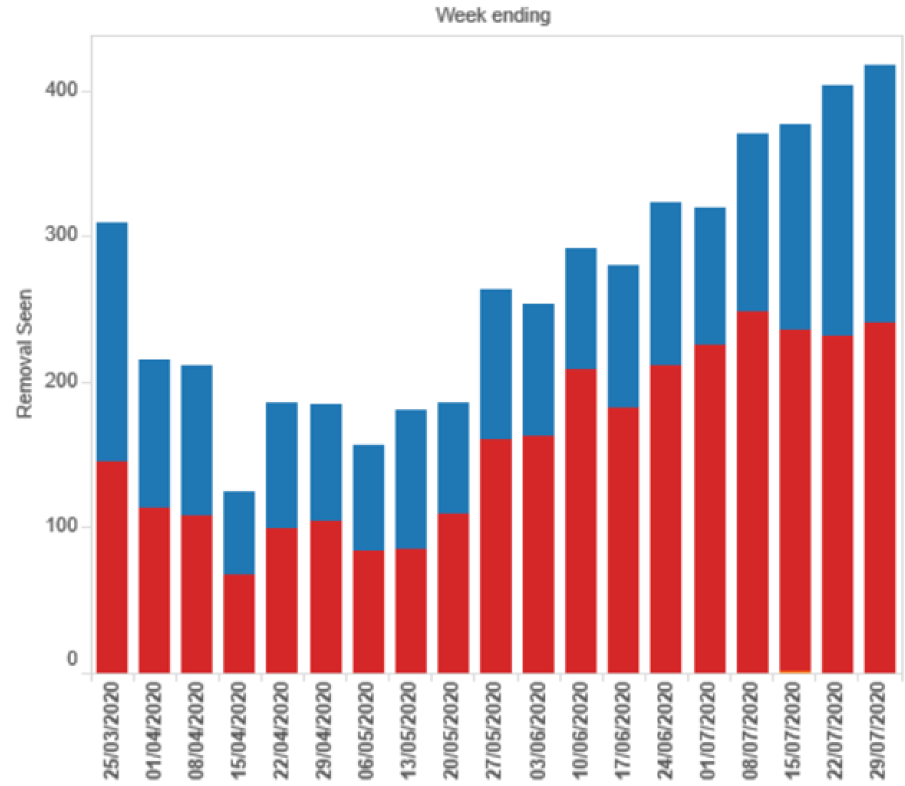
Covid Impact on Inpatient Waits:-

	Pre-Covid – Early March 20	Jun 20	% Change
Waiting List Size – Urgent & Urgent Suspicion of Cancer	1,677	2,547	+51.9%
Waiting List Size – Routine	9,699	10,847	+11.8%
>26 Week Breaches	810	3,122	+404.9%
>52 Week Breaches	61	278	+437.7%

Inpatient Weekly Additions by Priority:-



Inpatient Weekly Removals Seen (Activity) by Priority:-



Key:-

Blue - Routine
Red – Urgent

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
Upper Endoscopy	625	374	792	1,276	1,823	1,909	1,871
Colonoscopy patients waiting over 6 wks	933	521	879	884	1,406	1,517	1,476
Flexible Sigmoidoscopy (Lower Endoscopy) patients waiting over 6 wks	340	297	332	331	464	502	503
Gastroenterology Diagnostic Performance	1,898	1,192	2,003	2,491	3,693	3,928	3,850
Gastroenterology Diagnostic >6 Week Trajectory	2,034	1,794	1,269	744	-	-	-
Difference	-136	-602	734	1,747	-	-	-

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
Flexible Cystoscopy (Urology Diagnostic) Performance	323	340	362	599	765	792	846
Urology Diagnostic >6 Week Trajectory	385	395	245	95	-	-	-
Difference	-62	-55	117	504	-	-	-

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
CT Performance	101	112	97	203	1,049	1,000	743
Trajectory >6 weeks	100	40	0	0	200	200	100
Difference	1	72	97	203	849	800	643

Specialty Radiology - MRI Lothian	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20
MRI Performance	87	260	588	448	2,070	1,973	1,329
Trajectory >6 weeks	150	150	0	0	500	400	300
Difference	-63	110	588	448	1,570	1,573	1,029

Specialty Radiology - General Ultrasound (not Vasc)	Apr 20	May 20	Jun 20
General Ultrasound Performance	2,565	2,793	2,031
Trajectory >6 weeks	0	0	0
Difference	2,565	2,793	2,031

There were 36 breaches for Barium Studies in Jun 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:-

31 Day performance

	Mar 19	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20
Urological	94.5%	91.2%	92.2%	90.3%	92.2%	89.4%	95.7%	71.8%
Colorectal (screened excluded)	85.7%	78.3%	88.6%	96.3%	87.1%	93.8%	92.6%	80.0%
Colorectal (screened only)	100.0%	100.0%	83.3%	55.6%	100.0%	60.0%	60.0%	50.0%
Melanoma	91.7%	95.7%	100.0%	100.0%	85.7%	83.3%	100.0%	100.0%
Breast (screened excluded)	98.1%	97.5%	100.0%	97.5%	98.0%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	95.1%	100.0%	96.9%	97.7%	100.0%	93.3%	n/a
Cervical (screened excluded)	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%
Cervical (screened only)	100.0%	100.0%	n/a	n/a	n/a	n/a	n/a	100.0%
Head & Neck	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lung	93.2%	93.9%	94.9%	100.0%	100.0%	98.4%	96.9%	100.0%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ovarian	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Upper Gastro-Intestinal (GI)	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
All Cancer Types	95.3%	94.5%	96.2%	96.1%	96.2%	95.0%	96.8%	90.8%
All Cancer Types Trajectory	92.9%	92.5%	93.7%	94.8%	94.9%	95.3%	95.1%	94.9%
Difference	2.4%	2.0%	2.5%	1.3%	1.3%	-0.3%	1.7%	-4.1%

62 Day performance

	Mar 19	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20
Urological	50.0%	51.7%	47.8%	67.7%	58.1%	57.8%	56.5%	46.9%
Colorectal (screened excluded)	55.6%	41.7%	38.1%	68.8%	75.0%	82.6%	78.9%	84.6%
Colorectal (screened only)	0.0%	0.0%	10.0%	11.1%	50.0%	50.0%	40.0%	0.0%
Melanoma	80.0%	82.4%	94.8%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened excluded)	90.6%	84.0%	92.9%	100.0%	90.9%	89.5%	93.8%	96.3%
Breast (screened only)	100.0%	97.7%	97.2%	100.0%	100.0%	100.0%	93.8%	n/a
Cervical (screened excluded)	100.0%	100.0%	100.0%	n/a	50.0%	50.0%	50.0%	100.0%
Cervical (screened only)	100.0%	0.0%	n/a	0.0%	n/a	n/a	100.0%	0.0%
Head & Neck	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	71.4%	92.3%
Lung	92.9%	93.3%	83.3%	84.0%	82.8%	83.3%	93.3%	92.9%
Lymphoma	100.0%	75.0%	83.3%	33.3%	100.0%	100.0%	100.0%	100.0%
Ovarian	100.0%	75.0%	33.3%	n/a	50.0%	66.7%	100.0%	100.0%
Upper Gastro-Intestinal (GI)	90.5%	100.0%	94.7%	94.4%	100.0%	100.0%	100.0%	100.0%
All Cancer Types	79.3%	78.0%	78.5%	83.8%	83.0%	82.2%	83.9%	82.9%
All Cancer Types Trajectory	89.5%	81.5%	81.2%	84.1%	88.3%	87.6%	86.9%	86.4%
Difference	-10.2%	-3.5%	-2.7%	-0.3%	-5.3%	-5.4%	-3.0%	-3.5%

Appendix 6 - Unscheduled Care Emergency Department Performance, Attendance & Admission

NHS Lothian reported compliance to the 4 hour Emergency Access Standard (4EAS) of 94.7% for Jun 20. Chart 1 below shows 4EAS performance for NHS Lothian and Table 1 beneath shows the month to date figures for 4EAS by Site as at 27th July 2020.

Chart 1: NHS Lothian 4 hour Emergency Access Standard Performance Jan 18 – Jun 20

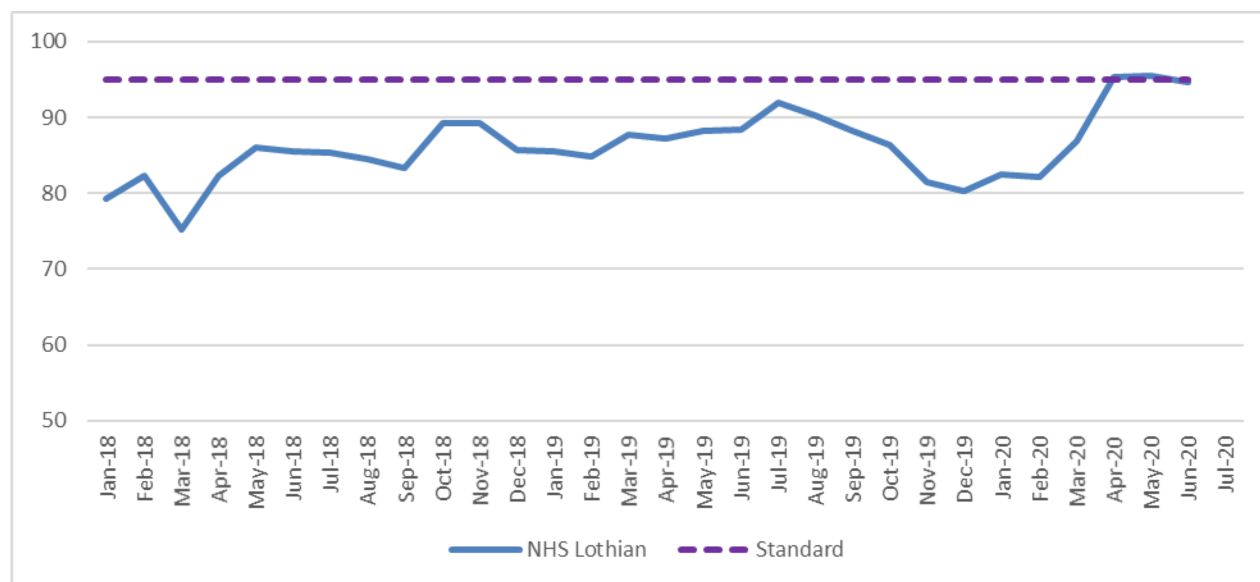


Table 1: 4 hour Emergency Access Standard Jul 2019 vs Jul 2020 (as at 27th July 2020)

	July 19	July 20 MTD	Difference
Royal Infirmary of Edinburgh	90.5%	94.0%	+3.5%
Western General Hospital	92.1%	94.4%	+2.3%
St John's Hospital	90.9%	95.8%	+4.9%
Royal Hospital for Sick Children	98.1%	97.5%	-0.6%
NHS Lothian	91.0%	95.0%	+4.0%

8 and 12 hour breaches have declined significantly following Covid, to some of the lowest levels for over a year. 8 hour breaches are however beginning to increase again.

Front door demand is now increasing as in Table 2 below, but remains lower than pre-Covid:-

Table 2: ED Attendances Jan 20 – Jun 20

Month	ROYAL INFIRMARY OF EDINBURGH	ST JOHN'S HOSPITAL AT HOWDEN	WESTERN GENERAL HOSPITAL	RHSC	NHS Lothian (Acute sites)
Jan 20 – pre-Covid	10,641	4,963	4,077	3,836	**23,517**
Feb 20 – pre-Covid	9,995	4,541	3,613	3,661	**21,810**
Mar 20	7,964	3,801	2,619	3,259	**17,643**
Apr 20	5,667	2,523	1,783	2,001	**11,974**
May 20	7,557	3,444	2,591	2,476	**16,068**
Jun 20	8,355	3,981	2,681	2,582	**17,599**

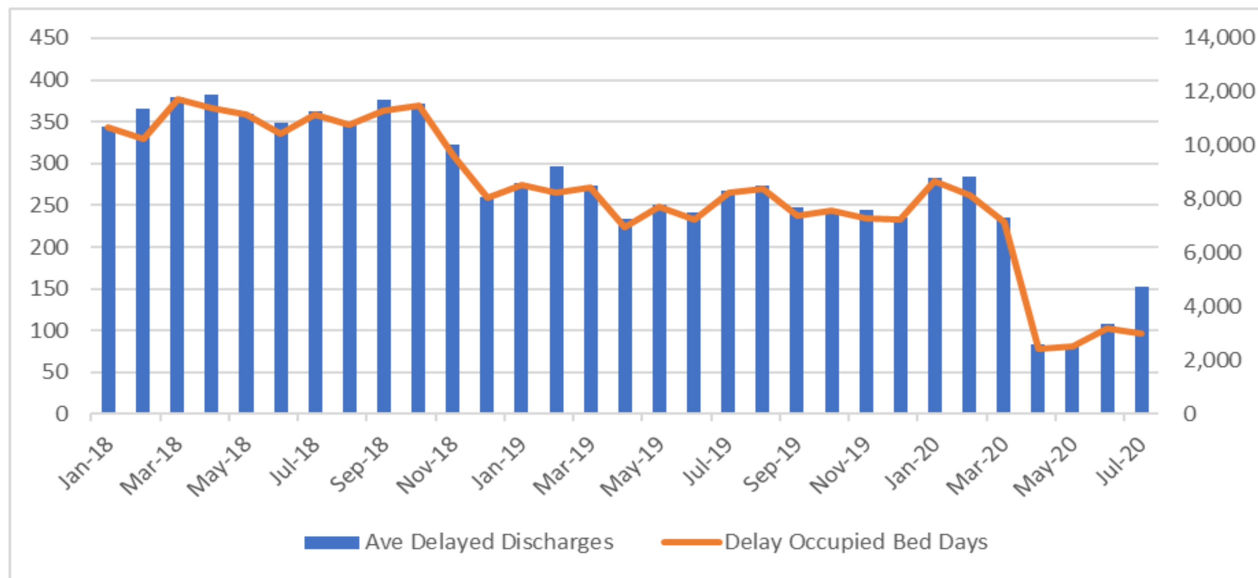
NHS Lothian began a 6-month pilot of remote telemedicine minor injuries assessment (Call MIA) on 1 April 2020. This initiative was planned prior to the Covid-19 pandemic, and originally focussed on minor injury patients as a low risk group. Initially both the video assessment and scheduled face to face appointments (where required) were provided from the Western General Hospital's Minor Injuries Unit. From 1st June, the scheduled appointments have also been provided from St John's Hospital and the Royal Infirmary of Edinburgh, and from 15th June appointments were provided at the Royal Hospital for Sick Children, in order to provide care at the site nearest to the patient. In recent weeks the team at St John's Hospital have begun to provide the remote assessment supporting the scale up of the service.

Between April 1st and June 28th Call MIA provided 571 video consultations, with 45% of these patients given self-care advice. Those that did require a face-to-face assessment were provided with a scheduled appointment at an acute site. Call MIA is currently only managing a small proportion of the overall minor injuries activity and further actions are underway as part of its roll out, including improving telephony infrastructure to enable a greater volume of calls to be processed, and signposting of patients who have called 111, planned from 5th August. Call MIA will become one part of our local model of managing and scheduling access to urgent care.

Chart 3 illustrates the significant reduction in delayed discharge numbers in April to date:-

Chart 3: NHS Lothian Average Delayed Discharges and Occupied Bed Days [1] Jan 18 – Jul 20 (MTD to 27th July)

[1] Average delayed discharges and occupied bed days includes code 9s and excludes code 100s


450
400
350
300
250
200
150
100
50
0
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Ave Delayed Discharges
Delay Occupied Bed Days

NHS LOTHIAN

Board Meeting
12 August 2020

Chief Officer, Acute Services

ST JOHN'S HOSPITAL PAEDIATRIC SERVICES – FOLLOW UP TO ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH (RCPCH) 2ND REVIEW REPORT

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board accept the recommendations of the Paediatric Programme Board following its review of the Royal College of Paediatrics and Child Health (RCPCH) second review Report and support the proposed 24/7 re- opening of the inpatient service in October 2020.

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

2 Recommendations

2.1 The Board is recommended to review and accept the Draft Action Plan covering the 13 Recommendations in the RCPCH Report.

2.2 To note the Paediatric Programme Board's assessment of the sustainability of the out of hours rota covering the St John's Paediatric Ward from September 2020 to end January 2021 and the position thereafter.

2.3 To accept the consequent recommendation of the Paediatric Programme Board that the Paediatric in patient ward at St John's should reopen 24/7, from 19 October 2020.

2.4 To accept that the Paediatric Programme Board (PPB) has now fulfilled its original remit and should now be dissolved, with the ongoing work to progress the Action Plan and sustain the St John's service being devolved principally to the Children's Clinical Management Team.

2.5 To accept the PPB's recommendation that the development of a coherent long term vision for the pan-Lothian paediatric service should be taken forward under the planned work to revise NHS Lothian's Clinical Strategy (all services), rather than by the PPB itself as recommended in the RCPCH Report.

3 Discussion of Key Issues

3.1 NHS Lothian invited the RCPCH to return and undertake a second follow up review of progress since their original Review and Report in 2016. This visit took place in February 2020 and the College's Report was received at the end of May 2020.

3.2 The Report congratulates NHS Lothian for making 'considerable and impressive efforts to support overnight inpatient services at St John's' over the last 4 years and highlights that the Board has remained resolutely committed to delivering the 'Option 1' 24/7 inpatient model. The Ward has been open 4 nights/week since March 2019.

3.3 The Report does note however that the RCPCH's original Option 1 recommendation, which was based on the St John's consultant team taking ownership of the rota, with an

expansion in consultant numbers, and all sharing in this rota commitment equally, has not happened and that the current arrangements are still fragile, relying on around 23 clinicians to support this.

3.4 This latest Report makes a number of short to medium term recommendations, both to progress efforts to achieve the ‘Option 1’ 24/7 service and sustain this, as well as to develop a long term vision for paediatric services across the whole of Lothian.

3.5 In terms of progressing ‘Option 1’, the Report recommends that NHS Lothian should support the St John’s team, working with colleagues at the Royal Hospital for Sick Children (RHSC), to develop an action plan for full implementation of a sustainable 24/7 service. This is linked to recommendations for a paediatric workforce group which should monitor rota gaps, agree recruitment strategies and help develop and maintain the sustainable workforce required. This work will be overseen by the Children’s Clinical Management Team, ensuring rotas are designed and published at a minimum of 3-6 months in advance.

3.6 The Report includes a recommendation that if a full inpatient service cannot be achieved and/or sustained within the next 12-18 months, then consideration should be given to whether the St John’s service should become a Short Stay Paediatric Assessment Unit (SSPAU), in line with Option 3 in the RCPCH’s original report in 2016.

3.7 The Paediatric Programme Board met on 16 June 2020 and again on 28 July 2020, to consider the College Review Report in detail, including a draft Action Plan, to update on recent successful recruitment activity and to assess the latest out of hours rota position. The PPB noted that recruitment which took place in June for 2 permanent Consultant posts and 1 locum post was successful, with 2 post holders due to start in September 2020 and 1 in January 2021. The availability of Advanced Paediatric Nurse Practitioners has also increased. The Clinical Director for St John’s and the St John’s team were able to confirm the detail of the non resident consultant out of hours rota and the middle grade resident out of hours rota position, from September 2020 through to end January 2021.

3.8 The overall assessment of the PPB was that the rota position was now ‘green’, with 41 shifts/month able to be covered from September 2020 and 43 shifts/ month able to be covered from January 2021(the average number of shifts which require to be covered each month is 40). It was noted that there were a few ward nursing posts in the process of recruitment, but once filled, the overall staffing situation was the best it had ever been. On this basis, the PPB agreed to recommend to NHS Lothian Board that the paediatric ward should extend its opening from the current 4 nights /week, to 7 nights from 19 October 2020.

3.9 The on going COVID-19 situation was recognised to be a new risk to staffing levels for all services and the PPB noted that many of those supporting the St John’s middle grade resident rota were also supporting other rotas at RHSC and at the Neonatal Unit at the Royal Infirmary. Staff sickness absence or the requirement to isolate due to COVID-19 infection risk could impact on rota sustainability, in the short term at least, on any of these sites, with St John’s being the most vulnerable, as the RHSC acute service and the Neonatal unit (including the St John’s Special Care Baby Unit) would always require to be prioritised to maintain patient safety (the RHSC service and the Neonatal service cannot be absorbed elsewhere, whereas the St John’s paediatric inpatient activity can be dealt with within RHSC if required, as it has been during past closures at St John’s).

3.10 Assuming that the recommendation of the PPB is accepted and the Draft Action Plan approved, the PPB would plan to meet once more to finalise the Action Plan, then it would be stepped down.

4 Key Risks

4.1 There is a risk that COVID-19 may impact on staff availability over the next 6 months which could result in short notice closure of the St John's inpatient ward. This might only be short term until staff returned to work but could be repeated over the course of the winter and is difficult to predict. If this did occur, the process for admitting West Lothian patients to RHSC would be reactivated and patient safety maintained.

5 Risk Register

5.1 There are no new risks for the Board Risk Register.

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 There will be a comprehensive communication plan to advise West Lothian families, GPs, LUCS, SAS and NHS 24 of the planned full reopening of the inpatient service from 19 October 2020.

8 Resource Implications

8.1 There are no new resource implications.

Fiona Mitchell
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31 July 2020
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List of Appendices

Appendix 1: Draft Action Plan

Action Plan

RCPCH Second Follow Up Report 2020: Recommendations and Proposed Actions

No.	Recommendation	Action	Leads	Timescale	RAG Status
1	NHS Lothian should support the general paediatricians to develop a cohort of doctors based at SJH to work a hybrid pattern, providing an enhanced Tier 2 rota and non-resident consultants to cover simultaneous emergencies.	Short life Workforce planning group to be set up	Clinical Director (CD) and Clinical Leads SJH	6-12 months	
2	NHS Lothian should ensure that there is consistency of expectation, as far as possible, regarding the participation of consultant paediatricians in resident on-call. There should be an expectation that all consultants over the age of 50 or 55 may choose to reduce or end their commitment to working resident night shifts but could continue resident shifts at other times during the week (e.g. evening shifts). This should apply to 'hybrid' consultants as well as appointments based at just one hospital.	Short life Workforce Group to review and make recommendations, with ER support, to the Children's Clinical Management Team (CMT)	CD and Clinical Leads SJH , with support from Employee Relations	6-12 months	
3	NHS Lothian should charge the Paediatric Programme Board (PPB) with developing a coherent long-term vision for the pan-Lothian paediatric service that goes beyond staffing rotas and overnight provision at SJH and harnesses the expertise from both SJH and RHSC.	This will be addressed as part of the wider planned work to revise NHS Lothian's Clinical Strategy (all services)	NHSL Strategic Planning Team to lead on. Input will be sought from all Children's services clinical teams.	12 months	
4	As part of work to develop a vision for the pan-Lothian service, the Paediatric Programme Board should seek to strengthen pathways that encompass acute and community paediatric services, including making	As 3 above- will be part of the work on the	As 3 above	12 months	

	effective use of the community nursing team, to support implementation of RCPCH standards to work across primary and secondary care.	revised NHS Lothian Clinical Strategy			
5	The Paediatric consultant teams at SJH, working in collaboration with colleagues at RHSC, should develop an action plan for fully implementing Option 1 in a manner that is sustainable and addresses concerns regarding the fragility of the service. If this cannot be achieved within the next 12-18 months, and doubts regarding sustainability cannot reliably be addressed, or if there are any further nights when the children's ward has to close unexpectedly, then consideration should be given to whether SJH should become a short-stay paediatric assessment unit (SSPAU) (see recommendation 6)	SJH team to take the lead in developing, monitoring and managing the Option 1 plan, in conjunction with RHSC colleagues and the Children's CMT	Clinical Leads and CD SJH	6-12 months	
6	Whilst working on recommendation 5, NHS Lothian should also begin to give consideration to alternative models of provision at SJH namely an action plan for the development of a short-stay paediatric assessment unit (SSPAU), should 'option 1' not be achieved.	SSPAU option to be scoped if Option 1 not looking viable after 12 months	SJH CD and Clinical Leads, Nursing Team and Children's CMT	12 months	
7	As part of work to develop a strategic vision for the service, NHS Lothian's Paediatric Programme Board should consider the distribution of paediatric services across SJH and RHSC and agree approaches to repatriation of patients. The underpinning principle should be that it is in the interest of children and their families for high quality care to be provided close to home where possible.	Review along with Remobilisation/Recovery plans to address impact of COVID –19. Links to the review of NHS Lothian Clinical Strategy	Children's CMT and NHS Lothian Strategic Planning	6-12 months	
8	Introduce a paediatric workforce group that meets regularly, monitoring and identifying rota gaps in advance, putting together recruitment packages and working closely with trusted locum agencies. This work could be undertaken by the PPB, or by a dedicated sub-group.	As Recommendation 1 &2, remit to Workforce Group, reporting to Children's CMT	CD and Clinical Leads SJH	6-12 months	
9	NHS Lothian should increase management support to the paediatric team at SJH to support recommendations 1, 3 and 4.	Increased CD support now in place, with additional support from	Children's Services CMT /NHS Strategic Planning Team	Already In place	

		the Children's Service Manager. Additional support available from NHSL Strategic Planning Manager for Children's services and SJH team			
10	Ensure the new Paediatric Clinical Director at SJH is supported in their role by senior leaders within the health board, and has access to training and mentorship as required, with sufficient time in their job plan dedicated to leading and developing the SJH team.	Ongoing support for CD now available. ADMD and Service Director to review with CD on ongoing basis	Children's CMT team/ADMD/Service Director	Already in place	
11	As part of long-term planning, NHS Lothian should actively pursue the potential offered to the service by recruiting and training physician associates. This may include providing daytime release at RHSC for doctors in training to attend SJH and providing a level of consistency and additional support to the SJH ward.	Remit to Workforce planning group, with support from NHSL workforce organisation and change expertise	CDs RHSC and SJH	12-24 months	
12	NHS Lothian should have a work programme that seeks to deliver compliance with the following RCPCH standards at both SJH and RHSC. *Facing the Future: together for child health; Facing the future: ongoing health needs.*	General Paediatricians at RHSC and SJH to work with CDs to scope the gap/ actions required and bring recommendations to the Children's CMT	RHSC & SJH teams/ CDs	12-24 months	
13	Ensure the strategy for advanced nursing practice enables nurses to: • Consolidate their 4 pillars of practice (clinical, education, leadership and audit/research) by ensuring that they have designated time within the rotas to do this (we would suggest 80% Clinical 20% non-clinical time). This will enhance their learning and skills and benefit the service being provided.	Children's Nursing management team to address, working with Paediatricians at both RHSC and SJH to ensure consistency for all	Associate Nurse Director for Children and Young People/ Clinical Nurse Managers	12-24 months	

	• Have an ongoing portfolio to evidence their scope of practice within the 4 pillars of advanced practice. They must be able to evidence their prescribing scope, radiology requesting scope as well as clinical scope at annual PADRs with medical mentor and Lead APNP/Consultant nurse in charge of the team.	Advanced Practice Nurses. Link to NHS Lothian Lead for Advanced Practice Nursing to ensure wider pan Lothian consistency			

NHS LOTHIAN

Board Meeting
12 August 2020

Medical Director

CLINICAL PRIORITISATION

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board supports the principle of clinical prioritisation, by which it is meant that those who require urgent treatment or assessment are treated first, according to their clinical need, and procedures or care is delivered in turn within categories.

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

2 Recommendations

The board is asked to:

2.1 Support the principle of clinical prioritisation for surgical treatment as requested by Scottish Government in the remobilisation plan and to understand the consequences of this for patients, for the reasons set out in the paper.

3 Discussion of Key Issues

3.1 The principle that those who are in need of urgent treatment should be seen or treated first is axiomatic for most healthcare professionals and well understood and usually accepted by most patients. There are two factors that bring the need to restate and support this principle to the fore in the current stage of remobilisation following Covid 19: the available capacity at every aspect of the healthcare system is reduced and the change in the provision of and the activity levels in non Covid related healthcare between March and June makes urgent presentation more likely- i.e. the numbers of urgent patients will rise.

3.2 The overall capacity to see, test and treat patients is reduced by the need for physical distancing measures, greater turnaround time between patients, additional environmental and equipment cleaning and by the use of PPE to a pre-Covid level approaching 60%. Although there is a separation in management discussion and in government reporting against standards about patients who are seen and admitted as emergencies (unscheduled care) and those who have a booked appointment in the correct time frame who are managed through a waiting list process (scheduled care), these two streams of patients pass through the same constrained resource at some point in their care, whether that is in an outpatient clinic, a CT scanner or an operating theatre. The same occurs in general practice, where the provision of same day appointments for patients with urgent problems competes with routine appointments for clinician time or space to be seen.

3.3 The amount of time or space set aside to manage both flows of patients usually reaches an equilibrium, but the consequences of imbalance need to be considered. Where there is inadequate capacity to meet the needs of scheduled care patients, their waiting time is extended, and this may take their wait beyond the expected waiting times, with potential adverse consequences on their health and wellbeing. Where there is inadequate capacity to meet the needs of unscheduled care patients, their length of stay in hospital may be extended resulting in overcrowding at front door areas for other patients as occupancy levels rise. In general practice, where a patient cannot access care, they may seek care elsewhere by presenting in the Emergency Department.

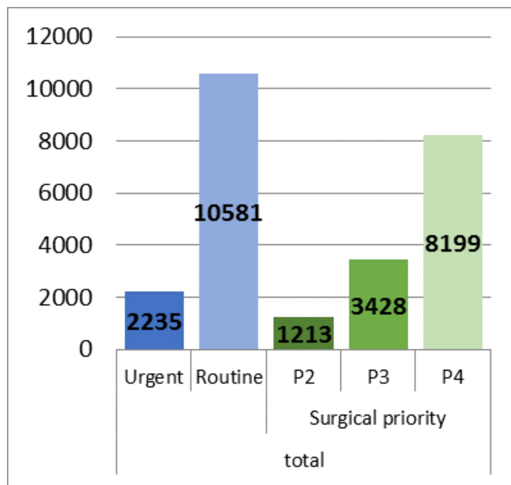
3.4 Additionally, there is well documented evidence that clinical outcomes are poorer for urgent patients who wait, for example in hip fracture patients, mortality begins to rise when fixation of the fracture is delayed beyond 24 safe operating hours. Poor clinical outcomes are associated with greater use of resources and a longer length of stay. Therefore, to maintain safe care for patients in all areas, sufficient capacity needs to be set aside for the needs of unscheduled care patients. CEPOD lists have evolved to address this need, and there are additional measures in endoscopy and radiology to ensure the needs of these patients are met.

3.5 When these arrangements are considered under remobilisation, there is a potential for the treatment of patients on a waiting list to be used as the performance measure, and while there is an acceptance that the 4hour ED standard is a whole system measure, the consequences and performance in the rest of the system is not visible.

3.6 The proposal from the Remobilisation team in Scottish Government is for boards to use the same standards and categories to demonstrate their activity and so allow comparison between boards and demonstration to the public that the same principles are being followed in each board area. For surgical specialties this can be addressed by using the surgical prioritisation guide developed by professional bodies which categorises procedures by categories 1a-4 as set out in the document accessible here

3.7 The attribution of individual procedures to categories of urgency is a starting point only and it should be expected that individual patient circumstances and severity of disease may result in movement of patients between categories. Patients in categories 1a and b do not usually get added to a waiting list but should have prioritised access to diagnostic and theatre capacity.

3.8 Preliminary work on the waiting lists for surgical treatment in NHS Lothian has been undertaken to describe how those currently waiting fall between these categories. This is shown in summary form below, both as the standard waiting times categorisation of urgent and routine and attributing cases based on case type and clinical notes to the priority 2-4 categories. Priority 1a and 1b cases are not usually entered onto a waiting list. Priority categories 2 and 3 account for 36% of the waiting list for inpatient or day case treatment overall, but this varies between specialty.



3.9 The consequence of the reduced capacity is that many patients in priority category 4 (over 12 weeks) will wait significantly longer than previously. Transparent and clear communication with patients is important to maintain trust in the system, especially when waiting times are increased. A similar process was put in place in NHS Grampian in 2018, reprioritising the elective surgical waiting lists only, with good levels of engagement from staff and patients. In NHS Lothian there is a keeping in touch process for patients with long waits and this is proposed to continue. Additionally, many clinical services are introducing a clinical element to this to ensure that there are clear communication routes for patients whose condition deteriorates. Some patients may no longer wish to proceed with a planned procedure and will be removed from the waiting list.

3.10 Detailed and additional work on the Ref Help service for GP and other referrers to articulate clearly the thresholds for referral, which will need to reflect the increased demand and reduced capacity in all parts of the system is underway.

3.11 The remobilisation team in Scottish Government are working to identify how to use similar clinical prioritisation processes to ensure within non-surgical services and mental health, so that those most urgently in need of assessment or treatment are prioritised.

3.12 It is not yet possible to quantify how many more patients will present in an urgent way, who would previously have been seen through a routine outpatient referral. Delayed presentations may be due to a number of factors including difficulty accessing health care services, fear of attending healthcare and reduced usual mechanisms designed to support earlier presentation of disease such as screening programmes. Under the system of clinical prioritisation, increases in urgent referrals and patient care will further delay routine patient care.

3.13 There will be an opportunity to consider and agree how the changes in likely waiting time and referral and treatment thresholds should be communicated to patients at the Board development session in September and how to include these aspects in the refreshed clinical strategy as it is developed to update Our Health Our Care Our Future.

4 Key Risks

4.1 There is a risk that clinical needs of patients are not prioritised over the need to deliver against waiting times and clinical outcomes for those patients are reduced.

4.2 If too much theatre capacity is set aside for unscheduled or urgent work, there is a risk that it is not used efficiently or effectively, as case numbers fluctuate on a day to day basis and

there is no longer an ability to call in patients at short notice (due to the requirement for preoperative testing).

4.3 Without a clear system to bring forward a patient based on increasing clinical need, patients waiting in a routine queue will suffer harm due to excess waiting times. Careful monitoring of the longest waits will highlight this and may allow mitigation by additional contact.

4.4 Additional monitoring has been put in place around Urgent Suspicion of Cancer waiting times at a local and regional level.

5 Risk Register

5.1 Risks relating to the delivery of safe care and performance against the 4 hour standard are already described on the risk register (3203 and 4688) as are risks about patient access to treatment (at 3211 and 4191)

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment has not been carried out on to date. There is the potential to adversely impact some sections of the population depending on the system used to escalate concerns or deterioration in an individual's condition and those who have limited or difficult access to their General Practitioner may be additionally impacted.

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

7.1 This section must be completed where appropriate: For all papers proposing strategies/ policies or service change, evidence must be presented on how legal duties of involvement have been met and how the outputs from informing, engaging and consulting have been used.

8 Resource Implications

8.1 The resource implications are not yet clear, as additional resources, financial and physical may be made available or restrictions on physical distancing and other constraints change.

Tracey Gillies
Medical Director
3 August 2020
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NHS LOTHIAN

Board Meeting
12th August 2020

Director of Finance

JUNE 2020 FINANCIAL POSITION

1 Purpose of the Report

1.1 This paper provides an update to the Board on the financial position at Period 3 for NHS Lothian, and updates on the process for the Quarter 1 review and forecast.

1.2 Any member wishing additional information on the detail behind this paper should contact the Director of Finance prior to the meeting.

2 Recommendations

2.1 The Board is recommended to:

- **Accept** this as a source of significant assurance that the Finance & Resources Committee (F&R) has considered the month 3 report on the 2020/21 financial position and has accepted limited assurance on achieving a breakeven position in this financial year.

3 Discussion of Key Issues

3.1 At its meeting on the 22nd July, the F&R Committee received a paper on the period 3 financial position, and an update on the progress made to update the financial projections for Covid-19 financial issues in this financial year. The F&R paper highlighted a period 3 year to date position of a £19.4m overspend against the Revenue Resource Limit (see Table 1).

Table 1: Financial Position to 30th June 2020

	Mth 1 £000	Mth 2 £000	Mth 3 £000	YTD £000
Pay	(5,079)	(4,631)	(4,463)	(14,173)
Non Pays	(1,079)	(801)	(4,078)	(5,958)
Income	513	10	239	762
In Month Total	**(5,646)**	**(5,422)**	**(8,301)**	**(19,369)**

3.2 The impact of the implementation of NHS Lothian's Covid-19 Mobilisation Plan and changes in services and functions required to meet these challenges continues to contribute significantly to the overspend position to date. Conversely, with activity levels below normal for most areas across Lothian, projections within the original Financial Plan forecast have not materialised as previously projected and expenditure is not consistent with previous year's trends.

3.3 The Financial Plan presented to the Board in April 2020 showed a projected deficit for the year ahead of £10.8m. Using this as a baseline allows for the estimation of the level of additional costs and offsetting flexibility arising from Covid-19. Currently the level of offsets

based on reduced activity, but including other variation from the financial plan is estimated at £11.5m as shown in Table 2 below, against additional costs of circa £31m.

Table 2: Breakdown of Financial Position to 30th June 2020

Breakdown of YTD Variance	£000's
20/21 Expected Financial Plan Gap	(2,715)
Estimated Impact of Covid Costs	(31,061)
Covid Funding Assumed to Date	2,926
Reduced Expenditure/Budget Offsets	11,482
YTD Variance as at June	**(19,368)**

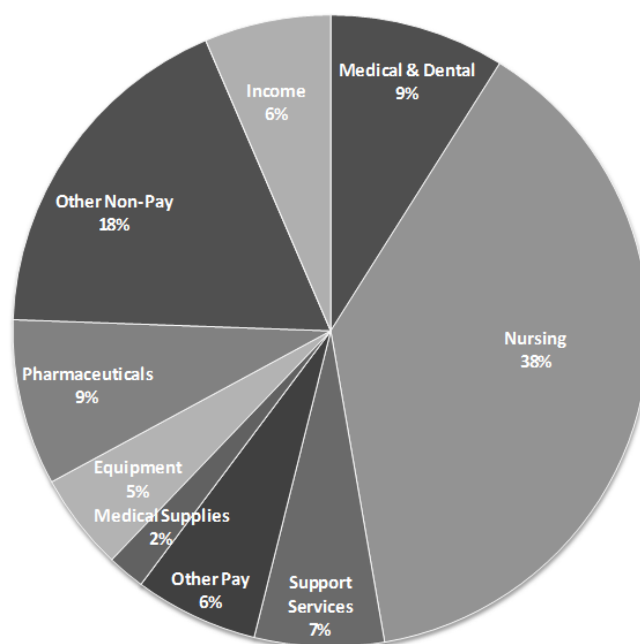
Financial Impact of Covid-19

3.4 As Table 2 above shows, the most significant impact on the financial position to date is the cost of supporting the services to manage Covid-19.

3.5 The latest review of Covid-19 related costs up to the end of June 2020 shows that the Board have incurred an estimated £31m of additional costs (before offsets for funding and underspends elsewhere). The breakdown of these costs is shown in table 3.

Table 3: Summary Breakdown of Covid-19 Additional Costs Incurred

YTD Position	YTD Variance £000's	YTD Net Covid-19 Costs £000's
Medical & Dental	(3,989)	2,771
Nursing	(7,049)	11,916
Support Services	(2,818)	2,048
Other Pay	(318)	1,958
Total Pay	**(14,173)**	**18,693**
Medical Supplies	3,553	595
Equipment Costs	(3,522)	1,542
Pharmaceuticals	(2,253)	2,641
Other Non-Pay	(3,736)	2,665
Total Non-Pay	**(5,957)**	**7,443**
Income	**761**	**1,998**
Flexibility & Reserves	**0**	**0**
Total	**(19,369)**	**28,135**
GP Payments (Funding Assumed)		2926
		31,061



3.6 The most significant costs incurred over the first quarter have been in relation to the new recruits and student nursing additional staffing costs. There is a process now underway to manage any extensions to original fixed term contracts and recruitment to existing vacancies. It is therefore envisaged that the level of additional Covid-19 staffing costs will reduce in the coming months.

3.7 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 in Set Aside and Core areas. Further work is required in order to provide accurate IJB level information and we will work with CFO colleagues to achieve this.

4 Quarter 1 Review

4.1 The process of the Q1 Review is now underway. Forecasting a year end outturn based on month 3 information is particularly challenging this year, particularly the impact mobilisation plans have had on costs to date. In addition, the effect of remobilisation on our cost base is difficult to assess as plans are in many cases at an embryonic stage.

4.2 The principles underpinning the Q1 forecast will be based on the Scottish Government document "Re-mobilise, Recover, Redesign: The Framework for NHS Scotland" published on 31st May, which sets out the core tasks for health boards in the months ahead. As part of the forecast, we aim to align the categories of additional costs within these broad headings.

4.3 At this stage, we expect that all net costs associated with Covid will be met by additional Scottish Government funding in-year. The Quarter 1 review will be a critical milestone in establishing the funding requirements for Lothian.

4.4 The F&R Committee was content to accept limited assurance on the achievement of financial balance this year on the basis that additional Covid related costs would be fully funded.

5 Key Risks

5.1 The F+R committee was updated on the financial risks relating to Covid and the completion of Local Mobilisation Plans (LMPs) to ensure an accurate collation of costs. The key risk for Lothian (and indeed all health boards) is that at this stage all Boards have yet to receive formal confirmation that there will be sufficient additional resources available to support the costs of Covid across Scotland in 20/21.

6 Risk Register

6.1 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)***

6.2 The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

7 Impact on Inequality, Including Health Inequalities

7.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

8.1 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.

9 Resource Implications

9.1 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
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30th July 2020
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NHS LOTHIAN

Board
12 August 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, and to consider addition of two new risks.

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

2 Recommendations

The Board is recommended to:

2.1 Accept a new risk, relating to Care homes onto the corporate risk register, as recommended by the Healthcare Governance Committee, which is set out in Appendix 1.

2.2 Accept a new risk associated with Legionella, onto the corporate risk register, as recommended by the Healthcare Governance Committee, set out in Appendix 2.

2.3 Note a decrease in the grading of the risk 'Facilities fit for purpose' following review by the Finance & Resources Committee.

2.4 Note an increase in the grading of the risk 'Nursing workforce' agreed by the Staff governance committee.

2.5 Accept the risk assurance table, as set out in Appendix 3, as a summary of all risks including levels of assurance and grading, as agreed by the relevant committee.

3 Discussion of Key Issues

3.1 The Board is asked to accept the addition of two new risks to the corporate risk register associated with care homes and with Legionella and water safety as described below. The risks are set out in full in Appendices 1 and 2.

3.1.1 **Care Homes (5034)**

Risk Description

There is an ongoing risk to the health and well-being of care home residents and staff from the current and any future Covid-19 outbreak. This is as a result of the potential for community transmission to a vulnerable population and the enhanced requirements for infection prevention and control within non-clinical environments.

Health Boards have been given additional responsibilities for multi-professional oversight in organisations that they have no formal jurisdiction over. This presents potential reputational, political and legal risk to NHS Lothian.

Committee Assurance

Healthcare Governance Committee will be the primary committee for assurance.

Grading – High (12)

Plans to mitigate the risk are in place, however, not fully implemented with continued development of processes to capture a reliable data set.

3.1.2 **Legionella (5020)**

Risk Description

There is a risk that Legionella may be present in water supplies to healthcare premises due to reduced or no usage of water in some areas during Covid pandemic, seasonal increase in water temperature and incomplete implementation of existing plans to improve systems of control around water safety, and provide assurance through documented evidence.

This may lead to harm to patients, staff and the general public, with potential prosecution under H&S law. In addition, the ability to remobilise services following Covid-19 will be affected where we are not able to demonstrate safety of water systems.

Committee Assurance

Healthcare Governance Committee will be the primary committee for assurance.

Grading – High (12)

Plans to mitigate the risk are in place, however, not fully implemented and in particular, there is a current lack of documentary evidence of compliance with legal requirements.

3.2 **Risk Register Update**

Strategic Risk Framework

3.2.1 Management and assurance committees of the Board are required to ensure that all NHS Lothian plans and controls to mitigate corporate risks have considered the following:-

- New models of Health & Social Care risk
- How the plans seek to improve and innovate
- Mechanisms for collaborative and joint working
- Engagement with the public and patients.

3.2.1 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.

3.2.2 There are currently 19 risks in Quarter 1 on the corporate risk register. The 9 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 (new risk)
9. Health of the population and impact on NHS Lothian services from Covid-19

3.2.3 Work to improve reliability of processes of assurance in the management of risks on the corporate risk register with risk owners, handlers and the relevant committees is now beginning. This includes examining alignment of assurance levels with grading of the risks, using data over time to evidence effectiveness of controls. The impact of Covid-19 on relevant risks will be considered as part of this exercise.

3.2.4 Covid has notably impacted on access and discharge risks, in that data demonstrates a reduction in risk for the 4-hour emergency care targets and for timely discharge. It is, however, recognised that the current situation is somewhat artificial and therefore risks should remain on the corporate risk register until the longer term impact is understood. Conversely, access to treatment risks are increased and further controls are being implemented through the re-mobilisation plans. The Healthcare governance committee has also agreed that the risk related to GP sustainability also required to be re-examined and will be reviewed at the September meeting.

4 Key Risks

4.1 The risk register process fails to identify, control or escalate risks that could have a significant impact on NHS Lothian.

5 Risk Register

5.1 Not applicable.

6 Impact on 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 July 2020
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List of Appendices

Appendix 1: New risk - Care Homes
Appendix 2: New risk - Legionella
Appendix 3: Risk Assurance Table

Appendix 1

Risk 5034 – Care Homes

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions

Protect and improve the health of our population	There is an ongoing risk to the health and well-being of care home residents and staff from the current and any future Covid-19 outbreak. This is as a result of the potential for community transmission to a vulnerable population and the enhanced requirements for infection prevention and control within non-clinical environments.
	
	Health Boards have been given additional responsibilities for multi professional oversight in organisations that they have no formal jurisdiction over. This presents potential
		4984 – Covid-19
		3726 – Delayed Discharge
		
		Associated Plans
		• NHSL Covid 19 Mobilisation Plan
		• NHSL Nursing and Midwifery Covid 19 Mobilisation Plan
		• NHSL Care Home Framework (under development)
		
		Assurance Committee(s)
		
		Healthcare Governance
			Governance and management
			
			Healthcare governance and Board will receive timely updates
			
			• Multi-agency Strategic Oversight Group, Chaired by Executive Nurse Director meets weekly
			• Multi-agency Daily Operational Huddle, chaired by Nurse Director Primary Care meets daily
			• Informed by each HSPC daily care home huddle
			• Dedicated Care Home Programme Team within Corporate Nursing
			• Development of local assurance tool – all care homes for review June-July 2020
			• Use of national safety huddle tool – 7/7 updates from each care home
			• Multi agency stakeholder engagement
			• Mutual aid staffing arrangement
			
			Policies, procedures and plans
			• Care Home Framework (under development) encompassing:
			  ◦ Agreed principles of working
			  ◦ Agreed multi-agency roles and responsibilities
			  ◦ Governance structures with agreed terms of reference and escalation plans
			  ◦ Agreed relationship with Care Inspectorate for regulatory inspections and assurance
				Covid 19 care home outbreaks
				Daily reporting of KPIs through national safety huddle
				Weekly DPH reporting to SG on care home testing
				Completion of Assurance reviews
					June 2020 Update
					Governance arrangements established
					
					Multi-agency relationships clarified and developing effective working
					
					Assurance reviews underway in all care homes across the HSCPs
					
					Participation in unannounced visits co-ordinated by the Care Inspectorate

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
	reputational, political and legal risk to NHS Lothian.	**Grading** • **High (12)**	reviews • Data management including Tableau dashboard • Education and training capacity • Pharmacy and medical capacity **Adequacy of controls** Inadequate – 6 weeks into new arrangements and continue to develop processes for capturing reliable data set		

Appendix 2

Risk 5020 – Legionella

Priority for Continuous Improvement	Risk Description	Linked Risks	Controls	Key Measures	Updates/actions
Protect and improve the health of our population	There is a risk that Legionella may be present in water supplies to healthcare premises due to reduced or no usage of water in some areas during Covid pandemic, seasonal increase in water temperature and incomplete implementation of existing plans to improve systems of control around water safety, and provide assurance through documented evidence. This may lead to harm to patients, staff and the general public, potential prosecution under H&S law. In addition, the ability to remobilise services following Covid-19 will be affected where we are not able to demonstrate safety	• HAI (1076) **Associated Plans** • Water safety plan **Assurance Committee** • Healthcare governance **Grading** **Suggest high (12)** (Major impact/likelihood possible)	**Governance and management** The NHS Lothian Water safety group provides strategic oversight and leads improvement for this work, chaired by NHS Lothian Medical Director and includes external, independent subject matter expert (AE Water) The group reports to HCG committee through the Pan Lothian Infection control committee. There is also a reporting line to Staff governance committee through Health & safety committee. Operationally, subgroups are in place for each acute hospital site and for the HSCPs and REAS, which link to local H&S and Infection prevention and control committees. Designated roles are in place as per legal requirements (HSE) including duty holders - (CEO) and HSCP chief officers and Designated person water (DPW) **Policies and plans** Local policy and guidance are in place and current being updated: - NHS Lothian Water Safety Policy - Draft template for site based Water safety plans developed and being tested All underpinned by national policy framework and suite of national guidance: • SHTM 04-01 Water Safety for Healthcare	Documented evidence of compliance with all aspects of SHTM 04-01 Part B Operational Management. E.g. Evidence of up to date Legionella risk assessments and water safety plans for all buildings Evidence that competence assessed, named individuals (with letter of appointment where appropriate) are performing key roles as outlined in SHTM 04-01 Part B. Evidence of monitoring records over last 5 years E.g. water flushing records Compliance with water temperature control Water monitoring results Compliance with testing schedules Results of microbiology testing as required	Water safety plans to be developed for all buildings and agreed by relevant site/service water safety groups – timescale to be agreed. Checklist to be implemented across all sites to provide documentary evidence of assessment of all relevant areas. Clear route for assurance for non- NHS Lothian owned premises, including primary care to be agreed – timescale to be agreed. Specific plan in development in relation to dental chairs and remobilisation of services – timescale to be agreed.

Priority for Continuous Improvement	Risk Description	Linked Risks	Controls	Key Measures	Updates/actions
	of water systems.		Premises Parts A to G, which sets out required documentation • HSE Approved Code of Practice L8 Legionnaires' Disease – the control of legionella bacteria in water systems, • Health Protection Guidance for neonatal units (NNUs) (levels 1, 2 & 3), adult and paediatric intensive care units (ICUs) in Scotland to minimise the risk of *Pseudomonas aeruginosa* infection from water (2018). **Procedures and monitoring** Various processes in place with improvement plans in place to demonstrate clear assurance processes (see actions). Water testing schedules and water temperature monitoring in place. Water safety information shared and reviewed via H&S groups. Legionella risk assessments in place. Problem assessment groups (PAGs) and Incident management teams (IMTs) convened as required to respond to issues. AEW provides annual independent audit. **Adequacy of controls** Inadequate - the control is not designed to properly manage the risk, and further controls and measures are required. This is due to incomplete implementation of plans and current lack of documentary evidence of compliance with legal requirements.		

Appendix 3

Risk Assurance Table

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
4984	Covid-19 New risk added June 2020	Healthcare Governance & Risk Committee July 2020 - HCG accepted limited assurance on this risk overall.	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
3600	Finance Update provided July 2020	Finance & Resources Committee (F&R) June 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)	Healthcare Governance Committee (HCG) HCG Jan 2019 update accepted moderate assurance	High 10	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
	Update provided July 2020	re plan in place to improve 4 hour performance and safety at RIE. Plan subject to external scrutiny.					
4688	Patient safety in RIE ED Update provided July 2020	HCG Committee Healthcare Governance considered plans in place to mitigate risk to safe, effective, person-centred care in March 2019 – Moderate assurance Audit & Risk Committee –November 2018 – Moderate assurance Plan also subject to external scrutiny.	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 July 2020	HCG Committee November 2018 HCG continued to accept limited assurance. September 2019 - as part of partnership annual report risk mitigation was discussed and improvements in delay discharges noted with a focus on sustainability.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3829	GP Sustainability. Update provided January 2020	HCG Committee July 2020 – HCG continued to accept limited assurance. Issues to be re-considered September 2020. Acknowledged that risk needs to be re-evaluated.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3211	Access to Treatment (Organisation Risk) Update provided July 2020	HCG Committee November 2019 - Moderate assurance was accepted around healthcare governance arrangements across NHS Lothian's Acute Services.	High 12	Very High 20	Very High 20	Very High 20	Very High 20
4191	Access to Treatment (Patient Risk)	HCG Committee September 2019 HCG accepted moderate assurance	Very High	Very High	Very High	Very High	Very High

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
	Update provided July 2020	on the management of clinical risk related to cancer waiting times.	20	20	20	20	20
4693	Brexit Update provided January 2020 **(CLOSED 09/04/2020)**	HCG Committee Agreement to keep under review pending discussions on trade agreements.	Very High 20	Very High 20	Very High 20	Closed 9/4/2020	Closed 9/4/2020
4820	Delivery of level 3 recovery plans Update provided July 2020	Board 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	Very High 20		High 12	High 12	High 12
4921	Bed Capacity in Acute Mental Health Update provided July 2020	Healthcare Governance Committee Jan 2020 - accepted moderate assurance. Due to report to HCG on adult inpatient services September 2020	High 15		High 15	High 15	High 15
4694	Waste Management Update provided July 2020	Staff Governance Committee August 2019 - Health & Safety Committee accepted moderate assurance. July 2020 - The actions and control measures which are being implemented still represent moderate assurance to the Staff Governance Committee.	High 15	High 15	High 15	High 15	High 15
3454	Learning from Complaints Update provided July 2020	HCG Committee July 2020 – Moderate assurance accepted.	High 12	High 16	High 16	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	High 16	High 16	High 16	High 16	High 16

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
		patient safety and quality of care.					
3189	Facilities Fit for Purpose Update provided July 2020	Finance & Resources Committee June 2020 - Moderate assurance agreed, reduction in grading from High 16 to high 12 (impact changed from high to moderate)	High 15	High 16	High 16	High 16	High 12
3455	Violence & Aggression. (Reported at H&S Committee) Update provided July 2020	Staff Governance Committee July 2020 - accepted moderate assurance	Med 9	High 15	High 15	High 15	High 15
3328	Roadways/ Traffic Management (Risk placed back on the Corporate Risk Register December 2015) (Reported at H&S Committee). Update provided January 2020	Staff Governance Committee July 2020- limited assurance accepted	High 12	High 12	High 12	High 12	High 12
1076	Healthcare Associated Infection Update provided July 2020	HCG Committee July 2020 - Moderate assurance accepted. Standing item on HCG agenda.	High 12	Med 9	Med 9	High 16	High 16
3828	Nursing Workforce Update provided July 2020	Staff Governance Committee 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	High 12	Med 6	Med 6	Med 6	High 12

NHS LOTHIAN

Board
12 August 2020

Chair of the Audit & Risk Committee

AUDIT & RISK COMMITTEE CONSIDERATION OF THE INTERNAL AUDIT OF RHCYP/DCN

1 Purpose of the Report

1.1 The purpose of this report is to inform the Board of the Audit & Risk Committee's key conclusions from the internal audit report 'Governance and Internal Controls: Royal Hospital for Children and Young People, Department of Clinical Neurosciences.'

1.2 This report is relevant to 'Achieving Value and Sustainability' element of Our Priorities for Continuous Improvement,

2 Recommendations

2.1 The Board is invited to accept this report as a source of significant assurance that the Audit & Risk Committee has properly considered the audit report, and note the comments made by the A&R Committee.

3 Discussion of Key Issues

3.1 The audit report, and the investigations leading to its publication, are long and complex. The Committee had discussed an early draft in January 2020 and agreed that, despite expectations that the final version would be available in April, it was necessary to await responses from all of the interested parties and complete all the investigations necessary. Consequently, a detailed discussion on the content of the final report took place at a special meeting of A&R on 31 July. Following the meeting the members met in private to reflect on the discussion and the report. They agreed that it may be helpful to provide this summary of their conclusions.

Quality of the Audit Report

3.2 The members unanimously agreed that the Chief Internal Auditor has completed an outstanding piece of work, recognising the scale and complexity of the subject matter. The members agreed that the Chief Internal Auditor had satisfactorily carried out the engagement, as specified in the Terms of Reference, and that the report has identified all of the key issues. The Committee noted that the Chief Internal Auditor was going to make some minor amendments to the report before it was presented to the Board, to reflect recently received detail (which are small points of clarification) and make some clarifications arising from matters raised in the Committee's discussion. The following comments are based on the discussion of the version of the report presented to the Committee.

Key Messages from the Report

3.3 The investigation did not identify a single point of failure. Rather, many parties missed many opportunities to identify that there was a problem with ventilation. Some decisions on the specification relating to ventilation were made early within the life of the project, and there appears to have been very little detailed scrutiny of, or rigorous

challenge to, those decisions. So one of the key points that emerges from the report is that the ventilation was not identified as a problem rather than it was not addressed.

3.4 The review did not identify any evidence of malicious behaviour or intent by any person or organisation.

3.5 The review identified that, throughout the project, external factors led to pressure to attend to and agree things quickly. The changes from a traditional capital build to an untested and new Non-Profit Distribution (NPD) model (with DCN added to the scope to the project), added complexity, de-stabilised what was in place, and introduced a delay to the project timeline. The Report states that there is no evidence of anyone doing – or identifying a need for – a Risk Assessment on the potential issues arising from introducing the NPD model after the project had been started as a Capital Build. Consequently efforts were made to pursue a streamlined procurement process in order to minimise the overall delay. Additionally, the report identifies that the financial situation of Project Co created a pressure to sign the contract in February 2015 (despite the reviewable design data [RDD] not being agreed by both parties) and, later, concluding the settlement agreement in February 2019.

3.6 The Committee took particular note that NHSL requested some 4-bedded rooms despite the fact that the SHTM does not identify 4-bedded rooms as a 'model room'. The report states that "the SHTM is the principal set of guidance…". Thus the committee feels that this should have alerted those concerned that there could be issues arising from this request. NHS Lothian and Multiplex had different views as to whether 4-bedded rooms were covered by the definition of a 'room' or a 'ward'. The fact that some of these 'rooms' were subject to different guidance on ventilation was not identified, and therefore was not discussed and resolved. While the request for 4-bedded rooms may not have been unreasonable, it is evident that the control processes at this stage of the project did not adequately respond to it.

Recommendations and Management Response

3.7 The Committee welcomed the recommendations and the management responses to them. However, while taking forward the recommendations will no doubt add value to the Board's system of governance and internal control, the members' agreed that the recommendations are pitched at a high level. Implementing the recommendations would not necessarily help reduce the risk of the operational-level errors which the report identified. These need to be addressed at a more 'granular' level.

3.8 The members agree that there are lessons to be learned that could be valid for the wider public sector. Despite the contractual arrangements which were put in place, the reality is that risk did not truly transfer from the Board to the private sector contractor. The Board could not walk away when problems were identified because it needed the facility. The members agreed that when the NHS Board is developing its systems of governance and internal control, it should consider the following issues:

- The Committee felt strongly that the project suffered by there not being an individual member of the project team, or external adviser, with a clear remit to take on this role. They would be responsible for ensuring that the requirements of any relevant legal requirements and guidance is absolutely understood. This role should include getting assurance that those requirements are properly factored into the design of the facility. The individual/adviser will require high level skills

and relevant experience which may well involve additional investment. However, it is felt that such extra costs are justified within the overall value of the project.

- The report makes it clear that the Board was responsible for defining 'Operational Functionality', which is a spatial concept concerned with layout and use of rooms and is not concerned with mechanical and engineering issues. The contractor is responsible for the technical design and satisfying the relevant legal requirements and guidance. A key learning point, which could be relevant for other public bodies, is that there must be controls in place to ensure that whatever is in the specification can actually be delivered by the contractor. This should be a process which provides quality assurance back to the Board through the Project team, led by an individual or team with a dedicated focus on that purpose.

- There needs to be stronger processes within the governance system to trigger escalation when there are differences between the Board's requirements, and what the contractors are able to or are prepared to deliver. The significance of those differences should be clearly explained to the Board. The Board [or relevant Committee] should consider how to respond to those differences with due regard to their impact on safe and effective care.

- When independent testers are engaged, they should be commissioned to test against all relevant legal requirements and guidance, rather than what is stated in any agreement between the parties. This would reduce the risk of any flaws previously embedded within the agreement being translated into the testing process.

- The Committee felt very strongly that the decision to have 4 bedded rooms, and the failure to recognise the implications of this decision, was a fundamental problem which undermined the whole project. In order to avoid similar issues in future it was felt that a project team needs access to an appropriately trained clinician, with experience of working on similar projects, in order to ensure that clinical requirements are effectively identified, communicated, and thereafter translated into the project.

- Within the Committee's discussion, it was observed that the importance of ventilation to the quality and functionality of the rooms did not appear to come through strongly at the early stages of the project. Although not specifically recommended in the report, it would be good practice for any future major hospital project to have a person within the project board leading on ventilation, water supply, infection control and related issues.

- The Board should seek to ensure that its executive leaders have the capacity and support to manage such complicated capital projects, while at the same time carrying out all of their other core duties. An executive may lead a significant capital project once in his or her career, and any lessons learned needs to be systemically learned by the organisation.

4 Key Risks

4.1 The Board and the wider public sector do not take the opportunity to learn from this project, leading to similar problems occurring in future projects.

5 Risk Register

5.1 The risk associated with RHCYP/DCN is already on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment is not required as the report does not have proposals with a specific impact on an identifiable group of people.

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

7.1 Public involvement is not required as this report has no specific proposals for action or change that will impact on planning and development of health services.

8 Resource Implications

8.1 This report is providing advice to the Board to help with the future management of projects and resources.

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31 July 2020
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