NHS Lothian Board

14 October 2020, 09:30 to 13:00
MS TEAMS

Agenda

Declaration of Interests

1. Declaration of Interests

Verbal

Esther Roberton

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

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

Items for Approval or Noting

2. Items proposed for Approval or Noting without further discussion

Decision

Esther Roberton

2.1. Minutes of Previous Board Meetings

2.1.1. Board Minutes 12 August 2020

For Approval

Esther Roberton

12-08-20 Public Board Minutes (draft to Board 141020).pdf (16 pages)

2.1.2. Board Minutes 24 September 2020

For Approval

Esther Roberton

24-09-20 Public Board (draft to board 141020).pdf (4 pages)

2.2. Appointment of Members to Committees

For Approval

Esther Roberton

14 October Apptments report (final 110920).pdf (2 pages)

2.3. Finance & Resources Committee Minutes - 17 June; 27 July & 26 August 2020

For Noting

Martin Hill

F&R 17-06-20 Minutes signed.pdf (6 pages)

F&R 22-07-20 Minutes signed.pdf (5 pages)

2.4. Healthcare Governance Committee Minutes - 14 July 2020

For Noting

Moira Whyte

HGC 14-07-20 Minutes signed.pdf (7 pages)

2.5. Audit and Risk Committee Minutes - 31 July 2020

For Noting

Mike Ash

31-07-20 ARC Signed Minutes.pdf (3 pages)

2.6. Edinburgh Integration Joint Board Minutes - 21 July 2020

For Noting

Angus McCann

E IJB 21 July 2020.pdf (4 pages)

2.7. West Lothian Integration Joint Board Minutes - 11 August 2020

For Noting

Bill McQueen

WL IJB 11 August 2020.pdf (6 pages)

2.8. East Lothian Integration Joint Board Minutes - 25 June 2020

For Noting

Fiona O'Donnell

EL IJB 25 June 2020.pdf (10 pages)

2.9. Midlothian Integration Joint Board Minutes - 13 February, 12 March, 16 April and 11 June 2020

For Noting

Carolyn Hirst

MIJB minutes 13 February 2020.pdf (10 pages)

MIJB minutes 12 March 2020.pdf (5 pages)

MIJB minutes 16 April 2020.pdf (15 pages)

MIJB minutes 11 June 2020.pdf (8 pages)

2.10. NHS Lothian Capital Developments with the Shawfair Development Area

For Noting

Susan Goldsmith

Shawfair Development Area Board Paper_Oct_2020.pdf (4 pages)

Appendix - Shawfair Developement Area IA Version 2-3 2020.pdf (46 pages)

2.11. West Edinburgh (Maybury) General Medical Services Provision Initial Agreement

For Noting

Susan Goldsmith

NHSL Board Cover Report West Edinburgh IA 141020.pdf (4 pages)

West Edinburgh Primary Care Provision Initial Agreement final.pdf (35 pages)

Items for Discussion

3. Board Chair's Report - October 2020

Verbal

Esther Roberton

4. Board Executive Team Report - October 2020

Discussion

Calum Campbell

Board Executive Team Report October 2020.pdf (13 pages)

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

Verbal

Esther Roberton

6. Covid-19 - Public Health Update

Discussion

Alison McCallum

Covid19 Public Health Update Report Oct 2020.pdf (5 pages)

7. Scheduled and Unscheduled Care Performance

Discussion

Jacquie Campbell

Board Paper_Sched Unsched Care_ Oct 20_Final_Submitted.pdf (18 pages)

8. Lothian Recovery Plan Updates

8.1. Psychological Therapies

Discussion

Alex McMahon

20201005-PT_Board Paper_Oct 20-V1.0.pdf (7 pages)

8.2. Child and Adolescent Mental Health Services

Discussion

Alex McMahon

CAMHS_Board Paper_Oct 20 V2 07-10-20.pdf (8 pages)

9. Initial Agreement – Edinburgh Cancer Centre Development

Discussion

Jim Crombie

Cover Paper - ECC IA NHSL Board Oct 2020 v3.pdf (10 pages)

Appendix 1 - Edinburgh Cancer Centre Initial Agreement v41 Oct 2020.pdf (232 pages)

Appendix 2 ECC Essential Services Satellite and Regional Graphi.pdf (1 pages)

10. August 2020 Financial Position and Quarter One Financial Forecast

Discussion

Susan Goldsmith

Finance report - Board 141020 - FINAL.pdf (6 pages)

11. Corporate Risk Register

Discussion

Tracey Gillies

Board Corporate Risk Register Report 14 October 2020 Final.pdf (12 pages)

12. RHCYP, DCN & CAMHS Project Update

Verbal

Susan Goldsmith

13. Terms of Reference of Planning, Performance & Development Committee

Discussion

Colin Briggs

- 141020- Cover PPDC (final to Board).pdf (3 pages)
- PPDC TOR (draft to Board 141020).pdf (2 pages)

14. Board and Committee Dates 2021

Discussion

Esther Roberton

- 141020- Cover Schedule for 2021 (final 250920).pdf (2 pages)
- Appendix 1 - Draft 2021 Timetable (240920).pdf (3 pages)

15. Future Board Meetings

- 09 December 2020

Verbal

Esther Roberton

16. Any Other Business

Verbal

Esther Roberton

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

Decision

Esther Roberton

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 12 August 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; Mrs K Kasper; Mr A McCann; Cllr D Milligan; Cllr J McGinty; Mr W McQueen; Mrs A Mitchell; Mr P Murray; Cllr F O'Donnell; Mr T Waterson; Dr R Williams and Professor M Whyte.

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

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

Declaration of Financial and Non-Financial Interest

42. 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.

42.1 There were no declarations of interest.

43. Chair's Introductory Comments

43.1 The Chair extended a warm welcome to Mr T Waterson as the Board's new Employee Director. She also congratulated Mrs Kasper on her pregnancy. The Chair reported that Mr Ash and Mrs Mitchell would remain on the Board as their membership had been extended, however they have stood down from chairing the Audit & Risk Committee and the Staff Governance Committee respectively. The Chair thanked both Mr Ash and Mrs Mitchell for their leadership and contributions in those roles.

43.2 The Chair also extended the Board's thanks to Ms Joanne Brown for her work on the internal audit of the Royal Hospital for Children and Young People / Department of Clinical Neurosciences.

44. Items for Approval

44.1 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. The Chair advised that paper 2.2 'Appointment of Committee Members' would be discussed separately.

44.2 The Board agreed items 2.1 and 2.3-2.8 on the agenda without further discussion.

Items for Discussion

45. Appointment of Committee Members

45.1 The Chair advised that the circulated paper had proposed that Mrs Mitchell would join the Edinburgh Integration Joint Board (IJB). However, on reflection Mrs Mitchell concluded that she could not undertake this role. The Board approved the recommendations in the report except the appointment of Mrs Mitchell to the IJB. The position would be reviewed and alternative proposals would be brought to a future Board meeting.

46. Approach to Future Board Meetings

46.1 The Chair commented that the recommendation in the Board paper was that the Board would continue not to convene its Board meetings in public up to and including its meeting on 9 December 2020. This is for the 'special reason' of protecting public health, and the health and wellbeing of anyone who would have otherwise attended the meeting. Meetings would therefore continue to be held by Teams or in any other manner which did not require the members or staff to physically meet.

46.2 Ms Hirst commented that although she was content to have meetings on Teams that she had concerns about the lack of opportunity for members of the general public to observe the Board's business. She questioned what other Boards were doing and whether this included recording meetings in order to have a public record.

46.3 The Board noted that the national Corporate Governance Group was looking at how to take Board meetings out of lockdown, and considering the various options. The Board noted that in NHS Fife the media was allowed to attend meetings via Teams.

46.4 Mr Payne advised that the intention was to develop and implement a consistent approach across Scotland.

46.5 The point was made that some IJB meetings were already streamed. The Chief Executive, Mr Payne and Mrs Mackay would look at opportunities around streaming and also inviting the media to join the meeting. Cllr Milligan reported that councils had been advised of the need to move back to public meetings by mid-September.

46.6 The Board agreed the recommendations contained in the circulated paper and in particular the need to continue to schedule six public Board meetings per year. Mr Connor advised that in a previous role in an English NHS Trust development sessions had been held in the afternoon of the public Board meeting.

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

47.1 The Vice Chair advised that at the Finance and Resources Committee meeting held on 22 July 2020, the Committee had reviewed the entry on the corporate risk register for RHCYP/DCN. The committee had also considered the appointment of counsel to the public inquiry, and the role of the Finance and Resources Committee in that process.

48. Board Executive Team Report

48.1 The Chief Executive advised that the production of a Board Executive Team report to the Board was something that he had done in previous Boards. He advised that he had agreed with colleagues that a similar report would be produced for NHS Lothian for a short period and then reviewed to consider its added value.

48.2 The Chief Executive advised in respect of his own section that it was important that the Board were aware that the Annual Review of the Board had been set for 16 November 2020 and further clarity would be provided once this was available. This would include whether non-executive Board members would be asked to actively participate as had been the case in some previous years.

48.3 Professor McCallum advised that it had been her intention to draft a paper for the Board meeting in respect of the Lothian testing strategy. This had been put on hold as she had received a copy of a confidential draft of the Scottish Government's national strategy. It has been agreed not to progress with the Lothian document until it could be clarified that a common approach was being proposed in both documents. Professor McCallum advised that she had responded offline to a number of questions raised by Mr McQueen in respect of environmental testing.

48.4 Mr Murray asked what the intended use was for Patient-Level Information and Costing Systems (PLICS). His understanding was that the original purpose was to help access IJB data, and asked whether there were any intentions for wider use. Mrs Goldsmith advised that there had been a requirement to change

supplier and as a result the system had been paused. She commented it would probably be the next financial year before the system was fully up and running, and this would be used to provide actual data for IJBs to use.

48.5 Mrs Mitchell welcomed the report and commented she would like a bit more structure around the paper to demonstrate how to map activity into strategic objectives, and to explain where issues would be developed. The Chair reported that a similar report was used in NHS24, and this mapped to the corporate objectives. The Chair advised she will explore this further.

48.6 The Chief Executive agreed that future iterations of the report should include contributions from IJB Chief Officers. This had been the practice in his previous roles. He reminded the Board that the development of the report was still in its evolutionary stages.

48.7 Professor McMahon, in response to a question from Mr McCann, advised that the healthcare associated infection report had shown positive progress in respect of sabs and c-diff, and that the issue was about sustaining this position into the future.

48.8 Mr Connor sought an update on the indicative date when the elective centre at St John's Hospital would come on stream. Mr Crombie advised that the Covid delay had allowed the system to revisit the design and planning assumptions around the elective centre. There will be an impact on the construction timeline, and we will develop a better understanding of this over the next few months. Mr Crombie advised that the timeline for the submission of the Full Business Case to the Scottish Government in February 2021 still remained, however this depended on the construction timeline. .

48.9 Mr Small in response to a question from Cllr O'Donnell around the flu vaccination provided details on the different approaches being proposed by each of the IJB areas.

48.10 The Vice-Chair commented that the Finance and Resources Committee often reflected on the relative inflexibility of revenue, partly because of PPP contracts. This had been considered in respect of looking at other funding routes for the replacement Eye Pavilion. The Committee has considered how to respond to alternatives to a traditional capital funding model.

48.11 The Vice-Chair commented that whilst he understood the position around the car parking situation at the Royal Infirmary of Edinburgh, the issue added to existing environmental concerns. He sought assurance that final proposals would include proper provision for cyclists and the charging of electric cars. The Chief Executive confirmed that these issues would be considered, and he accepted that the car parking proposals were in direct opposition to strategic objectives, but were necessary.

48.12 Mr Crombie reported in respect of the Eye Pavilion, that there had been a clear signal from the Scottish Capital Investment Group that no capital would be available. So other funding sources should be considered and this process was

currently underway, with nothing having yet been agreed. He commented that further discussion around this would be held at the Finance and Resources Committee. Mrs Goldsmith will prepare a report which considers the implications and associated risks of different funding models.

48.13 It was pointed out that in other organisations the Board receives separate reports from the Chief Executive and the Chair. The Chair advised that she would normally produce a report to the Board, and confirmed she would do so moving forward. She provided the Board with details of individual discussions that she and the Chief Executive had held with MSPs.

48.14 Mr Small responded to a question from Mr Waterson, and advised that for flu vaccinations there is a national fee structure in place. Any charges made by GP practices and the payment of these were not within the gift of NHS Lothian. Professor McMahon provided an update on national work in respect of band 3 nurses and healthcare support workers in relation to the vaccination process. He commented that bank usage would only be utilised for weekend working and this position that would be kept under review. Mr Waterson agreed that he would continue these discussions separately and offline with both Professor McCallum and Professor McMahon.

48.15 The Board noted that regular routine eye care had recommenced on 3 August 2020.

48.16 The Chair reminded Board members that they were now receiving regular press summaries on a trial basis and invited feedback on the effectiveness of this process.

48.17 The Chief Executive thanked Board members for the positive feedback to the Board Executive Team report. He confirmed that he would review its structure, noted the suggestion that future reports should be grouped around themes rather than directors, and that the report should include contributions from the four IJB chief officers. The Chair welcomed the report and asked Board members in the future if they had issues of interest to make contact with the appropriate director offline.

49. Covid-19 – Public Health Update

49.1 Professor McCallum advised the Covid position was still an evolving picture. She commented that in Lothian there had been low levels of community transmission and that some signals of individual cases were being investigated. In terms of asymptomatic cases for workers in care homes it was noted that to date there had been no sign of infection or other issues in the care home environment. The Board were advised that venue specific issues were being addressed.

49.2 Ms Hirst updated on discussions held at the Midlothian IJB in respect of the impact of flu vaccinations, and also the opportunities around this to do other contacts while patients were receiving their vaccination. She felt there was a

need to deliver more locally, and ensure services were easily accessible to members of the public in order to reduce the need for people to travel. She also questioned the position in respect of the variation in local authority areas in terms of infection and death rates.

49.3 Professor McCallum concurred that moving into winter there would be opportunities to undertake extra contact, and that this would be done as much as possible to ensure needs were being addressed. Additionally interventions would be put in place with the third sector, housing and local authorities for vulnerable populations. With regard to variations by local authority, Professor McCallum advised there was a lot of work ongoing with partnerships and the University of Edinburgh and Datatech around this issue, and she would provide details once they were available.

49.4 Mrs Mitchell expressed concerns in terms of contact tracing in relation to efficiency and delays in passing data between the national and local centres. She commented that it appeared there were different ways of notifying people of their results. Professor McCallum reported that Mr McQueen had also asked related questions and she had responded to him offline. She reported that there was a two-tier system in Scotland, and this was different from the approach used in England. The Board was provided with details of how the Scottish system worked. It was noted that basic contact tracing could be undertaken by the national centre, although at the moment because of the lower numbers involved, the local system was providing support around individual cases. The use of text messaging was important, with it being noted for clinical tests, the clinician needed to take responsibility for ensuring patients received their results. It was noted however that in some instances the use of automatic text messaging was not appropriate. The need for a fail-safe system was stressed to ensure people did not get lost in the system. The Chair commented that she was reassured that the local system was able to provide assistance nationally and hoped that this was a reciprocal arrangement.

49.5 Professor McCallum advised that NHS Lothian was working with the Scottish Government to explain why Lothian figures looked higher than the position for the rest of Scotland, and to develop a new matrix. Possible reasons for the Lothian position was provided to the Board. Cllr Gordon felt there was a need to make the public aware of the reasons for the higher Lothian return. It was agreed that Professor McCallum and Mrs Mackay would discuss this offline. Cllr O'Donnell questioned whether travel restrictions would be applied at times of increased lockdowns and whether the tourist sector would be advised not to take bookings from these areas. Professor McCallum commented that if her advice was taken, and there was ability under the Public Health Act, then she would prefer bookings not to be accepted. It was pointed out however there were exceptions and that the tourist sector had been fantastic in helping the system find safe places for people to self-isolate. Professor McCallum was keen that the existing partnership between local authorities, NHS Lothian, the tourist industry and the third sector continued.

49.6 Cllr O'Donnell further questioned in terms of care homes and a possible second wave whether patients would only be discharged to a care home following a

Covid-19 negative test result. Professor McCallum advised that this was always a finely balanced clinical decision underpinned by public health principles. The position would depend on the risk assessment and what was best for the patient. Professor McCallum commented in some instances it would be clinically inappropriate and in others, the person might refuse a test. It was for these reasons that an individual risk assessment was important.

49.7 Cllr O'Donnell highlighted that in respect of education, it would be important to recognise that older staff like domestics etc, and not just teachers, might be at great risk following the re-opening of schools. Professor McCallum confirmed that this issue was now covered by the guidance. Public engagement and feedback from patients would be added into a future iteration of the Board paper.

49.8 Mr McQueen questioned what was being done to protect black ethnic minority (BME) staff from avoidable exposure, and whether there was a need for a national risk assessment tool. He sought advice on the timescale for the completion of any work and how this would be handled with appropriate staff. Professor McCallum commented on the emerging relationship with Public Health Scotland. She suggested there would be merit in adopting a 'Once for Scotland' approach with both Public Health Scotland and the Scottish Government to reach an aligned position. Professor McCallum reported that Directors of Public Health met weekly, there were no issues about a lack of integration, and relationships were developing in a positive way. A wider community planning relationship was also developing.

49.9 Professor McCallum updated the Board on the developing BME network. She and the Chief Executive along with the Director of the Occupational Health Service had met with BME colleagues to talk through the issues. It was noted that it would be important to ensure that BME specific issues were not lost in the wider risk assessment. Mrs Butler advised that the assessment tool that had been developed was for all staff and not just BME staff, as there were also other risk factors and groups of vulnerable people. The risk assessment in the first instance has been about shielding staff. It was recognised that further work was needed around communications. The Chief Executive concurred with the points made about vulnerable groups including age, obesity and gender, whilst accepting the need to minimise anxiety amongst BME staff.

49.10 Professor Whyte updated on what was being done by the University of Edinburgh in respect of the anticipated influx of students in the summer. It was noted that local and national discussions were taking place. At the moment the system was not testing asymptomatic contacts. Professor Whyte questioned whether it would be possible to influence that agenda. The Chair advised that she was aware of one university that was looking at testing all staff and students. The point was made that some groups were more at risk than others.

49.11 Dr Donald suggested in terms of the complexity of testing, that communications were important in respect of how to obtain access to a test, how to receive results and any necessary follow-up. She felt that there would be benefit in

providing a summary sheet, as currently people were not aware of the nuances. This could be an iterative document that would change over time.

49.12 The Chair commented that the points made had been important and would be taken into account when the Lothian strategy was produced in conjunction with the Scottish Government wide publication. Dr Donald advised that she would be happy to work with colleagues in the development of the strategy.

49.13 The Board agreed the recommendation contained in the circulated paper.

50. Test Strategy

50.1 The Board agreed this issue had been discussed elsewhere on the agenda.

51. Scheduled and Unscheduled Care Performance / Clinical Prioritisation

51.1 The Board agreed to take the above items together given the linkages between the issues.

51.2 Scheduled Care and Unscheduled Care Performance – Mrs Campbell reported in terms of scheduled care that outpatient services were experiencing continued pressure. The level was lower than pre-Covid although urgent suspicion of cancer was up to pre-Covid levels. There had been a reduction in activity and capacity because of the need for physical distancing. The Board noted that a detailed risk assessment had been undertaken to reduce distancing from 2 metres down to 1 metre for outpatient services, and this would be considered at the Corporate Management Team the following week. If this proposal which would have clinical support was signed off then this would have a positive impact on service delivery. A visit had been made to the Louisa Jordan Hospital in Glasgow to consider the capacity that they might be able to provide. The position was being risk assessed as there would be a need to move staff to Glasgow to support the capacity.

51.3 The Board were advised that there were around 39,000 patients waiting more than 12 weeks for treatment. In terms of the treatment time guarantee (TTG) the main focus was about remobilising theatre capacity. There remained reduced capacity because of the requirement to undertake enhanced cleaning and the need to don and doff PPE.

51.4 Mrs Campbell reported in terms of inpatient day cases that the focus was on urgent and suspicion of cancer. It was noted that 31 day and 62 day cancer performance was being monitored. There was currently a specific pressure in urology with work underway to explore how services could be increased using both the Western General Hospital (WGH) and private providers. It was reported that additional non-recurrent funding had been received to support endoscopy by using facilities in Fife, as well as the WGH enhancements.

51.5 Unscheduled Care Performance – The Board was advised that performance for July was at 95%, with the system continuing to maintain red and green pathways. It was noted there were real pressures at the Royal Infirmary of Edinburgh, with activity especially on Mondays being up to pre-Covid levels, partly as a result of increased requirements for resuscitation. The current focus remained on winter and how to schedule unscheduled care, with a focus on diverting self-presenting patients to more appropriate services.

51.6 Clinical Prioritisation – Ms Gillies advised that the remobilisation plan sought the adoption of a unified Scottish approach. The plan followed guidance which the four surgical colleges in the UK developed, and therefore had a level of professional endorsement. It was noted that learning from Grampian had also been useful. Ms Gillies advised that the current issue was that there were increased pressures from new patients waiting for treatment that the system did not have capacity to provide. The Board was advised that waiting resulted in a poor experience for patients, particularly those with urgent needs who would experience a poorer outcome, as explained in the paper.

51.7 The Board received a brief summary of how patients on the waiting list were broken down. It was noted that the split between urgent and routine was the same as for the rest of Scotland (20% - 80% split). It was reported that category 1 patients were not on the waiting list, and were admitted in an unplanned way and would be the first call on resources.

51.8 Ms Gillies reported that national work was underway looking at data submitted via remobilisation plans. The focus remained on those with most urgent needs first. This approach was currently only endorsed for surgical specialties although discussions were being rolled out elsewhere. The Board noted the importance of maintaining communication with patients who were on the waiting list and this was partly being done via 'keep in touch'. There was a need to have a process to escalate patients and this was being drawn out in the review of Grampian work.

51.9 The Board was advised that in all likelihood the system would see an increase in the number of patients presenting with urgent conditions (categories 1 & 2), with there already being some evidence of this in cancer services. This meant that some people might have to wait longer and it was important that there was clear communication around this. Ms Gillies commented that although this was an unpalatable message, it was important this was communicated in a transparent manner and that a route for escalation was maintained. The Chair advised there had been a clear message at the Chairs Group about the need for both national and local messaging.

51.10 Mrs Campbell, in response to question from Mr McCann about theatre output, advised that ongoing work was underway around theatres. The position pre-Covid had been 200-250 elective sessions per week, moving down to 75, although the position was now recovering to 100 theatre sessions. It was hoped to move to a position of 84% with there already being evidence of increases in activity. A similar exercise was being done for outpatient activity. The Board noted there had been a significant reduction in the number of 'face to face'

consultations with initiatives like 'near me' having been deployed. Work was underway looking at how to mitigate the loss of activity, including the use of patient initiated follow-up. The diagnostic capacity had been affected in relation to the need for physical spacing and using PPE, leading to increased turnaround between patients. The Board was advised that consideration was being given to increasing productivity by reducing the 2-metre distancing position to 1 metre, supported by appropriate mitigating actions and clinical sign-off.

51.11 Dr Donald commented that positive feedback had been received in respect of communication with patients. She stressed the importance of also communicating to GPs in order that they were aware of the process for accessing services. Dr Donald felt there were significant opportunities to schedule unscheduled care either locally or nationally. She questioned whether there was anything that the Board could do to facilitate this process. The Board was advised that the access team were updating patient letters to emphasise that access to services would look different, and these messages would continue to be developed.

51.12 Mrs Campbell reported that work around scheduling unscheduled care was a national initiative, and the Scottish Government has communicated its expectations. NHS Lothian has established a Programme Board to look at the local requirements and actions. The Chief Executive advised that he and the Chief Executive of NHS24 co-chaired the National Group to make scheduling unscheduled care a reality. He advised that by the end of October 2020, all heath boards would be required to have system in place to have self-presenters using 111, establish a flow centre, and develop 'call Mia' or steps to put people into hot clinics and then to the Emergency Departments. It was accepted that the clinical triage process would not be perfect by the 31 October 2020, and this would be an issue for the Scottish Government to address. The Chief Executive stressed the need to have robust arrangements in place before the onset of winter. The Chair commented that what was being described represented a significant shift in the way services were delivered.

51.13 Ms Hirst commented in terms of the clinical prioritisation paper and other Board papers that there was a need for a standard paragraph in particular to reflect the impacts of recommendations and policies. She was concerned that in all instances impact assessments had not been carried out. Ms Hirst was clear that there was a need for transparency and communication in terms of clinical prioritisation, and the need to explain to patients why there were not getting treated. The Chair concurred that there was an ongoing need for this to happen both nationally and locally.

51.14 Mr Murray questioned the Scottish Government position in respect of the TTG target, with the additional pressure of managing COVID given that the targets were not capable of being met, and on that basis, health systems should not be held to account whilst COVID remains a live issue. He questioned in terms of the ability to satisfy demand, whether scenario planning was in place to alter the profile of people with most need against less urgent requirements. He commented there would be an increase in demand for care in the community,

and therefore a need to reflect on the balance of service provision between the community and the acute sectors.

51.15 Ms Gillies commented that discussions were ongoing with clinicians about referral advice, for both new referrals and repeats. It was noted that it would not be possible for the system to be too purist in its approach. The other point that needed to be considered was the position in respect of patients already on the waiting list. It was noted that since the onset of Covid, some patients' appetite for treatment might have changed, and people might exercise their personal choice and right not to come forward for treatment.

51.16 Mr McQueen commented that the paper suggested that it was not yet possible to quantify the number of patients who presented with urgent conditions. He questioned whether it would be of benefit to the system if this was possible. He also questioned in terms of theatres whether the loss of pre-operative tests was insurmountable. Ms Gillies commented in respect of the second point that the position was currently limited to patients requiring transplantation. Testing might improve over the next few months. Guidance was already in place around red and amber pathways and any patient that had a negative test. Ms Gillies advised that she was keen to move back to a position of having a pool of patients able to attend hospital to be treated in 'quick time'.

51.17 Ms Gillies commented in terms of theatre capacity set aside for category 1 patients that more needed to be allocated because each case was taking longer. She concurred that there was a need to use theatre sessions better and as effectively as possible. Ms Gillies commented that she could not state specifically how much capacity had been put aside although the position that would continue to be monitored.

51.18 Professor Whyte advised that she was grateful to Ms Gillies for highlighting the importance of looking at other specialties other than cancer and urgents. She was concerned in respect of outpatients and the inability to review patients on a 'face to face' basis. She felt that the use of the telephone and video calling was a holding measure rather than a permanent solution. She was keen that consideration was given to how to review patients in person in order that proper examinations could be undertaken.

51.19 Ms Kasper commented that the paper made sobering reading. She advised that she was concerned about the underlying assumption that there was a need to make do with the capacity available and questioned to what degree that was being challenged. She was concerned that at the moment the discussion was about doing things better and smarter and scaling down the services available. The point was made that for some people there was no alternative to the NHS especially from an inequality perspective. Ms Kasper felt there might be a need to increase capacity to sustain the health of the population. The Chair commented that this was a fair point and that IJBs would also be seeking to increase capacity in the community.

51.20 Ms Campbell commented that she agreed with the points made and advised the Board that there had been positive feedback from a significant number of

patients about telephone and 'near me' experiences. She commented however that there was still a need to build capacity to provide a 'face to face' service wherever possible and appropriate. The Board was reminded that discussions about how patients were contacted and treated was clinically led. The Chair commented that the positive feedback from patients was gratifying although it was important to remember that this had been during a period where options were severely restricted.

51.21 The Chief Executive commented that the points made by Ms Kasper were fair. His view was that it is clear there was a need for Lothian to obtain its fair NRAC (National Resource Allocation Committee) share and this had been rehearsed with the Scottish Government. He stressed however that NHS Lothian would need to live within budget and that Scottish Government resources and funding would be under pressure. The Chief Executive advised in that regard he would anticipate difficult times ahead.

51.22 Cllr O'Donnell reminded the Board that within the NHS Lothian area there are the two fastest growing local authority areas by population. The Board acknowledged this point and the challenges it brought. Mrs Campbell undertook to pick up a number of issues around the paper with Mr Murray offline.

51.23 The Board agreed the recommendations contained in both of the circulated papers.

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

52.1 Ms Campbell referred to the circulated report and reminded the Board that the RCPCH had been invited to undertake a further review with the report having been received in May 2020. The key issues of the report were outlined to the Board.

52.2 The Board noted that the Paediatric Programme Board had met and taken cognisance of the effect of the report on the middle grade rota. Ms Campbell advised that the rota had been clinically reviewed and positive feedback had been received that the rota could be sustained and would cope with normal variations in demand and annual leave. On this basis the Paediatric Programme Board had recommended that the paediatric inpatient ward at St John's Hospital (SJH) should reopen on a 24/7 basis from 19 October 2020. Issues around paediatric services would form part of the clinical strategy for the Board that was under development.

52.3 The Chair thanked the Paediatric Programme Board for their considerable efforts in moving the position to a satisfactory and positive conclusion. The Vice Chair also added his personal thanks as Chair of the Programme Board to colleagues who had put in considerable work over the previous 4 years. He was confident that the clinical management team would be able to progress the recommendations effectively.

52.4 Mr Connor commented in respect of the proposed disbandment of the Paediatric Programme Board and the further recommendations that further work should be progressed by the Children's Clinical Management Team that there was a need for this to be effectively communicated. He noted that the recommendation had been specific about the Paediatric Programme Board overseeing some of the recommendations. The Board agreed that future communications should be through the St John's Hospital Stakeholder Group and this would allow the Paediatric Programme Board to be stood down. The Board agreed that the Chief Executive and his team would consider how best to communicate this position.

52.5 Cllr McGinty advised that the report had been helpful and set the way forward. He echoed the thanks of others whilst recognising the services ongoing fragility.

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

53. June 2020 Financial Position

53.1 Mrs Goldsmith advised that she was in the unusual position of reporting an overspend of £19m at this point in the year. This included an estimated £31m in respect of Covid costs. She advised that this related in a large part to staffing costs and new recruits, with it being anticipated that these costs would reduce as students and others were subsumed into permanent posts. Mrs Goldsmith reported that a lot of work was underway to obtain a full understanding of the financial implications of Covid. The Chair commented that a significant issue would be the ability to draw down Scottish Government funding to cover the costs.

53.2 Mr McQueen questioned whether the Scottish Government was joined up in respect of the mobilisation plan, and whether it was realistic about the application of the overspend. Mrs Goldsmith reported that there was a heavy reliance on the finance community to determine the Covid impact and to provide an interpretation of the mobilisation approach. It was recognised that it would be useful for there to be a system-wide recognition of the financial consequences.

53.3 Mrs Goldsmith reported that a quarter 1 financial review would be undertaken and work would continue with Scottish Government colleagues, whilst recognising the need to maintain local control.

53.4 The Chair commented that her understanding was that NHS Lothian was not out of line with other Boards in terms of the financial position around Covid. The Board noted that the Chair, Chief Executive and Mrs Goldsmith would maintain appropriate focus on financial control.

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

54. Corporate Risk Register

54.1 Ms Gillies advised that the circulated paper was self explanatory and proposed the addition of the following two new risks onto the corporate risk register; -

1. Care homes, as recommended by the Healthcare Governance Committee
2. Legionella in terms of controls around water safety premises that had been used less frequently than in previous pathways, including primary care premises

54.2 Ms Gillies commented that some premises were owned by GPs rather than NHS Lothian. There were potential issues about temperature control and regular flushing of water systems, with the current position being unclear. This would remain an important focus of the Water Safety Group.

54.3 The Board noted that following review by the Finance and Resource Committee it was being recommended that the 'facilities fit for purpose' risk should be downgraded. Mr Murray commented that the paper appeared to be focusing on aspects of care homes where the risk should be overseen by IJBs and HSCPs. He questioned whether there should be a component in the risk register for IJBs to fill the gap. Professor McMahon reported that the IJB Chief Officers would be reporting to the Healthcare Governance Committee in respect of care homes in areas that they had responsibility for. He advised that national work streams were underway to tease out lines of responsibility in respect of care homes. It was noted that the risk register focused on NHS Lothian's responsibility. The Board was advised that the Scottish Executive Nurse Director Group discussed this issue on a weekly basis. Professor McMahon advised if the current Executive Nurse Director responsibilities extended beyond 31 November 2020 as anticipated, then it was appropriate to spend time resolving responsibility issues.

54.4 Dr Williams commented in respect to legionella that he believed one of the main actions was to run water for a prolonged period of time and this did not fit with the environmental agenda. He questioned whether other options were available. Ms Gillies commented that currently temperature issues and flushing were statutory requirements, and that NHS Lothian followed health and safety guidance.

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

55. Audit and Risk Committee Consideration of the Internal Audit of Royal Hospital for Children and Young People / Department of Clinical Neurosciences (RHCYP/DCN)

55.1 Mr Ash as Chair of the Audit and Risk Committee reminded Board members of the background to NHS Lothian commissioning the internal audit report.

55.2 Mr Ash advised that it was proper that the Audit and Risk Committee provided assurance to the Board that the Committee had carried out its remit.

55.3 The Board noted that further discussion would be held in private session later in the day.

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

56. Royal Hospital for Children and Young People, Department of Clinical Neurosciences and Child Adolescent Mental Health Services (RHCPY, DCN & CAMHS)

56.1 Mrs Goldsmith provided the Board with a verbal update on the RHCYP/DCN & CAMHS project. The Board noted that Supplemental Agreement 2 (SA2) had now been signed. A review is being carried out in relation to why it had taken so long to conclude. It was hoped that this would improve processes for future changes. As SA2 had been signed it would be possible for estimated costs to be produced. The Board noted that the programme was still on target and work had progressed in advance of SA2 having been formally signed. Mrs Goldsmith advised that she expected work would be completed within the timeline of the critical care and haematology / oncology enhancements. The Board noted the ventilation equipment was now onsite.

56.2 Mrs Goldsmith reported that it was gratifying to see the hospital being used in the way it had been intended. The Chair concurred that it was important to put on record that all of DCN and 70% of outpatient services for the Royal Hospital of Sick Children had now moved on to the new site. The Board recorded its thanks to Mrs Goldsmith and her team for concluding SA2 and also to clinical teams for their efforts in populating the building.

56.3 The Chair commented that she would liaise with IHSL about bringing forward the indicative programme if this were at all possible. She felt that lessons learned from this project would be important for the wider public sector.

56.4 The Board welcomed the positive update report.

57. Future Board Meetings

57.1 The Board agreed the September Board meeting would be a development session followed by a formal Board meeting in October.

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

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

Chair's Signature ……

Date ……

Mrs Esther Roberton
Interim Chair – Lothian NHS Board

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 10:00am on Thursday, 24 September 2020 using Microsoft Teams.

Present:

Non-Executive Board Members: Mr M Hill (Vice-Chair)(In the Chair); Mr M Ash; Mr M Connor; Dr P Donald; Ms F Ireland; Mrs K Kasper; Mr A McCann; Cllr D Milligan; Mrs A Mitchell; Mr P Murray; Cllr F O'Donnell; Mr T Waterson and Professor M Whyte.

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

In Attendance: Mrs J Campbell (Chief Officer, Acute Services); Mrs J Butler (Director of HR & OD); Mr C Briggs (Director of Strategic Planning); Mr D A Small (Director of Primary Care Transformation); Mr P Lock (Director of Improvement); Mrs J Mackay (Director of Communications & Public Engagement); Ms K Dee. Deputy Director of Public Health and Health Policy at NHS Lothian; Mr C Marriott, Deputy Director of Finance, NHS Lothian; Mr A Payne (Head of Corporate Governance); Ms L Guthrie (Lead Infection & Prevention Control Nurse, NHS Lothian)(Item 62.1) and Mr C Graham (Secretariat Manager, Corporate Governance Team).

Apologies for absence received from Mrs E Roberton (Chair); Dr R Williams; Cllr G Gordon; Ms C Hirst; Mr W McQueen; Cllr J McGinty; Mr J Crombie (Deputy Chief Executive); Ms T Gillies (Executive Medical Director) and Mrs S Goldsmith (Director of Finance).

59. Declaration of Financial and Non-Financial Interest

59.1 The Chair reminded members that they should declare any financial and non- financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

59.2 There were no declarations of interest.

60. Chair's Introductory Comments

60.1 Mr Hill informed the Board that this additional meeting had been called so that the Board may consider the Four-Country Infection Prevention on Guidance for the Remobilisation of Health and Care Services and the Board's proposed approach. The Board needs to agree its position so that executive management can proceed quickly to respond to the situation.

61. Items for Approval

61.1 Minutes of Previous Board Meeting held on 12 August 2020 - Mr Hill confirmed that there were amendments and clarifications required to the minutes following notifications from Cllr O'Donnell and Mr Murray. The minutes would therefore be removed from the consent agenda for the meeting and would be brought back to the Board meeting on 14 October 2020. This allowed time for the amendments and clarifications to take place.

62. Items for Discussion

62.1 Four-Country Infection Prevention on Guidance for the Remobilisation of Health and Care Services

62.1.1 Professor McMahon introduced the report recommending that the Board note the publication of the four-country guidance which was published on the 21 August 2020, with the expectation that it be implemented from 7 September 2020.

62.1.2 Professor McMahon explained that most Boards, including Lothian, had not implemented the guidance. The guidance requires the introduction of Green, Red and Amber pathways. The guidance was to work to the two-metre rule where possible, with risk assessments to be carried out for services and sites where this was not possible, along with the use of hierarchy controls to mitigate risk. Colleagues are currently working on the risk assessments, developing what the pathways would look like, as well as taking forward actions around patient safety, personal protective equipment ('PPE'), cleaning and signage. It may take two-three weeks to complete the risk assessments.

62.1.3 Professor McMahon outlined that the work was being undertaken in partnership with the staff-side. The Board noted that the proposal would be to have oversight of implementation of the guidance through the weekly Strategic Group for PPE which in turn would advise the Executive Leadership Team of any operational challenges. The Board's Healthcare Governance Committee would be the designated governance committee to have oversight and routine updates would be taken there as required, and where appropriate to the Board. If the Board agreed to the proposal, there were communications to staff and patients that had been prepared. This includes the development of patient information leaflets to set out control measures that would be in place, and to help patients understand what is visible and not visible to them e.g. ventilation, environmental control.

62.1.4 There was discussion on how the pathways would work, and how quickly they could be implemented if agreed. The discussion considered the need for flexibility of spaces being used, along with the challenges and implications around restricting visiting within the Green pathway. The discussion also included the implications of the pathways on testing of staff, the reinforcement of staff messaging in relation to PPE and infection control, and national testing of staff working with vulnerable client groups. Ms Campbell advised that she did not think it would be possible to have a dedicated whole site for the green pathway, however it may be possible to create dedicated green areas within sites.

62.1.5 Mr Waterson detailed the opinions and concerns that had been raised from staff-side colleagues. The Board noted that opinions on the move from 2-metres to 1-metre were now almost aligned, however there remained a disagreement with regard to the type of PPE which the guidance states should be used in the green pathway, which includes operating theatres. The guidance does not require FFP3face masks to be worn, and this is a change from what staff have been previously using, and are comfortable with using. Mr Waterson highlighted that the staff-side do not support this change of practice, and this could lead to a dispute with trade unions.

62.1.6 Professor McMahon stated that any staff member with anxiety or concerns in relation to PPE would still be able to request an individual risk assessment. Ms Guthrie explained the risk-based approach to PPE, and added that all guidance documents had gone through professional royal colleges and trade unions. There is a precautionary approach being taken to Aerosol Generating Procedures (AGPs) and enhanced PPE. For AGPs there were no circumstances where a guarantee could be given that no risk exists, however where a patient coming into hospital and had self-isolated for 14 days (2 Covid-19 incubation periods), there could be confidence that the patient is truly negative for Coronavirus. Consequently there would therefore be no additional risk to staff undertaking clinical duties. and the guidance in relation to PPE could be followed. This was advice from the highest scientific level. Ms Guthrie also highlighted that the people within the operating theatre departments who were affected by the change in practice represented a small number of staff. Miss Ireland confirmed that the Area Clinical Forum would also be supportive of the principle of a risk assessment approach to the implementation of the guidance

62.1.7 Professor McMahon confirmed that a national discussion would need to take place and that any changes to national guidance would be honoured and worked through at local level.

62.1.8 There was further discussion on the staff-side concerns; levels of PPE and risk; pathways capacity; cleaning regimes; limiting of staff moving between pathways where possible; having protected Green pathways; and monitoring of the levels of infection within staff.

62.1.9 The Board acknowledged the staff-side concerns which Mr Waterson raised, and that it would be appropriate to escalate them through established channels. Mr Campbell reiterated that the Board will follow national guidance, and apply risk assessments to manage the risk associated with specific situations, issues or concerns. If there was a change in national guidance, then the Board would observe that revised guidance.

62.1.10 The Board agreed to approve the approach to the guidance and agreed to the following recommendations:

1. NHS Lothian should, where possible, work within the 2-metres guidance as set out in the four-country guidance
2. Service areas that require to undertake a risk assessment, using the hierarchy of control as set out in the guidance are intensive care units, respiratory services, endoscopy, theatres with some work required in mental health, maternity and neonatal units. Each risk assessment will be reviewed and signed off by the Executive Leadership Group
3. The weekly Strategic Group for PPE will have oversight of the implementation of the guidance and in turn advises the Executive Leadership Team of any operational challenges
4. The Board's Healthcare Governance Committee will be the designated governance committee to have oversight and that routine updates will be taken there as required, and where appropriate to the Board
5. To note the communications to staff that have been developed.
6. To note that in relation to the 'Green' pathway NHS Lothian may have to introduce limited or no visiting within this pathway to protect patients and staff and keep the pathway as free of COVID as possible.
7. That the identified staff-side concerns be raised at the appropriate national groups, e.g. national groups for Board Chief Executives, Nurse Directors and Medical Directors – **CC/AMcM/TG/TW**

63. Future Board Meetings

63.1 The next Board meetings will be on 14 October and 09 December 2020.

64. Any Other Business

64.1 There was no other business.

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

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

Chair's Signature ……

Date ……

Mrs Esther Roberton
Interim Chair – Lothian NHS Board

NHS LOTHIAN

Board
14 October 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.

1.2 There is currently a process underway to appoint three new members to the NHS Board. Once those new members are in place, there will be a holistic review of the membership of committees and integration joint boards.

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

2 Recommendations

The Board is recommended to:

2.1 Re-appoint Martin Connor as a member of the Audit & Risk Committee with effect from 4 October 2020 to 3 October 2023.

2.2 Re-appoint John McGinty as a member of the Audit & Risk Committee with effect from 6 December 2020 to 5 December 2023.

2.3 Re-nominate Martin Connor as a voting member of West Lothian Integration Joint Board from 6 December 2020 to 5 December 2023.

2.4 Re-nominate Angus McCann as a voting member of Edinburgh Integration Joint Board from 1 January 2021 to 30 June 2023.

3 Discussion of Key Issues

Interim Chair

3.1 The Cabinet Secretary has extended the Interim Chair's appointment for a further four months. The appointment ends on 31 March 2021.

Audit & Risk Committee

3.2 The Board appoints members to the Audit & Risk Committee for fixed terms, so that it may periodically consider whether the members remain independent. The appointment terms of Martin Connor and John McGinty end on 3rd October and 5 December respectively. It is recommended that the Board re-appoints them both for three years.

West Lothian Integration Joint Board

3.3 Martin Connor's current term as a voting member of the integration joint board ends on 5 December 2020. It is recommended that the Board re-nominate him as a member for a further three years.

Edinburgh Integration Joint Board

3.4 Angus McCann's current term as a voting member of the integration joint board ends on 31 December 2020. It is recommended that the Board re-nominate him as a member from 1 January 2021 to 30 June 2023.

4 Key Risks

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

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

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

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

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

8 Resource Implications

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

Alan Payne
Head of Corporate Governance
9 September 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 17th June 2020 by videoconference.

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

In Attendance: Mr N. Bradbury, Capital Finance Manager; Ms L. Cameron, Strategic Programme Manager (item 15.1); Mr C. Campbell, Interim Chief Executive (Designate); Mr J. Crombie, Deputy Chief Executive; Mr G. Curley, Director of Operations, Facilities (item 15.1); Mr I. Graham, Director of Capital Planning and Projects; Dr J. Hopton, Programme Director, Facilities (items 16.2 and 16.3); Ms W. Macmillan, Business Manager; Mr C. Marriott, Deputy Director of Finance; Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes); Ms E. Roberton, Interim Board Chair; Mr C. Stirling, Site Director, Western General Hospital.

Apologies: Ms T. Gillies, Medical Director; Councillor J. McGinty, Non Executive Board Member; 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.

14. Committee Business

14.1 Minutes and Actions from Previous Meeting (20 May 2020)

14.1.1 The minutes from the meeting held on 20 May 2020 were approved as a correct record.

14.1.2 The updated cumulative action note had been previously circulated and was discussed.

15. Capital

15.1 Oncology Enabling – Full Business Case

15.1.1 Mr Stirling presented the previously circulated paper. It was noted that the lifetime cost of the enabling works were up to the year 2025. This date had been given as a marker for when the new cancer centre would be available, but the lifetime was likely to be longer due to mitigating factors. The decision had been taken that improved cancer provision was urgently required.

15.1.2 In response to a question about whether the design would have been different if the need for social distancing had been taken into account, Mr Crombie explained that carrying out this project as a refurbishment with limited space added constraints to any flexibility around social distancing. Mr Stirling noted that the development of further capacity in NHS Fife and NHS Borders to reduce the need for patients to travel far from home would be a benefit here, as would service innovations to mitigate existing constraints, for instance 'near me' online consultations.

15.1.3 It was noted that the site did include flexibility in capacity by deploying extra areas and that as modeling progressed it would become more clear what additional needs there might be in the demand profile following COVID-19. There was also flexibility to move to 7 day working if this was required in the future.

15.1.4 The contingency had been calculated as 3% of construction costs but there had been an increase in estimated costs of 10% between the outline business case and the full business case. Mr Bradbury advised that in the full business case 70% of costs were based on actual tenders, rather than the estimates used for the outline business case. In addition to the 3% contingency there was also a non specific £0.5 million extra contingency for the site to cover general market fluctuation.

15.1.5 It was noted that the £300,000 revenue benefit implied would not be a saving as the increase in capacity would mean higher revenue costs on staffing. It was noted that a lot of good work had been done in cancer services to manage efficiencies.

15.1.6 The business case assumed that the funding for this project would be allocated by NRAC and this had been included in the Board's financial plan on that basis, but it may be funded in a different way as the process for Board endorsement of the financial plan was still to be completed.

15.1.7 A team were considering possibilities for the expansion of cancer clinical trials as part of an adjacent project to this as it was recognised that clinical trials brought benefit to patients and financial value through access to new drugs.

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

15.2 Review of the Facilities Fit for Purpose risk

15.2.1 Mr Crombie presented the previously circulated paper and explained the relationship with the 'six dimensions of quality' referred to in the paper, as the enhancement of buildings was part of the provision of safe and effective patient care. There needed to be indicators to identify risks related to facilities and buildings including datix incidents and trends.

15.2.2 The measures outlined in the paper for identification of risk in the estate would be divided into core measures applicable to all sites so that overall trends could be monitored and separate sets of measures for different levels of building or site so that more specific data could be collected.

15.2.3 It was noted that communication and negotiation with external partners in PFI and PPP facilities management had presented challenges and that skills for commercial interaction and negotiation within NHS Lothian needed to be further developed, requiring a resource focused on this. It was noted that there were now 10 PPP projects in NHS Lothian with a total value of over £100 million. A proposal for better management of these would be brought to the Finance and Resources Committee at a future meeting. **SG**

15.2.4 Members accepted the recommendations laid out in the paper and supported the approach. A further update paper would be provided as the project developed. **JC**

15.3 Property and Asset Management Investment Programme

15.3.1 Mr Graham presented the previously circulated paper. It was noted that rapid innovations in response to COVID-19 such as 'Digital First' and 'Near Me' incurred capital expenditure and could be considered as pilots but would require a strategy and business case process for approval to continue. The process put in place would need to provide sufficient assurance while maintaining appropriate momentum. It was suggested that more work from senior management and the Board was needed to drive digital innovation forward.

15.3.2 The flexible buildings model being considered for the Eye Hospital was discussed. Mr Graham explained that this would be a collaborative process whereby commercial space would be provided for start up businesses to lease within the building. In the future these spaces could be taken over to increase capacity. This was an alternative funding model PPP/PFI and was being piloted by Guy's and St Thomas' NHS Foundation Trust in London. Some clinical areas such as clinics and outpatients were suitable for conversion from office spaces.

15.3.3 Members accepted the recommendations laid out in the paper, including moderate assurance on the delivery of the programme for the year 2020/21 and limited assurance for future years.

15.4 Royal Hospital for Children and Young People and Department of Clinical Neurosciences – Legal and Commercial Update

15.4.1 Ms Goldsmith presented the previously circulated paper. Members were reminded that this paper and discussion were commercially confidential as the agreement had not yet been signed.

15.4.2 Since the last update it had been agreed between Bouygues and the legal team that the Bouygues helpdesk would be the single point of contact for front line services in the event of any problems with the ventilation system. The final paperwork detailing this agreement was still to be received.

15.4.3 The definitions used in the agreement were of a legal rather than a commercial nature but there was potential for any weaknesses to be exploited in future. The legal advisors McRoberts were completing a due diligence report which would be available by 24 June 2020.

15.4.4 The supplemental agreement 2 was now in an agreed form. NHS Lothian had commented on early drafts of the services contract and the final version was awaited; these had already been agreed by IHSL and Bouygues. The technical documents were in the final version but IHSL had proposed some slight changes in the area of work which could affect indemnity agreements; the legal team was investigating this.

15.4.5 It was noted that commercial interests of the contractors were holding back the timeline for signing the agreement and McRoberts were working hard to overcome this.

15.4.6 The Board had the responsibility to accept the risks of SA2 before the agreement was made, and this had been done at a previous Board meeting which delegated authority to sign the agreement to executive officers. No enhanced risks had been identified since Board approval took place. A due diligence report would be carried out on the review of risk but sign off of the agreement could take place before this.

15.4.7 Although it was not necessary for the Board to review the due diligence report before the SA2 was signed, to gain full assurance on the process, it was agreed that the report would be reviewed by the Interim Board Chair, Interim Chief Executive and Chair of the Finance and Resources Committee before the SA2 was signed by the Finance Director as executive officer with delegated responsibility.

SG / ER / CC / MH

15.4.8 Ms Goldsmith advised that the target cost for the programme had not changed since Board approval but that there could be variation after SA2 had been signed as the contract was not fixed. Any variations would be signed off using the usual process through the Finance and Resources Committee.

15.4.9 Members accepted the recommendations laid out in the paper.

15.5 Community Empowerment Act Annual Report

15.5.1 Mr Payne presented the previously circulated paper. Members accepted the recommendations laid out in the paper and accepted significant assurance.

16. Revenue

16.1 Financial Position, April 2020

16.1.1 Mr Marriott introduced the previously circulated paper. It was noted that although community dental practices had not been operating in the first two months of the year it had been agreed nationally that community contractors would continue to receive some payments, and that some of their staff had taken on other temporary roles in the NHS Board.

16.1.2 Private hospitals including Spire Murrayfield were contracted nationally. Contracts have been based on packages of care rather than on space but this may change in the future. In Lothian this provision had been used mainly for cancer care.

16.1.3 It was noted that although the Scottish Government had advised that all COVID-19 response costs would be funded centrally, the details of the measurements of these

costs and the amount to be allocated were not yet known and offsetting income was therefore not assumed in the financial report presented for month 1. Not all Boards were reporting the same way, so comparisons would be difficult.

16.1.4 The overspend for month 2 (May) had been calculated with a cumulative overspend of £11 million, £5 million of which was May overspend. The COVID spend was £17 million but this had been offset by a reduction in unscheduled care spend of £11 million. This was similar to month 1. After month 3 forecasting would be done to the end of the year and this would feed into the strategic plan.

16.1.5 It was noted that £1.3 million savings were expected during the period but only £200,000 had been achieved. The priority for the first two months of the year had been on the COVID-19 response but now there could be a refocus on efficiency programmes including any changes and innovations implemented as part of the COVID response which could continue. Some savings made in the first two months such as in drugs schemes would come through later.

16.1.6 It was agreed that as the Scottish Government funding for COVID-19 had not yet been confirmed, assurance on break even at the end of the financial year could not yet be taken.

16.2 Financial Forecasting 2020/21

16.2.1 Ms Goldsmith introduced the previously circulated paper. The risk noted in item 5.1 of the paper that services may be reduced in the future due to the financial challenge was highlighted and members asked how this risk would be articulated and communicated. Ms Goldsmith advised that the impact of temporary reduction of services in scheduled care had been captured. Remobilisation plans would show what can be delivered and where there would be a gap in delivery. New ways of providing services including digital solutions and support of IJB and community services that had been implemented as part of the COVID response could mitigate some of this gap.

16.2.2 It was noted that joint working between IJBs and NHS Lothian was essential and needed to be further strengthened as part of remobilisation and future strategy.

16.2.3 Ms Goldsmith reported that the finance team had started to assign work on the financial framework beyond 2020/21.

16.3 Transfer of Portering and Waste Management Services

16.2.1 The chair welcomed Dr Hopton to the meeting and she presented the previously circulated paper. The transfer would be concluded following completion of the lenders approval process, with the aim of September 2020.

16.2.2 The need for better commercial negotiation was highlighted as it often took a long time to reach an acceptable agreement, and the delay in this case had a cost due to monthly payments to Consort for the service. Ms Goldsmith noted that this tied in with the decision of the Committee earlier in the meeting to create a skilled team for the management of the PPP/PFI portfolio.

16.2.3 Members accepted the recommendations laid out in the paper, accepted significant assurance on the supplemental agreement, and agreed to delegate authority for sign off to the Finance Director.

16.3 Climate Change and Sustainability

16.3.1 Dr Hopton gave a verbal update. Planning was being adapted in response to COVID-19 restrictions and opportunities regarding digital working and reduction of travel. A programme of webinars for staff would begin in July. The Analytical Services team had agreed to provide an information analyst to support data analysis work and there had been discussion with the Communications Team on communications support being made available.

17. Committee Business

17.1 Committee Workplan

17.1.1 Mr Payne presented the previously circulated paper with the draft Committee workplan. Members accepted the recommendations laid out in the paper and accepted the current Committee workplan.

17.2 Reflection on the meeting

17.2.1 It was agreed that the update on oncology enabling works and the complexity and the uncertainty around funding and financial forecasting would be highlighted at the next Board meeting.

17.2.2 It was also agreed that a Board development session on the strategic plan be recommended.

17.2.3 Members agreed to continue with monthly meetings of the Committee at present because of the importance of keeping up to date with financial planning and with developments with the children's hospital, but this would be kept under review.

18. Date of Next Meeting

18.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 22 July 2020**.

19. Meeting Dates in 2020

19.1 Further meetings would take place on the following dates in 2020:
- 26 August 2020;
- 23 September 2020;
- 28 October 2020;
- 25 November 2020.

Signed by the Chair on 22-07-20
Original in file

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 22 July 2020 by videoconference.

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

In Attendance: Ms J. Campbell, Acute Services Director; Mr I. Graham, Director of Capital Planning and Projects; Dr J. Hopton, Programme Director, Facilities (item 22.3); Mr C. Marriott, Deputy Director of Finance; Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes); Mr D. White, Strategic, Planning and Quality Manager, Edinburgh Health and Social Care Partnership (item 21.3).

Apologies: Ms T. Gillies, Medical Director; Professor A. McMahon, Executive Nurse Director; Professor M. Whyte, Non Executive Board Member.

Chair's Welcome and Introductions

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

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

20. Committee Business

20.1 Declaration of Interests

20.1.1 Mr McCann noted that he was a neighbour of Lord Brodie, who had been appointed chair of the Public Inquiry on the new children's hospitals.

20.2 Minutes and Actions from Previous Meeting (17 June 2020)

20.2.1 The minutes from the meeting held on 17 June 2020 were approved as a correct record.

20.2.2 The updated cumulative action note had been previously circulated and would be updated.

21. Capital

21.1 Property and Asset Management Investment Programme

21.1.1 Mr Graham presented the previously circulated paper. Regarding the eHealth IT improvement programme Ms Goldsmith outlined plans for investment in infrastructure and devices which would allow service models to be developed for digital delivery of

care and business cases put forward showing how improvements to quality of patient care, access and delivery would be made. The Scottish Government may be approached for funding for devices and infrastructure. This would be part of a long term piece of work on capacity planning.

21.1.2 A process for prioritising resources for digital development would be devised to ensure that investment was made where there would be most benefit while also taking advantage of areas with good clinical leadership who had come forward with ideas. The implementation of digital development would be supported by the Medical Director, the Director of eHealth, the Finance Director and the Director of Improvement. A paper would be submitted to the next Committee meeting giving more detail on progress. **TG / SG**

21.1.3 The business case for development of regional laboratory services had been scrutinised nationally but not locally although NHS Lothian would be providing funding. This Committee wanted to ensure on behalf of the Board that the possibility for efficiency improvements had been properly considered. It was pointed out that this was the second national procurement where there had been concern as to the governance process, the other being Microsoft 365. Mr Graham had asked for further information which would be included in the next report. **IG**

21.1.4 Members accepted the recommendations laid out in the paper, agreeing moderate assurance on delivery of the programme and approved the eHealth infrastructure rolling programme and the backlog maintenance programme for 2020/21.

21.2 <u>Major Trauma Ward, Royal Infirmary of Edinburgh: Standard Business Case</u>

21.2.1 This paper had been withdrawn from the agenda as further work was required before it could be presented for approval.

21.3 <u>Provision of General Medical Service Edinburgh South: Standard Business Case</u>

21.3.1 The chair welcomed Mr White to the meeting and he presented the previously circulated paper. It was clarified that in the model proposed NHS Lothian would lease the property from the landlord and then sublet this to the GP practice.

21.3.2 The information included in the business case had been provided to the Edinburgh Integration Joint Board at its last meeting but had not been discussed. Mr McCann would ensure discussion at the next meeting of that Board. The approval of the capital business case was with NHS Lothian as provider of the capital funding.

21.3.3 The balance between population based strategic planning and reacting to specific problems in GP provision was discussed. Mr White advised that an analysis of population expansion in Edinburgh was updated every two years which allowed informed strategic decision making on provision, but he also noted that it was important to be able to take up commercial opportunities when they were available. It was also noted that the majority of GP practices in Edinburgh were independent and under no obligation to comply with IJB strategic plans, although this was not a significant issue, since there were good relationships.

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

21.4 Review of Corporate Risk on the Royal Hospital for Children and Young People and Department for Clinical Neurosciences

21.4.1 Ms Goldsmith presented the previously circulated paper. Children's Services outpatients were moving in to the new hospital that week and DCN services had completed their move. Works were continuing on the rest of the hospital but the agreement had not yet been signed due to a technical point regarding insurance for the funders which was being worked through. Members noted the importance of acknowledging the complexity of commercial contracts and negotiations, including in presenting the Board's evidence to the Public Inquiry.

21.4.2 Following detailed discussion, Members accepted the recommendations laid out in the paper and agreed to the proposed entry on the corporate risk register.

21.5 Appointment of Counsel to the Public Inquiry

21.5.1 Ms Goldsmith presented the previously circulated paper and proposed that the oversight of the Public Inquiry by the Finance and Resources Committee on behalf of the Board should be recommended to the Board. As the Inquiry was using public funding the cost and progress should be regularly reviewed. Updates from the Central Legal Office on funding would be provided as well as what the appointed Counsel were providing for these fees.

21.5.2 Ms Goldsmith advised that there would be engagement with the CLO and with McRoberts solicitors to create data packs to ensure that all those from the Board called as witnesses at the Inquiry would have access to accurate, factual information.

21.5.3 The role of the Counsel in the Inquiry was to look after the interest of the Board and to help the Board bring into the public domain an accurate view of what happened while avoiding unwarranted criticism. They would provide advice and support to those giving evidence in the Inquiry. It was noted that the aim of a Public Inquiry was not adversarial but was to enable learning from experience.

21.5.4 It was currently understood that there would be no initial funding from the Scottish Government to cover the Board's costs for the Inquiry although some may be allocated at a later date.

21.5.5 Members accepted the recommendations laid out in the paper to appoint the Counsel proposed, and also agreed to recommend to the Board that the Finance and Resources Committee act as the Board's governance process to oversee resources and engagement between the Board and the Inquiry, on behalf of the Board.

22. Revenue

22.1 Commercial Strategy – Royal Infirmary of Edinburgh Public Private Partnership Contract

22.1.1 Ms Goldsmith presented the previously circulated paper. Members strongly supported the aim of getting value and cost efficiency from the Consort contract. It was suggested that putting in place a new team while retaining the previous team reporting though Estates and to the Finance Director respectively could create a decision making risk that Consort could exploit. Ms Goldsmith recognised this risk and work was being done to clearly define responsibilities. There would be a single lead for all communication with Consort, which would also call on the experience of the facilities team.

22.1.2 Ms Goldsmith advised that the team needed more development and that the organisational change process would be used to improve in house technical expertise and legal expertise.

22.1.3 The focus of the new team would be to ensure that there were plans in place for the end of the primary period in 2027. This would require engagement with the Scottish Government. Ms Goldsmith advised that the other PFI and PPP contracts were less problematic for the end of the primary period but any risks would be identified.

22.1.4 Progress on the commercial strategy team would be updated to the Executive Team until the organisational change process had been completed, after which there would be a further update to this Committee.

22.1.5 Ms Goldsmith would bring a paper to the next Committee outlining a structure for reporting on the Royal Infirmary of Edinburgh contract management process. **SG**

22.1.6 Members accepted the recommendations laid out in the paper.

22.2 Financial Position – June 2020

22.2.1 Mr Marriott presented the previously circulated paper, noting a deterioration in the overall financial position. It was noted that as efficiency savings were worked up throughout the year some of them had been developed without the knowledge of changes required due to COVID but some were developed taking these changes into account. Some savings were related to GP prescribing and these would come through later in the year.

22.2.2 Winter planning would be approached differently as part of the remobilisation strategy and working with the Integration Joint Boards. Work had already started on planning for early influenza vaccinations.

22.2.3 Members accepted the recommendations laid out in the paper and accepted limited assurance on ability to achieve break even in 2020/21.

22.3 Update on Climate Change and Sustainability

22.3.1 The chair welcomed Dr Hopton to the meeting and she gave a verbal update. The team was working on a strategic framework to cover all areas of sustainability work and reporting to the Committee. The framework would be agreed at the Corporate Management Team before being submitted to the Finance and Resources Committee.

22.3.2 There had been a successful webinar on COVID and environmental sustainability chaired by Martin Hill and attended by 140 participants.

22.3.3 Progress had been made on active travel work and Sustrans was keen to work with NHS Lothian. Work had started on strengthening this relationship and securing funding.

22.3.4 Dr Hopton wanted to emphasise the level of commitment and engagement from staff in all disciplines with regard to strengthening new models of care delivery using digital technology to improve sustainability.

22.3.5 Dr Hopton advised that that there was engagement with local authority climate committees and this was at a stage where opportunities for joint working were being considered. Mr Hill agreed to discuss with the Chief Executive opportunities for NHS Lothian, as the largest employer in Edinburgh, to work with the Council's Climate Change Commission

22.3.6 A written update would be submitted to the next meeting. **JH**

22.4 Royal Infirmary of Edinburgh Car Park Expansion

22.4.1 Ms Goldsmith presented the previously circulated paper. The expansion of the car park had been agreed on the basis of an immediate and pressing need to increase capacity although it was acknowledged that this was not in line with the sustainability strategy. It was requested that the car park should include facilities for electric cars and cyclists.

22.4.2 Members accepted the recommendations laid out in the paper.

23. Committee Business

23.1 Reflection on the meeting

23.1.1 It was agreed that the discussion on the relationship between the Board and the Public Inquiry and the role of the Finance and Resources Committee would be highlighted at the next Board meeting. **MH**

24. Date of Next Meeting

24.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 26 August 2020**.

25. Meeting Dates in 2020

25.1 Further meetings would take place on the following dates in 2020:
- 23 September 2020;
- 28 October 2020;
- 25 November 2020.

Signed by the Chair on 26-08-2020
Original in file

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 14 July 2020 by video conference.

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; Mr S. Kerr, Patient and Public Representative; Ms S. Mackie, Patient and Public Representative; Ms L. Rumbles, Partnership Representative.

In attendance: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Mr C. Campbell, Interim Chief Executive (until 10.00); Ms J. Campbell, Chief Officer, Acute Services; Ms S. Gibbs, Quality and Safety Assurance Lead; Ms T. Gillies, Medical Director; Ms F. Huffer, Head of Dietetics (on behalf of Ms Myles); Ms M. Hughes, Chief Nurse, West Lothian Health and Social Care Partnership; Ms G. McAuley, Nurse Director, Acute Services; Professor A. McCallum, Director of Public Health and Health Policy; Ms A. Macdonald, Chief Officer, East Lothian Health and Social Care Partnership; Ms F. McGuire, Chief Midwife (item 18.4); Ms T. McKigen, Services Director, Royal Edinburgh Hospital (items 18.1 and 18.2); Professor A. McMahon, Executive Nurse Director; Ms J. Morrison, Head of Patient Experience; Dr E. Murdoch, Consultant Neonatologist (item 18.4); Ms B. Pillath, Committee Administrator (minutes); Professor A. Timoney, Director of Pharmacy.

Apologies: Mr J. Crombie, Deputy Chief Executive; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Dr C. Whitworth, Medical Director, Acute Services.

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.

13. Minutes from Previous Meeting (12 May 2020)

13.1 The minutes from the meeting held on 12 March 2020 were approved as a correct record.

13.2 The updated cumulative action note had been previously circulated.

14. Patient Story

14.1 Ms Mackie read out feedback from the family of a patient in ward 56 who had died of COVID-19. The family were abroad and expressed their thanks for effective communication and the arrangements made for them to speak to the patient by video call. The patient group saw this as an example of effective rapid change in processes in response to the COVID-19 restrictions and noted that staff had been redeployed to these areas and had been given support to work effectively.

15. Emerging Issues

15.1 COVID-19 Response and Remobilisation

15.1.1 Ms Gillies presented the previously circulated paper. This paper had been reviewed in advance of the meeting by the patient and public representatives and Ms Mackie reported that they recognised the significant work that had gone into the response and planning for the future. They had commented on possible inequalities in patient access to IT equipment for virtual consultations, and on the need to engage with the public to reassurance patients that it was safe to attend hospital and clinics.

15.1.2 Ms Gillies advised that the possible inequalities in access had been recognised; this had been a result of rapid introduction of new processes and a more strategic approach was now required. She also noted that many consultations had been carried out over the telephone rather than by video call.

15.1.3 Work had been done to inform individuals attending appointments what was in place to ensure clinics were safe and letting them know what was needed from them, for instance not arriving early for appointments. A patient information leaflet was available for hospital patients and for outpatients information was included in the appointment letter.

15.1.4 Barriers remained to increasing capacity including time for extra cleaning between patients and putting on PPE. The Scottish Government had indicated that a certain amount of capacity should be kept free in case of any increase in COVID-19 patients. Capacity for other urgent cases also needed to be larger than usual because of a trend of patients presenting later in their illness. This would increase waiting times for routine procedures.

15.1.5 A communications strategy for the public on COVID that was more targeted than the Scottish Government communications was discuss but there was a need to ensure confusing messages were not sent out in light of the large amount of guidance available and at a time when there was increased central control from the Scottish Government. The Chief Executive was working with groups from the Scottish Government on getting relevant messages out to the public. Ms Hirst suggested that the reach and extent of messaging should be increased.

15.1.6 Professor McCallum advised that an integrated national and local test and trace strategy was being established, noting that isolation and support was important particularly due to the proportion of asymptomatic cases. Extra capacity was available for testing in case of local outbreaks and the time to result was being decreased. Care home staff and patients were being tested weekly where there was a positive case in the care home.

15.1.7 Professor McCallum noted that due to a certain level of false positives it needed to be clear that no blame was placed on healthcare workers testing positive and appropriate support for isolation in order not to deter engagement.

15.1.8 It was noted that assessment of healthcare inequalities in the COVID response and remobilisation had not been carried out. This was due to the changing nature of the guidance at this time, but it would be carried out when guidance was stable and would

be needed for longer term planning. Professor McCallum advised that the principles for reducing health inequalities applied to COVID as to other areas and these principles were being taken into account during planning.

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

15.2 COVID-19 Care Home Response

15.2.1 Professor McMahon presented the previously circulated paper. It was noted that care home managers were responding positively to infection control input, training and advice, particularly in the use of PPE. Training was being carried out by the Infection Prevention and Control Team in addition to all other training in NHS Lothian and so some planning of resources would need to take place as this responsibility was expected to continue.

15.2.2 This paper had been reviewed in advance of the meeting by the patient and public representatives and Mr Kerr noted that the high risk to the Health Board in accountability for training in areas it did not have responsibility for had been discussed but that the actions taken outlined in the paper had been reassuring.

15.2.3 A Scottish Government group was considering data collection direct from care homes but that the health Board would also have access to this data.

15.2.4 Emerging data suggested that the risk to care homes was related to size and characteristics of the homes, management arrangements and acceptance of the guidance given by the Health Board. Strengthening relationships with care homes was key to making improvements. 40% of care homes in Lothian had not had an outbreak of COVID-19.

15.2.5 It was noted that non older people's care homes had not been a cause for concern regarding COVID-19 but that they were included in oversight of measures. Professor McCallum noted that any closed setting was at a higher risk for spread of any infection and testing and tracing had started early in these areas.

15.2.6 Care homes oversight would be included in Health and Social Care Partnerships Annual Reports for all four areas.

15.2.7 Members accepted the recommendations laid out in the paper, and accepted limited assurance at this stage. Professor McMahon agreed to raise the risk to the Board of the new responsibility of oversight of care homes. **AMcM**

16. Person Centred Culture

16.1 Patient Experience and Feedback

16.1.1 Professor McMahon introduced the previously circulated paper, which focussed on 3 of the 9 indicators as part of the reporting schedule agreed. Ms Morrison advised that any complaints which were relevant to both the Board and a health and social care partnership would be allocated to either social care or health for response following discussion with the relevant area.

16.1.2 Ms Morrison advised that the feedback team were now working from home but were being supported by a daily huddle with the band 6 team leader and fortnightly meetings with the team as whole. Individual members of the team were taking calls for one hour at a time and working to a timetable.

16.1.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance. The next 3 indicators would be considered at the next meeting in September 2020. **AMcM**

17. Safe Care

17.1 Healthcare Associated Infection

17.1.1 Professor McMahon presented the previously circulated paper. Members accepted the recommendations laid out in the paper and accepted moderate assurance.

17.2 Hospital Standard Mortality Rate

17.2.1 Ms Gillies gave a verbal update noting that regular reports on Hospital Standard Mortality Rate would normally be brought to the Committee, but that during the pandemic this data would not be meaningful. An escalation process for deteriorating patients was being developed at a site level. Once the conditions were stable then an update on the HSMR and National Record of Scotland deaths figures would be brought to the Committee.

17.3 Public Protection Update

17.3.1 Professor McMahon presented the previously circulated paper. Service provision had continued throughout the COVID-19 response. Members accepted the recommendations laid out in the paper and accepted moderate assurance.

17.4 Evaluation of Winter Performance

17.4.1 Ms Campbell presented the previously circulated paper. Ms Campbell advised that the programme boards responsible for winter planning took into account whole system workings and collaborated between primary and secondary care and social care to ensure that measures put in place did not negatively affect any other area of the system.

17.4.2 It was noted that COVID-19 highlighted access inequalities both in terms of IT access and access to private transport so local access was being taken into consideration including learning from the COVID hubs.

17.4.3 Members accepted the recommendations laid out in the paper and accepted significant assurance with thanks to the team for the detailed plan and evidence presented.

18. Effective Care

18.1 REAS Governance – Specialist Regional Services

18.1.1 Ms McKigen presented the previously circulated paper. Members noted the high level of detail giving confidence that there was effective oversight for regional services; they accepted the recommendations laid out in the paper and accepted moderate assurance.

18.2 REAS Fatal Accident Inquiry Action Plan

18.2.1 Ms McKigen presented the previously circulated paper. Members accepted the recommendations laid out in the paper and accepted moderate assurance. The action plan was accepted and would be sent to the Sheriff as required by the formal process for fatal accident inquiry.

18.3 Children's Services Assurance – Children and Families

18.3.1 Professor McMahon introduced the previously circulated paper. It was noted that the Programme Board would provide operational assurance and would feed into the Healthcare Governance Committee. Given the range of areas to cover the Healthcare Governance Committee would not have the capacity to consider all these in detail itself. Professor McMahon would discuss further with Ms Bennett on this process including whether the group should be chaired by a Non Executive Board member as proposed in the paper. **AMcM / JB**

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

18.4 Women's Services Assurance

18.4.1 The chair welcomed Ms McGuire to the meeting and she presented the previously circulated paper. Members supported the detailed and ambitious quality improvement plan and Dr Murdoch advised that after a number of audits there was confidence that this could be delivered.

18.4.2 Members accepted the recommendations laid out in the paper and accepted significant assurance on the service improvement plan.

18.4.3 Dr Murdoch noted thanks for the support of the Board on quality assurance and managing adverse events.

18.5 GP and Primary Care Sustainability

18.5.1 Mr Small presented the previously circulated paper. This paper had been reviewed in advance of the meeting by the patient and public representatives group. It was agreed that the next update would include more information on how quality of care and access could be monitored and an evaluation of equality of access especially in the context of virtual consultations. **DS**

18.5.2 The next update would also include an evaluation of the implementation of the GP contract and evaluation of the Health and Social Care Partnership improvement plans. **DS**

18.5.3 Members accepted the recommendations laid out in the paper and accepted limited assurance with a further update to be submitted at the next meeting on 8 September 2020. **DS**

18.6 NHS Lothian Screening Services Restart

18.6.1 Professor McCallum presented the previously circulated paper and members accepted the recommendations laid out.

18.7 Safe and Effective Cancer Care

18.7.1 Ms Gillies gave a verbal update. The Cancer Services teams were putting a significant amount of work into planning for the remobilisation of services. Most cancer services had continued throughout the COVID-19 response and quality performance indicators continued to be reported. As reports run at a year in arrears the numbers during the COVID period would not be included until next years' report.

18.7.2 A paper giving an update on the quality performance indicators would be submitted to the next meeting on 8 September 2020. **TG**

19. Exception Reporting Only

Members noted the following previously circulated papers:

19.1 Voluntary Services Annual Report;
19.2 Tissue Viability Annual Report.

20. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

20.1 Lothian Infection Control Advisory Committee, 10 December 2019;
20.2 Policy Approval Group, 28 January 2020;
20.3 Area Drug and Therapeutics Committee, 7 February 2020;
20.4 Public Protection Action Group, 6 May 2020;
20.5 Organ Donation Sub Committee, 20 February 2020.

21. Corporate Risk Register

21.1 Ms Gillies presented the previously circulated paper and advised that it had been noted by the Board that most of the risks recorded needed to be reviewed in terms of the changes made in the COVID-19 response. Ms Gibbs would be working with risk owners over the next few months to update risks and controls, adding any relevant new risks and controls.

21.2 There was one new risk to recommend to the Board; the water safety risk of additional areas not in use for the last few months and the delay in implementing improvement plans due to COVID-19.

21.3 Members accepted the recommendations laid out in the paper including the changes in risk to be recommended to the Board.

22. Date of Next Meeting

22.1 The next meeting of the Healthcare Governance Committee would take place at **9.00am** on **Tuesday 8 September 2020** by video conference.

23. Further Meeting Dates

23.1 Further meetings would take place on the following dates in 2020:
- 10 November 2020.

Signed by the Chair on 23-09-2020
Original in file

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee Meeting held at 10:00 am on Friday, 31 July 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; and Mr M. Connor, Non-Executive Board Member.

In Attendance:
Ms J. Brown, Chief Internal Auditor; Mr C. Campbell, Chief Executive; Mr J. Crombie, Deputy Chief Executive; Ms S. Goldsmith, Director of Finance; Mr M. Hill, Non-Executive Board Member; Mr A. Payne, Head of Corporate Governance; Ms E. Robertson, Interim Chair and Miss L. Baird, Committee Administrator.

Apologies:
Councillor J McGinty, Non-Executive Board Member.

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. Mr McQueen declared an interest as a member of the Finance and Resource Committee that approved the signing of the settlement agreement in February 2019.

18. Minutes of the previous meeting held on 22 June 2020

18.1 The minutes of the meeting held on 22 June 2020 were accepted as an accurate record and approved.

19. Governance and internal controls: Royal Hospital for Children and Young People, and Department of Clinical Neurosciences, Edinburgh

19.1 Ms Brown introduced the previously circulated report. She noted that it was not possible to identify one single cause of failure which resulted in the errors as there were several contributing events. Overall all parties involved had missed opportunities to pick up errors.

19.2 Ms Brown advised that the report had been fact-checked with several parties. Members noted that Scottish Futures Trust ('SFT') and MacRoberts had proposed amendments that would not change the conclusion or the substance of the report. Ms Brown would look at these and amend the report in advance of the Board meeting. **JBr**

19.3 There were discussions on the role of Davis Langdon and the transfer of liability when they ceased to exist. Ms Brown advised that Davis Langdon had been subcontracted by Mott Macdonald. NHS Lothian held the contract with Mott Macdonald, therefore when Davis Langdon ceased to exist that work and liability reverted to Mott Macdonald as the main appointed technical advisors.

19.4 It was recognised that there were two influential points relating to the speed of decision that were to the detriment of the project. The first related to the switch from a traditional capital funded project to an Non-Profit Distribution ('NPD') project, and adding the Department of Clinical Neurosciences to the scope of the project, which did de-stabilise the arrangements. The second related to the desire to limit the impact of this change on the overall project/ procurement timeline, and the desire for parties not to be held back. This in turn led to the initial contract being signed while there was still a significant amount of reviewable design data ('RDD') that was not agreed at the time of signing. The committee agreed that lessons should be learnt regarding the speed of decisions taken and their impact on the outcome of the project. The Committee noted that the significance of the issue of ventilation did not appear as a key issue in the early stages of the project.

19.5 Ms Brown highlighted that under the contract, NHS Lothian was responsible for 'operational functionality', which is a spatial issue, and nothing to do with mechanical and engineering issues. It is the role of technical advisors to undertake the line-by-line review, and to advise the NHS Lothian project team. At the point of signing the contract a significant amount of reviewable design data was not agreed between NHS Lothian and Project Co. This position was captured in the contract. Internal audit understand it is not unusual to have a degree of RDD not agreed at this point in the contract discussions, but this did appear to be significant. Whilst this was discussed at the Project Board, SFT did not identify a concern in their key stage report, and a desire was referenced by both SFT and Project Co to move to financial close.

19.6 Mr Hill commented on lessons learnt from previous NHS 24 projects that had run into contractual errors. Lessons had identified that there was a clear expectation to appoint a single person to oversee the whole contract. He noted that it in this case the complexity of scope and scale meant that no one could be expected to review all points and identify errors. Members agreed that the appointment of a single person to oversee future projects would mitigate risk of similar errors occurring in future Lothian and public projects. An individual acting on behalf of the procuring organisation should be responsible for ensuring that any technical or legal requirements are competently translated into the specifications for every room. It is essential to have assurance that any identified requirements can actually be delivered by the contractors.

19.7 Mr Hill highlighted that there is a requirement for capital projects in England to have a doctor who had been trained in project development as part of the team. Members agreed a clinician with the relevant expertise to support projects in this way would be invaluable. The Committee agreed to recommend that going forward there is a suitably qualified clinician as part of every project team. Ms Brown agreed to amend the report to include this as part of the recommendations within the report. **JBr**

19.8 The Committee noted that there a number of issues related to confusion around the roles and responsibilities of the key stakeholders. Members supported the implementation of a single overarching role in all projects, but highlighted that this alone may not address all of the issues identified within the report. The Chair agreed to flag to the Board the importance of oversight of all aspects of future NHS Lothian and other public projects. **MA**

19.9 The Committee discussed the appointment of the technical advisors and the independent tester, and their critical role in the project. It was acknowledged that that the independent tester had been appointed through a joint process with NHS Lothian and Project Co. The Committee noted that the independent tester appeared to be testing against what had been agreed between the parties, rather than testing against the relevant technical guidelines and requirements. The Committee agreed that the role of the independent tester should be to test against the technical requirements. Mott Macdonald was appointed to the project in 2011 through a recognised public sector procurement framework contract. There were a number of technical advisors involved in projects, Mott Macdonald being one of the main companies who advise public bodies on similar projects.

19.10 Members questioned to what degree the request for the 4-bedded rooms had impacted on the outcome of the project. The discussion highlighted that request for 4-bedded rooms was not unreasonable; the issue arose in translating that request in a manner which would meet the technical requirements and translating it into the specification of the building. The relevant technical memorandum does not recognise a 4-bedded room as a model room. Therefore it was the process that was broken rather that the request being unreasonable.

19.11 Ms Brown advised the Committee that some key decisions were made very early on in the project, but there appears to have been limited review or challenge to those earlier decisions.

19.12 Ms Goldsmith advised the Committee that the 'overall management commentary' would be slightly adjusted and this would be reflected in the version which goes to the Board.

19.13 The Committee accepted the report. The chair and Members expressed their gratitude to Ms Brown and her team for the exemplary work and the time involved in the completion of the internal audit report.

19.14 Subject to the small changes being made by Ms Brown, the Committee agreed to recommend that the report goes forward to the Board. The Chair of the Audit and Risk Committee will provide a short report to the August Board meeting. The Chair request that Ms Brown flag the changes made to the members of the Audit and Risk Committee. **JBr**

20. Any Other Competent Business

20.1 Audit and Risk Chair – The Chair noted that he was stepping down as Chair of the Audit and Risk Committee. He thanked the team for their support and hard work during his terms as Chair, noting that Mr Connor would take up the role of Audit and Risk Committee from 24 August 2020.

20.2 Ms Robertson expressed thanks on behalf of the Board to Mr Ash for his hard work and dedication over the years and wished him well for the future.

21. Date of Next Meeting

21.1 The next meeting of the Audit and Risk Committee is scheduled for Monday, 24 August 2020 at 9.30 a.m. via MS Teams.

Signed by the Chair: 24 August 2020

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 21 July 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, Andrew Coull, Councillor Phil Doggart, Christine Farquhar, Helen FitzGerald, Councillor George Gordon, Kirsten Hey, Martin Hill, Jackie Irvine, Jacqui Macrae, Councillor Melanie Main, Ian McKay, Peter Murray, Moira Pringle, Judith Proctor, Ella Simpson and Richard Williams.

Apologies: Mike Ash

Officers: Tom Cowan, Rachael Docking, Ann Duff, Tony Duncan, Rachel Gentleman, Lauren Howie, Linda Irvine Fitzpatrick, Jayne Kemp, Jenny McCann, Katie McWilliam, Jake Montgomery and Hazel Stewart.

1. Minutes

Decision

1) To approve the minute of the Edinburgh Integration Joint Board of 28 April 2020.

2) To approve the minute of the Edinburgh Integration Joint Board of 16 June 2020.

2. Rolling Actions Log

The Rolling Actions Log for July 2020 was presented.

Decision

1) To agree provide an update on the recruitment of carers and service user representatives and estimated timescales following the meeting.

2) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log, submitted.)

3. Edinburgh Integration Joint Board Governance Report

A report on some aspects of governance of the Board was submitted. Approval was sought to resume committee meetings which had been temporarily amended and proposed some amendments to the process for these meetings, the meetings schedule for the IJB for 2021 and the terms of reference for the five committees.

Decision

1) To agree to the resumption of committees to be held virtually until the end of 2020.

2) To note the Clinical and Care Governance Committee meeting had been rescheduled from 6 August to 27 August.

3) To agree the 2021 dates for the EIJB meetings and development sessions.

4) To agree the Terms of Reference for EIJB committees subject to a change in the number of non-voting members of Performance and Delivery Committee from two to four.

5) To clarify if the timescale for issuing committee meeting papers would be 5 days or 5 working days before meetings.

6) To note that the governance of development sessions would be discussed at a later date.

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

4. Return to Transformation

An update on the transformation programme set out the progress made to date, the impact of Covid-19 and the planning for return to transformation. The Board was asked to approve a two-phase approach to the delivery of the transformation.

Decision

1) To approve the two-phase approach to the delivery of transformation as set out in the report.

2) To emphasise the sustainability commitments within the strategic plan and to note that sustainability would be included in the review of the strategic plan by the SPG later in the year.

3) To note that a report on the wider sustainability considerations should be submitted to the Board at a later date.

(Reference – report by the Head of Strategic Planning, Edinburgh Integration Joint Board, submitted.)

5. Savings and Recovery Programme 2020/21

The Savings and Recovery Programme 2020/21 was presented. Approval was sought for Phase 1 of the programme set out in the report, which would allow the Board to set a balanced budget for the year.

Further details on Phase 2 of the programme and a three-year savings programme would be presented to the Board at a later date.

Decision

1) To agree Phase 1 of the Savings and Recovery Programme.
2) To note the content of Phase 2 of the Savings Programme and agree to receive more detailed plans about the proposals at a future meeting.
3) To agree to award the Carers contracts from 1 January 2021.
4) To note Phase 3 of the Savings Programme.
5) To agree that more details about the proposed three-year Savings Programme is brought back for consideration by the Edinburgh Integration Joint Board by the end of the year.

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

Dissent

Christine Farquhar requested that her dissent to the above decision be recorded.

6. 2020/21 Financial Plan

Approval was sought of the 2020/21 financial plan. An update was also provided on the potential financial implications of Covid-19.

Decision

1) To agree the 2020/21 financial plan as presented in the report.
2) To note that, whilst financial balance could be achieved in year, this relied heavily on one off measures.
3) To agree to receive a first draft of the 2021/22 budget in line with our partners financial planning timescales;
4) To note that both partners have commissioned work to further understand the financial impact of COVID-19.

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

7. Mental Health Services (including Substance Misuse): Quality Assurance – referral from the Clinical and Care Governance Committee

The Clinical and Care Governance Committee on 28 April 2020 considered a report by the Head of Operations on mental health services quality assurance.

The report had been referred to the Board for consideration and approval to support the HSCP joining the Royal College of Psychiatrists Accreditation Scheme for adult inpatient and community mental health teams.

Decision

To support the proposal that the Edinburgh Health and Social Care Partnership join the Royal College of Psychiatrists Accreditation Scheme for adult inpatient and community mental health teams.

(Reference – report by Head of Head of Operations, Edinburgh Health and Social Care Partnership; Clinical and Care Governance Committee, 28 April 2020)

8. Valedictory

The Chair informed the Board that Mike Ash had resigned as a member of the Edinburgh Integration Joint Board and thanked him for his input and work during his time as a member.

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within WEBEX VIRTUAL MEETING ROOM, on 30 JUNE 2020.

Present

Voting Members – Harry Cartmill (Chair), Bill McQueen, Martin Connor, Martin Hill, Alex Joyce, George Paul and Damian Timson

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

Absent – Dom McGuire and Martin Murray

In attendance – Carol Bebbington (Interim Head of Health), Lorna Kemp (Project Officer), Yvonne Lawton (Head of Strategic Planning and Performance) and James Millar (Standards Officer)

The Chair opened the meeting by thanking Bill McQueen for chairing previous meetings in his absence.

1 DECLARATIONS OF INTEREST

There were no declarations of interest made.

2 MINUTES

The Board approved the minute of its meeting held on 10 March 2020 as a correct record.

3 MINUTES FOR NOTING

The Board noted the minutes of the West Lothian Integration Joint Board Audit, Risk and Governance Committee held on Wednesday 4 March 2020.

4 MEMBERSHIP & MEETING CHANGES

The Clerk advised the Board that on 26 May West Lothian Council had reappointed Councillors Harry Cartmill, George Paul and Damian Timson to the IJB and had designated Councillor Cartmill as Chair/Vice Chair as appropriate.

5 WEST LOTHIAN IJB 2020/21 BUDGET UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2020/21 budget

position, including initial Covid-19 financial implications, and, based on current partner funding contribution assumptions, providing an updated high-level medium-term financial outlook.

During discussion, it was clarified that further financial support from the Scottish Government was expected, although this was still to be confirmed. Reassurances were also provided regarding budget being available for St John's Hospital Emergency Department.

It was recommended that the Board:

1. Note the indicative three-year budget resources for IJB delegated resources based on existing partner planning assumptions and support the ongoing development of medium-term financial planning during 2020/21 to take account of the implications of Covid-19;

2. Note the updated financial contribution received from NHS Lothian in respect of 2020/21 IJB delegated functions;

3. Note the currently estimated financial implications resulting from Covid-19 and arrangements in place to monitor this and the overall 2020/21 budget position taking account of the pandemic; and

4. Agree that Directions be updated and re-issued by the Chief Officer to NHS Lothian taking account of the updated 2020/21 budget resources advised.

Decision

To approve the recommendations in the report.

6 CONSIDERATION OF 2019/20 ANNUAL ACCOUNTS (UNAUDITED)

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer presenting the unaudited 2019/20 Annual Accounts of the West Lothian Integration Joint Board.

Board members requested that achievement of targets, progress made with commissioning plans and how IJB responds to the requirements of other health and care organisations be clearly shown in annual reporting.

It was recommended that the Board:

1. Consider the overall 2019/20 Annual Accounts prior to submission to Ernst and Young (EY) for audit and publication;

2. Agree the letters provided by NHS Lothian and West Lothian Council, along with partner financial ledger reports used throughout the year, provide assurance of the year end spend and funding contained in the unaudited annual accounts; and

3. Agree to suspend compliance during the coronavirus emergency

period with the duty to make hard copies of the annual accounts available for public inspection and copying, noting that copies could be provided instead by electronic means or by post.

Decision

1. To approve the recommendations in the report.

2. To ensure achievement of targets, including IJB's response to the requirements of other relevant health and care organisations, is clearly shown in annual reporting.

3. To bring a report to a future meeting showing work done in the context of commissioning plans.

7 ANNUAL PERFORMANCE REPORT 2019/20

The Board considered a report (copies of which had been circulated) by the Director presenting the Integration Joint Board's Annual Performance Report 2019/20 for consideration, approval and publication by 31 July 2020. The report also presented the most up-to-date performance against the health and social care integration indicators and a summary of performance against national and local indicators which supported National Health and Wellbeing Outcomes.

It was noted during discussion that efforts would be made to disseminate report findings as widely and as frequently as possible. Publishing a summary version of the report ensuring a balance between concise and comprehensive content was also suggested.

It was recommended that the Board:

1. Agree publication of the IJB's Annual Performance Report by 31 July 2020 subject to minor amendments and inclusion of any data updates available by that time;

2. Note the summary report and performance against the core suite of integration indicators; and

3. Note performance against local and national indicators which support National Health and Wellbeing Outcomes.

Decision

To approve the recommendations in the report.

8 SELF-ASSESSMENT - SURVEY QUESTIONS

The Board considered a report (copies of which had been circulated) by the Chief Officer presenting arrangements for carrying out periodic self-assessment of the Board's administrative arrangements and activity.

It was recommended that the Board:

1. Consider carrying out a self-assessment of the Board's effectiveness by the use of the questionnaire in the appendix;

2. Consider using the questionnaire to assess communication with the Board during the COVID-19 outbreak and to consult the Board on formalising induction and member support arrangements; and

3. Agree to the questionnaire being issued to Board members and the results reported to a future meeting.

Decision

To approve the recommendations in the report subject to minor amendments to the content and presentation of the questionnaire.

9 ANNUAL REVIEW OF RECORDS MANAGEMENT PLAN

The Board considered a report (copies of which had been circulated) by the Chief Officer presenting a draft revised Records Management Plan to the IJB for approval to submit to the Keeper of Records for agreement.

It was recommended that the Board:

1. Note that the Records Management Plan was required to be reviewed annually;

2. Note that a new element was included in the revised model records management plan and that guidance for IJBs would be provided;

3. Agree the recommended changes to the Plan and its submission to the Keeper of Records for agreement; and

4. Agree that a Progress Update Review would not be submitted this year.

Decision

To approve the recommendations in the report.

10 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.

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

1. To note the recommendation in the report.

2. To request that Audit, Risk and Governance Committee formally carry out a risk register review in light of Covid-19.

11 COVID-19 RESPONSE

The Board considered a report (copies of which had been circulated) by the Chief Officer providing an update to the West Lothian IJB on how services within the West Lothian Health and Social Care Partnership had responded to the Covid-19 pandemic.

The Board wished to thank staff in all health and care settings for their formidable efforts during the Covid-19 crisis and commended their flexibility and adaptability as they resumed normal activities while still facing challenges relating to the virus.

It was recommended that the Board note the partnership response to the Covid-19 pandemic and the work to be undertaken to remobilise services as the pandemic eased.

Decision

To note the recommendation in the report.

12 DELEGATED ACTIONS TAKEN IN TERMS OF STANDING ORDER 16 DUE TO COVID-19

a. COVID-19: CANCELLATION OF BOARD MEETING

Decision

To note action taken in terms of Standing Order 16.

13 WORKPLAN

A workplan had been circulated for information.

Decision

1. To note the workplan.

2. To add a further update report on Covid-19 to the August meeting.

14 CLOSING REMARKS

As this was Alex Joyce's last Board meeting, the Chief Officer thanked him for his contribution to the Board and wished him a happy retirement.

The Chair then thanked health care practitioners across Lothian for their support relating to his personal health circumstances.

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 25 JUNE 2020
VIA DIGITAL MEETINGS SYSTEM

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

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

Officers Present from NHS Lothian/East Lothian Council:
Ms L Berry
Mr P Currie
Ms D Gray
Mr J Hetherington
Ms J Ogden-Smith
Ms C Cockburn
Ms C Goodwin
Ms L Kerr
Ms J Holland
Mr D Stainbank

Visitors Present:
Ms E Scoburgh, Audit Scotland

Clerk:
Ms F Currie

Apologies:
Lesley White

Declarations of Interest:
None

The Chair welcomed members to the meeting which was being conducted via MS Teams.

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD OF 26 MARCH 2020 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board (IJB) meeting on 26 March 2020 were approved.

2. MATTERS ARISING FROM THE MINUTES OF 26 MARCH

There were no matters arising.

3. CHAIR'S REPORT

The Chair confirmed that the emergency recess procedures put in place on 27th March had now come to an end, allowing for the resumption of formal business meetings. However, she stressed that the threat from COVID-19 was by no means over and that there may be occasions over the coming weeks and months where it may be necessary to return to emergency governance arrangements. Members would be notified of any change and kept informed of any decisions taken under these arrangements.

Peter Murray reported that a Remobilisation & Recovery Group had recently been set up by the Cabinet Secretary. Mr Murray had been appointed as one of the members and would provide feedback to the IJB on progress.

Marilyn McNeill asked whether there was any data on the number of people who had heeded the message 'not to go to the doctor' and were currently awaiting treatment. The Chair advised that NHS Lothian had recently produced an update on this issue and she would be happy to share the information with Ms McNeill. However, it should be noted that the figures covered the whole of Lothian.

Shamin Akhtar advised that the Council's Education Committee had met that morning to discuss plans for children to return to school in August. She reinforced the importance of ensuring that childcare, particularly for key workers, continued to receive adequate funding.

The Chair thanked her colleague for the reminder that, without appropriate childcare, staff within health and social care could not fulfil their roles.

4. COVID-RELATED HSCP SERVICE CHANGES

The Chief Officer had submitted a report updating the IJB on the temporary changes made across HSCP managed and commissioned services resulting from COVID-19 and those changes that may apply in the longer term.

Paul Currie presented the report outlining the key points and highlighting the tremendous efforts of staff in responding to the health crisis. He advised members that the experience gathered during the past few months had helped to inform the NHS Lothian Remobilisation Plan. He added that guidance and polices were still subject to frequent changes and flexibility would continue to be required in both planning and delivery over the coming months.

The Chair said it was very useful to see the scale of the work and the impact on current and future practice within services.

Mr Murray remarked that this was a very powerful document and huge credit was due to staff for their work in responding to the crisis and in developing new ways of working.

Fiona Ireland agreed with Mr Murray, noting that the document demonstrated very clearly the work that had been done on shifting the balance of care. She said it would be important to understand the impact on services and on staff, and to ensure that this was part of the discussion on the need for revised or new Directions and changes to funding during the current year.

Alison MacDonald acknowledged that there was still a lot of work to be done to fully take account of and learn from the experiences of staff. She advised that a questionnaire would shortly be issued seeking feedback from NHS staff on working arrangements and this would be followed by a wider piece of work across health and social care.

Patricia Donald said the paper was hugely impressive and she welcomed the discussions taking place on how to build on this work to improve services in future. She highlighted the evolution of CTAC; and mental health and rehabilitation services as examples of positive changes which could have long-term benefits.

Ms MacDonald acknowledged the potential of these and other services to improve practice and outcomes and Lesley Berry provided some examples of improvements to services across the county.

Iain Gorman provided some feedback on the changes to mental health services and how the delivery mechanisms had been remodelled to provide a less centralised service. He hoped that this work would be further developed and allow services to reach other clients that may previously have been missed.

Thomas Miller said that the Unions fully supported the plans for a staff survey. He emphasised the importance of learning lessons from this crisis and ensuring that staff felt valued and that their contribution was fully recognised.

Responding to a question from the Chair, Laura Kerr advised that discussions were taking place around community support and the needs of individuals and day centres across this sector. The idea being to build on the increased community spirit and volunteering seen during the past few months.

Councillor Akhtar commended both NHS and social care staff across the county and urged the IJB to give particular consideration to staff from BAME backgrounds who had been disproportionately impacted by COVID-19.

The Chair thanked everyone for their contributions to the debate.

Decision

The IJB agreed to:

i. Accept the summary of the many actions taken across all HSCP services over the last three months (some arising from centrally delivered service changes and UK and Scottish Government Policy) to respond to restrictions arising from COVID-19;

ii. Note that guidance and policy has changed regularly. This has required managers to continue to adapt their service delivery offer to patients and clients. Flexibility in planning and delivery of HSCP services is likely to be required for many months yet;

iii. Note that enforced changes to services have allowed for exploration of different ways of working, including increased utilisation of video and other technologies in patient assessment and care and for service management; and

iv. Note the development themes below that are common across the service summaries. Further work is needed to review these and to take action where indicated:

- Continue the rollout of technologies
- Redesign premises
- Consolidate new ways of working
- Extend partnership/joint working
- Address 'digital exclusion' and vulnerability.

The Members agreed to take Item 6 next.

6. NHS LOTHIAN COVID-19 REMOBILISATION PLAN

The Chief Officer had submitted a report informing the IJB of the plans underway through which NHS Lothian will remobilise services across Lothian, covering those centrally delivered by the Board, those managed by the four HSCPs, hosted services and independent contractor services.

Ms MacDonald and Mr Currie presented the report pointing out that the Plan had been drawn together in a very short timeframe and would be subject to revision. It was a starting point for considering how to move forward, how to influence the shape of services in the future and to best serve the people of East Lothian. The Plan had been submitted to the Scottish Government in April and had been approved in principle. While some uncertainty remained around the flow of monies associated with the Plan, the costs would be reviewed at Quarter 1 and officers would continue to pursue all options for funding to support this work.

Mr Murray emphasised the need for the IJB to act swiftly to influence the shape and direction of travel and to return services to their previous levels of capacity.

The Chair agreed and added that workforce planning would be a key aspect of this work.

Dr Donald raised concerns about the impact of the backlog on GPs and cautioned against plans which placed too great an additional burden on these services.

Ms MacDonald confirmed that discussions had taken place on this issue. She was mindful of the need to consider carefully how and where this work should be allocated and that GP practices should not be overloaded.

Ms Ireland agreed that the timeframe for developing the Plan was unfortunate but added that the IJB had an opportunity to claim back from the centre some of the power to determine how future services could look. It was important that the IJB identified areas where a change in Directions would allow services to be delivered differently, rather than simply returning to business as usual.

Paul White said he would be interested to see the future level of demand for services, noting that demand had been suppressed due to concerns about COVID-19 or through community self-management. He suggested that a focus on the latter might help to solve more challenges at local level, particularly as the availability of funding would likely reduce and the need to redesign services would be greater than ever. One of the positive outcomes from COVID-19 had been that more people seemed to take on board the prevention message; he suggested that this might be extended to other health issues.

The Chair said that community capacity and building on successful and sustainable community connections was an interesting point. She also noted that the IJB needed to work on its engagement strategies to improve communication to and from the public.

Ms MacDonald reminded members that the IJB was part of the Integrated Care Forum, involving all four Lothian IJBs, and that they should be working with their neighbouring IJBs to maximise opportunities for East Lothian.

Mr Murray welcomed Mr White's remarks and suggested that the possibility of an increased reliance on more holistic service provision was something that the IJB should debate in more detail. He also acknowledged the point made by Ms MacDonald, reflecting on his experiences as a member of the Edinburgh IJB.

The Chair suggested the possibility of arranging a development day to discuss these and other issues.

Decision

The IJB agreed to:

i. Accept the Remobilisation Plan which NHS Lothian Board is receiving for approval on 24th June, and the plans therein to bring suspended health and social care services back into operation in a phased way. The Plan commits to reintroduce those of highest clinical priority first;

ii. Note the Remobilisation Plan covers: acute service areas not delegated to the IJBs; those areas delegated to the IJBs which require local strategic and operational planning work and some delegated areas in which action is underway (e.g. roll-out of 'Near Me under the direction of Scottish Government) and which for reasons of expediency, happened without consultation with IJBs. The delivery of future actions concerning areas of IJB responsibility may require Directions and as such will be subject to IJB scrutiny; and

iii. Note that the Remobilisation Plan will develop further, as there is an expectation that the Scottish Government may ask for extension of the plan to end March 2021. The further version of the Remobilisation Plan will include Winter Plan arrangements for Lothian.

5. 2020-21 DIRECTIONS

The Chief Officer had submitted a report updating the IJB on the plans to review the suite of Directions to ensure they were relevant to policy and service delivery requirements in the short and longer term arising from the current COVID-19 outbreak.

Mr Currie presented the report outlining the background and purpose and drawing members' attention to the information contained in the summary. The expectation was

that the Change Boards would carry out a formal review of the current Directions and consider whether new Directions were required. It was also possible that some service reviews may need to be revisited.

Ms McNeill asked about reprovision of services and was advised that an update would be provided under Agenda Item 10.

Mr Murray thanked officers for providing such a comprehensive analysis. He advised members that the Cabinet Secretary had recently commented on the importance of IJBs reviewing and revising their strategic direction at this time and using the response to the pandemic as an opportunity to redesign services with a community-first approach. He also referred to the impending review of social care as an opportunity to influence the direction of travel for future services and to bid for increased funding for IJBs. He welcomed the references to staff within the document, the importance of their contribution to service redesign, and he emphasised the need to take a new and more inclusive approach to commissioning of services. He concluded that the previous suggestion of a development day would be a useful first step.

Ms Ireland highlighted the remit and work of the Shifting the Balance of Care Group which had met during the pandemic and were discussing how to increase public and third sector engagement through virtual means.

Ms MacDonald acknowledged the need for Change Boards and other groups to begin this work but cautioned that officers were still incredibly busy dealing with the pandemic and that NHS Lothian remained subject to emergency procedures.

The Chair said it was important to make that point and to be realistic about what could be achieved in the short term. She added that the Change Boards and groups may wish to consider whether other members could take on greater responsibility for driving work forward in the meantime.

Decision

The IJB agreed:

i. To note the summary of the impact of COVID-19 on Directions;

ii. That the Change Boards should be asked to formally review all current Directions and to make recommendations for any new Directions to deliver continuing priorities and any new priorities arising from COVID-19 or Government and partner policies;

iii. To accept that the Scottish Government relaxation of deadlines will delay completion of planned work related to Directions, including the review of the Integration Scheme, the production of the IJB Annual Performance Report for 2019-20 and review of the Primary Care Improvement Plan; and

iv. To accept that some completed service reviews will need to be revisited in view of changes imposed by COVID-19 action.

7. ANNUAL INTERNAL AUDIT OPINION AND REPORT

The Chief Internal Auditor had submitted a report informing the IJB of the internal audit work undertaken in 2019/20 and providing an opinion on the overall adequacy and effectiveness of the IJB's framework of governance, risk management and control.

Duncan Stainbank presented the report outlining the main points which included a summary of the internal controls, the audit reports prepared during 2019/20 and the work that had been delayed due to COVID-19. He highlighted the evaluation of the IJB's controls and governance and the areas with scope for improvement. He concluded that 'reasonable assurance' could be placed on the overall adequacy and effectiveness of the IJB's framework of governance, risk management and control for the year ended 31 March 2020.

In response to a question from the Chair, he confirmed that the improvement actions had been agreed by Management but that some may take longer to complete due to the current situation. Implementation of all actions would be reviewed as part of the audit team's follow up work and a further update provided.

Decision

The IJB agreed to note that the Internal Audit Opinion and Report 2019/20 was a formal confirmation of Internal Audit's opinion on the overall adequacy and effectiveness of the IJB's framework of governance, risk management and control for the year ended 31 March 2020.

8. 2019/20 DRAFT UNAUDITED ANNUAL ACCOUNTS

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

Claire Flanagan presented the report outlining the contents of the management commentary, annual governance statement and the financial statements. The accounts required to be published by the end of June and submitted for review by the IJB's external auditors. She advised that IJB had ended the 2019/20 financial year with an underspend of £626,000 and this would be added to the IJB's existing reserves.

In reply to a question from the Chair, Ms MacDonald confirmed that non-voting members were able to claim expenses and that forms and guidance were available from her office.

Ms Flanagan responded to questions on the IJB's reserves policy and the use of both allocated and unallocated reserves. She reminded members that the policy recommended a minimum of 2% reserves and the IJB had yet to reach this figure. She also confirmed that further dialogue would take place with the Scottish Government over the costs of responding to the pandemic and any potential implications for IJB reserves.

Ms McNeill confirmed that she had received expenses but noted that she had been required to seek out the information on how to claim as this had not formed part of her orientation as a new non-voting member.

Esther Scoburgh offered her thanks to Ms Flanagan and Ms MacDonald for preparing the accounts and adhering to the timetable for doing so during such an unprecedented situation.

The Chair also added her thanks noting that not all IJBs had been able to complete their accounts within the usual timeframe.

Decision

The IJB agreed that the draft annual accounts could be published and presented for audit.

9. INTERNAL AUDIT OF EAST LOTHIAN IJB STRATEGIC CHANGE PRIORITIES AND DELIVERY

The Chief Officer had submitted a report presenting the recommendations of an NHS Lothian Internal Audit report on East Lothian IJB strategic change priorities and their delivery, and the management actions planned in response.

Mr Currie presented the report outlining the background and key findings of the audit work. He advised that all of the recommendations and proposed management actions had been agreed and that the actions would be addressed by the relevant Change Boards. He said the intention was to deliver the proposed actions within the stated timescale but that the continuing response to the pandemic may impact on some completion dates.

The Chair reiterated the point made previously regarding the continuing impact of the pandemic on staff resources and the need to take into account the demands on officer time.

Decision

The IJB agreed:

i. To accept the attached Internal Audit report on East Lothian IJB Strategic Change Priorities and Delivery;

ii. To note the report has been agreed with the Chief Internal Auditor for East Lothian Integration Joint Board. It has been considered at the NHS Lothian Audit and Risk Committee, but has still to be presented to the East Lothian Integration Joint Board Audit and Risk Committee; and

iii. That the East Lothian Change Boards should (with the input of their Reference Groups and the Strategic Planning Group) address the audit recommendations, through the proposed management actions.

10. UPDATE ON SHIFTING THE BALANCE OF CARE IN NORTH BERWICK, DUNBAR AND MUSSELBURGH

Ms MacDonald provided a brief update on the progress in relation to transforming care for older people in North Berwick, Dunbar and Musselburgh. She advised members that, as they might appreciate, no work had taken place during the past 3 months but that there was now a project team in place who were ready to take things forward. Money had been secured from the Scottish Futures Trust to undertake work on identifying those who required care and this information would be used to prepare a report to inform the IJB's strategic decision-making.

In response to questions from Ms McNeill, Ms MacDonald advised that a new Change Board would be formed to take forward this work and that time was required to interrogate the information and formulate possible options. There would be an opportunity for community engagement during this process and particularly around the potential options.

The Chair also noted the likelihood of future changes to national policy and the importance of the IJB remaining in step with this.

Ms McNeill suggested that providing a one page update on progress would be helpful for community groups at this stage. The Chair endorsed this suggestion but cautioned against including a timeline for actions given the continuing impacts of COVID-19 on staff resources.

Ms MacDonald referred to the redesign of services within Ward 2 at Belhaven Hospital as an example of positive change. She pointed out that while the ward had been closed as an in-patient facility it was now working very successfully as a multi-disciplinary community hub.

The Chair invited members to note this verbal update.

11. UPDATE ON THE REVIEW OF THE INTEGRATION SCHEME

Mr Currie presented the SBAR report updating the IJB on the planned review of all four IJB Integration Schemes in Lothian.

He indicated that the SBAR was a new report format (**S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation) which was being trialled and he welcomed feedback from members.

He advised members of the planned review of the integration schemes had been suspended due to COVID-19 and that NHS Lothian were now considering when and how the reviews would be carried out.

Decision

The IJB agreed:

i. To support the NHS Lothian plan to inform the Scottish Government of its intentions to work with partner Local Authorities on the Integration Scheme Review; and

ii. That HSCP officers should support NHS Lothian and East Lothian Council in the process of developing the revised Integration Scheme and carrying out a consultation in East Lothian.

12. UPDATE ON THE DELAYED IJB ANNUAL PERFORMANCE REPORT

Mr Currie presented the SBAR report updating the IJB on the delay to the publication of the 2019-20 IJB Annual performance Report.

He informed members that discussions were underway nationally between integration colleagues on delaying publication of the IJB Annual performance Reports for 2019-20 until, at the very latest, end September 2020. He added that as the report covered the previous financial year it would only contain brief references to the impact of the pandemic. He thanked his colleague, Jane Ogden-Smith, for her work on preparing the report.

The Chair also acknowledged the work of Ms Ogden-Smith in providing very helpful and regular public communications during the pandemic. She also commended Ms MacDonald's blog as a very useful source of information.

Decision

The IJB agreed:

i. To accept that a delay to the 2019-20 Annual Performance Report publication is reasonable given the current disruption to usual business and the focus of the HSCP's energies on maintenance of its key services and on outcomes reporting.

ii. That work on the 2019-20 Annual Performance Report should be recommenced when feasible, but with a view to producing it by the end of August 2020 at the latest.

Signed .....

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

Midlothian Health & Social Care Partnership

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 13 February 2020	2.00pm	Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ.

Present (voting members):

Cllr Catherine Johnstone (Chair)	Carolyn Hirst (Vice Chair)
Cllr Derek Milligan	
Cllr Pauline Winchester	

Present (non-voting members):

Morag Barrow (Chief Officer)	Claire Flanagan (Chief Finance Officer)
Alison White (Chief Social Work Officer)	Caroline Myles (Chief Nurse)
James Hill (Staff side representative)	Keith Chapman (User/Carer)
Ewan Aitken (Third Sector)	

In attendance:

Mairi Simpson (Integration Manager)	Jamie Megaw (Strategic Programme Manager)
Matthew Curl (TEC Strategic Lead)	Mike Broadway (Clerk)

Apologies:

Cllr Jim Muirhead	Tricia Donald
Alex Joyce	Angus McCann
Fiona Huffer (Head of Dietetics)	Hamish Reid (GP/Clinical Director)
Wanda Fairgrieve (Staff side representative)	Johanne Simpson (Medical Practitioner)
Jill Stacey (Chief Internal Auditor)	

Midlothian Integration Joint Board

Thursday 13 February 2020

1. Welcome and introductions

The Chair, Catherine Johnstone, welcomed everyone to this meeting of the Midlothian Integration Joint Board, following which there was a round of introductions.

2. Order of Business

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

3. Declarations of interest

No declarations of interest were received.

4. Minutes of Previous Meetings

4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 5 December 2019 were submitted and approved as a correct record.

4.2 The Minutes of Meeting of the MIJB Audit and Risk Committee held on 5 September 2019 were submitted and noted.

4.3 A Rolling Action Log – February 2020 was submitted.

Thereafter, the Board, having received updates on the various action points detailed therein, agreed:-

(a) to close off completed actions with the exception of those actions whose expected completion date had not yet passed;

(b) to note that the quarterly update on progress against delivery of the Transformation Programme was included as part of today's agenda; and

(c) to note that a working group had been set up to progress the role of the IJB in the Development and Strategic Planning processes; its links into Community Planning and how it interacted with other agencies and that a further report would be brought back to the Board in due course.

(**Action: Chief Officer/Chief Finance Officer/Clerk**)

5. Public Reports

Report No.	Report Title	Presented by:
5.1	eFrailty: a future model for frailty.	Jamie Megaw

Midlothian Integration Joint Board

Thursday 13 February 2020

Executive Summary of Report

The purpose of this report was to outline progress in developing the efrailty programme and to present for the Board's consideration proposals for a future model to address deficits in the frailty system of care which the MIJB were asked to support.

The report highlighted that there had been a 50% increase in people over 75 in Midlothian in the last 20 years and growth in this cohort was predicted to increase faster over the next decade. Frailty was a distinctive health state related to the ageing process where multiple body systems gradually lose their in-built reserves. The increasing prevalence of frailty, as a result of the rapidly growing ageing population, was unsustainable in the current utilisation of the health and care system.

Midlothian Health and Social Care Partnership and Midlothian GP Cluster have been using the electronic frailty index (eFI) to understand service utilisation, the quality of care provided and been using this information to inform strategic direction and service developments. The electronic frailty index (eFI) is a validated method to identify frailty using coding in GP patient records.

The model of care which had emerged builds on the current pilots underway and places Midlothian IJB and HSCP in a strong position to improve outcomes and patient/staff experience and to reduce hospital activity.

Summary of discussion

The Board, having heard from Strategic Programme Manager, Jamie Megaw, who explained the proposals in some detail and thereafter responded to Members' questions and comments, discussed the emerging proposed Model of Care and acknowledged the importance of delivering changes that ensured people got the right support at the right time by the right service.

In response to concerns regarding the ability to successfully deliver all the necessary components required to support the proposed eFrailty Model of Care, Jamie sought to reassure Members by explaining that work was already under way to overcome issues relating to information sharing, ensure the robustness of the electronic frailty index (eFI) building on the tech pathfinder work being undertaken by Matthew's team and to also build on the highly successful pilots already operating. This was seen as the start of a process and there would be on-going dialogue with the Board as the proposals progressed and developed.

Decision

After further discussion and questions to Officers, the Board:

- **Noted the progress the GP Cluster and the HSCP have made to understand who has frailty and to improve the quality of care and service provision**
- **Noted that as more people become frail in Midlothian without change this will see by 2026 an increase of 6500 bed days in the Royal Infirmary**
- **Noted that 4% of the population account for 31% of Midlothian's unscheduled care activity in hospitals.**
- **Noted the strategic direction and the need to identify appropriate funding**

• **Agreed to continue consideration of adopting a whole-Midlothian approach or to work across half the county, until the merits of each course of action became clearer** • **Agreed that the Chief Officer and Chief Finance Officer explore financial support and funding options within NHS Lothian to allow the efrailty programme to develop and to evaluate its impact across the system.**
Action
Chief Officer/Chief Finance Officer/Strategic Programme Manager

Report No.	Report Title	Presented by:
5.2	Appointment of Independent Member of the MIJB Audit and Risk Committee	Morag Barrow

Executive Summary of Report

With reference to paragraph 7.1 of the Minutes of the Audit and Risk Committee of 7 March 2019, there was submitted a report the purpose of which was to gain approval by the MIJB for the appointment of Pam Russell as the independent member of the MIJB Audit and Risk Committee following an open recruitment process to meet best practice. The appointment of the independent member of the MIJB Audit and Risk Committee would be for a fixed period to 31 October 2022.

Decision

Having heard from Chief Officer, Morag Barrow, the Board;

- **approved the appointment of Pam Russell as independent member of the MIJB Audit and Risk Committee following an open recruitment process to meet best practice; and**
- **thanked, and expressed its appreciation, to outgoing independent member Jane Cuthbert for her contributions to the work of the MIJB Audit and Risk Committee.**

Action

Chief Officer/Chief Finance Officer/Clerk

Report No.	Report Title	Presented by:
5.3	IJB Improvement Goals Progress	Jamie Megaw

Executive Summary of Report

With reference to paragraph 5.4 of the Minutes of 14 February 2019, there was submitted a report updating the Board on performance and improvement towards achieving the Local Improvement Goals set by the MIJB based on the indicators recommended by the Ministerial Strategic Group for Health and Community Care. The improvement goals focused on reducing unscheduled hospital and institutional care using data provided by the Health and Social Care team at ISD Scotland.

Midlothian Integration Joint Board

Thursday 13 February 2020

Summary of discussion
Having heard from Jamie Megaw, Strategic Programme Manager, who responded to Members' questions and comments, the Board in considering the current progress against the local improvement goals discussed the impact of actions resulting from the NHS Lothian Escalation Recovery Plan. It being felt that it would be useful if possible to include before and after information in future reports. The potential for joint working with other IJBs was also raised, with the Chief Officer seeking to reassure Members that this was already being explored. With regards unplanned admissions the difficulties regarding the recording of those admitted to the Emergency and Observation Unit at the Royal Infirmary was acknowledged and although no immediately obvious solution was evident it was accepted that a more suitable mechanism ideally had to be found to record this important information.
Decision
After further discussion, the Board:- • **Noted the current performance across the improvement goals.** • **Noted the inclusion of further information about performance in Midlothian against the Core Suite of Indicators.** • **Noted that where possible information regarding the impact of actions resulting from the NHS Lothian Escalation Recovery Plan would be included in future report.** • **Noted that efforts would be made to find a more suitable mechanism for recording admissions to the Emergency and Observation Unit.**
Action
Chief Officer/Strategic Programme Manager

Report No.	Report Title	Presented by:
5.4	Partnership Digital Programme	Matthew Curl

Executive Summary of Report
The purpose of this report was to provide the MIJB with an update on the rationale and opportunity for a Partnership Digital Programme to support transformation and integration efforts. The report provided outline background and context of the strategic importance of digital to support health and social integration and care model transformation. Further, it provided a brief definition of digital not as a thing but as a way of doing things and a broader schema for 'technology' as a concept. The report also outlined a strategic framework for developing a Partnership Digital Programme along with example key workstreams ready or in progress prior to framework approval. The proposal was supported by a new Digital Development IJB Direction; a draft of which was appended to the report.

Midlothian Integration Joint Board

Thursday 13 February 2020

Summary of discussion
Having heard from Matthew Curl, TEC Strategic Lead, who responded to Members' questions and comments, the Board in considering the proposal discussed the potential to involve the third sector and also how to engage the 20% predominately older members of the community who don't use digital technology. It being pointed out in the case of the latter that they would be picked up as part of the proposed pathfinder, but that this would hopefully be just one of a suite of measures available in the future. Which in turn raised the issue of the need to future proof the proposals and also the potential for possible UK wide application.

Decision
After further discussion, the Board: • **Approved and supported the strategic framework and developing Partnership Digital Programme; and** • **Approved the new IJB direction (first iteration) to support the above.**
Action
Chief Officer/TEC Strategic Lead

Report No.	Report Title	Presented by:
5.5	Clinical and Care Governance Report	Caroline Myles

Executive Summary of Report
With reference to paragraph 5.4 of the Minutes of 14 February 2019, there was submitted a report the purpose of which was to provide assurance to the Midlothian Integrated Joint Board as to the clinical and care governance arrangements within Midlothian, highlighting good practice and identifying any emerging issues or risks. It also set out the proposed areas for monthly reporting.
Summary of discussion
Having heard from Chief Nurse, Caroline Myles who responded to Members' questions and comments, the Board welcome plans for a regular report and also the development of a clinical and care governance dashboard which would provide a summary/overview of agreed reports in one screen.
Decision
After further discussion, the Board: • **Noted and approved the plan for the content of this monthly report;** • **Noted the proposed development of a clinical and care governance dashboard; and** • **Noted the proposal for the Chief Nurse to include a routine report on clinical and care governance to each IJB meeting.**
Action
Chief Nurse

Midlothian Integration Joint Board

Thursday 13 February 2020

Report No.	Report Title	Presented by:
5.6	Chief Officer Report	Morag Barrow

Executive Summary of Report

This report provided a summary of the key service pressures and service developments which had occurred during the previous months in health and social care, highlighting in particular a number of key activities, as well as looking ahead at future developments.

Summary of discussion

The Board heard from Morag Barrow (Chief Officer), who highlighted in particular the following –

- Update on the progress being made on the delivery of the NHS Lothian Recovery Plan, following the decision by Scottish Government to place NHS Lothian on Level 3 of Performance Escalation matrix.
- Details of the proposed timeline for the review of the Scheme of Integration.
- Midlothian Council had recently restructured to introduce two Directorates (i) People and Partnerships and (ii) Place. The Health and Social Care Partnership was aligned to the People and Partnerships Directorate.
- As the plans for the redesign of the Emergency Department in the Royal Infirmary continue to be developed, the option of the provision of a minor injuries service in Midlothian was being considered.
- Update on changes within the NHS Lothian Board.
- Concerns regarding the spread of coronavirus.

In discussing the Chief Officer's report the Board considered the circumstances leading to the departure of the NHS Lothian Board Chair and felt this might provide an opportunity to raise the issue of funding and also to invite his successor to a future meeting of the Midlothian IJB.

Decision

After further discussion and questions to the Chief Officer, the Board:-

- **Noted the issues and updates raised in the report.**
- **Agreed to explore the possibility of inviting the new interim chair of the NHS Lothian Board to a future meeting of the MIJB; and**
- **Noted that the issue of IJB funding would be raised through the Chief Officers/Chief Finance Officers groups.**

Action

Chief Officer/Chief Finance Officer

Report No.	Report Title	Presented by:
5.7	Midlothian Primary Care Improvement Plan – Update January 2020	Jamie Megaw

Midlothian Integration Joint Board

Thursday 13 February 2020

Executive Summary of Report
With reference to paragraph 4.3 of the Minutes of 7 June 2018, there was submitted a report providing an update on the Primary Care Improvement Plan (PCIP); outlining the impact of the PCIP initiatives for the general practice population; and detailing the future developments in each key area.
Summary of discussion
Having heard from Strategic Programme Manager, Jamie Megaw, who responded to Members' questions and comments, the Board in considering the update, discussed the ongoing pressures within pharmacotherapy services.
Decision
The Board, after further discussion, agreed to:- • **note the progress made in implementing the Midlothian PCIP; and** • **support the future developments.**
Action
Chief Officer/Strategic Programme Manager

Report No.	Report Title	Presented by:
5.8	Statutory Guidance on Directions from Integration Authorities to Health Boards and Local Authorities	Mairi Simpson
Executive Summary of Report		
The purpose of this report was to inform the MIJB that the Scottish Government had published Statutory Guidance on Directions from Integration Authorities to Health Boards and Local Authorities. The report explained that it was important that members of the Midlothian IJB were aware of the new guidance and the legislative requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 with regard to Directions and were provided assurance that Midlothian practice would reflect the Guidance.		
Summary of discussion		
Having heard from Integration Manager. Mairi Simpson who responded to Members' questions and comments, the Board considered the use made of Directions and welcomed further clarity on the matter.		
Decision		
After further discussion, the Board noted: • **the revised statutory guidance on Directions, published on 27 January 2020; and** • **the actions proposed to ensure that Midlothian IJB was meeting the statutory obligations contained within the guidance and advise on any changes/additions.**		
Action		
Chief Officer/Integration Manager		

Midlothian Integration Joint Board

Thursday 13 February 2020

Report No.	Report Title	Presented by:
5.9	Finance Update – IJB Reserves Position	Claire Flanagan

Executive Summary of Report and Summary of discussion

With reference to paragraph 5.7 of the Minutes of 10 October 2019, there was submitted a report the purpose of which was to provide Members with a reminder about the Reserves Policy, together with an update on the current reserves held.

The report also sought support from the MIJB to reinvest funding recently disaggregated from a Medicine of the Elderly ward closure on the Western General site into local unscheduled care functions.

Decision

After discussion and having heard from Claire Flanagan, Chief Finance Officer, who responded to Members questions and comments, the Board agreed to:

- **Note the current IJB reserve position.**
- **Funding from the ward closure being used to support local unscheduled care.**

Action

Chief Finance Officer/Chief Officer

Report No.	Report Title	Presented by:
5.10	Finance Update– Quarter 3 2019/20 & Transformation Programme Update	Claire Flanagan

Executive Summary of Report

This report set out the results of the MIJB's partner's (Midlothian Council and NHS Lothian) quarter three financial reviews, considered how this impacted on the projected financial position for the IJB for 2019/20 and provided an update on the programme of transformation work being undertaken.

The report advise that these forecasts projected that the health 'arm' of the MIJB would be underspent and the social care 'arm' of the MIJB would be overspent, although in balance through recovery actions.

Summary of discussion

Having heard from Claire Flanagan, Chief Finance Officer, who responded to Members' questions and comments, the Board in reviewing the financial position acknowledged the challenging financial landscape and the importance of the ongoing dialogue with both NHS Lothian and Midlothian Council.

Decision

After further discussion, the Board:

- **Noted the position as laid out in the report for the quarter three financial reviews for 2019/20 ; and**
- **Noted the update on the programmes of transformation work.**

Action

Chief Finance Officer

Midlothian Integration Joint Board

Thursday 13 February 2020

Report No.	Report Title	Presented by:
5.11	Summary of Midlothian Strategic Planning Group Discussion (8th January 2020)	Mairi Simpson
Executive Summary of Report		
With reference to paragraph 5.6 of the Minutes of 12 December 2019, there was submitted a report the purpose of which was to summarise the key discussion points arising from the Midlothian Strategic Planning Group meeting held on 8th January 2020.		
Summary of discussion		
Having heard from Mairi Simpson, Integration Manager, who responded to Members questions and comments, the Board welcomed the report.		
Decision		
The Board noted the summary of discussion/decision at the Midlothian Strategic Planning Group on 8th January 2020.		
Action		
Chief Officer/Integration Manager		

6. Private Reports

Exclusion of Members of the Public

In view of the nature of the business to be transacted, the Board agreed that the public be excluded from the meeting during discussion of the undernoted item, as contained in the Addendum hereto, as there might be disclosed exempt information as defined in paragraph 6, 8 and 9 of Part I of Schedule 7A to the Local Government (Scotland) Act 1973:-

Report No.	Report Title	Presented by:
6.1	Vision paper for Care at Home: stage 2	Morag Barrow
Decision		
The Board commented on, and approved, the recommissioning plans.		

7. Date of next meeting

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

- Thursday 12 March 2020 2pm Joint Special Midlothian Integration Joint Board/Development Workshop
- Thursday 9 April 2020 2pm Midlothian Integration Joint Board

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

The meeting terminated at 3.57 pm.

Minute of Special Meeting

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 12th March 2020	2.00pm	Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ.

Present (voting members):

Cllr Catherine Johnstone (Chair)	Carolyn Hirst (Vice Chair)
Cllr Derek Milligan	Tricia Donald
	Alex Joyce
	Angus McCann

Present (non-voting members):

Morag Barrow (Chief Officer)	Claire Flanagan (Chief Finance Officer)
Caroline Myles (Chief Nurse)	Fiona Huffer (Head of Dietetics)
Wanda Fairgrieve (Staff side representative)	Keith Chapman (User/Carer)
Ewan Aitken (Third Sector)	

In attendance:

Craig Marriott (Depute Director of Finance, NHS Lothian)	Gary Fairley (Chief Officer Corporate Solutions, Midlothian Council)
Grace Cowan (Head of Primary Care and Older Peoples Services)	Mairi Simpson (Integration Manager)
Lianne Swadel (Programme Manager)	Jordan Miller (NHS Lothian)
Mike Broadway (Clerk)	

Apologies:

Cllr Jim Muirhead	Cllr Pauline Winchester
Alison White (Chief Social Work Officer)	Hamish Reid (GP/Clinical Director)
Johanne Sinpson (Medical Practitioner)	James Hill (Staff side representative)

Midlothian Integration Joint Board

Thursday 12 March 2020

1. Welcome and introductions

The Chair, Catherine Johnstone, welcomed everyone to this Special Meeting of the Midlothian Integration Joint Board, following which there was a round of introductions.

2. Order of Business

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

The Board endorsed the Chair's decision to accept as urgent, due to the Board's interest in the matter, an additional item of business - 4.4 Update on Covid19 (Coronavirus) and Midlothian Resilience Planning – which would be dealt with as the first item of public business

3. Declarations of interest

No declarations of interest were received.

4. Public Reports

Report No.	Report Title	Presented by:
4.4	Update on Covid19 (Coronavirus) and Midlothian Resilience Planning	Morag Barrow

Executive Summary of Report

Chief Officer, Morag Barrow, provided the Board with an update on Covid-19 (Coronavirus) and Midlothian resilience planning. She outlined the steps that were being taken both locally and nationally in response to, and planning for, the spread of coronavirus, which was beginning to gather pace. Whilst a key focus would be the Primary Care response and Acute Service provision, services for the vulnerable also required to be able to cope. In this regards, Midlothian already enjoyed good engagement with both the voluntary sector and many other partner organisations and was also making good use of new technology, albeit it may require that use would require to be accelerated.

Summary of discussion

The Board, in considering the present situation, discussed the ability of current services to cope with fewer staff numbers and much greater demand, particularly in certain key area. Whilst this was clearly a matter for some concern, the ongoing resilience planning that was underway sought to address these pressures in a measured way and mitigate the impacts as far as that was possible.

Decision

The Board, after further discussion and question to Officers, noted the current position and actions being taken.

Action

Chief Officer

Midlothian Integration Joint Board

Thursday 12 March 2020

Report No.	Report Title	Presented by:
4.1	Financial Update – Budget Offers from Partners	Claire Flanagan

Executive Summary of Report

The purpose of this report was to provide the Board with confirmation of the formal Midlothian Council budget offer to the MIJB and an update on the current indicative proposed budget offer and principles for 2020/21 from NHS Lothian. Further to this the report provided an update on the financial challenges facing the MIJB and the ongoing transformation work to support delivery of savings in the coming financial year 2020/21.

Summary of discussion

The Board heard initially from Craig Marriott, Deputy Director of Finance, NHS Lothian and Gary Fairley, Chief Officer Corporate Solutions, Midlothian Council, regarding the budget positions of their respective organisations, with both seeking to emphasise that the budget offers should be considered in the context of the challenging financial climate facing both partners, forecasted expenditure and the resulting financial gap.

The Board, then heard from Chief Finance Officer, Claire Flanagan, who in acknowledging the challenging financial landscape in which the partners and indeed the MIJB were operating and the importance of the ongoing transformation work within the HSCP to drive out the saving required to balance the budget, sought to address the "fair and adequacy" measure used by the Board when considering the partners' budgetary offers.

The Board in considering the welcome support offered by its partners debated whether more pressure need to put on central government to secure a better funding deal for health and social care integration generally.

Decision

After further discussion and questions to the Officers, the Board:

- **Agreed and accepted the formal Midlothian Council budget offer for 2020/21;**
- **Agreed the principles of the indicative budget from NHS Lothian based on an iteration of their Financial Plan reported to their Finance & Resources Committee in January 2020 and recent correspondence; and**
- **Noted the transformation work to deliver savings.**

Action

Chief Finance Officer/Chief Officer

Report No.	Report Title	Presented by:
4.2	Midlothian IJB Directions 2020	Mairi Simpson

Midlothian Integration Joint Board

Thursday 12 March 2020

Executive Summary of Report
The purpose of this report was to set out for the Board consideration the draft Directions which it was proposed to issue to Midlothian Council and NHS Lothian for 2020. The draft Directions set out the proposed areas of focus to be addressed over the coming year and identified the key changes that needed to be progressed to support the delivery of health and care services in Midlothian. The Directions were aligned to the Strategic Commissioning Plan 2019-22 and would be supported by a local Delivery Plan for 2020-21.
Summary of discussion
The Board, heard from Mairi Simpson (Integration Manager), who explained that the draft Directions had been informed by the Strategic Planning Group who had held a workshop on 8th January 2020 to review the existing Directions and who had propose three new Directions, as follows: • Direction 21: Allied Health Professionals • Direction 22: Digital Development • Direction 23: Health and Social Care Partnership Maturity. Once the new Directions had been issued it would be important to discuss them with the service areas implicated. The Direction on Digital Development was of particular interest as whilst eHealth and Digital Services were not delegated functions per se, they were core services described in the Midlothian Integration Scheme (section 5.3). Additionally, given the current budget position the Direction concerning finance was still being developed. Other areas that the Board might wish to consider Directions for included Housing, demographic pressures and patient transport. Ultimately it was hoped to move to a rolling approach to the issue of Directions, which would then be reviewed twice yearly. The Board, in discussing the draft Directions, felt that given the links between health and homelessness/housing that a single Direction covering this area might be beneficial, if the right form of words could be found. Otherwise, the proposed new Direction covering Digital Technology was seen as a welcome addition, and the Direction on Finance was awaited with interest.
Decision
The Board, after further discussion and questions to Officers, agreed: • **To note the draft Midlothian IJB Directions for 2020; and** • **To note plans to seeking formal approval of the Directions at the April 2020 Board meeting.**
Action
Integration Manager/Chief Officer

Report No.	Report Title	Presented by:
4.3	Proposed Use of Vacated Glenlee Ward at Midlothian Community Hospital	Lianne Swadel

Midlothian Integration Joint Board

Thursday 12 March 2020

Executive Summary of Report
With reference to paragraph 5.4 of the Minutes of 10 October 2019, there was submitted a report the purpose of which was to advise the Board that with the repatriation of the (East Lothian) patients from Midlothian Community Hospital Glenlee and Rossbank wards, there was now an opportunity where there were 16 beds available for alternative use in Glenlee Ward.. The report noted that Midlothian and East Lothian Integration Joint Boards both had Directions 2019/20 to repatriate patients belonging to East Lothian who had in recent years accessed Midlothian Community Hospital - specifically wards Rossbank and Glenlee and explored in detail the two options being considered for this alternative use: • Step up / step down facility • Chemotherapy/infusions beds
Summary of discussion
The Board, having heard from Lianne Swadel (Programme Manager), considered the two options concluding that both merited support.
Decision
After further discussion and question to Officers, the Board • **Noted the options for the proposed use of Glenlee Ward at Midlothian Community Hospital.** • **Agreed that based on the information presented, including costings, usage and demand, to support the preferred option of step up/step down facility.** • **Noted that the chemotherapy option would be reconsidered when additional space within Midlothian Community Hospital became available spring/summer 2021.** • **Agree to the Health &Social Care Partnership identifying options for financing the change.**
Action
Chief Officer/Chief Finance Officer

5. Private Reports

No private business to be discussed at this meeting.

6. Date of next meeting

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

• Thursday 9th April 2020	2pm	Midlothian Integration Joint Board
• Thursday 14th May 2020	2pm	Development Workshop

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

The meeting terminated at 3.35 pm.

Midlothian Health & Social Care Partnership

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 16th April 2020	1.00pm	As a consequence of the current public health restrictions this was a virtual meeting held using Zoom, involving voting members only.

Present (voting members):

Cllr Catherine Johnstone (Chair)	Carolyn Hirst (Vice Chair)
Cllr Derek Milligan	Alex Joyce
Cllr Jim Muirhead	Angus McCann
Cllr Pauline Winchester	

In attendance:

Morag Barrow (Chief Officer)	Claire Flanagan (Chief Finance Officer)
Mairi Simpson (Integration Manager)	Mike Broadway (Clerk)

Apologies:

Tricia Donald	

Midlothian Integration Joint Board

Thursday 16 April 2020

1. Welcome and introductions

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

The Board noted that the arrangements for today's meeting had been agreed in advance to take account of the current public health restrictions as a result of the current Covid19 (Coronavirus) pandemic. Although non-voting members were not present they had nonetheless been given the opportunity to feed in any questions or comments on the business under consideration.

2. Order of Business

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

3. Declarations of interest

No declarations of interest were received.

4. Public Reports

Report No.	Report Title	Presented by:
4.1	Covid-19 (Coronavirus) Management in Midlothian	Morag Barrow

Executive Summary of Report

Chief Officer, Morag Barrow, provided the Board with a detailed update on Covid-19 (Coronavirus) Management in Midlothian. In particular, she outlined the key actions that were being taken locally by the Midlothian Health and Social Care Partnership in response to Covid-19, as set out in the **Appendix** hereto, which would form the basis of the next weekly update to be circulated to all Board members. Whilst perhaps understandably the principle focus of attention had been on the Primary Care response and Acute Service provision, care services for the vulnerable had also been required to be able to cope with unprecedented increases in the level of demand. In this regards, Midlothian had through its positive engagement with both the voluntary sector and many other partner organisations, coped remarkable well so far, helped by the success of social distancing measures that had been introduced nationally. Good use was also being made of new technology, which it was hoped to build on and extend once the current pandemic was over.

Summary of discussion

The Board, having thanked the Chief Officer for her update, considered how well services appeared to be coping with the current situation, the importance of ongoing resilience planning, and adherence to social distancing advice, to ensure that this remained the case.

Thereafter, the Board discussed the following matters:-

Midlothian Integration Joint Board

Thursday 16 April 2020

- Pharmacies – the possibility of increasing the level of home deliveries for prescriptions and other medicines in order to prevent often lengthy queues forming outside Chemists. This had already been raised but without a great deal of success, however the matter would be revisited.
- Testing – for all Health and Social Care staff continued and all staff groups had been made aware of the processes involved. The possibility of a more local based provision would be explored, but in the meantime such provision would be considered on a case by case basis.
- Care Homes – were an acknowledged area of concern given the age and underlying health issues of many of those who lived in them. A Care Home Strategy had been put in place and there were regular meetings with local providers to offer support and share good practice. Care Home were also being encouraged to undertake weekly infection control audits. Additionally, the Scottish Government were looking at set up a national care home support team.
- Acute Services - a broad overview of the current situation within Acute showed that there was sufficient capacity to cope with current demand, which was encouraging. Although it was acknowledged that this position could very easily change and that there was a need to remain vigilant.
- Home Visits - contact was being maintained with existing clients by phone or video call where this was possible and appropriate. However, when necessary home visits were still taking place. Staff had been issued with a stock of PPE to cover all home visits they had in their workplan, along with guidance on PPE requirements and also on putting on, and taking off, PPE. The NHSL infection control team had been contacted to provide on-site visits and issue guidance where required.
- ‘’Normal’ Business – the levels of non Covid-19 related cases had been lower than would have been expected, which had given rise to some concerns that people were not seeking the treatment they perhaps need for fear of coronavirus and that there could be a spike in activity. Steps may require to be taken to encourage those needing assistance to get the help they might require.
- Primary Care – this was one of the areas that had experienced perhaps the biggest changes with an increased emphasis on the use of new technology. Telephone triage and video conferencing were helping GP practices to continue to provide services to the community and the indications were encouraging, providing a possible platform for the future.
- Community Engagement - the Care for People group comprising council staff, NHS, third sector, community councils and faith groups was one of the first groups to be established and had been found to be a very positive way to engage widely to meet the needs of the community. The Council was also proactively working with other groups such as the Red Cross and local Foodbanks to ensure those in greatest need got the support they required.
- New Beginnings – acknowledged the opportunities presented by some of the enforced changes to shape future service provision, particularly in the use of new technology. Noted that work was already ongoing to collect and collate data and information to help shape potential future service models.

Midlothian Integration Joint Board

Thursday 16 April 2020

Decision
The Board, after further discussion and question to Officers, noted the update from the Chief Officer and welcomed plans for a weekly update to be circulated to all Board members.
Action
Chief Officer

Report No.	Report Title	Presented by:
4.2	NHS Lothian Formal Budget Offer to the Midlothian IJB for 2020/21	Claire Flanagan

Executive Summary of Report

With reference to paragraph 4.1 of the Minutes of 12 March 2020, there was submitted a report the purpose of which was to provide the Board with confirmation of the formal 2020/21 budget offer from NHS Lothian for consideration. The budget offer from Midlothian Council having already been accepted at the March MIJB meeting.

Summary of discussion

The Board heard from Chief Finance Officer, Claire Flanagan who confirmed that the formal 2020/21 budget offer received from NHS Lothian was in line with the principles shared by NHS Lothian and reported to the MIJB at its meeting in March. In seeking to address the "fair and adequacy" measure used by the Board when considering the partners' budgetary offers, it was worth bearing in mind that the 2020/21 budget proposals were presented on the basis of "business as usual". The ongoing and developing COVID-19 issues highlighted that this was clearly not the case and that extraordinary costs were being, and would continue to be, incurred for the foreseeable future. These costs were being recorded separately, on the assumption that they would be covered by the partners, and ultimately by the Government.

The Board in considering the welcome support offered by both its partners discussed the likelihood of the potential efficiency plans developed by Officers being achieved given the current COVID-19 situation. With regards the level of savings actually required to be achieved, a point raised by Euan Aitken on behalf of the Voluntary Sector, Claire clarified that the £849,000 referenced in Midlothian Council's letter wasn't the savings allocated to the Midlothian IJB, this equated to the 2% savings threshold that Scottish Government/ COSLA had advised Local Authorities they had the option of applying. The Council hadn't applied up to this threshold level and had instead maintained the level of savings at £500,000 which was the level the Board had been planning on as a HSCP.

Decision

The Board, after further discussion and questions to Officers:

- **Accepted the formal budget offer from NHS Lothian for 2020/21.**

Midlothian Integration Joint Board

Thursday 16 April 2020

- **Noted that the 2020/21 budget had been approved on the basis of "business as usual", however the ongoing and developing COVID-19 issues highlighted that this was clearly not the case.**
- **Noted the wider risks and, in particular, the rapidly developing situation in response to the COVID 19 pandemic.**

Action
Chief Finance Officer/Chief Officer

Report No.	Report Title	Presented by:
4.3	Midlothian IJB Directions 2020	Mairi Simpson

Executive Summary of Report

With reference to paragraph 4.2 of the Minutes of 12 March 2020, there was submitted a report the purpose of which was to set out for the Board consideration of the Directions which it was proposed to issue to Midlothian Council and NHS Lothian for 2020.

The report explained that the proposed Directions identify key changes that needed to be progressed to support the delivery of health and care services in Midlothian. The Directions were aligned to the Strategic Commissioning Plan 2019-22 and would be supported by a local Delivery Plan for 2020-21.

Summary of discussion

The Board, heard from Mairi Simpson (Integration Manager), who explained that as with the budget, the proposed Directions were presented on the basis of "business as usual", however the ongoing and developing COVID-19 issues highlighted that this was clearly not going to be the case, and it was important there was an awareness of this going forward.

Arising from Members question and comments, at this and the previous meeting, Mairi advised that issues around housing/homelessness had been incorporated into the Housing Direction 16; that dental; ophthalmic and audiology services were cover under Direction 7; that issues relating to obesity were dealt with in Direction 19: Public Health and that Direction 20: Services to People Under 18yrs linked into GIRFEC (Getting It Right For Every Child). Whilst new or revised Directions could be issued as required, ultimately it was hoped to move to a rolling approach to the issue of Directions, which would then be reviewed twice yearly.

The Board, in discussing the proposed Directions, welcomed plans to explore introducing a more robust tracking system, suggesting that it would be helpful if the recipient service areas and prospective target dates could also be included as part of that process. With regards the role of the 3rd Sector, which had been raised by Euan Aitken on behalf of the Voluntary Sector, the need to better acknowledge their role in the delivery of the Directions and the Strategic Plan was agreed.

Decision

After further discussion, the Board agreed:

- **To approved the Directions for 2020.**

Midlothian Integration Joint Board

Thursday 16 April 2020

Action
Integration Manager/Chief Officer

Report No.	Report Title	Presented by:
4.4	Covid-19 Emergency Recess Procedures	Morag Barrow

Executive Summary of Report

The purpose of this report was to seek approval to put in place procedures for decision-making processes in the event that Midlothian Integration Joint Board and its associated Committees were unable to convene because of the COVID-19 outbreak.

The report examined the potential implications of the current COVID-19 crisis on the management of the MIJB business, and proposed the cancellation of meetings of the MIJB, the MIJB Audit and Risk Committee and the Strategic Planning Group. Instead, MIJB business would be managed through a combination of:

- Delegation to the MIJB Chief Officer in consultation with the MIJB Chair and Vice-Chair.
- Circulation of reports by email and formal approval of recommendations by a minimum of three voting members of the MIJB.
- Delay of key aspects of MIJB business that were not deemed critical in light of the current crisis.

The report also sought to ensure MIJB sustainability through clear arrangements for Deputes for the IJB Chair, Vice-Chair and Chief Officer.

Summary of discussion

The Board, having heard from Chief Officer, Morag Barrow, discussed the proposed procedures, acknowledging that if approved they would result in the Development Workshop Session on 14 May 2020, the Audit and Risk Committee scheduled for 4 June 2020 and the Midlothian Integration Joint Board meeting on 11 June 2020 all being cancelled. It was proposed that for the avoidance of doubt that a specific date be identified by which the Emergency Recess period would be formally reviewed: this was agreed as being by no later than 15 July 2020, and that for the approval of recommendations by way of the circulation of an emailed report, the number of voting members required be brought into line with the quorum for Board meetings, that is four rather than three. Consideration was also given to the issue of the appointment of members to deputise for the Chair and Vice-Chair for the duration of the Emergency Recess period, it being noted that in terms of paragraph 3.2.5 of the Integration Scheme arrangements for the appointment of the Chair and Vice-Chair were left to the respective partners to determine, so the same would apply to the appointment of a member to deputise for them. The Chief Officer sought to reassure the Board that should circumstance change sufficiently that an earlier review was possible then this would be undertaken.

Decision

After further discussion and question to Officers, the Board

• **Approved the COVID-19 Emergency Recess Procedures as outlined in the report, subject to the amendments identified above.** • **Delegated to the IJB Chief Officer, in consultation with the IJB Chair and Vice Chair, the decision-making authority to invoke the COVID-19 Emergency Recess Procedures as and when necessary.** • **Agreed that the Emergency Recess Period be formally reviewed by no later than 15 July 2020.** • **Delegated to the IJB Chief Officer, in consultation with the IJB Chair and Vice- Chair, decision-making powers regarding expenditure as specified in the report.** • **Agreed to request the partners (NHS Lothian and Midlothian Council) nominate Deputes for the IJB Chair and Vice Chair for approving business during the Emergency Recess Period, should they themselves be unavailable.** • **Agreed to the proposed delay in the production of the 2019-20 IJB Annual Performance Report and the review of the Integration Scheme, given the need to give priority to responding the COVID-19 crisis.** • **Noted that the proposed arrangements in this report were compliant with the current IJB Standing Orders and therefore no amendments were required.**
Action
Chief Officer/Chief Finance Officer

5. Private Reports

No private business to be discussed at this meeting.

6. Date of next meeting

The date of the next meeting of the Midlothian Integration Joint Board will be confirmed in due course.

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

The meeting terminated at 2.05 pm.

Midlothian Health and Social Care Partnership

COVID-19 Weekly Update

17/4/20

1. USE OF DATA FOR MONITORING & MODELLING

Work underway to **improve access to and use of data related to COVID-19.**

- Access to Tableau dashboard on COVID-19 granted on 8th April although still to find evidence that it will allow us to drill down to Midlothian level data.
- Participated in ISD demonstration on 9th April to consider HSCP modeling about staff absence and its impact.
- LIST analyst assistance secured to work with COVID Core Team to access
    - Information on the wider system to help us forecast demand – ITU and ERI bed occupancy, hospital admissions from Midlothian, etc
    - Information on how our services are 'performing' – for example, increased capacity in care at home, increased capacity in hospital at home, people supported by Discharge to Assess, use of the new Primary care assessment centre etc
    - Service use and demographic information that may help us plan – for example information to assist plan for an intermediate care / step-down type facility for patients who were positive for COVID that need more rehabilitation/personal care assistance between discharge and returning home. A way of tracking/predicting numbers of these types of patients, split by general and ITU discharges, will be helpful as will the demographics/profile of the of patients who may be suitable.

Performance and monitoring indicators being developed.

2. OUR PRIORITY AREAS

1. MANAGEMENT ARRANGEMENTS FOR PANDEMIC RESPONSE

Leadership

- Core COVID-19 Response Team and management arrangements have continued to operate effectively. The team coordinate COVID-19 planning and maintain the Covid Action Log. Electronic meeting and document sharing arrangements are in place.
- Updated Mobilisation Plan prepared and submitted to the Scottish Government with agreement to fund received.
- Resilience Plans for each service have been updated. They include arrangements for surge capacity and staff absence.
- Midlothian H&SCP continues to contribute to governance and resilience planning at NHS Lothian and Midlothian Council. This includes Lothian H&SCP/Chief Officer Tactical Group, the Lothian Primary Care Tactical Group and Midlothian Council Strategic Incident Management group, and NHS Lothian Strategic incident Management Group. The Chief Officer also has daily calls with National Chief Officers and Scottish Government representation.

Staff Wellbeing

- Sub-group established to consider staff wellbeing and emotional support. A dedicated staff wellbeing lead has been identified to develop a local support plan that includes opportunities available within Midlothian Council and NHS Lothian.
- Midlothian Council Education team continues to ensure that school hub places are available for key workers
- Staff testing all for health and social care staff continues and all staff groups have been made aware of the processes.

2. SERVICE PRIORITIES

Support People to Return Home from Hospital where feasible

- Enhanced discharge to assess team 7/7 working
- Additional training and recruitment for staff deployed from non-essential services to Care
- Enhanced staffing in Flow Hub to coordinate discharge

Support People at Home to Stay Well

- Hospital at Home continues to prevent admission where safe
- Musculoskeletal physiotherapists top up training in Respiratory care to enhance Community Respiratory team
- Midlothian Rehabilitation team supporting MCH wards and Highbank Intermediate care to keep people in Midlothian, with the aim to prevent admission to ERI

Quality care for people in care homes and other provisions

- Enhanced meeting infrastructure for all Midlothian Care Homes to ensure communication, and sharing of practice
- Quality Assurance Officer in post to provide and support and scrutiny role – weekly infection control audits in each care home
- Enhanced District Nursing support to be in place through Mobilisation plan

Prepare for step-down capacity in a non-hospital or care setting

- Work is underway to plan a step-down rehabilitation provision that would be suitable for people who are recovering from COVID-19 - they will not need an acute hospital bed but will not be well enough to go home. They will benefit from rehabilitation, nutrition and other support. Care pathways and workforce requirements are being mapped.

Primary Care Assessment Centre

- Primary Care Assessment Centre opened on Monday 30th March.
- Numbers of attendances dropping, in line with acute bed useage

Palliative Care/Glenlee Ward

- Arrangements have progressed very promptly for a new palliative care provision at Midlothian Community Hospital. Work on the ward infrastructure is complete and will be ready to accept patients form 20/4/20
- A staff team has been established; care pathways designed, pharmacy arrangements agreed, infection control processes reviewed and expert advice sought, etc.
- Medical and nursing support from Marie Curie has been secured
- Emotional support to families is being planned.

Staff and client testing

- Wards and care homes have been supported to undertake resident/patient testing as appropriate
- Staff testing has begun and is supporting people to return to work more promptly than they would otherwise following self-isolation.

Pharmacy

- Pharmacy support to other services disrupted by this pandemic has been progressed, for example substance misuse services.

Develop pathways and support for vulnerable groups

- Work has progressed with partners in housing and homelessness services to agree a care pathway for people living in homeless hostels affected by COVID-19

Public protection

- Public Protection – working in partnership with partner's clear guidance for staff regarding Adult Support and Protection, Child Protection and Violence against women has been developed to ensure that we can keep people safe whilst ensuring that we are promoting social distancing and protecting individuals and staff wellbeing.
- There is potential for additional costs to Midlothian if we need to accommodate more children as a result of not being able to provide more significant support in situ.
- We continue to have concerns regarding low referral rates for domestic abuse cases. We are exploring media campaigns to highlight that we are still available for contact
- The Chief Social Work Officer is currently liaising with legal to ensure that guidance linked to the new Act is clear for staff in order for us to implement effectively.
- Workforce – SSSC is currently scoping a national recruitment portal for social care staff and has called for people who are still registered or recently de-registered and are keen to return to service to contact them. A list of qualified social workers keen to return to practice to support us through the challenges of COVID has already been received in the locality. Those registered to provide care and support will be with us locally in the next few days.
- Justice – work is currently underway to scenario plan for the potential early release of prisoners, no definite date has been set for this. Midlothian is well placed as a weekly meeting with all key partners who would need to engage in a positive release of prisoners continue to meet (virtually) and would be able to proactively plan for any prisoner entitled to early release. Nationally there are concerns regarding the risk of spread of COVID if positive prisoners who are not currently symptomatic are released into the community.
- We continue to manage MAPPA cases effectively and in accordance with new national guidance.
- Mental Health – there are concerns that discussions re ethical ceilings and decision making for people with complex heath care, learning disability, mental health and capacity issues are variable across the country. Within Midlothian we pride ourselves on a human rights based approach and this is something that we will monitor closely throughout the COVID period.

3. WORKFORCE

Recruitment

- Staff recruited via Midlothian Council and NHS Lothian recruitment campaigns. Awaiting confirmation around the staff available to work in Midlothian recruited via the NHS Lothian campaign.
- Staff redeployed from council services to provide additional support to the H&SC and the Council's contact centre. In addition qualified and unqualified NHS staff have been redeployed (eg increase administrative support to primary care and MSK physiotherapists retrained to support the Community Respiratory Team).
- Prompt induction, training and/or retraining of new carer recruits and redeployed staff

Support Unpaid Carers

- Support to unpaid carers agreed in partnership with VOCAL and other local organisations that offer carer support. This includes a policy on access to PPE and a letter to confirm the role of carers should restrictions on movement be intensified. Information and support advice published on the Midlothian Council for unpaid carers.

Home working

- All non-essential staff encouraged to work from home where this is possible.
- Remote working through MS Teams, Zoom and teleconference.
- Secure global desktop secured for critical staff although access to this has been slow due the level of demand.

Staff Wellbeing

- It is important to ensure our staff feels supported at this time of increased anxiety across health and social care. Regular updates for staff groups are being provided, and team leaders and service managers are ensuring visibility is increased on a face to face basis with staff. Our senior management team have also been attending service areas frequently to speak with frontline staff and listen to any concerns.

- We have received a generous donation of Easter eggs for our frontline staff - all care at home staff were given an Easter egg during holy week as a token of our thanks for the hard work they are doing in the community on the frontline. Our Community nurses were also given Eggs last week.

- We organised a lunch for staff with support from Costco – this was delivered to basis at lunchtime on Thursday 2nd April, again as a thank you for the work staff are doing.

- A variety of local businesses are also donating food directly to service areas – Dominos pizza, Itihass curry, and Crispy Creme doughnuts

- **REACH OUT** – for Midlothian council, third sector, and carers. Monday – Friday 12pm – 2pm or email to arrange another time (within normal working hours). **0131 285 9600** or **Reachout@midlothian.gov.uk**. Please leave your name and number.
- **Here For You Staff Wellbeing** – for NHS staff and volunteers Monday – Friday 8am– 6pm 0131 451 7445 or if you can't call between 8am and 6pm, please email **Here4U@nhslothian.scot.nhs.uk** with your name and contact details and they'll get in touch to arrange a time to speak with you.

4. MEASURES TO REDUCE TRANSMISSION RISK TO STAFF, UNPAID CARERS AND CLIENTS

Personal Protective Equipment (PPE)

- Health Protection Scotland guidance is followed at all times although this presents a challenge as some of the equipment recommended difficult to get due to global demand
- A local lead for PPE has been identified and processes are being clarified and shared with staff teams. It is complex as there are a range of ordering processes (NHS procurement, NHS PPE store, social care PPE triage line (NSS). PPE has presented a huge challenge but Midlothian is well organised.
- Concerns regarding stock availability have been escalated to Scottish Government through appropriate governance routes
- Communications to staff teams via communication bulletins
- Work with unions/staffside representatives has been supportive and helpful.

5. COVID-19 UPDATE COMMUNITY SETTINGS:

As we envisaged we are now starting to see a rise in the number of community Covid-19 cases (this is in line with the expected curve). Our services have been preparing for this for some months now and are at this time in a good position to manage the care of individuals either within their own homes, care home settings, ward settings.

Midlothian Community Hospital (MCH)

- Our community Covid Assessment hub continues to operate from Cairngreen unit at MCH. This operates in conjunction with the NHS 111 covid19 triage line and patients calling in to this line are given appointments at the assessment centre for review by clinical team.

- Glenlee Ward: We now have a 20 bedded ward ready to accept patients from the community who require additional clinical support to manage their covid19 illness. This has been a fast paced change to the ward usage, the support from staff to transform and staff the unit has been excellent and should be highlighted as an example of the dedication of our staff groups in delivering the best possible care to the citizens of Midlothian at this time.

Patient Flow (Delays)

There has been a huge drive to get patients home through a whole system approach, to ease pressure on acute beds during the Covid19 situation, as well as supporting Midlothian residents to get home as quick as possible in a safe way

Our performance has been excellent with our delays reducing to circa 4

Care at home

Supervisors are meeting face to face with staff weekly to ensure support and to update with any information

Contact details for all staff email and mobile have been updated.

Staff are being issued with 4 days stock of PPE to cover all visits they have in their workplan. This links with their 4 days on 4 days off rota.

Guidance on PPE requirements and also on donning/doffing (putting on and taking off) PPE has been issued to all care at home staff.

NHSL infection control team has been contacted to provide on-site visits and issue guidance where required

6. COMMUNICATION

The Mid COVID-19 Core Group has developed a communication plan and each day sends

- An update to service managers following the 9am service update
- An update to all staff to make people aware of service changes, new developments, staff wellbeing information and to ensure all service areas are aware of updates to national guidance on patient/client care and staff safety. Midlothian HSCP asks service areas to follow Health Protection Scotland guidelines at all times.

Communication Plan also includes information shared to

- Local community
- People receiving a service from the Partnership

Communication methods

- All forms of communication have been used - including social media, daily bulletins, posters, etc

Communication from NHS Lothian and Midlothian Council has been shared or incorporated into local communications

- For example NHS Lothian Speed Read, Midlothian Council Chief Executive updates, etc

7. USE OF TECHNOLOGY

There has been an investment in technology to support our pandemic response.

Technology to aid Pandemic Planning

- For example Microsoft Teams and Zoom

Technology that supports non-face to face service delivery

- For example Attend Anywhere/Near me

Technology that supports service to operate differently during the Pandemic

- For example remote access to IT systems and increased Docman licenses

Technology that supports people to communicate with loved ones

- iPads and Tablets to use Facetime/Skype

8. SUPPORT COMMUNITY RESPONSES

Partnership work with third sector, community development teams and welfare rights services to develop and coordinate

- a community response
- efforts to reach and support vulnerable people in the community
- Emergency Help Reference Document developed and shared with local service providers inc Duty Team

Tools to identify vulnerable people in the community agreed

Plans for those shielding have progressed – led by the Care for People Group (Midlothian Council) and planned alongside representatives from the Community Planning Partnership

- Data provided by the government regarding shielding is being cross referenced against local data, both social work data and that held by our GP practices. 2049 residents of Midlothian have received letters and a proactive communication is now being undertaken by staff within the H&SCP. Of these people the majority are aged over 60 and over half have received the letter due to respiratory conditions which is unsurprising given the mining history and prevalence of COPD in Midlothian.
- A phone line and email address has been set up and is staffed by H&SCP staff to triage any issues and ensure that appropriate supports are put in place. Contact via this route has not been significant. It appears that to date only a small number of shielding letter recipients have arranged for the national food box to be delivered, this may increase over the coming days. Most people have requested support in order to collect prescriptions or food, they have been appropriately signposted to support. Most have just required advice and reassurance. Where necessary we are supporting people to apply for the national food parcel.
- The Care for People group comprises of staff with the council, NHS, third sector interface, community councils and faith groups. There is a well-established and tested methodology locally and this has found to be a positive way to engage widely to meet the needs of the community. There has been a focus on developing volunteer guidance to ensure that both people who are volunteering and those who require support are kept safe and well throughout this period.

- Care for people are closely monitoring and coordinating the volunteer response locally to avoid duplication and ensure we meet the needs of as many people as possible. Council staff, who are PVG checked are supporting with some of the more specific roles that are required, particularly in relation to medication delivery. Kindness postcards have already been sent to those who had identified with waste services that they needed assistance and from this week they will also be sent to all single person households.

9. PREPARE FOR ADDITIONAL DEATHS

Palliative Care

- See section 2

Dealing with the deceased

- Liaised with Midlothian Council colleagues who are working with local funeral directors and have identified a large scale body storage facility in Midlothian
- Death certification processes during the pandemic has been reviewed and amended.

3. RISKS

COVID-19 specific Risk register is being developed. Key risks include – access to workforce, access to PPE in line with national guidance, sustaining a response, community acceptability of pandemic plans and their impact on existing services, pace of change, maintaining a level of quality and individualized care, etc

Finance – Mobilisation plans to Scottish Government for additional funding

4. POST EVENT RECOVERY PLAN AND EVENT REVIEW

Lead person has been identified to lead on a plan for **service return and recovery** and the pandemic response reduces

As mentioned in section 3, measures **are being agreed to assist us to analyse the impact** of our pandemic response and the impact of the pandemic on local communities and services.

A huge to thanks to all the HSCP staff and teams for their commitment and professionalism in a challenging time. Their kindness and compassion is evident in all areas of service delivery.

Morag Barrow
Chief Officer

17/4/20

Morag.barrow@nhslothian.scot.nhs.uk

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
MIJB Minute	Thursday 16th April 2020	1.00pm	As a consequence of the current public health restrictions this was a virtual meeting held using Microsoft Teams, involving voting members only.

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

In attendance:		
Morag Barrow (Chief Officer)	Claire Flanagan (Chief Finance Officer)	Caroline Myles (Chief Nurse)
Hamish Reid (GP/Clinical Director)	Grace Cowan (Head of Primary Care and Older Peoples Services)	Jamie Megaw (Strategic Programme Manager)
Mairi Simpson (Integration Manager)	Jill Stacey (Chief Internal Auditor)	Mike Broadway (Clerk)
Janet Ritchie (Democratic Services Officer)		

1. Welcome and introductions

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

The Board noted that the arrangements for today's meeting had been agreed in advance to take account of the current public health restrictions as a result of the current Covid19 (Coronavirus) pandemic. Although non-voting members were not present they had nonetheless been given the opportunity to feed in any questions or comments on the business under consideration.

2. Order of Business

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

3. Declarations of interest

No declarations of interest were received.

4. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed	Comments
4.1 Chief Officers Report - Report by Chief Officer This report provided a summary of the key service pressures and service developments which had occurred during the previous months in health and social care, highlighting in particular a number of key activities, as well as looking ahead at future developments. The Board in discussing the report were concerned that funding for the Local Mobilisation Plan (LMP) was still not certain, and whilst acknowledging the possible reasons for this, felt that assurance should nonetheless be sought that it would be addressed.	• Noted the update from the Chief Officer and the issues raised in the report. • Agreed that in the event that the deadline for the submission of the Annual Report was not extended that authority be delegated to the Chief Officer to submit the report prior to the next scheduled MIJB meeting, if required. • Agreed to conclude the emergency recess arrangements and resume normal business as from this meeting; with future meetings being held virtually using Microsoft Teams. • Agreed that assurances be sought that the net financial implications arising from the approved Covid Mobilisation Plan would be met in full and that no funding would require to be diverted from adversely impacted baseline services.	Chief Officer All to Note Chief Officer/ Chief Finance Officer	27/08/2020 Ongoing	

Report Title/Summary	Decision	Action Owner	Date to be Completed	Comments
4.2 Internal Audit Annual Assurance Report 2019/20 - Report by Chief Internal Auditor The purpose of the report was to present the Internal Audit Annual Assurance Report for the year to 31 March 2020 for the Midlothian Integration Joint Board (MIJB) which included the Chief Internal Auditor's independent assurance opinion on the adequacy of MIJB's overall control environment. The report explained that the Public Sector Internal Audit Standards (PSIAS) required the MIJB's Chief Internal Auditor to prepare an annual report that incorporates the annual opinion on the adequacy and effectiveness of Midlothian Integration Joint Board's framework of governance, risk management and control, a summary of the work that supports the opinion, and a statement on conformance with the PSIAS.	• Approved the Midlothian Integration Joint Board Internal Audit Annual Assurance Report 2019/20 as appended to the report; and • Noted the assurances contained therein.	Chief Internal Auditor		
4.3 Annual Governance Statement 2019/20 - Report by Chief Officer The purpose of this report was to present the draft Annual Governance Statement 2019/20 of the Midlothian Integration Joint Board by the Chief Officer that would be published in the Annual Report and Accounts. The report explained that the Annual Governance Statement 2019/20, in compliance with the CIPFA/ SOLACE Framework, provided details of the MIJB's Governance Framework,	• Approved the Annual Governance Statement 2019/20 for the Midlothian Integration Joint Board as appended to the report; and • Approved publication of the Annual Governance Statement in the Annual Report and Accounts 2019/20 of the Midlothian Integration Joint Board.	Chief Internal Auditor Chief Internal Auditor		

Report Title/Summary	Decision	Action Owner	Date to be Completed	Comments
the annual Review of Framework undertaken, Improvement Areas of Governance, and Overall Opinion.				
4.4 Draft Unaudited Annual Accounts 2019-20 - Report by Chief Finance Officer The purpose of this report was to present the unaudited Annual Accounts of the MIJB for the year ending 31 March 2020 for consideration and approval. The report explained that the MIJB was required to prepare a set of annual accounts for the financial year 2019/20. A draft of these accounts must be agreed by the MIJB before 30 June whereupon the draft must be published on the MIJB's website and presented to the MIJB's auditors for review.	• Agree that the draft annual accounts can be published and presented for audit.	Chief Finance Officer	30/06/2020	
4.5 COVID-19 State of Emergency– HSCP Recovery Plan - Report by Integration Manager The purpose of this report was to explain how the Midlothian HSCP was seeking to learn from the experience of operating in a prolonged period of emergency, arising from COVID-19, through the development and implementation of a Recovery Plan in full recognition of the continuing major threat to the population posed by COVID virus.	• Approved the Recovery Plan in principle. • Agreed to contribute on an ongoing basis to the actions included in the Plan. • Agreed that the Strategic Planning Group would receive regular progress reports. • Agreed that actions arising from the Plan would require to feed into the 2019-22 Strategic Plan. • Agreed that no new or amended Directions required to be issued to NHS Lothian and/or Midlothian Council at this current time.	Chief Officer All Chief Officer Chief Officer Chief Officer		

Report Title/Summary	Decision	Action Owner	Date to be Completed	Comments
The Recovery Plan was designed to enable the Partnership to meet the broader health and care needs of the Midlothian population in the continued presence of COVID, sitting alongside the Plans and timetables developed by NHS Lothian and Midlothian Council for the gradual resumption of their respective services.				
4.6 Clinical and Care Governance - Report by Chief Nurse The purpose of this report was to provide assurance to the Board as to the clinical and care governance arrangements within Midlothian, highlighting good practice and identifying any emerging issues or risks. It also set out proposals to develop a Clinical and Care Governance review dashboard which would show a summary/ overview of agreed reports on a single screen.	• Noted and approved the content of this report. • Noted the proposed development of a clinical and care governance dashboard			
4.7 Re-modelling of Wards at Midlothian Community Hospital - Report by Chief Nurse The purpose of this report was to present an update to the Board regarding changes made to the wards at Midlothian Community Hospital which have been reconfigured to allow for a Red Covid ward and Green non-Covid wards. This will facilitate flow of patients from other hospitals and other settings while maintaining their safety and reducing the risk of infection transmission.	• Noted and approved the content of the report			

Report Title/Summary	Decision	Action Owner	Date to be Completed	Comments
4.8 Midlothian HSCP Care Homes Briefing Paper – Report by Head of Primary Care and Older People's Services The purpose of this report was to provide an update on the current situation, and an overview of the work to date, with Care homes in Midlothian and the enhanced response now required following the release of the Coronavirus (COVID-19): Clinical and practical guidance for adult care homes 15 May 2020 published by the Scottish Government and the amendments to the Coronavirus (COVID-19); a framework for decision making (15 May 2020). This work will continue to progress at pace agreeing and establishing local clinical governance arrangements, and overview of Care homes within Midlothian. In considering the report, the Board discussed the need to independently review as a matter of some urgency how Adult Care Homes had operated during the Covid-19 emergency in order to determine what had been successful and where lessons could be learned that would assist in dealing with such issues in the future.	• Noted the update on current COVID-19 work within Older Adult Care Homes in Midlothian. • Noted the significant work undertaken by the HSCP team to adhere to related guidance at all times. • Agreed to the setting up of an urgent independent review to assist in understanding the requirements that will need to be taken into account in shaping future work to support Older Adult Care Homes in Midlothian.	Head of Primary Care and Older People's Services		
4.9 COVID-19 - Test and Protect Briefing – Report by Head of Primary Care and Older People's Services The purpose of this report was to provide an update on the work being undertaken to support the roll out of Test and Protect within Midlothian.	• Noted the test and protect plan for Midlothian • Noted the significant work undertaken by the HSCP team to develop and implement this model • Noted the potential benefit to residents, staff and population in Midlothian			

Report Title/Summary	Decision	Action Owner	Date to be Completed	Comments
Sederunt: Tricia Donald left the meeting at the conclusion of the foregoing item of business at 4.01pm				
4.10 Midlothian's response to Shielding – Report by Chief Social Work Officer The purpose of this report was to highlight the work undertaken within the HSCP to support the 3218 people within Midlothian identified as needing to 'shield'.	• Noted the work undertaken to support people who are 'shielding' within Midlothian			
4.11 COVID-19 Personal Protection Equipment - Update and Future Management – Report by Chief Officer The purpose of this report was to provide an update on the current situation with provision of Personal Protection Equipment (PPE) for staff and the requirement for planning into future use and provision as the COVID-19 situation progresses. The Board acknowledged the challenges presented in ensuring there were sufficient stocks of PPE and considered that this was an area where more could possibly be done to encourage local suppliers.	• Noted the issues and update within the report • Noted and welcomed the assurance given to the Board that HPS/NHS guidance had been followed at all times for all Health and Social Care Staff.			

5. Private Reports

Exclusion of Members of the Public

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

5.1 Covid-19 (Coronavirus) Related Data – Report by Chief Officer - Noted

6. Date of next meeting

The next meeting of the Midlothian Integration Joint Board would be held on Thursday 27 August 2020 at 2.00 pm. (**Action: All Members to Note**)

The meeting terminated at 4.27 pm.

NHS LOTHIAN

Board Meeting – Consent Agenda
14th October 2020

Morag Barrow, Joint Director of Midlothian HSCP

NHS LOTHIAN CAPITAL DEVELOPMENTS WITH THE SHAWFAIR DEVELOPMENT AREA

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board provide consent to the Initial Agreement for capital development of healthcare facilities in response to the planned population growth within the Shawfair Development Area

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

2 Recommendations

2.1 Note that the Initial Agreement has been supported by the NHS Lothian Board's Finance and Resources Committee on August 26th 2020.

2.2 Provide consent to the Initial Agreement for submission to the Scottish Government's Capital Investment Group for approval to develop the Business Case.

3 Discussion of Key Issues

3.1 The Shawfair Development Area (SDA) relates to the part of Midlothian which lies to the north of the A720 City Bypass. It contains the villages of Danderhall, Newton and Millerhill. The Midlothian Local Development Plan makes provision for significant scales of growth, including the expansions of Danderhall and the creation of a new settlement of Shawfair encompassing Newton and Millerhill. This plan allocates land for around 4,900 houses and 23.5 hectares of employment land, and a town centre including a supermarket, schools, sports facilities, a medical centre and library.

3.2 There is expected to be over 14,500 people living in the Shawfair Development Area. Currently there are under 4,000 people living in this area.

3.3 The majority of the SDA is only served by Danderhall Practice. This is a small practice with 3,700 registered patients. It operates from a building that consists in part of a temporary structure and is insufficient to meet the demands from the increasing population. The partners of the practice do not want to increase beyond 7,500 registered patients. This means there is a requirement for NHS Lothian to establish a second General Practice in the SDA.

3.4 The 2018 NHS Lothian Capital Prioritisation Process ranked 1st the reprovision of Danderhall Practice's premises in the Lothian Primary Care priorities, The provision of a second practice premises in the Shawfair Development Area was ranked 3rd. It was requested by the Lothian Capital Investment Group that both capital developments were included in a single Initial Agreement, recognising the co-dependencies of the two developments.

3.5 Capital investment in healthcare facilities in the SDA is necessary to enable sufficient HSPC and GMS services to be available. This forms part of the Midlothian HSCP strategic plan to increase capacity in General Practice to accommodate the 31,000 new residents that will move in the county as a result of house building. The other components of this plan are

- Increase capacity in Loanhead Practice (completed)
- Establish new practice in East of county in Newtongrange (completed)
- Increase capacity in Dalkeith medical practice (in progress)
- Support Danderhall practice to increase in size and establish second practice in the Shawfair Development Area (this paper)
- Establish new practice in south Bonnyrigg/Rosewell (in progress, at pre-IA stage)

3.6 A project board has developed the Initial Agreement. The Project Board has representation from the HSCP, NHS Lothian Capital, Finance and Facilities, Danderhall Practice, Midlothian Council and a Patient representative. Service users have been further involved in the process through survey and the local community council.

3.7 An Initial Agreement was presented to LCIG in August 2019 which recommended two options for progress. LCIG requested a site feasibility study for Option 5 (retain and adapt the existing Danderhall Practice premises and establish a new practice in Shawfair Town Centre) to assess the potential of the current Danderhall Practice site. The study concluded that the site is **not feasible** to accommodate both the required practice building and car parking. This has informed the Project Board which is now recommending one option for progress to Business Case stage.

3.8 The process developing the long-list of options was framed by the requirement to have two practices within the Shawfair Development Area because the current practice has ambitions to grow to a maximum of 7,500 registered patients.

3.9 The house building in the SDA will lead to two main community centres, Danderhall and the new Shawfair town centre. All options in the Initial Agreement are based on healthcare facilities in either both or in one of these centres.

3.10 Public engagement has identified a strong preference from local councillors and current population for one practice to be within Danderhall. The HSCP also supports the development of at least one practice within Danderhall because of the level of healthcare need within the existing population (65% of Danderhall Practice's current registered population are within SIMD 1 or 2). There were some concerns raised at the community council about both practices being located in Danderhall village. Further informing and engagement work is required in the Business Case phase on the benefits and drawbacks to the communities from the preferred option.

3.11 The option recommended by the Project Board is:

Option 7: A single new building in Danderhall to house both practices.

3.12 The NHS Lothian Board's Finance and Resources committee reviewed the Initial Agreement on August 26th 2020 and supports it being submitted to the Scottish Government's Capital Investment Group.

4 Key Risks

4.1 Population Growth

The current healthcare assets in the SDA are insufficient to meet the population growth planned in the area. Capital and revenue investment are required to ensure there are sufficient HSCP and GMS services with accommodation.

4.2 Rate of Population Growth

The rate is predicted using the Midlothian Council's Annual Housing Land Audit. This forecasts growth over future years. This rate is influenced by demand for property which is affected by a range of external factors (e.g. economical growth of the region).

The expected rate of house building means that the current Danderhall Practice building will reach capacity in 2022. If the practice is within a building that can accommodate a practice-list size of 7,500 then the new population can be absorbed up to 2025. After this a second practice will be required.

4.3 Affordability

The capital costs of the options are £9.6M for Option 7 with annual revenue cost of £495K. An important concern is *when* the buildings are required. Both options require at least one practice building with capacity for 7,500 registered patients after 2022/23 but the second practice is not required, from a pure numbers perspective, until 2025. The preferred option will lead to a new building where a considerable proportion of the building will remain unused for its original purpose for three years. However there are financial benefits of this option as it avoids the decant costs required for Option 5 whilst Danderhall Practice building is developed and can be used by the HSCP for accommodation of other services.

5 Risk Register

5.1 There is a high risk that without sufficient investment in healthcare facilities then NHS Lothian will fail to provide General Medical Services to the population in the Shawfair Development Area.

5.2 There one risk identified on the NHS Lothian Corporate Risk Register that development relates to:

- GP Sustainability (Datix ID 3829)

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment has not been completed for this project.

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

7.1 There has been public involvement in the development of the Initial Agreement through a combination of questionnaire, meeting with the Danderhall Community Council and briefings with local Councillors. There has been a public representative on the project board throughout the development of the Initial Agreement.

7.2 This work has identified a strong preference from local councillors and current population for one practice to be within Danderhall. The HSCP also supports the development of at least one practice within Danderhall because of the level of healthcare need within the existing population (65% of Danderhall Practice's current registered population are within SIMD 1 or 2). There were some concerns raised at the community council about both practices being located in Danderhall village. Further

informing and engagement work is required in the Business Case phase on the benefits and drawbacks to the communities from the preferred option.

8 Resource Implications

8.1 The resource implications are £9.6M capital costs and £512K recurring revenue costs

Jamie Megaw
Strategic Programme Manager
4th September 2020
Jamie.megaw@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1:Shawfair Development Area HSCP Capital Developments – Initial Agreement (version 2.3)

Shawfair Development Area
HSCP Capital Developments

NHS Lothian

Initial Agreement

Project Owner: Jamie Megaw, Strategic Programme Manager

Project Sponsor: Morag Barrow, Joint Director

Date: 19/06/2020

Version: 2.3

Version History

Version	Date	Author(s)	Comments
1.0	20/09/18	Jamie Megaw	First Draft for Project Board
1.1	19/10/18	Jamie Megaw	Amended after Project Board meeting
1.2	28/11/18	Jamie Megaw	Amended after Project Board meeting
1.3	11/01/19	Jamie Megaw	Amended after Project Board Meeting
1.4	08/03/19	Jamie Megaw	Draft for Project Board Approval
1.5	11/04/19	Laura Smith	Updated options
1.6	15/03/19	Jamie Megaw	Draft for Project Board
1.7	30/04/19	Laura Smith	Financial and Economic Case Update
1.8	03/05/19	Jamie Megaw	
1.9	29/05/19	Laura Smith	Updated Benefits Scoring
1.10	07/06/19	Jamie Megaw	
1.11	12/06/19	Immy Tricker	Updated financial/ economic case
1.12	09/07/19	Jamie Megaw	Updated existing arrangements and drivers for change sections
1.13	06/08/19	Laura Smith	Update Economic Case tables
1.14	16/08/19	Campbell Kerr	Commercial Case completion
1.15	19/08/19	Laura Smith	Update Financial/Economic Case
1.16	20/08/19	Jamie Megaw	Summary completed
2.1	12/06/20	Jamie Megaw	Revised following conclusion of site feasibility study
2.2	12/06/20	Jamie Megaw	Incorporated changes from Laura Smith
2.3	19/06/20	Jamie Megaw	Final Version for approval by Midlothian HSCP SMT on 23rd June 2020

Contents

1 Executive Summary

1.1 Purpose

To progress to agreement for capital funding for healthcare facilities for the Shawfair Development Area in Midlothian.

1.2 Background and Strategic Context

The Shawfair Development Area (SDA) relates to that part of Midlothian which lies to the north of the A720 City Bypass. It contains the villages of Danderhall, Newton and Millerhill. The Midlothian Local Development Plan makes provision for significant scales of growth, including the expansions of Danderhall and the creation of a new settlement of Shawfair encompassing Newton and Millerhill. This plan allocates land for around 4,900 houses and 23.5 hectares of employment land, and a town centre including a supermarket, schools, sports facilities, a medical centre and library. House building has commenced in the SDA with 154 houses completed by March 2019.

There is expected to be around 14,500 people living in the Shawfair Development Area.

The majority of the SDA is only served by Danderhall Practice. This is a small practice with 3,723 registered patients (May 2020). It operates from a building that consists in part of a temporary structure and is insufficient to meet the demands from the increasing population. The partners of the practice do not want to increase beyond 7,500 registered patients and the current facility could provide healthcare for a maximum of 5,000 registered patients. This means there is a requirement for NHS Lothian to establish a second General Practice in the SDA.

The 2018 NHS Lothian Capital Prioritisation Process ranked 1st the reprovision of Danderhall Practice's premises in the Lothian Primary Care priorities, The provision of a second practice premises in the Shawfair Development Area was ranked 3rd. It was requested by the Lothian Capital Investment Group that both capital developments were included in a single Initial Agreement, recognising the co-dependencies of the two developments.

Capital investment in healthcare facilities in the SDA is necessary to enable sufficient HSPC and GMS services to be available. This forms part of the Midlothian HSCP strategic plan to increase capacity in General Practice to accommodate the 31,000 new residents that will move in the county as a result of house building. The other components of this plan are

- Increase capacity in Loanhead Practice (completed)
- Establish new practice in East of county in Newtongrange (completed)
- Increase capacity in Dalkeith medical practice (in progress)
- Support Danderhall practice to increase in size and establish second practice in the Shawfair Development Area (in progress)
- Establish new practice in south Bonnyrigg/Rosewell (in progress, at pre-IA stage)

1.3 Need for Change

The principle driver for change is the significant increase in the population within the Shawfair Development Area (SDA). The rate of population growth is driven by the pace of house building. This is dependent on market forces but the latest estimate from the 2019 Midlothian Housing Audit shows that house builders expect to build 1,158 dwellings in the SDA before April 2024. This is expected to lead to an increase in the

population of around 2,700. The population predicted to increase by a further 1,800 by March 2025. Beyond this the population is estimated to continue to grow by a further 7,400.

There are three other drivers for change identified in this IA:

1) The existing Danderhall Practice building consists in part of temporary modular accommodation and is of substandard quality.
2) *The new GP Contract supports practices to become more safe and sustainable. Additional roles are being developed by the HSCP to work in practice teams and require additional working space and consulting rooms.*
3) *Danderhall Practice needs to increase the number of registered patients to make the practice more sustainable*

1.4 Investment Objectives

The investment objectives for this Initial Agreement are described in the following table:

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)
Existing service arrangements unable to cope with future projected levels of population growth and address health care needs from the current population.	Improve and sustain service arrangements to respond to the demands of the known significant population growth and existing deprivation needs.
Existing practice unable to provide GMS to current and future population.	Improve service capacity to enable everyone in area to access GMS and other primary care services.
The practice is operating from premises which are neither functionally suitable nor sustainable.	Improve functional suitability of the healthcare estate and address long term future needs. Improve the patient and staff experience.
Existing service arrangements unsustainable without increasing the size of the registered practice population.	Facilitate an increase of the number of patients registered with Danderhall Practice. Facility to accommodate the rapid growth forecast in the SDA.
Transformation of primary care services to meet the requirements of the new GMS contract.	Enable delivery of the Primary Care Improvement Plan.

1.5 The Preferred Option(s)

Option 7 is the preferred option (Single Building in Danderhall to house both practices).

There were eight options identified on the long-listed options. Three options were discounted and five options were short-listed.

In summer 2019 there were two preferred options presented to LCIG. They were Option 5 (Retain and adapt existing Danderhall practice and create new practice in Shawfair) and Option 7 (Single building to house two practices in Danderhall (existing or new site). These options scored the highest based on the Economic Assessment but were not the highest scoring option in the non-financial options appraisal; this was Option 6 (New buildings for both practices, one in Shawfair and one in Danderhall). This was discounted due to the higher economic cost per benefits point.

Further work was requested by LCIG to determine the feasibility for the current practice building to be adapted as required in Option 5. This work has been completed and concluded that the current site is not feasible and therefore Option 5 must be discounted. This means that Option 7 is the preferred option (Single building in Danderhall to house two practices).

1.6 Readiness to proceed

A benefits register and initial high level risk register for the project are included in **Appendix 2: Benefits Register** and **Appendix 3: Risk Register**, respectively.

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

NHS Lothian and Midlothian Health and Social Care Partnership are ready to proceed with this proposal and are committed to ensure the necessary resources are in place to manage it. Section 6.3 below details the project management arrangements. Section 6.2 outlines the governance support and reporting structure for the proposal.

1.7 Conclusion

The substantial population growth in the Shawfair Development Area (SDA) as a result of house building will result in residents not being able to register with a General Practice for General Medical Services if capital investment in premises is not undertaken to allow an increased provision.

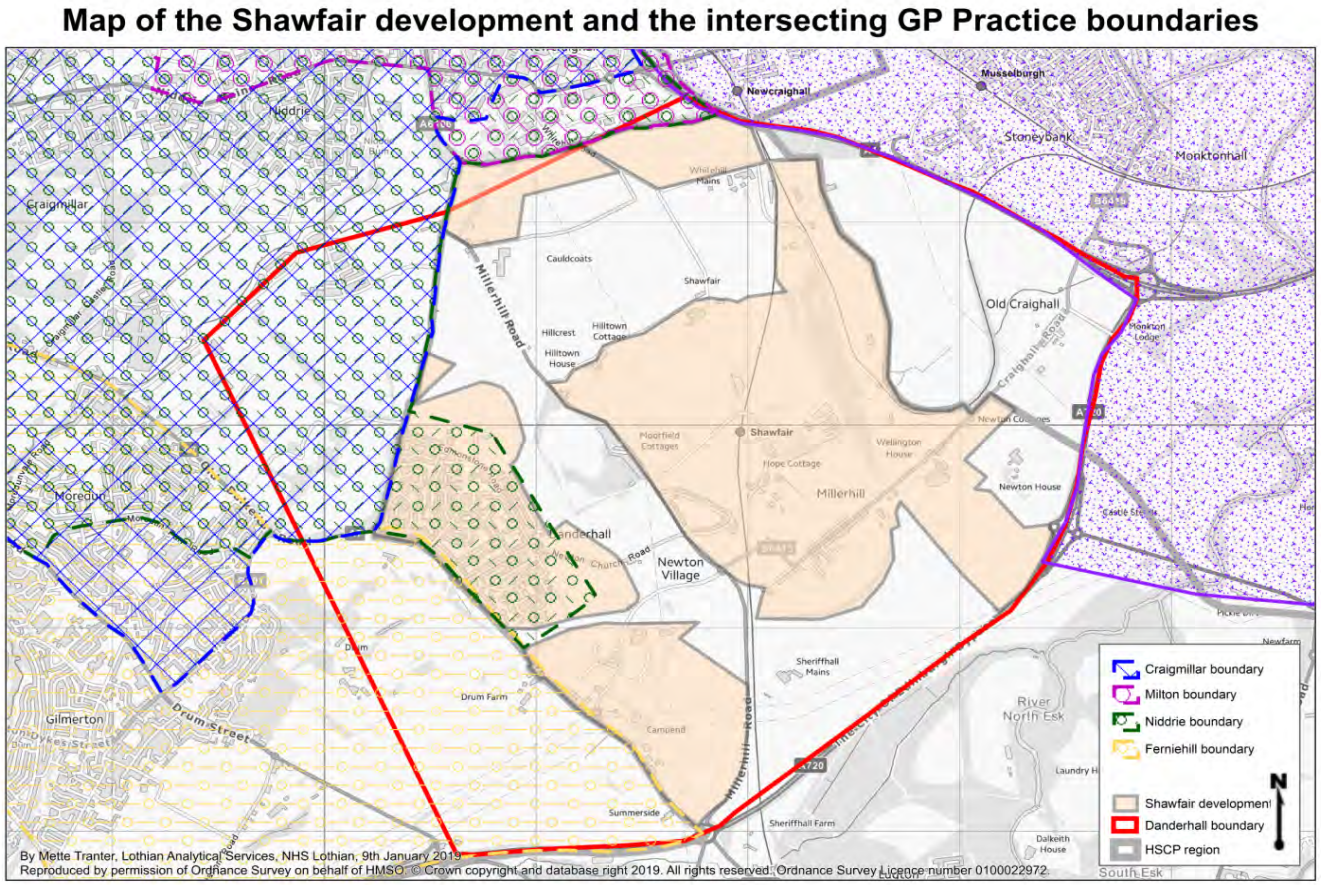
2 The Strategic Case

2.1 Existing Arrangements

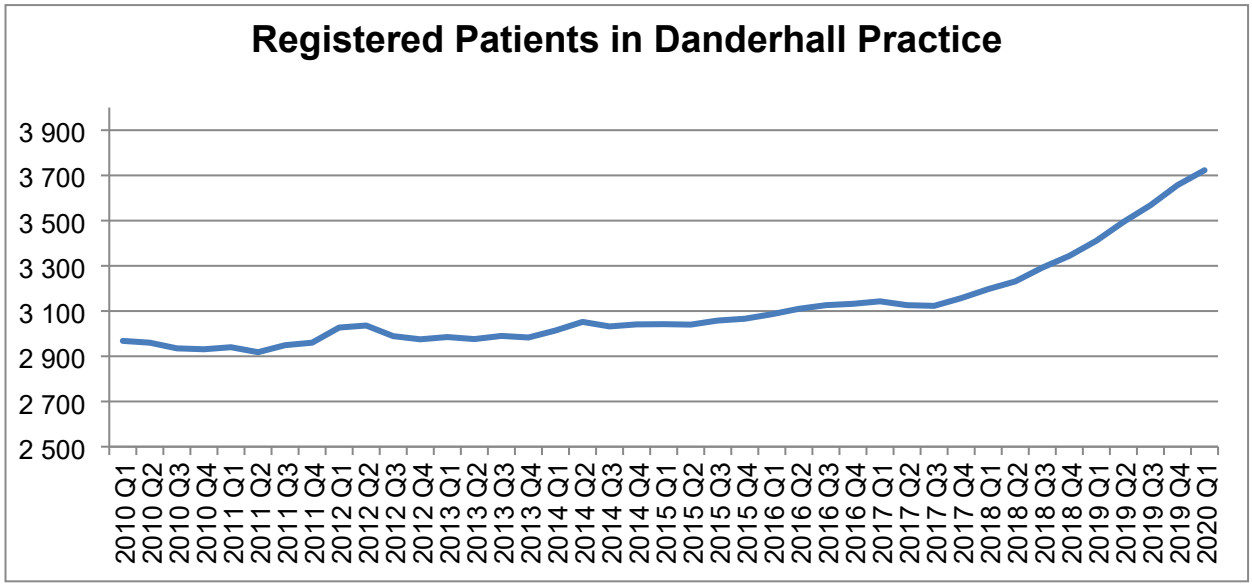
Primary care for the settlements of Danderhall and Shawfair and neighbouring villages is presently provided by the Danderhall Medical Practice located in Danderhall. There is minor overlap with the boundaries of two practices located within Edinburgh.

Figure 1 below shows the present practice boundaries and the location of this and neighbouring practices.

Figure 1: Danderhall Medical Practice - Practice Boundary



Danderhall Practice had 3,723 registered patients in May 2020 and has an open list for new registrations. All the neighbouring practices noted above also have open lists for new registrations at present with the exception of Ferniehill Practice which has had a restricted list since 1 March 2016



The practice currently provides the following services:

- GMS (General Medical Services) - two full time GP partners in the practice and a locum GP.
- Health Visitor
- Midwife
- Wellbeing
- Advanced Physiotherapy Practitioner
- Pharmacist

The Danderhall Practice's premises provide accommodation for a single GP practice. The building was constructed in 1991 and has been extended with a SIBCAS modular building. This extension is sub-optimal and was intended as a temporary option with a life of approximately 10 year which has now been exceeded. The total footprint of the existing building includes:

Table 1: Current Accommodation

Permanent brick building:	SIBCAS
• Waiting room • 1 HCA room • 2 Practice Nurse rooms • 3 GP consulting rooms • 1 boiler cupboard • toilets • 1 cleaning cupboard • 3 storage cupboards • 1 electric meter cupboard • Reception area with back office space	• 1 Clinical waste store • toilets • 1 Health Visitor clinical room • 1 Health Visitor office • 1 Physiotherapy room • 1 GP room • 1 meeting room • 1 Practice Manager's office • 1 admin office • 1 staff room • 2 storage cupboards

The building currently housing the practice is not suitable for the future provision of primary care services due to the aging building fabric and size limitations.

The Partners of Danderhall Practice want to increase the size of their registered patient list to around 7,500. This will increase the sustainability of the practice. The current building is insufficient to provide General Medical Services to the predicted growing population and to accommodate the additional services that will be developed through the Midlothian Primary Care Improvement Plan.

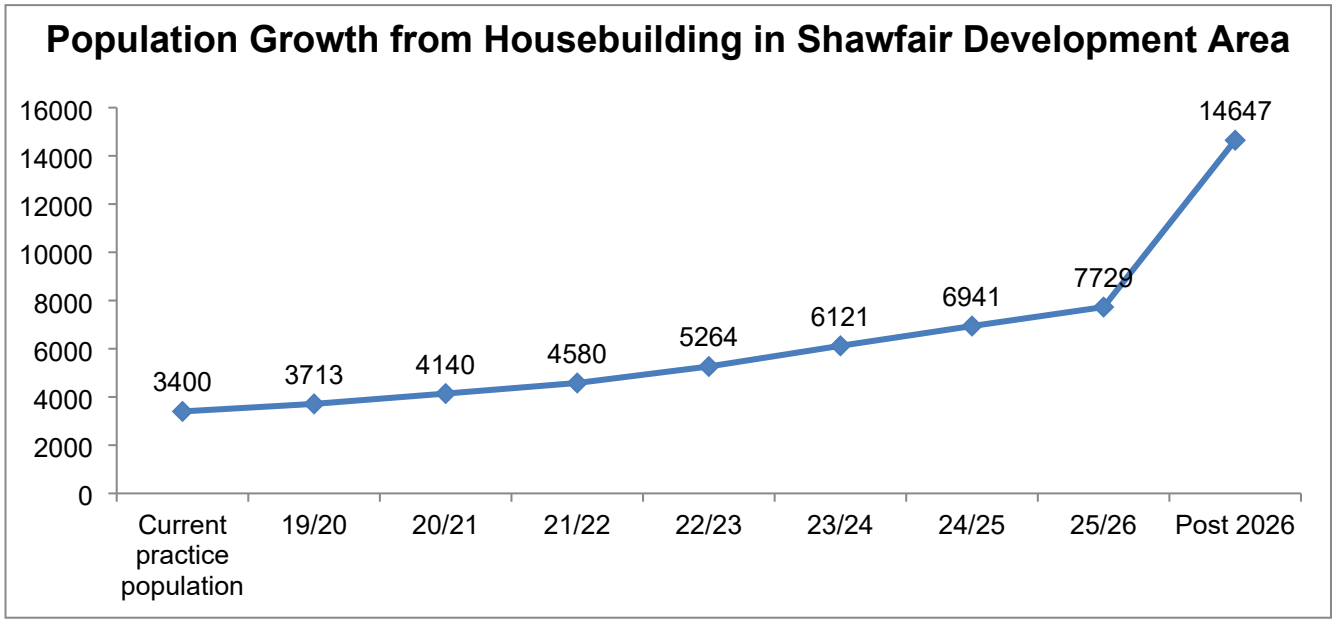
The current building has sufficient consulting rooms to sustain a maximum practice list size of around 5,000 registered patients providing there is modification to the building to expand waiting areas. This is expected to be reached in 2022/23 based on predicted rate of house building.

The key driver for change is the increase in the population expected in both the Danderhall area and the Shawfair Development area which the current primary care provision at Danderhall will not be able to meet the requirements of in the current building.

2.2 Drivers for Change

The principle driver for change is the significant increase in the population within the Shawfair Development Area (SDA). The rate of population growth is driven by the pace of house building. This is dependent on market forces but the latest estimate from the 2019 Midlothian Housing Audit shows that house builders expect to build 1,158 dwellings in the SDA before April 2024. This is expected to lead to an increase in the population of around 2,700. The population predicted to increase by a further 1,800 by March 2025. Beyond this the population is estimated to continue to grow by a further 7,400.

The graph below shows the predicted population growth within the Shawfair and Danderhall area over the next 6 years.



The Midlothian Local Development Plan makes provision for significant scales of growth, including an expansion of Danderhall and the creation of a new settlement of Shawfair, encompassing Newton and Millerhill. These plans allocated land for around 4,800 houses, a town centre including a supermarket, schools, sports facilities, medical centre, library and community woodland and open space. This house building equates in a new population of around 11,500.

The existing boundary of Danderhall Practice extends into an area within the Edinburgh HSCP where further house building is planned. This area is covered by three practices, which includes Danderhall. It is expected that around 1,000 dwellings are to be built in this area, leading to an expected increase of 2,350 people in the population.

A proportion of the 2,350 people moving into new houses in Edinburgh in the area covered by Danderhall Practice will register with this practice and increase the pressure on existing staff.

The substantial population growth in the Shawfair Development Area (SDA) as a result of house building will result in residents not being able to register with a General Practice for General Medical Services if capital investment in premises is not undertaken to allow an increased provision.

The results of the 2018 NHS Lothian Capital Prioritisation Process ranked 1st the reprovision of Danderhall Practice's premises in the Lothian Primary Care priorities, The provision of a second practice premises in the Shawfair Development Area was ranked 3rd.

The re-provision of Danderhall Practice's premises and the provision of premises for a new practice within the Shawfair Development Area (SDA) are consistent with the NHS Lothian primary care premises prioritisation and Midlothian HSCP premises strategy.

The table below summarises the need for change, the impact it is having on present service delivery and why action is required now:

Table 2: Summary of the Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
The existing Danderhall Practice building consists in part of temporary modular accommodation and is of substandard quality.	The practice is operating from premises which are neither functionally suitable nor sustainable.	The temporary accommodation is likely to increase the difficulty of the practice to attract and retain staff that will be required to meet the healthcare needs of the larger population. The accommodation doesn't provide the functional space needed to deliver the strategic primary care objectives of the HSCP.
Substantial population growth in the area and sustained and increasing pressure on GP team from current practice population from increasing prevalence of frailty, co-morbidities and mental ill health.	Existing service arrangements unable to cope with future projected levels of health care needs from the current population	House building has now commenced on multiple sites in the Shawfair Development Area leading to rapid population growth. 63% of the practice's population are in the two most deprived quintile categories. There is an increasingly ageing population with 17% over 65 and frailty data shows that people under 65 living in areas of deprivation are at greater risk of frailty than those in more affluent areas. Failure to respond now will likely increase hospital activity, particularly in the RIE which is easily accessible from the SDA.
	Existing practice unable to provide GMS to future population.	House building has now commenced on multiple sites in the Shawfair Development Area. New population likely to include large numbers of families with babies and young children, an age group which are higher uses of healthcare than the general population.
Danderhall Practice needs to increase the number of registered patients to make the practice more sustainable	Existing service arrangements unsustainable without increasing the size of the registered practice population	GMS income has declined over recent years making it more difficult for smaller practices to remain financially viable. It has become harder for practices to attract and retain staff due to workforce constraints in the market. The practices in the SDA need to appeal to new staff to compete with other practices in the UK. Current practice-size makes it difficult to cover planned and unplanned leave without a reduction in service provision
The new GP Contract supports practices to become more safe and sustainable. Additional roles are being developed by the HSCP to work in practice teams and require additional working space and consulting rooms.	Transformation of primary care services to meet the requirements of the new GMS contract	The new GP contract came into effect on 1st April 2018

2.3 Investment Objectives

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

Table 3: Investment Objectives

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)
Existing service arrangements unable to cope with future projected levels of population growth and address health care needs from the current population.	Improve and sustain service arrangements to respond to the demands of the known significant population growth and existing deprivation needs.
Existing practice unable to provide GMS to current and future population.	Improve service capacity to enable everyone in area to access GMS and other primary care services.
The practice is operating from premises which are neither functionally suitable nor sustainable.	Improve functional suitability of the healthcare estate and address long term future needs. Improve the patient and staff experience.
Existing service arrangements unsustainable without increasing the size of the registered practice population.	Facilitate an increase of the number of patients registered with Danderhall Practice. Facility to accommodate the rapid growth forecast in the SDA.
Transformation of primary care services to meet the requirements of the new GMS contract.	Enable delivery of the Primary Care Improvement Plan.

2.4 Benefits

A Strategic Assessment (SA), included in **Appendix 1: Strategic Assessment**, was completed identifying the need for change, benefits of addressing these needs and their link to the Scottish Government (SG) five Strategic Investment Priorities of: Safe; Person-Centred; Effective Quality of Care; Health of Population; Efficient: Value and Sustainability

The above investment objectives and the SA have informed the development of a Benefits Register (**Appendix 2: Benefits Register**). As per the draft Scottish Capital Investment Manual guidance on `Benefits Realisation`, this initial register is intended to record all the main benefits of the proposal. A full Benefits Realisation Plan will be developed at OBC stage.

The key benefits to be gained from the proposal are as below:

- Suitable premises to allow NHS Lothian to fulfil legal obligation to provide access to General Medical Services.
- Enable the existing practice to expand to accommodate up to 7,500 registered patients.

- Ability of the practice and HSCP to fully respond to changes described in the new GP contact and associated Memorandum of Understanding.
- Ability to allow the HSCP to provide community services to the current and new population in the area.

2.5 Strategic Risks

The table below highlights key strategic risks that may undermine the realisation of benefits and the achievement of the investment objectives. These are described thematically and potential safeguards and actions in place to prevent these:

Table 4: Strategic Risks

Theme	Risk	Safeguard
Rate of house building	The rate may increase or decrease dependent on market factors.	Use the annual Midlothian Housing Audit to monitor house builders' plans in the SDA
Workforce	Danderhall Practice cannot recruit additional workforce to provide care for increase in number of registered patients. The HSCP cannot recruit workforce to staff second practice.	Midlothian HSCP support work of NHS Lothian and Scottish Government to increase workforce. Midlothian HSCP and General Practices work together to make Midlothian an attractive place to work for new applicants.
Business Risks	Failure to gain planning permission from Midlothian Council. Failure to identify land for premises.	Work with Midlothian Council and stakeholders to ensure all planning requirements are addressed.
Service Risks	Stakeholder expectations of build exceed affordability.	Include stakeholders in business case development and options appraisal process.

A register of strategic risks is included in **Appendix 3: Risk Register** . A full risk register will be developed for the project at the OBC stage.

2.6 Constraints and Dependencies

The key constraints to be considered are:

- The current premises occupied by Danderhall Practice are owned by the practice's partners.
- Availability of NHS Lothian capital funds
- Availability of Midlothian HSCP revenue funds
- Availability of potential sites in the SDA including the land allocation in Shawfair agreed in the Section 75.

The key dependencies to be considered are:

- Agreement between Midlothian HSCP and Danderhall Practice as to the preferred option which will meet the service and financial objectives of the practice and NHS Lothian.

- NHS Lothian approval throughout the business case process and provision of capital and revenue funding.
- Disposal of existing premises if another site is used for the Danderhall Practice
- Requirement to identify and purchase land
- Decant requirements if the capital development is on existing site in Danderhall.

3 Economic Case

3.1 Do minimum/baseline

It is not feasible to continue with the existing arrangements ('Do Nothing') as outlined in the Strategic Case because of the significant house building in the Shawfair Development Area, insufficient health centre capacity and a current dependency on a temporary building that forms part of Danderhall practice.

If a Do-Nothing option is pursued then the likely scenario is Danderhall Practice will continue to register new patients until around 2021/2022 when the physical constraints of the existing building will prevent further growth. At this stage the practice will need to restrict their list to new registrations. Currently almost the whole of the Shawfair Development Area is covered only by Danderhall Practice so new patients will continue to be registered to Danderhall Practice by the NSS Patient Registration Service. This could lead to Partners in the practice returning the GMS contract to NHS Lothian due to concerns over patient safety and staff workload.

The building would have no ongoing maintenance leading to further operational constraints and an increasingly poorer working environment.

This scenario assumes that the practice can recruit new staff. The state of the current accommodation combined with the certainty that the practice workload will become unsustainable will increasingly make recruitment difficult.

A Do Minimum option is described instead as the baseline scenario. In the Do Minimum option the existing building used by Danderhall Practice is maintained. There will be no capital investment in the existing building and there would be no second practice developed within the Shawfair Development Area (SDA). This option will allow the Danderhall practice to register new patients until around 2022/23 when the physical constraints of the building are expected to be reached. At this point the practice would need to take action to restrict new registrations but there are limited alternative practices to register patients.

This option will prevent Danderhall Practice from reaching the partners' preferred list-size of up to 7,500 and this may mean that the practice does not reach a capacity that improves its sustainability. It will also constrain Midlothian HSCP from developing additional services to support the current practice team in Danderhall.

Table 5: Do Minimum

Strategic Scope of Option	Do Minimum
Service provision	Ongoing maintenance of the existing practice in Danderhall. GMS will be provided by one practice within this building. It will be insufficient for the predicted population growth. Where possible new residents will be encouraged to register with existing neighbouring practices. This will only be possible for a small proportion of new residents because of the limited coverage of the Shawfair Development Area by another practice and prevailing access issues in Niddrie practice.
Service arrangements	The current practice will provide GMS for its registered population. The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. The constraints of the building will restrict the HSCP to fully implement the PCIP for this practice.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice. The HSCP will provide additional services within the constraints of the Danderhall Practice building.
Supporting assets	The existing Danderhall Practice building will be maintained in its current state.
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services. This will become increasingly difficult as more patients are registered with the practice.

3.2 Engagement with Stakeholders

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

Table 6: Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
Patients/ service users/ General Public	Patients and service users affected by this proposal include the population registered to Danderhall Practice, the people residing within the Shawfair Development Area and the people who will move in to new houses in the area. It is not possible to consult with a population that is not living in the area yet so engagement has focussed on the established population. Their involvement in its development includes representation on the project board, patient survey through Danderhall Practice and meetings with the community council and local councillors. The impact that this has had on the proposal's development includes the expectation from the public, service users and elected representatives that at least one General Practice should remain within Danderhall village.	Patient / service user groups were surveyed by the practice on behalf of the project board on preferences for the future location of the practice or practices within the Shawfair Development Area. This survey was conducted between 9th October 2018 and 31st October 2018. There were 413 questionnaires completed which represents 13% of the practice's registered patients. 84% of responses supported a health centre remaining within Danderhall Village The local Community Council have been invited to attend all the project board meetings and been copied into all papers. The Community Council discussed the recommended options of this Initial Agreement on 26th March 2019. The outcome of this meeting was: 1) There is support for one General Practice to remain in Danderhall Village 2) There was concern about the impact on Danderhall Village if both general practices were to be included in one building. The concern in particular related to the increased traffic to the village of people using the health centre but also the distance to travel for people who are yet to move into area but will be living in Shawfair. 3) There was concern about where the health centre in Danderhall would be built and a potential impact on existing community assets. 4) Agreement for further consultation and involvement from the CC particular in the Business Case phase where detail about the options including the building design will be developed.
Staff/ Resources	Staff affected by this proposal includes the Danderhall Practice team. To a much lesser extent HSCP staff who provide services in the Shawfair Development Area are also affected.	The Manager and Partners from Danderhall Practice have been actively involved throughout the development of this Initial Agreement though membership of the Project Board.

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
	Their involvement in its development includes strong representation on the project (all partners and practice manager attend the Project Board.	Staff in the HSCP were involved though discussion at the HSCP and at the HSCP's Joint Management Team. This Initial Agreement was approved at the Midlothian HSCP Senior Management Team on 23rd June 2020.
Other key stakeholders and partners	Other key stakeholders identified for this proposal include local elected representatives. Their involvement in the development of this proposal has consisted of briefing meetings with representatives from the HSCP	Support for this proposal has been gained through briefing meetings. Confirmed support that at least one Practice will be located within Danderhall Village was made on 5th March 2019.

Further engagement with stakeholders will take place as this proposal progresses into OBC stage.

3.3 Long-listed Options

There are eight options identified on the long-listed options. Three options were discounted and five options were short-listed.

The options were considered within the context of the functions required in the new building(s)

Functions within the Healthcare Centres in the Shawfair Development Area

The range of professionals working within a healthcare centre is changing quickly in Midlothian. This is primarily being driven by the 2018 General Medical Services Contract but prior to this the Midlothian HSCP was already providing third sector led services within General Practice.

The contract moves primary care further away from the historical model of a General Practitioner providing direct holistic care for all their patients to the role of the GP as the expert medical generalist supported by a multidisciplinary and potentially multi agency team.

This will impact on the design of new healthcare facilities which must be designed to incorporate the strategic direction set in the contract.

1) 2018 General Medical Services Contract

The building(s) must enable General Practices working from them to provide the functions required within the 2018 General Medical Services Contract.

There will be around 14,000 people living with the Shawfair Development Area and almost all these people will register with one of the two practises that will be in the new healthcare facilities. The building(s) will require sufficient space for practice teams to work and provide healthcare needs for this population and include the staff team that would have been employed by a practice prior to the new contract (GPs, nurses, practice manager and administrative team).

The new contract focuses on how care will change by: maintaining and improving access (contact); introducing a wider range of health professionals to support the expert medical generalist (comprehensiveness); enabling more time with the GP for patients when it is really needed (continuity); and providing more information and support for patients (co-ordination).

The Midlothian Primary Care Improvement Plan describes the changes that will happen over three years as the 2018 GMS contract is implemented. The final model and workforce is unclear but will incorporate the following professional roles which need accommodation in the new building(s) to provide clinical care.

- MSK Advanced Practitioner Physiotherapist (modelled at 1 session per 1900 population)
- Pharmacists (modelled at 6 sessions per 8000 population)
- Pharmacist Technicians (modelled at 3 sessions per 8000 population)
- Community Psychiatric Nurse (model not known)
- Wellbeing Professionals (providing support for people with anxiety or depression)
- Community Treatment and Care services

There are significant elements of the Primary Care Improvement Plan where the model is unknown and will be developed during the next two years. Crucially these include vaccinations and community treatment and care functions.

2) Evolving models of service delivery

The new buildings need to have space to allow for new functions to be provided from within the General Practices.

The relationship between General Practice and third sector organisations has developed quickly in Midlothian during recent years; with all practices in the county now have at least one third sector organisation provide services from within practice building. Three practices in the county now have at least two third-sector organisations regularly in the building during the working week. Therefore, there is a requirement for further consulting space/meeting rooms for clients within the new building(s) developed for Danderhall and Shawfair.

Patient Group meetings

There is increasing evidence in the effectiveness of people with similar health conditions meeting within small groups with a health care professional or team to improve outcomes from their condition. COPD, Substance Misuse, Frailty and Diabetes are all conditions where this approach is being used elsewhere in Midlothian or across the UK.

The healthcare building(s) need to provide space that be used for group meetings, this space should be available in evenings and weekends to allow groups to be held during times which are more convenient for patients. This will require the design of the building to allow access to these spaces whilst maintaining security in the other parts of the building.

HSCP functions

Midlothian HSCP requires consulting room and office space for community-based staff working in the Shawfair Development Area. The HSCP also requires office accommodation for the newly formed Discharge to Assess Team which provides a service across Midlothian who requires a base close to the Edinburgh Royal Infirmary.

Further Primary Care Functions

There may be the requirement and benefit to accommodate a pharmacy and a dentist within the building to ensure access to these functions in the Shawfair Development Area as the population grows. These have not been included in the scope of the Initial Agreement and this will be considered during the Business Case stage.

The eight options which were included on the long lists were as included in the below and further detailed in the following table.

- Option 1: Do Nothing
- Option 2: Do minimum - ongoing maintenance only
- Option 3: Develop existing premises at Danderhall
- Option 4: Ongoing maintenance to existing practice and new practice
- Option 5: Retain and adapt existing Danderhall practice premises and create new practice in Shawfair
- Option 6: New buildings for two practices – one in Danderhall (existing or new site), one in Shawfair
- Option 7: Single building to house two practices in Danderhall (existing or new site)
- Option 8: Single building to house two practices in Shawfair

Appendix 4: Strategic Scope of Long Listed Options details the strategic scope of the long list of options identified above. This summarises, for each option, the service provision and requirements, the service provider and workforce arrangements, the supporting assets and the expectations of the public and service users.

3.3.1 Initial Assessment of Options

Each of the long- listed options have been assessed for their advantages and disadvantages, and the extent to which they meet the investment objectives (as outlined in the Strategic Case) to identify the preferred solution(s). This does not include the 'do nothing' option as this has been discounted as it is not feasible. Option 2 – do minimum is included as the baseline option.

The results of this assessment are summarised below. This resulted in five options (inclusive of the do minimum baseline) being taken forward for further assessment as part of the shortlist.

Table 7: Assessment of options against investment objectives: Options 2-5

	Option 2: Do minimum – ongoing maintenance only	**Option 3:** Develop existing premises	**Option 4:** Ongoing maintenance to existing practice and new practice in Shawfair	**Option 5:** Retain and adapt existing Danderhall practice and create new practice in Shawfair
Advantages (Strengths & Opportunities)	Invest in existing practices and premises to increase capacity	Invest in existing practices and premises to increase capacity	Addresses some of the capacity and access needs Functionally suitable premises, long term provision at Shawfair site – limited at Danderhall	Addresses capacity and access needs Functionally suitable premises, long term provision

	Option 2: Do minimum – ongoing maintenance only	Option 3: Develop existing premises	Option 4: Ongoing maintenance to existing practice and new practice in Shawfair	Option 5: Retain and adapt existing Danderhall practice and create new practice in Shawfair
Disadvantages (Weaknesses & Threats)	Will not address all strategic drivers; part solution only with limited impact Capacity across project area constrained	Will not address all strategic drivers; part solution only with limited impact Capacity across project constrained	Challenges/ difficulties of setting up new practice Significant revenue implications until practice stable Building environment may impact on staff recruitment to existing practice Capacity in Danderhall practice constrained	Site feasibility study in 2019 concluded that the current site is not suitable for adaption to accommodate the required building and car parking Challenges/ difficulties of setting up new practice Significant revenue implications until stable practice Building environment may impact on staff recruitment to existing practice Capacity growth in Danderhall limited
Does it meet the Investment Objectives (Fully, Partially, No, n/a):				
Investment Objective 1	No	No	Partially	Partially
Investment Objective 2	No	Partially	Partially	Partially
Investment Objective 3	No	No	Partially	Partially
Investment Objective 4	No	No	Partially	Partially
Investment Objective 5	No	No	Partially	Partially
Are the indicative costs likely to be affordable?				
Affordability	Yes	Yes	Yes	Yes
Preferred/ Possible/ Rejected	Baseline	Rejected	Rejected	Possible

Table 8: Assessment of options against investment objectives: Options 6-8

	Option 6: New buildings for two practices – one in Danderhall (existing or new site), one in Shawfair	Option 7: Single building to house two practices in Danderhall (existing or new site)	Option 8: Single building to house two practices in Shawfair
Advantages (Strengths & Opportunities)	Addresses capacity Functionally suitable premises Sustainable, long term need	Addresses capacity Functionally suitable premises Sustainable, long term need	Addresses capacity Functionally suitable premises Sustainable, long term need

	Option 6: New buildings for two practices – one in Danderhall (existing or new site), one in Shawfair	Option 7: Single building to house two practices in Danderhall (existing or new site)	Option 8: Single building to house two practices in Shawfair
	Close to home for both communalities		
Disadvantages (Weaknesses & Threats)	Challenges/ difficulties of setting up new practice Significant revenue implications until practice stable	Challenges/ difficulties of setting up new practice Significant revenue implications until practice stable Further to travel for people living in East of the SDA Impact on viability of Shawfair town centre	Challenges/ difficulties of setting up new practice Significant revenue implications until practice stable Further to travel for people living in Danderhall Lack of public/political support
Does it meet the Investment Objectives (Fully, Partially, No, n/a):			
Investment Objective 1	Fully	Partially	Partially
Investment Objective 2	Fully	Fully	Fully
Investment Objective 3	Fully	Fully	Fully
Investment Objective 4	Fully	Partially	Partially
Investment Objective 5	Fully	Fully	Fully
Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)			
Affordability	Yes	Yes	Yes
Preferred/ Possible/ Rejected	Preferred	Preferred	Preferred

3.4 Short-listed Options and Preferred Way Forward

3.4.1 Shortlisted options

From the initial assessment above the following short-listed options have been identified:

Table 9: Short Listed Options

Option	Description
Option 2	Do Minimum (Baseline) – ongoing maintenance to Danderhall Practice only
Option 5	Retain and adapt existing Danderhall practice and create new practice in Shawfair
Option 6	New buildings for two practices – one in Danderhall (existing or new site), one in Shawfair
Option 7	Single building to house two practices in Danderhall (existing or new site)
Option 8	Single building to house two practices in Shawfair

3.4.2 Non-financial benefits assessment

Each of the shortlisted options was assessed against the benefits included in the benefits register in **Appendix 2: Benefits Register**. Each of the identified benefits was weighted and following this each of the shortlisted options was scored against its ability to deliver the required benefits. The results of the benefits assessment are summarised below:

Table 10: Results of Non-Financial Benefits Assessment

#	Benefit	Weight (%)	Option 2	Option 5	Option 6	Option 7	Option 8
1	Reduces pressure on acute services through increased provision and treatment in primary care	4%	0	4	8	8	8
2	Increased local provision and access to treatment making best use of available NHS Lothian, HSCP and Practice resources	18%	0	5	9	10	10
3	Provides easy to access, local primary healthcare for all of the local population close to home	25%	4	7	10	8	3
4	Space and facilities to house 3rd sector agencies and Health & Social Care partners to enable delivery of wider primary care services closer to home	5%	1	3	8	9	9
5	Improves staff and patient safety by removing risks associated with aging assets	8%	1	8	10	10	10
6	Improves patient experience - enables care delivered with privacy and dignity through a facility with the appropriate space that is accessible for all	10%	1	8	10	10	10
7	Provides wider economic and community benefits: a facility that can be used by other community groups and/ or provide a focus point for the local area and residents	5%	0	5	8	8	8
8	Provides sustainable practice(s) for the future which are adaptable to growth, new initiatives and changes in policy	25%	0	3	9	10	10
Total Weighted Benefits Points			**123**	**540**	**929**	**927**	**802**

From the results in Table 10, it is noted that the options that will deliver the most non financial benefits alone are Option 6 and Option 7.

3.4.3 Indicative Costs

The table below details the indicative whole life costs associated with each of the shortlisted options. For further detail around the determination of the costs see the Financial Case.

Table 11: Indicative Costs of Shortlisted Options

Cost (£k)	Option 2	Option 5	Option 6	Option 7	Option 8

NPV of whole life capital costs	0	4,749	9,037	7,713	7,034
NPV of Incremental whole life operating costs	0	7,271	9,268	8,518	8,518
Total Net Present Value (NPV) of Costs	**0**	**12,020**	**18,305**	**16,231**	**15,552**

The additional assumptions associated with the calculation of the NPV of costs are:

- A discount rate of 3.5% has been used in line with Government guidelines.
- A useful life of 50 years has been determined for the projects.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.

3.4.4 Overall assessment and preferred way forward

The table below show the weighted benefit points for each shortlisted option, the NPV of costs and the calculated cost per benefit point. This calculated cost per benefit point has been used to rank the options and identified the preferred way forward.

Table 12: Economic Assessment Summary

Option Appraisal	Option 2	Option 5	Option 6	Option 7	Option 8
Weighted benefits points	**123**	**540**	**929**	**927**	**802**
NPV of Costs (£k)	0	12,020	18,305	16,231	15,552
Cost per benefits point (£k)	n/a	22.26	19.70	17.51	19.39
Rank	**5**	**4**	**3**	**1**	**2**

Option 2 has been discounted as it ranks lowest due to its inability to deliver any of the benefits or investment objectives previously identified.

Option 5 is discounted because of the site feasibility report conclusions and the high cost per benefits point compared to other options.

The preferred option within the Initial Agreement is Option 7 (Single building to house two practices in Danderhall (existing or new site). This option scored the highest based on the Economic Assessment and was one of the two highest scoring option in the non-financial options appraisal; This option scored 927 benefits points and Option 6 scored 929 benefits points but is discounted due to the higher economic cost per benefits point.

There is a stated preference from the Community Council, service users of Danderhall Practice and elected Councillors for the area for one of the General Practices to be located within Danderhall. The Midlothian HSCP also supports this because it retains a health centre in the community in Development Area with the high prevalence of frailty, co-morbidities and deprivation.

It is recommended that NHS Lothian 7 to Outline Business Case stage where the implementation of the solution shall be further developed and tested for value for money. At this stage more detailed consultation will be undertaken with local residents and stakeholders.

3.5 Design Quality Objectives

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

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

4 The Commercial Case

4.1 Procurement Strategy

The total indicative costs for the preferred options at this stage are both below £10.0m including VAT which are within NHS Lothian's delegated limit. However, as the project is driven by increased population growth and not maintenance of NHS Lothian's existing estate, this project must also be submitted to the Scottish Government Capital Investment Group (CIG).

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

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

4.2 Timetable

A detailed Project Plan will be produced for the OBC and is dependent on the ability to deliver a solution to the preferred option. At this stage the table below shows the proposed timetable for the progression of the business case and indicative project delivery milestones assuming a single phase solution:

Table 13: Project Timetable

Key Milestone	Date
Initial Agreement approved	July 2020
Outline Business Case approved	April 2021
Purchase of land completed (if required)	April 2022
Full Business Case approved	April 2022
Construction starts	June 2022
Construction complete and handover begins	June 2023
Service commences	August 2023

5 The Financial Case

5.1 Capital Affordability

The estimated capital cost associated with each of the short listed options is detailed in the table below. Construction costs were provided by independent quantity surveyors.

Table 14: Capital Costs

Capital Cost (£k)	Option 2: Do minimum - baseline	Option 5: Retain and adapt existing Danderhall practice and create new practice in Shawfair	Option 6: New buildings for two practices - one in Danderhall (existing or new site), one in Shawfair	Option 7: Single building to house two practices in Danderhall (existing or new site)	Option 8: Single building to house two practices in Shawfair
Construction	0	3,879	6,920	5,260	5,260
Professional Fees, Surveys	0	350	690	515	515
Equipment, fixtures, fittings, furniture, IT, Telephony	0	144	289	248	248
Land Purchase	0	0	375	585	0
Building Purchase	0	210	0	0	0
Inflation	0	170	340	270	270
Optimism Bias	0	856	1,550	1,238	1,133
Total Cost (excl VAT)	**0**	**5,609**	**10,164**	**8,116**	**7,426**
VAT (net of recovery)	0	1,056	1,901	1,525	1,387
Total Capital Cost	**0**	**6,665**	**12,065**	**9,641**	**8,813**

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

- Optimism bias has been included at 18% of all costs following assessment in line with SCIM guidance.
- Construction costs have been estimated by using a sqm rate on the basis of previous similar type projects.
- An inflation allowance of has been included based on the BCIS TPI to Q4 2020 pricing levels.
- VAT has been included at 20% on all costs. VAT recovery has been assumed on professional fees. VAT recovery will be further assessed in the OBC.
- Land purchase and building purchase fees are estimates as provided by the district valuer. Due to the existing section 75 agreement for the SDA no land purchase costs have been included for land in Shawfair (see **Appendix 5: Extract from the Shawfair Section 75 Agreement**).
- Equipment, fixtures, fittings, furniture, IT and Telephony costs are all based on sqm rates from similar previous projects.

5.2 Revenue Affordability

The estimated recurring annual revenue costs associated with each of the short listed options are detailed in the table below.

Table 15: Annual Revenue Costs

Annual Revenue Cost/year (£k)	Option 2: Do minimum - baseline	Option 5: Retain and adapt existing Danderhall practice and create new practice in Shawfair	Option 6: New buildings for two practices - one in Danderhall (existing or new site), one in Shawfair	Option 7: Single building to house two practices in Danderhall (existing or new site)	Option 8: Single building to house two practices in Shawfair
HSCP Staffing	0	221	221	221	221
Facilities	0	57	114	98	98
Depreciation	0	133	241	193	176
Total Annual Revenue Cost	**0**	**411**	**576**	**512**	**495**

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

- Depreciation is based on a useful life of 50 years and assumed to be funded from the existing NHS Lothian Depreciation funding allocation.
- Staffing costs are based on the following additional staffing, that will be provided via the HSCP:

Role	Band	WTE
MSK APP	7	0.80
Pharmacist	7	1.00
Pharmacist Technicians	5	0.50
CPN	6	1.00
Wellbeing Service	5	1.70
Total		**5.00**

- No one off revenue costs (e.g. cost of decant) have been identified for the project at this stage.
- Practice related costs have not been included in revenue costs as these will be funded via GMS income. However, it is noted that there will be an increase in these revenue costs due to the creation of a new practice. Further work will be done at OBC stage to look to identify these costs.

Revenue funding will be from various sources: The PCIF will be utilised for HSCP staffing relating to the new GP contract and described in the Midlothian Primary Care Improvement Plan. Depreciation costs will be covered from various sources. The Finance Business Partner (Claire Flanagan) has reviewed these and will continue to be informed as the project progresses into OBC stage. The revenue funding for the preferred options are detailed in the table below:

Table 16: Summary of Revenue Funding

Revenue Cost/ Funding	Option 5: Retain and adapt existing Danderhall practice and create new practice in Shawfair	Option 6: New buildings for two practices - one in Danderhall (existing or new site), one in Shawfair	Option 7: Single building to house two practices in Danderhall (existing or new site)	Option 8: Single building to house two practices in Shawfair
Total Annual Incremental Revenue Cost	**411**	**576**	**512**	**495**
Primary Care Improvement Fund	221	221	221	221
Funding – existing NHSL depreciation budget	133	241	193	176
Funding - GP Practices/HSCP	57	114	98	98
Total Funding	**411**	**576**	**512**	**495**
Funding Gap	**-**	**-**	**-**	**-**

Revenue costs will continue to be assessed and refined through the OBC process. Increased revenue costs under the current contract, such as heat, light and power, are the responsibility of the practice. It is therefore assumed that there will be no funding gap as this costs will be funded by the GP practices or HSCP where required/agreed.

5.3 Overall Affordability

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

Funding for capital costs has been assumed to be from a specific allocation from the Scottish Government.

Funding has been identified for the additional revenue costs from the Primary Care Improvement Fund and existing NHSL depreciation budget and these have been reviewed and agreed by the Finance Business Partner.

All costs will continue to be refined through the OBC process.

The overall affordability of the project is also affected by the phasing of the building and service requirements. Due to the planned house building expansion it has been assumed that an additional practice for Shawfair is not required to be completed until year 5 in terms of construction. Table 17 shows the estimated phasing of capital costs.

Table 17: Capital Cost Phasing

Capital Costs						
Option #	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
2	-	-	-	-	-	-
5	629	-	-	-	3,018	3,018
6	3,016	3,016	-	-	3,016	3,017
7	4,821	4,820	-	-	-	-
8	4,406	4,407	-	-	-	-

Key assumptions and notes associated to the above are as below:

- Costs have not been discounted and do include inflation.
- Costs for new buildings have been spread equally over two years.
- Option 5 includes the extension of existing Danderhall building in Year 0 to address short term growth and building of a new practice in Shawfair over two years in Years 4 and 5.
- Option 6 again assumes new builds over 2 years, with the construction of a new Danderhall practice in Years 0 and 1, with Shawfair commencing Year 4, completion in Year 5.
- Options 7 and 8 assume construction over 2 years in Year 0 and 1 for both practices.
- Costs for new buildings have been spread equally over two years.

6 The Management Case

6.1 Readiness to proceed

A benefits register and initial high level risk register for the project are included in **Appendix 2: Benefits Register** and **Appendix 3: Risk Register**, respectively.

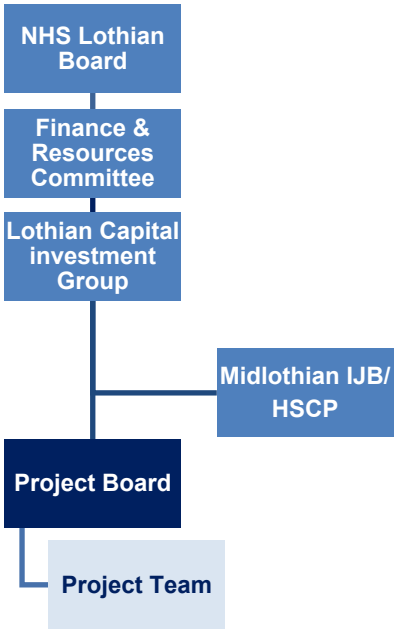
Detail of the proposed timeframe for development of the business case is included in the Commercial Case and any interdependencies with other projects are included in the Strategic Case.

NHS Lothian and Midlothian Health and Social Care Partnership are ready to proceed with this proposal and are committed to ensure the necessary resources are in place to manage it. Section 6.3 below details the project management arrangements. Section 6.2 outlines the governance support and reporting structure for the proposal.

6.2 Governance support for the proposal

Engagement with Stakeholders is detailed in the Strategic Case and includes information on how members of the proposal's governance arrangements have been involved in its development to date and will continue to support it.

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



6.3 Project Management

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

Hub SE has been appointed as specialist external advisors. Legal advice for the project (if required) will be obtained from the Central Legal Office.

Table 18: Project Management Structure

Role	Individual	Capability and Experience
Project Sponsor	Morag Barrow, Joint Director, Midlothian HSCP	Experienced Director within health and care.
Project Owner/ Manager	Jamie Megaw, Strategic Planning Manager	Experienced senior manager within health and care.
Capital Finance Support	Immy Tricker/ Laura-Jane Smith	Experience supporting multiple capital investment projects including similar primary care provisions.
Capital Planning Manager	Campbell Kerr	Capital planning manager with >10 year experience supporting primary care investment in Lothian.
Finance Business Partner	Clare Flanagan	Business partner with >10 year experience in supporting service delivery.
Service Representatives	Nadia Fernie, Meryl Peat, Hedley Philpott	Practice manager and partners of Danderhall Medical Practice
Patient Representative	Gillian Thomson	Local resident and patient of the practice
Midlothian Council Representative	Neil Davidson	Nominated representative of Midlothian Council with experience of capital projects and the Shawfair Development Area site planning
Facilities support	Brain Robb, NHS Lothian Facilities	Facilities manager with experience of supporting the development of several capital projects from a facilities standpoint.

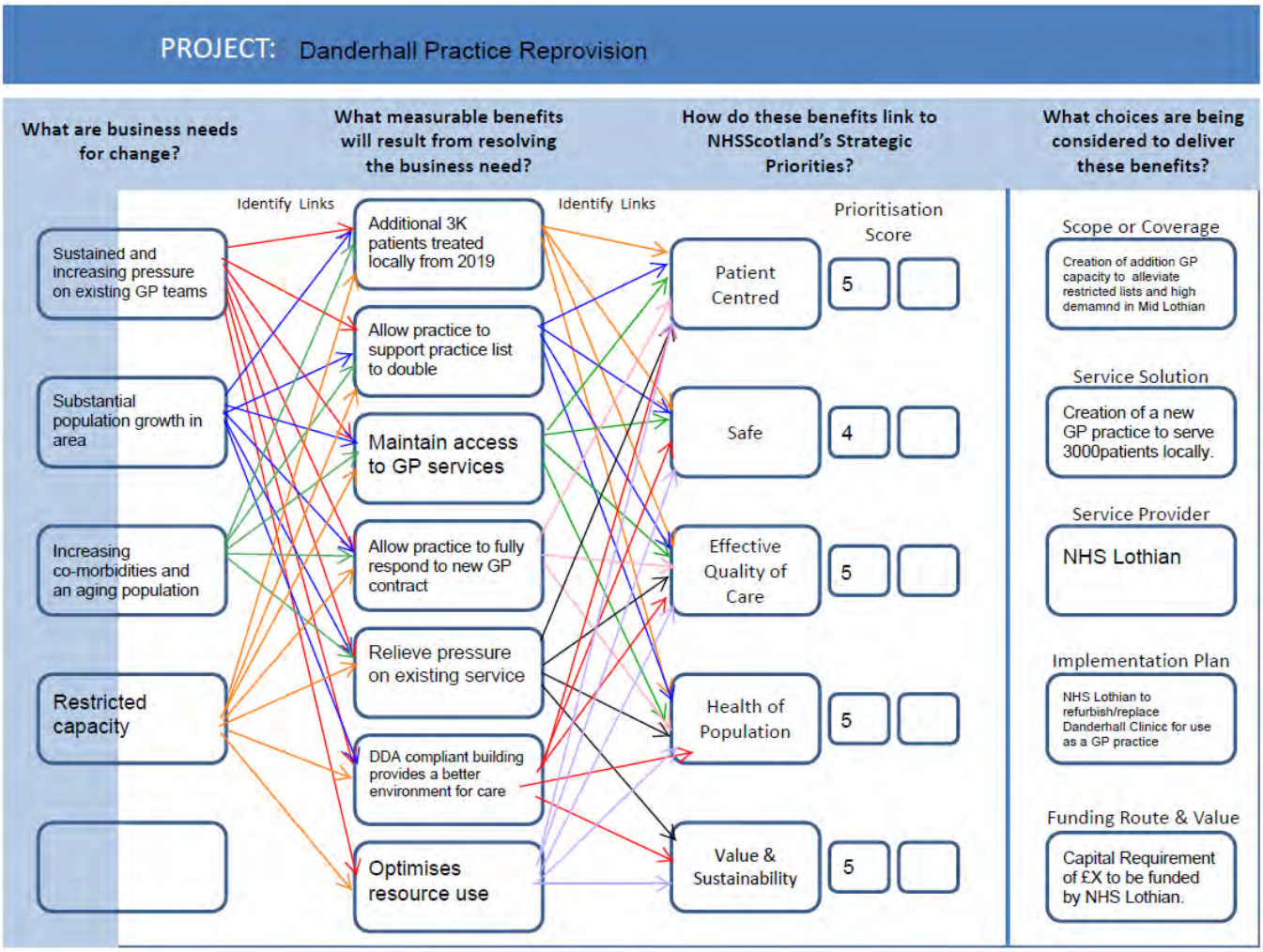
7 Conclusion

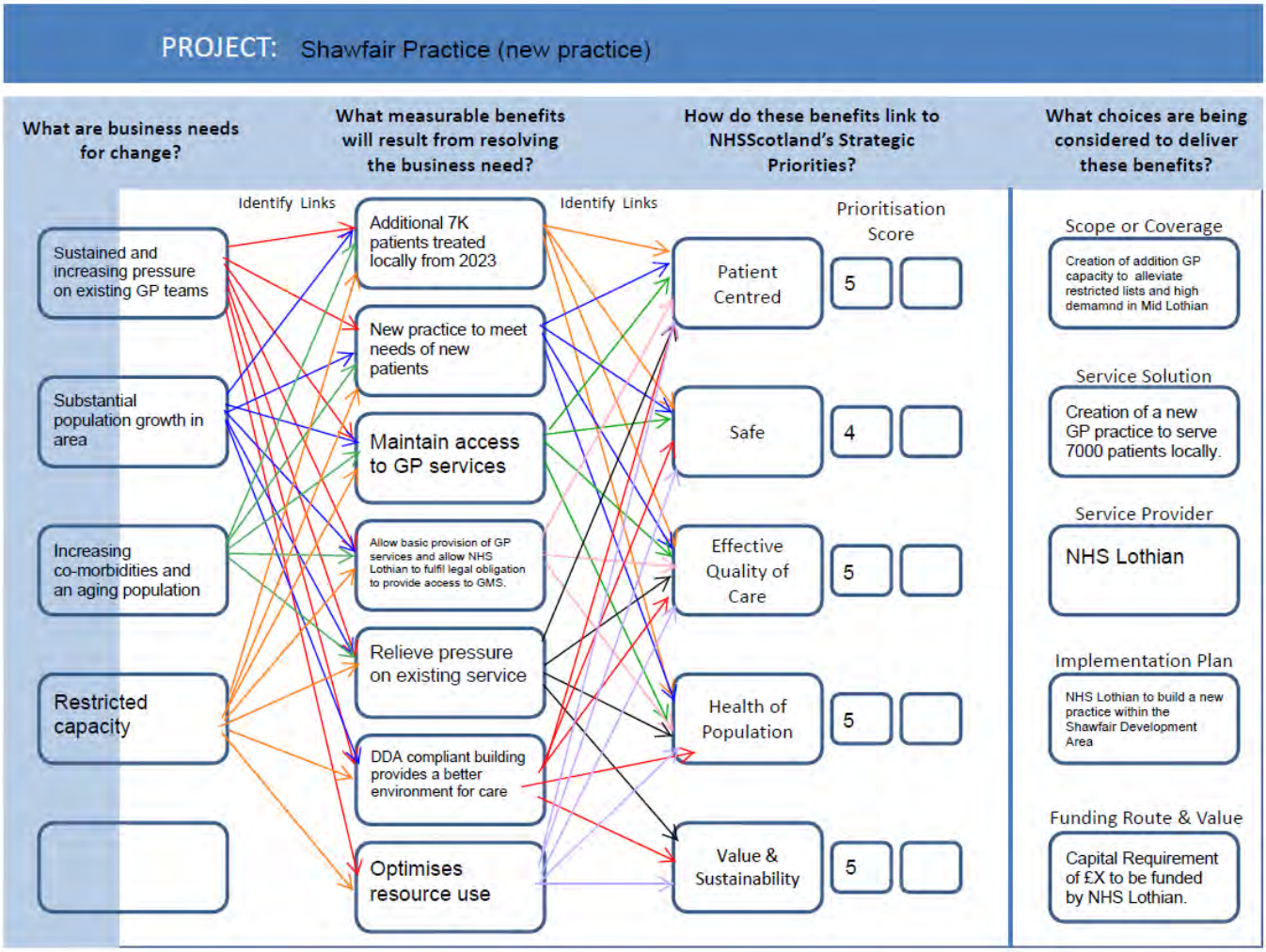
The strategic assessment for this proposal (included in **Appendix 1: Strategic Assessment**) scored 24 out of a possible maximum score of 25.

The proposal has been prioritised by the relevant governance groups and identified as a priority for NHS Lothian and Midlothian Health and Social Care Partnership.

The project team has identified a preferred way forward that meets the investment objectives and delivers the realisation of the required benefits.

Appendix 1: Strategic Assessment




PROJECT: Shawfair Practice (new practice)
What are business needs for change?
What measurable benefits will result from resolving the business need?
How do these benefits link to NHSScotland's Strategic Priorities?
What choices are being considered to deliver these benefits?
Identify Links
Identify Links
Prioritisation Score
Sustained and increasing pressure on existing GP teams
Substantial population growth in area
Increasing co-morbidities and an aging population
Restricted capacity
Additional 7K patients treated locally from 2023
New practice to meet needs of new patients
Maintain access to GP services
Allow basic provision of GP services and allow NHS Lothian to fulfil legal obligation to provide access to GMS.
Relieve pressure on existing service
DDA compliant building provides a better environment for care
Optimises resource use
Patient Centred
Safe
Effective Quality of Care
Health of Population
Value & Sustainability
5
4
5
5
5
Scope or Coverage
Creation of addition GP capacity to alleviate restricted lists and high demamnd in Mid Lothian
Service Solution
Creation of a new GP practice to serve 7000 patients locally.
Service Provider
NHS Lothian
Implementation Plan
NHS Lothian to build a new practice within the Shawfair Development Area
Funding Route & Value
Capital Requirement of £X to be funded by NHS Lothian.

Appendix 2: Benefits

Register

Danderhall/ Shawfair GP Reprovision												
1. Benefits Register						*2. Prioritisation*	*3. Realisation*					
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
1	Reduces pressure on acute services through increased provision and treatment in primary care	Qualitatively	Healthcare services provided on site	Limited services other than GMS	Wider healthcare services provided	3 - Moderately important	Staff, NHSL	Strategic Programme Manager	Improve and sustain service arrangements	Delivery of wider transfer of provision from acute to primary care		12 months post operation
2	Increased local provision and access to treatment making best use of available NHS Lothian, HSCP and Practice resources	Qualitatively	Maintenance of unrestricted list and number of registrations	List unrestricted	List continues to be unrestricted	5 - Vital	Patients, Public, Staff, GP Partners, NHSL, MHSCP	Strategic Programme Manager	Improve service capacity	Availability of resources to provide local provision		12 months post operation
3	Provides easy to access, local primary healthcare for all of the local population close to home	Qualitatively	Patient and staff feedback	Assessment ongoing through surveys	Provision that enables growth and delivery of required services to local population	5 - Vital	Patients, Public	Strategic Programme Manager	Improve service capacity Improve the patient and staff experience			12 months post operation

Danderhall/ Shawfair GP Reprovision												
1. Benefits Register						*2. Prioritisation*	*3. Realisation*					
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
4	Space and facilities to house 3rd sector agencies and Health & Social Care partners to enable delivery of wider primary care services closer to home	Qualitatively	Patient, community and staff feedback. Utilisation of building.	Assessment ongoing through surveys	Improved feedback	5 - Vital	Patients, Public, Staff, GP Partners, NHSL, MHSCP	Strategic Programme Manager	Improve functional suitability Facility to accommodate the rapid growth forecast in the SDA Improve the patient and staff experience	Involvement and engagement from local community	Involvement and engagement from local community	12 months post operation
5	Improves staff and patient safety by removing risks associated with aging assets	Qualitatively	Classification of assets/ maintenance costs	Poor quality asset with ongoing maintenance issues	High quality asset with low maintenance requirements	5 - Vital	Patients, Staff, GP Partners	Strategic Programme Manager	Improve functional suitability Improve the patient and staff experience			12 months post operation
6	Improves patient experience - enables care delivered with privacy and dignity through a facility with the appropriate space that is accessible for all	Qualitatively	Patient and staff feedback	Assessment ongoing through surveys	Improved feedback	5 - Vital	Patients, Staff, GP Partners	Strategic Programme Manager	Improve functional suitability Improve the patient and staff experience			12 months post operation
7	Provides wider economic and community benefits: a facility that can be used by other community	Qualitatively	Patient, community and staff feedback. Utilisation of building.	Assessment ongoing through surveys	Improved feedback and high building utilisation	3 - Moderately important	Patients, Public	Strategic Programme Manager	Improve functional suitability of the healthcare estate and address long term future needs	Involvement and engagement from local community	Involvement and engagement from local community	12 months post operation

Danderhall/ Shawfair GP Reprovision												
1. Benefits Register						*2. Prioritisation*	*3. Realisation*					
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
	groups and/ or provide a focus point for the local area and residents											
8	Provides sustainable practice(s) for the future which are adaptable to growth, new initiatives and changes in policy	Qualitatively	Patient and staff feedback	Partners restricted in growth by current building	Provision that enables growth and delivery of required services to local population	5 - Vital	Patients, Staff, GP Partners, NHSL, MHSCP	Strategic Programme Manager	Improve service capacity Enable delivery of the Primary Care Improvement Plan			12 months post operation

Appendix 3: Risk Register

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner Type	Risk Owner Individual
1	Actual future demand for the service does not match the levels projected: the rate of house building is out with the control of the project and therefore may increase or decrease dependent on market factors resulting in an increased or decreased requirement for GP services in the area.	Non-Financial	3	1	Low	As part of the IA analysis is being completed of house-building and associated population growth in the area to provide a clear baseline of the demand for services.	Mitigate	Project Board	n/a
2	Failure to recruit the required additional staff to provide the new service model.	Non-Financial	3	2	Medium	The proposed service model is presently being developed as part of the IA. As part of this the ability to recruit to posts in the required timeframe will be considered.	Mitigate	Project Board	n/a
3	There is not sufficient capital funding for implementation of the preferred option	Financial	4	2	Medium	The strategic assessment for the provision of primary care in Danderhall/ Shawfair was prioritised as part of the NHS Lothian 18/19 capital funding prioritisation process. Through this it was identified as high priority and capital funding has been earmarked for the project within the NHSL Capital 5 year plan.	Tolerate	Project Board	n/a

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
4	Stakeholder expectations of preferred solution exceed affordability.	Financial	1	2	Low	The Project Board has invited both patient and community council representation to sit on the Board. The Board has also completed one patient survey as part of the IA development and will complete a second as the proposals develop.	Mitigate	Project Board	n/a
5	Poor stakeholder involvement results in a lack of support for the project.	Unquantifiable	2	1	Low	The Project Board has invited both patient and community council representation to sit on the Board. The Board has also completed one patient survey as part of the IA development and will complete a second as the proposals develop.	Mitigate	Project Board	n/a
6	Failure to gain planning permission from Midlothian Council for implementation of the preferred option.	Unquantifiable	3	1	Low	Midlothian Council are represented on the Project Board by their Special Projects Co-ordinator enabling early awareness, consultation and agreement on all planning related matters are the preferred solution is identified.	Mitigate	Project Board	n/a
7	Failure to identify suitable site(s) for provision of services.	Non-Financial	4	1	Medium	Through the IA process an initial site search has already been completed with several options identified. These will continue to be refined as the preferred option is identified.	Mitigate	Project Board	n/a

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
8	Decant: Unable to decant staff / clients from existing site in a timely manner to enable any required works	Non-Financial	3	2	Medium	Any requirements for decant will be identified as part of the IA option appraisal process and solutions for these included in the description of the options. All interdependencies will also be highlighted in the project timetable determined through the IA.	Mitigate	Project Board	n/a

Appendix 4: Strategic Scope of Long Listed Options

Strategic Scope of Option 1 Do Nothing	
Service provision	There will be no maintenance to the existing practice in Danderhall. GMS will be provided by one practice within this building. It will be insufficient for the predicted population growth.
Service arrangements	The current practice will provide GMS for its registered population. The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. The constraints of the building will restrict the HSCP to fully implement the PCIP for this practice. However, this will be insufficient for the predicted population growth. There will be circa 9,000 people who will move into new houses in the SDA who will not be able to register with a practice. Where possible new residents will be encouraged to register with existing neighbouring practices. This will only be possible for a small proportion of new residents because of the limited coverage of the Shawfair Development Area by another practice and prevailing access issues in Niddrie practice.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice. The HSCP will provide additional services within the constraints of the Danderhall Practice building.
Supporting assets	The existing Danderhall Practice will not be maintained.
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services. This will become increasingly difficult as more patients are registered with the practice. Service users will expect a healthcare facility that is being maintained.
Strategic Scope of Option 2: Do Minimum – ongoing maintenance	
Service provision	The existing healthcare facility in Danderhall will be maintained. GMS will be provided by one practice within this building. It will be insufficient for the predicted population growth. Where possible new residents will be encouraged to register with existing neighbouring practices. This will only be possible for a small proportion of new residents because of the limited coverage of the Shawfair Development Area by another practice and prevailing access issues in Niddrie practice.
Service arrangements	The current practice will provide GMS for its registered population. The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. The constraints of the building will restrict the HSCP to fully implement the PCIP for this practice.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice. The HSCP will provide additional services within the constraints of the Danderhall Practice building.
Supporting assets	The existing Danderhall Practice will be maintained
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services. This will become increasingly difficult as more patients are registered with the practice.
Strategic Scope of Option 3: Develop existing premises	

Service provision	The existing healthcare facility in Danderhall will be maintained and developed. GMS will be provided by one practice within this building. It will be insufficient for the predicted population growth. Where possible new residents will be encouraged to register with existing neighbouring practices. This will only be possible for a small proportion of new residents because of the limited coverage of the Shawfair Development Area by another practice and prevailing access issues in Niddrie practice.
Service arrangements	The current practice will provide GMS for its registered population. The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. The constraints of the building will restrict the HSCP to fully implement the PCIP for this practice.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice. The HSCP will provide additional services within the constraints of the Danderhall Practice building.
Supporting assets	The existing Danderhall Practice will be maintained and developed. The temporary SIBCAS extension will be replaced with a permanent extension of the building.
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services. This will become increasingly difficult as more patients are registered with the practice.
Strategic Scope of Option 4: Ongoing maintenance to existing practice and new practice	
Service provision	The existing healthcare facility in Danderhall will be maintained and developed and a second healthcare facility will be built within Shawfair. GMS will be provided by two practices within two healthcare facilities. It will be sufficient for the predicted population growth but does not address the issues regarding sustainability of the practice in Danderhall.
Service arrangements	The current practice will provide GMS for its registered population and the new practice in Shawfair will provide for the new population moving into the SDA. The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. The constraints of the building at Danderhall will restrict the HSCP to fully implement the PCIP for this practice.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice and the new Shawfair practice. The HSCP will provide additional services at both practices but this will be constrained by the capacity of the Danderhall Practice building.
Supporting assets	The existing Danderhall Practice will be maintained and developed. The temporary SIBCAS extension will be replaced with a permanent extension of the building. A new healthcare facility will be constructed in Shawfair. There is a S75 agreement for developers to provide an appropriately remediated and serviced site within the Shawfair town centre capable of providing a footprint for 1,650 square meter net internal area for use as a medical and/or community health centre.
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services.
Strategic Scope of Option 5: Retain and adapt existing Danderhall practice and create new practice in Shawfair	

Service provision	GMS will be provided by two practices within two healthcare facilities. It will be sufficient for the predicted population growth.
Service arrangements	There will be two General Practices providing GMS in the SDA The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. There will be no constraints caused by the building.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice and the new Shawfair practice. The HSCP will provide additional services at both practices.
Supporting assets	Two new healthcare facilities will be developed. A new healthcare facility will be constructed in Shawfair. There is a S75 agreement for developers to provide an appropriately remediated and serviced site within the Shawfair town centre capable of providing a footprint for 1,650 square meter net internal area (unless a lesser area is agreed) for use as a medical and/or community health centre.
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services.
Strategic Scope of Option 6: New buildings for two practices– one in Danderhall (existing or new site), one in Shawfair	
Service provision	GMS will be provided by two practices within two healthcare facilities. It will be sufficient for the predicted population growth.
Service arrangements	There will be two General Practices providing GMS in the SDA. The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. There will be no constraints caused by the buildings
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice and the second practice. The HSCP will provide additional services at both practices.
Supporting assets	Two new healthcare facilities will be constructed and the current healthcare facility will be disposed of. A new healthcare facility will be constructed in Shawfair. There is a S75 agreement for developers to provide an appropriately remediated and serviced site within the Shawfair town centre capable of providing a footprint for 1,650 square meter net internal area (unless a lesser area is agreed) for use as a medical and/or community health centre.
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services.
Strategic Scope of Option 7: Single building to house two practices in Danderhall	
Service provision	GMS will be provided by two practices within one healthcare facility. It will be sufficient for the predicted population growth.

Service arrangements	There will be two General Practices providing GMS in the SDA The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. There will be no constraints caused by the building.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice and the second practice. The HSCP will provide additional services at both practices.
Supporting assets	One new healthcare facility will be constructed and the current healthcare facility will be disposed of.
Public & service user expectations	The current population, primarily in Danderhall, want a practice to remain in the village. Service users need access to GMS services.
Strategic Scope of Option 8: One Single building to house two practices in Shawfair	
Service provision	GMS will be provided by two practices within one healthcare facility. It will be sufficient for the predicted population growth.
Service arrangements	There will be two General Practices providing GMS in the SDA The HSCP will provide additional functions described in the Midlothian 2018 Primary Care Improvement Plan. There will be no constraints caused by the building.
Service provider and workforce arrangements	GMS service will be provided by Danderhall Practice and the second practice. The HSCP will provide additional services at both practices.
Supporting assets	One new healthcare facility will be constructed and the current healthcare facility will be disposed of.
Public & service user expectations	The expectation is that the existing population, primarily in Danderhall, will want a practice to remain in or very close to the village. Service users will want access to GMS services.

Appendix 5: Extract from the Shawfair Section 75 Agreement

'Community Health/Medical Centre

The Developers shall transfer to the Local Authority or such other party as the Local Health Authority may nominate for the Price, ownership in an appropriately remediated and serviced site within the Town Centre to be agreed with Midlothain ("the Community Health Site") capable of providing a footprint of 1,650-sqm net internal area (unless a lesser area is agreed in writing by Midlothian in consultation with the LHA) suitable for use as a medical and /or community health centre for the benefit of the Shawfair Community ("the Health Centre") to the reasonable satisfaction of Midlothian, in consultation with the Local Health Authority...."

NHS Lothian

Board Meeting
14 October 2020

Director of Finance, NHS Lothian

WEST EDINBURGH (MAYBURY) GENERAL MEDICAL SERVICES PROVISION INITIAL AGREEMENT

1. Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the Initial Agreement for West Edinburgh (Maybury) General Medical Services (GMS) provision.

1.2 NHS Lothian invited Edinburgh Health and Social Care Partnership (EHSCP) to submit an Initial Agreement for this proposal following the conclusion of the 2020-2021 Capital Prioritisation Process.

1.3 Approval was given by Edinburgh Integration Joint Board on 24 August 2020, by NHS Lothian Capital Investment Group on 15 July 2020 and by NHS Lothian Finance and Resources Committee on 26 August 2020.

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

2. Recommendations

2.1 The Board is recommended to approve this Initial Agreement for submission to the Scottish Government Capital Investment Group (CIG). The Board is assured that the Finance and Resources Committee reviewed the Initial Agreement at the meeting on 26 August 2020 and supports its submission to the Scottish Government CIG. In parallel, EHSCP will continue to develop the business case.

3. Discussion of Key Issues

3.1 The population of Edinburgh has increased by some 65,000 people over the last 10 years and will continue to grow at a rate c5,000-6000 per annum, until at least 2026. This trend is expected to continue further in the next Local Development Plan known as City Plan 2030.

3.2 The EHSCP Primary Care and Population Growth Assessment is 2016-2026, is the comprehensive strategic assessment of the primary care pressures and needs across the city. It reflects the extensive housing developments set out in the City of Edinburgh Council (CEC) Local Development Plan (LDP) 2016-2026 and the consequent capital investment required to meet this need and that of re-

provision schemes to deliver sustainable primary care in Edinburgh. This assessment was formally endorsed by Edinburgh Integration Joint Board in September 2017 and by NHS Lothian Capital Investment Group in March 2018

3.3 Greenfield space (site HSG19) (Initial Agreement appendix 2) adjacent to Maybury and between Turnhouse Road and the main rail link to Fife, has been released for housing development through the City of Edinburgh (CEC) Local Development Plan 2016 – 2026. It is proposed that the site will accommodate 1750 housing units, of which 25% will be affordable housing split over three development sites and equating to 3,675 additional population based on a standard planning minimum of 2.1 people per housing unit. As the provision of a primary school is included within the site, it is likely that the development will comprise predominantly family housing which is likely to increase the number of occupants per unit. As this is currently a greenbelt site on the outskirts of Edinburgh there is no existing GMS provision for any of the proposed housing, and GP practices nearby are at capacity or zoned for separate developments.

3.4 The adjacent area of South Gyle and Edinburgh Park has already expanded with an increase of 778 houses equating to 1634 additional population minimum. Much of this area was green belt or a business development area and has therefore had no previous requirement or provision for GP services.

3.5 Proposals for further housing and commercial developments in the area have been included in City Plan 2030 at several sites in the surrounding area (Edinburgh Park and South Gyle, Edinburgh International Business Gateway and Crosswinds). As City Plan 2030 also supports the development of the West Edinburgh transport corridor, improving transport links on the west side of the city, there is an increased likelihood of this area being selected for future development. It was anticipated that a City Plan 2030 would be submitted to elected members in August 2020, following completion of the consultation period. This is now likely to be delayed till later in the year due to Covid-19. The report will also specifically consider the impact of the pandemic.

3.6 In addition, approval has recently been given for 1350 houses in Phase 1 of Edinburgh Garden District development which equates to 2835 additional population minimum. The Garden District site is the south west corner, where the bypass meets the A8 westbound, next to the Gogar roundabout. The effects on population growth as a result of this potential expansion will be subject to separate consideration, but are likely to be significant as the overall development proposed is circa 3,000 units

3.7 The three GP practices most directly affected by housing developments in the West Edinburgh area (Parkgrove, East Craigs and Cramond Medical Practices) do not have sufficient physical capacity to ensure that all the new population from the extensive local planned housing developments will be able to access General Medical Services (GMS). Other practices, such as the Ladywell Medical Practices, are already at capacity, unable to accommodate new growth and are likely to experience the ripple effect as the population expands.

3.8 Parkgrove Medical Practice has benefited from small scheme funding and has been altered to enable increased capacity of the practice list allow them to register most of the new population anticipated from the Cammo development and to accommodate the development of a Community Treatment and Care centre. Cramond Medical Practice received a capital contribution from their Landlord linked to lease renewal , augmented by NHS Lothian, which will allow them to reconfigure their consulting space. This work, delayed by Covid 19, is due to start in summer 2020. This should allow them to accommodate the remaining population unable to register with Parkgrove.

3.9 East Craigs Medical Practice has also benefited from small schemes funding to create additional space to enable them to expand their practice list and are willing to grow, however this will still not provide sufficient capacity to accommodate all of the increased population.

3.10 Additionally, the introduction of the new GMS Contract (Scotland) on 1st April 2018 requires boards to provide alternative delivery of certain services to enable implementation of the contract. These changes such as Mental Health Hubs will impact on the accommodation requirements to support the current and future population of the area.

3.11 The preferred option is for NHSL, in collaboration with CEC, to consider a joint development of a new GP practice for c10,000 and a primary school, built on a site which has been identified with sufficient space and is suitable for both facilities. The building will be built to Passivhaus standards or similar and will enjoy the benefits of shared space, reducing the overall footprint and meeting the 2030 carbon neutral standards required by CEC and NHS. Following the impact of Covid 19, CEC has reviewed and revised their programme with an anticipated completion date of May 2023. There may be design considerations for primary care premises resulting from the Covid 19 experience. There will be an opportunity to articulate these at business case development.

3.12 EHSCP and NHS Lothian have worked with CEC Children and Families to develop the proposal for the joint development which optimises design and shares common space within the available footprint.

3.13 The options under consideration in the Initial Agreement will enable the development of an additional General Medical Practice in the immediate vicinity with the capacity for approximately 10,000 list size.

4. Key Risks

4.1 Uncertainty of timescale requirements and pressures on practices as a result of the impact of Covid 19 on the anticipated programme of housing developments.

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

5. Risk Register

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

6. Impact on Inequality, Including Health Inequalities

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

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

7.1 Whilst there has been initial engagement through the Community Council, it is difficult to engage with the general public since the delivery of the new practice is in response to the population expansion which is yet to be in situ. The EHSCP Patient Involvement Worker will support engagement with the future population when appropriate.

8. Resource Implications

8.1 The resource implications at this stage are a capital investment of c£4million (including VAT). It is anticipated that the procurement of the project will be led by CEC supported by Edinburgh Health and Social Care Partnership and NHSL.

8.2 It is proposed that NHSL will provide a Capital Grant to CEC for the construction cost and then lease the completed facility from CEC.

8.3 As this proposal is driven by population growth, and does not represent upgrades/ alterations to any of NHS Lothian's existing estate, it is proposed a specific allocation is requested from the Scottish Government for the project.

Fiona Cowan
Project Manager, Primary Care Support Team, EHSCP
9 September 2020
Fiona.cowan@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Initial Agreement West Edinburgh (Maybury) GMS Provision

West Edinburgh (Maybury) General Medical Services Provision

NHS Lothian

Initial Agreement

Project Owner: *Fiona Cowan*

Project Sponsor: *David White*

Date: *28/07/2020*

Version: *1.9*

Version History

Version	Date	Author(s)	Comments
1.0	27/02/2020	Fiona Cowan	First Draft
1.1	04/03/2020	Fiona Cowan	Review and update of IA
1.2	02/04/2020	Fiona Cowan	Review and update of IA
1.3	27/04/2020	Fiona Cowan	Review and update of IA
1.4.	05/05/2020	Fiona Cowan	Review and update of IA
1.5	24/06/2020	Fiona Cowan	Review and update of IA
1.6	01/07/2020	Laura Smith	Update template & Financial/Economic cases
1.7	8/07/20	Fiona Cowan	Final Version
1.8	20/07/20	Fiona Cowan	Final Review for Edinburgh Integrated Joint Board and Finance and Resource Committee
1.9	28/07/2020	Immy Tricker	Minor updates to financial/ economic cases

Contents

1 Executive Summary

1.1 Purpose

1.1.1 The purpose of the Initial Agreement is to seek approval for the proposal from Edinburgh Health and Social Care Partnership (EHSCP) / Edinburgh Joint Integration Board (EIJB) to consider the provision of General Medical Services (GMS) in West Edinburgh.

1.1.2 The proposal is to develop sufficient accommodation to deliver the additional capacity required as a result of housing developments being built in the area.

1.2 Background and Strategic Context

1.2.1 Greenfield space (site HSG19), adjacent to the Maybury and between Turnhouse Road and the main rail link to Fife, has been released for housing development through the City of Edinburgh (CEC) Local Development Plan 2016 – 2026. It is proposed that the site will accommodate 1750 housing units of which 25% will be affordable housing split over three development sites and equating to 3,675 additional population based on a standard planning minimum of 2.1 people per housing unit. As the provision of a primary school is included within the site, it is likely that the development will comprise predominantly family housing which will significantly increase the number of occupants per unit. As this is currently a greenbelt site on the outskirts of Edinburgh there is no GMS provision for any of the proposed housing, and only a limited number of GP practices nearby.

1.2.2 The adjacent area of South Gyle and Edinburgh Park has already expanded with an increase of 778 houses equating to 1634 additional population, based on a minimum of 2.1 people per housing unit. Much of this area was green belt or a business development area previously and as such has had no requirement or provision for GP services in the past.

1.2.3 Proposals for further housing and commercial developments in the area have been included in City Plan 2030 at several sites in the surrounding area (Edinburgh Park and South Gyle, Edinburgh International Business Gateway and Crosswinds). As City Plan 2030 also proposes the development of the West Edinburgh transport corridor, improving transport links on the west side of the city, there is an increased likelihood of this area being selected for future development. It was anticipated that a report would be submitted to elected members in August 2020, following completion of the consultation period. The report has been postponed due to Covid-19 and will also specifically consider the impact of the pandemic.

1.2.4 In addition, approval has recently been given for 1350 houses in Phase 1 of Edinburgh Garden District development. The potential expansion of this site up to circa 3000 houses will be subject to separate consideration but is likely to be significant as the overall development proposed could be up to circa 3,000.

1.2.5 The increased population will have a direct impact on Barclay East Craigs Medical Practice and Parkgrove Medical Practice and to a lesser extent on Cramond Medical Practice. Inevitably this will have a ripple effect on other practices, such as Ladywell Medical Practices, further into Edinburgh as the population expands.

1.2.6 **Barclay Medical Practice East Craigs** (list size 8,569, April 2020)

The practice is located in purpose built premises owned by NHS Lothian which are functionally suitable for the delivery of primary care. The practice is willing to grow but does not have sufficient capacity to accommodate the population expected as a result of development HSG19. The practice catchment area includes part of the West Edinburgh development sites and the practice will be in a position to accommodate some of the early population increase but the overall volume will ultimately necessitate the development of an additional new practice.

1.2.7 **Parkgrove Medical Practice** (list size 3,190, April 2020)

Parkgrove Medical Practice is a salaried practice in premises leased by NHS Lothian, which remain in reasonable condition and which are functionally suitable for delivery of primary care. Space within Parkgrove has been altered to enable most of the new population in Cammo to be able to register with the practice and to facilitate the development of one of Primary Care's Community Treatment and Care Centres (CTAC) which will open later in 2020. The lease for the building has recently been negotiated for a further 20 years.

1.2.8 **Cramond Medical Practice** (list size 8,864, April 2020)

Independent practice in GP leased premises which are in reasonable condition and suitable for the delivery of primary care. The practice received a capital contribution from the landlord, which, with additional capital support from NHS Lothian, will enable them to adjust the internal design of the building to have all consulting space accessible on the ground floor. The practice boundary was reduced recently but continues to include the development at Cammo and will be able to accommodate the remaining population unable to register with Parkgrove.

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

1.2.10 Additionally the introduction of the new GMS Contract (Scotland) on 1st April 2018 requires boards to provide alternative delivery of certain service to enable implementation of the contract. These changes such as Mental Health Hubs will impact on the accommodation requirements to support the current and future population of the area.

1.3 Need for Change

1.3.1 While there is some capacity in existing practices as detailed above, it is insufficient to manage the anticipated increase. There is currently no GMS provision for any of the proposed housing since it is presently a greenbelt site.

1.3.2 The Integration Joint Board previously approved the EHSCP Population Growth and Primary Care Premises Assessment 2016-26, and the subsequent high prioritisation of this area need through the NHS Lothian Capital Prioritisation Programme which invited the submission of the Initial Agreement. The Strategic Assessment (SA) identified that existing practices, due to a mixture of limitations of workforce and physical capacity, are unable to provide GMS to the significant additional population generated by the new housing

1.3.3 The population of Edinburgh has increased by some 65,000 people over the last ten years and will continue to grow at a rate of c 5,000 per annum until at least 2026. This trend is expected to continue with the subsequent implementation of City Plan 2030 which will ultimately supersede

the current development plan. Most of the growth has been absorbed into existing primary care provision without commensurate development of additional physical capacity.

1.3.4 City of Edinburgh (CEC) Local Development Plan 2016 – 2026 details the planned housing developments across the city. The West Edinburgh site which is shown in Appendix 2: Site Maps comprises a significant area of land within the plan where extensive housing is programmed. .

1.3.5 Although the house building programming extends over several years, the Housing Land Audit (HLA) 2019 details the expected completions rate of circa 200 houses per annum in the Maybury area. If developers are confident of house sales, that rate may be increased however the economic impact on the build rate as a result of the Covid-19 pandemic is yet to be assessed and may result in a decrease in the annual completion rate. HLA 2020 has been delayed due to Covid-19 however it is anticipated that a draft will be available later this year with an indication of future building programmes.

1.3.6 In addition to the above, Edinburgh Garden District, which was originally recommended not to be approved by CEC and was subsequently referred to the Scottish Government Reporters, had the decision overturned in April 2020 and approval given for the development of Phase 1 which includes 1350 houses, equating to 2835 additional population minimum.

1.4 Investment Objectives

1.4.1 The investment objectives the project seeks to achieve are

- To improve service capacity to enable everyone to access GMS
- The development of additional General Medical Practice
- To enable delivery of the Primary Care Improvement Plan as required for implementation of the new GMS contract

1.5 The Preferred Option(s)

1.5.1 The preferred option is for NHSL, in collaboration with CEC, to consider a joint development of a new GP practice and a primary school, built on a site which has been identified with sufficient space and is suitable for both facilities. The building will be built to meet the 2030 carbon neutral standards required by CEC and NHS and will enjoy the benefits of shared space and reducing the overall footprint.

1.5.2 The resource implication is a capital investment of c£4million (including VAT) based on construction commencing in 2021.

1.6 Readiness to proceed

1.6.1 The preferred option will be delivered in partnership with CEC. CEC will lead the procurement with NHSL providing a Capital Grant to CEC. CEC will be supported by NHS Lothian and Edinburgh Health and Social Care Partnership.

1.6.2 A benefits register has been included in Appendix 3 and a high level risk register in Appendix 4. A full risk register will be developed for the project at the Standard Business Case stage.

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

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

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

1.7 Conclusion

1.7.1 The strategic assessment for this proposal (included in Appendix 1: Strategic Assessment) scored 21 (weighted score) out of a possible maximum score of 25.

1.7.2 The proposal has been prioritised by the relevant governance groups and identified as a priority for NHS Lothian as part of the NHS Capital Prioritisation Process 2020/21.

2 The Strategic Case

2.1 Existing Arrangements

2.1.1 Greenfield space (site HSG19) adjacent to Maybury and between Turnhouse Road and the main rail link to Fife, has been released for housing development through the City of Edinburgh (CEC) Local Development Plan 2016 – 2026. It is proposed that the site will accommodate 1750 housing units of which 25% will be affordable housing split over three development sites and equating to 3,675 additional population based on a standard planning minimum of 2.1 people per housing unit. As the provision of a primary school is included within the site, it is likely that the development will comprise predominantly family housing which will significantly increase the number of occupants per unit. As this is currently a greenbelt site on the outskirts of Edinburgh there is no GMS provision for any of the proposed housing, and only a limited number of GP practices nearby.

2.1.2 Whilst not included in this proposal, Cammo development is located immediately to the north of HSG19 where an additional 655 dwelling places are scheduled to be built starting in 2019. GMS provision for the additional population from Cammo can be accommodated in Parkgrove Medical Practice and Cramond Medical Practice.

A map showing development site HSG19 is attached as Appendix 2: Site Map

2.1.3 Within the past three years the adjacent area of South Gyle and Edinburgh Park has expanded with an increase of 778 houses which equates to 1634 additional population, based on a minimum of 2.1 occupants per unit. Much of this area was green belt or a business development area and as such has had no requirement or provision for GP services in the past.

2.1.4 Proposals for further housing and commercial developments in the area have been included in City Plan 2030 at several sites in the surrounding area (Edinburgh Park and South Gyle, Edinburgh International Business Gateway and Crosswinds) and are being deliberated as part of the consultation process. It was anticipated that a report would be submitted to elected members in August 2020, following completion of the consultation period. The report has been postponed due to Covid-19 and will also specifically consider the impact of the pandemic.

2.1.5 In addition, approval has recently been given for 1350 houses in Phase 1 of Edinburgh Garden District development. The effects on population growth as a result of this potential expansion will be subject to separate consideration but are likely to be significant as the overall development proposed is circa 3,000.

2.1.6 Additionally, City Plan 2030 proposes the development of the West Edinburgh transport corridor, improving transport links on the west side of the city and thus increasing the likelihood of this area being selected for future development.

2.1.7 The increased population will have a direct impact on Barclay East Craigs Medical Practice and Parkgrove Medical Practice and to a lesser extent on Cramond Medical Practice. Inevitably this will have a ripple effect on other practices, such as Ladywell Medical Practices, further into Edinburgh as the population expands.

2.1.8 **Barclay Medical Practice East Craigs** (list size 8,569 April 2020)

East Craigs Medical Practice has been managed by the Barclay Medical Practice Group since 2017. The practice is located in purpose built premises circa30 years old which were bought by NHS Lothian 2017 and have since benefitted from a small scheme to create an additional consulting room which has enabled them to increase the practice list. The practice is willing to grow but does not have sufficient capacity to accommodate the population expected as a result of development HSG19. The practice catchment area includes part of the West Edinburgh development sites and the practice will be in a position to accommodate some of the early population increase but the overall volume will ultimately necessitate the development of an additional new practice.

2.1.9 **Parkgrove Medical Practice** (list size 3,190 April 2020)

Parkgrove Medical Practice is a salaried practice in premises leased by NHS Lothian, which remain in reasonable condition and which are functionally suitable for delivery of primary care. The premises received support for a small scheme in 2019 enabling them to increase the capacity of the practice list. Space within Parkgrove has been altered to enable most of the new population in Cammo to be able to register with the practice and to facilitate the development of one of Primary Care's Community Treatment and Care Centres (CTAC) which will open later in 2020. The lease for the building has recently been negotiated for a further 20 years.

The lists for these two practices show that an average of 6.92% patients are over 75 years old while 8.91% of the practice are in the lowest deprivation quintile.

2.1.10 **Cramond Medical Practice** (list size 8,864 April 2020)

Independent practice in GP leased premises which are in reasonable condition and suitable for the delivery of primary care. The practice received a capital contribution, from the landlord, linked to lease renewal towards dilapidations and upgrading the premises in 2019, which, with additional capital support from NHS Lothian, will enable them to adjust the internal design of the building to have all consulting space accessible on the ground floor. The practice boundary was reduced recently but continues to include the development at Cammo and will be able to accommodate the remaining population unable to register with Parkgrove. Cramond has one of the highest ratios of elderly within Edinburgh; 13.53% are over 75 years of age compared to an average of 7.06% for Edinburgh. Only 0.84% of the entire practice is within the highest deprivation quintile.

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

2.1.12 Additionally the introduction of the new GMS Contract (Scotland) on 1st April 2018 requires boards to provide alternative delivery of certain service to enable implementation of the contract. These changes such as Mental Health Hubs will impact on the accommodation requirements to support the current and future population of the area.

2.2 Drivers for Change

The following section expands on the need for change as identified in the Strategic Assessment (included in Appendix 1) and describes the anticipated impact if nothing is done to address these needs and why action should be taken now through this proposal.

2.2.1 This Initial Agreement (IA) proposes that an additional General Medical Practice for circa 10k patients be built in West Edinburgh to accommodate the planned population due to the development of housing within West Edinburgh. While there is some capacity in existing practices as detailed above, it is insufficient to manage the anticipated increase. There is currently no GMS provision for any of the proposed housing since it is currently a greenbelt site; there is however an option for provision of a GP Practice of approximate list size 10k included within the site plans.

2.2.2 The Integration Joint Board previously approved the EHSCP Population Growth and Primary Care Premises Assessment 2016-26, and the subsequent high prioritisation of this area need through the NHS Lothian Capital Prioritisation Programme which invited the submission of the Initial Agreement.

2.2.3 The Strategic Assessment (SA) identified that existing practices, due to a mixture of limitations of workforce and physical capacity, are unable to provide GMS to the significant additional population generated by the new housing

2.2.4 The population of Edinburgh has increased by some 65,000 people over the last ten years and will continue to grow at a rate of c 5,000 per annum until at least 2026. This trend is expected to continue with the subsequent implementation of City Plan 2030 which will ultimately supersede the current development plan. Most of the growth has been absorbed into existing primary care provision without commensurate development of additional physical capacity.

2.2.5 City of Edinburgh (CEC) Local Development Plan 2016 – 2026 details the planned housing developments across the city. The West Edinburgh site which is shown in Appendix 2: Site Maps comprises a significant area of land within the plan where extensive housing is programmed.

2.2.6 Although the house building programming extends over several years, the Housing Land Audit (HLA) 2019 details the expected completions rate of circa 200 houses per annum in the Maybury area. If developers are confident of house sales, that rate may be increased however the economic impact on the build rate as a result of the Covid-19 pandemic is yet to be assessed and may result in a decrease in the annual completion rate. HLA 2020 has been delayed due to Covid-19 however it is anticipated that a draft will be available later this year with an indication of future building programmes. The known planned developments are illustrated in **Table 1**.

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

Table 1: Planned Developments

Area	Number of Housing Unit	Population*
Anticipated increase in population which cannot be accommodated within existing GMS facilities and which therefore requires additional provision		
Edinburgh Park/South Gyle	778	1,633
Maybury Central	1,400	2,940
Maybury East	220	462
Maybury West	130	273
Total	2,528	5,308
Increase in population anticipated to be absorbed by Parkgrove Practice and Cramond Practice		
Cammo	655	1376

* Population projections have been calculated by multiplying the planned number of units to be built by the average household size for Edinburgh, source National Records Scotland (NRS). The average household size of 2.1 has been used in these calculations, although it is expected to decrease over time. Given the predominance of family housing to be built within all developments, it is likely that the population figure could be significantly higher and the numbers illustrated are the **minimum**.

2.2.8 In addition to the above, Edinburgh Garden District, which was originally recommended not to be approved by CEC and was subsequently referred to the Scottish Government Reporters, had the decision overturned in April 2020 and approval given for the development of Phase 1 which includes 1350 houses, equating to 2835 additional population. Again, this housing development will primarily be family dwelling places and it is therefore likely that the numbers estimated using the average household size will be greater than stated. The overall development proposed could be up to circa 3,000 houses.

2.2.9 Early discussions with the landlord's agent for site HSG19 considered the need for provision of GMS services to serve the population resulting from the housing development. Consequently a suitable location on the site has been safeguarded, without legal commitment, for the development of a GP practice of approximate list size 10k. This would be purpose built, developer leased, ground floor accommodation, with dwelling places above.

2.2.10 Simultaneously, the need to provide additional educational facilities within the locality has provided an opportunity for NHSL to collaborate with CEC to consider a joint development of new health premises and primary school with shared amenities. A proposal is being developed with CEC for a GP practice combined with the new school to be built on a site which has been identified with sufficient space and is suitable for both facilities. The building will enjoy the benefits of shared space reducing the overall footprint and meeting the 2030 carbon neutral standards required by CEC and NHS.

2.2.11 Whilst there are significant advantages to a collaborative approach to this provision, the projected timescales of requirement vary. CEC is required to provide the new school when the first houses are completed in 2023. In other circumstances, EHSCP would normally aim for completion of new medical premises when the potential population would reach a minimum list size of 2000. In this scenario, completion would be required around 2024/25.

2.2.12 The comparator to the joint development is a separate stand alone, developer led building. While all CEC and NHS new builds will be built to Passivhaus standards or similar and will meet the 2030 carbon neutral targets, it is likely that it will be more challenging to meet the environmental consideration in a developer led construction.

2.2.13 As a result of the Covid-19 pandemic, the construction industry is experiencing delays and disruption at all stages of development. Whilst completion dates noted above are as stated in the Housing Land Audit, a number of factors, including government guidance on lockdown, restricted movement in the housing market and availability of materials, will impact the ability to meet these timescales. It is therefore likely that the timescales may be delayed, resulting in a later completion date being required.

2.2.14 Recent developments of GP premises within NHS Lothian have followed a relatively standard schedule of accommodation and building layout. As a result of experiences during Covid 19 which altered the modus operandi within GP practices, it is anticipated that the design and requirements of future health premises will be altered to embrace new ways of working and meet stringent infection control requirements. This is may cause further delays whilst standards are in development stages.

2.2.15 Edinburgh Health and Social Care Partnership (EHSCP) and NHS Lothian Primary Care Contracts Organisation (PCCO) will develop the proposal to create a new practice partnership and invite business case submission from interested parties to deliver it. It is anticipated this could replicate previous models whereby an existing partnership, supported by investment, will seed the new practice by taking on additional patients, in its current premises, to an agreed list size – although other options are possible. Subsequently that patient cohort will form the nucleus of the new practice which the parent practice will have the opportunity to continue to manage as a branch practice, or can choose to relinquish it whereupon it can be advertised as a new partnership.

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

Table 2: Summary of the Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now?
Significant planned population increases in areas with little or no General Medical Services (GMS) provision	Pressures on existing practices to provide GMS provision to expanding population	Existing services under strain by additional capacity required to address this
Potential for the West Edinburgh developments to increase further in future Local Development Plan	Existing service arrangements unable to cope with future projected levels of population growth	City of Edinburgh Council Local Development Plan details the housing developments programmed for the area with additional 4000 population expected within 5years and an increase of 1700 planned beyond 2026. Release of more land for development will result in further population pressures.
Existing local practices do not have the physical capacity to absorb the additional population nor the desire to expand so significantly	Additional population unable to register for GMS provision	The timescales and practical issues relating to introducing new GMS services to an area are such that early actions are required to ensure practice list availability when the population growth reaches approximately 2000
Planned developments will generate sufficient population to offer a sustainable business model for new practices and provide development opportunity to existing practices through the new contract	Alteration to existing practices maximised to accommodate population growth, additional practice required to meet population needs and GMS contract implementation	New GMS contract came into effect on 1st April 2018, with time limited implementation for delivery of the Primary Care Improvement Plan to deliver the contract requirements
Opportunities to address and accommodate workforce uncertainty to meet new contract and locality needs.	Ability to recruit workforce is affected by condition of premises. Development of new premises for a new practice will have a positive impact on recruitment.	Time implications of setting up new practice / management support may be challenging and onerous. Early planned intervention will enable best solution to practice development

2.3 Investment Objectives

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

Table 3: Investment Objectives

Effect of the need for change on the organisation	What has to be achieved to deliver the necessary change? (Investment Objectives)
Existing service arrangements unable to cope with future projected levels of population growth	Improve service capacity to enable everyone to access GMS
Additional pressures on existing practices nearby to provide GMS provision to expanding population	Development of additional General Medical Practice
Transformation of primary care services to meet the requirements of the new GMS contract	Enable delivery of the Primary Care Improvement Plan as required for implementation of the new GMS contract

2.4 Benefits

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

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

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

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

- Ensure everyone has access to GMS through provision of adequate capacity
- Ensure that people who use health and social care services have positive experiences and their dignity respected
- Support the attainment of HEAT targets
- Provides safe and easy access to GP services. Premises are DDA compliant
- Delivery functionally suitable and sustainable healthcare estate
- Optimise financial and resource usage through an efficient estate and a stable health care system

2.5 Strategic Risks

2.5.1 The table below highlights key strategic risks that may undermine the realisation of benefits and the achievement of the investment objectives. These are described thematically and potential safeguards and actions in place to prevent these:

Table 4: Strategic Risks

Theme	Risk	Safeguard
Business	Failure to acquire suitable site or premises for development	Work with partners and developers to identify opportunities
	Proposed development not well received by patients and public	Clear communication and engagement plan at an early stage
Workforce	Insufficient workforce to meet the required capacity provision	Joint working by EHSCP and practices to facilitate required recruitment
Funding	Capital or revenue funding to deliver the project is unaffordable	Optimise resource usage Value engineering Cost certainty for business case
Scope	Scope of the project exceeds deliverability	Clarity on scope from outset Reduction of scope
Capacity	Future developments exceed capacity of practice	Monitor Housing Land Audit for changes
External	Earlier / later impact and timing than projected of population growth	Monitor anticipated growth and projected timing

A register of strategic risks is included in Appendix 4: Risk Register. A full risk register will be developed for the project at the Standard Business Case stage.

2.6 Constraints and Dependencies

2.6.1 The key constraints to be considered are:

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

2.6.2 The key dependencies to be considered are:

- Availability of suitable sites and solutions which can be secured within appropriate timescales for partner agencies
- Agreement with practices to capacity increase to address growth

3 Economic Case

3.1 Do nothing/baseline

3.1.1 There is no existing provision as outlined in Section 2.1 and 'Do Nothing' is not feasible as it does not address any of the strategic drivers for change and has the potential to cause existing practice instability. A 'Do Minimum' option is therefore included as the baseline (as required by the Scottish Capital Investment Manual guidelines) against which other options are assessed. This will only address the strategic drivers in part and will result in capacity constraints which fail to provide for the population growth in the area. The table below defines the 'Do Minimum' option including the requirements to implement this option.

Table 5: Do Minimum

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

3.2 Engagement with Stakeholders

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

Table 6: Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
General public	Initial engagement has been through the Corstorphine Community Council	Representative from the community council has confirmed support for GMS development in the area
Key stakeholders: Barclay East Craigs, Parkgrove and Cramond Medical Practices Cardross, Site Agents	 Early discussions have taken place with all practices to keep them abreast of proposals Early discussions about space and location requirements for a GP practice	 Support confirmed Proposal supported and potential site safeguarded within development
Partners: City of Edinburgh Council	Discussions to develop a collaborative project	CEC have indicated a desire to undertake a joint project

3.2.2 Whilst there has been initial engagement through the Community council, it is difficult to engage with the general public since the delivery of the new practice is in response to the population expansion which has yet to be in situ. The EHSCP Patient Involvement Worker will support engagement with the future population when appropriate.

3.2.3 Until there is an agreed solution to the development of the practice it is not known how this may affect staff, however local practices will engage with their own staff as the project progresses.

3.3 Long-listed Options

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

3.3.2 The key outcome of this project is to ensure that sufficient capacity is provided to accommodate the planned growth in the local area. Existing practices have already indicated that they do not wish to increase their practice population by the quantity generated by the housing developments. It is therefore essential that a new practice is developed within the vicinity.

3.3.3 The options identified are outlined below

Option 1: Do Minimum - minor refurbishment in existing practices to increase capacity to accommodate some of the increased population due to the housing expansion

Option 2: New build for a new practice in a joint development with City of Edinburgh Council Education Department

Option 3: NHS leased premises in a new build for a new practice on a standalone site

The table below summarises the long list of options identified:

Table 7: Long-listed options

Strategic Scope of Option	Option 1 Do minimum	Option 2 New build in partnership with CEC	Option 3 NHS Leased premises
Service provision	As current arrangements	Increases GMS capacity	Increases GMS capacity
Service arrangements	Continue with existing	New practice with high risk of failure and significant revenue implications until practice stable	New practice with high risk of failure and significant revenue implications until practice stable
Service provider and workforce arrangements	Existing GMS provision – will provide additional workforce to address any increases	Will require additional workforce to staff the practice. Will address recruitment difficulties impacted by premise conditions	Will require additional workforce to staff the practice. Will address recruitment difficulties impacted by premise conditions
Supporting assets	Minor refurbishment to accommodate some of the population increase due to housing expansion	Purpose built premises designed with sufficient and appropriate space to accommodate the new population.	Purpose built premises designed with sufficient and appropriate space to accommodate the new population.
Public & service user expectations	Insufficient capacity to manage growth of the population who will expect full access to GMS and require ability to register with a GP in the area.	Will provide full access to GMS and opportunity to register with a GP in the local area from	Will provide full access to GMS and opportunity to register with a GP in the local area.

3.3.4 Initial Assessment of Options

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

Table 8: Assessment of options against investment objectives

	Option 1 Do minimum	Option 2 New build in partnership with CEC	Option 3 NHS leased premises
Advantages (Strengths & Opportunities)		Addresses capacity and access needs Functionally suitable premises Long term provision of sustainable practice	Addresses capacity and access needs Functionally suitable premises Long term provision of sustainable practice
Disadvantages (Weaknesses & Threats)	Insufficient capacity to address population growth	Required timescales for completion differ for partners	Environmental targets more challenging to meet
	Does it meet the Investment Objectives (Fully, Partially, No, n/a):		
Investment Objective 1	No	Yes	Yes
Investment Objective 2	No	Yes	Yes
Investment Objective 3	No	Yes	Yes
	Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)		
Affordability			
Preferred/Possible/ Rejected	Reject	Preferred	Possible

3.4 Shortlisted Options and Preferred Way Forward

3.4.1 Shortlisted options

From the initial assessment above the following short-listed options have been identified:

Table 9: Short Listed Options

Option	Description
Option 1	Do Minimum
Option 2	New build in partnership with City of Edinburgh Council (CEC)
Option 3	NHS leased premises in a new build for a new practice on a standalone site

3.4.2 Non-financial benefits assessment

Each of the shortlisted options was assessed against the benefits included in the benefits register

. Each of the identified benefits was weighted and following this each of the shortlisted options was scored against its ability to deliver the required benefits. The full assessment is contained in Appendix 5: Non-Financial benefits Assessment.

The results of the benefits assessment are summarised below:

Table 10: Results of Non-Financial Benefits Assessment

#	Benefit	Weight (%)	Option 1 Do minimum	Option 2 New build in partnership with CEC	Option 3 NHS leased premises
1	Everyone has access to a GP	25%	0	10	10
2	Ensure that people who use health and social care services have positive experiences and their dignity respected	15%	2	10	10
3	Support the attainment of HEAT targets *Reduces the rate of emergency inpatient bed days for people aged 75 *Reduces the rate of attendance at A&E *Supports early cancer detection	15%	2	8	8
4	Provides safe and easy access to GP services	20%	2	9	9
5	Ensure the functional suitability of the healthcare estate	15%	7	10	10
6	Optimise financial and resource usage through an efficient estate	10%	7	10	9
	Total Weighted Benefits Points		**275**	**950**	**940**

From the table above it is noted that the options that will deliver the most benefits is Option 2.

3.4.3 Indicative costs

The table below details the indicative whole life costs associated with each of the shortlisted options. For further detail around the determination of the costs see the Financial Case.

The additional assumptions associated with the calculation of the NPV of costs are:

- A discount rate of 3.5% has been used in line with Government guidelines.
- A useful life of 20 years has been determined for the projects, on the basis of other similar type leased projects
- The base date for the proposal is October 2022.
- Phasing of the costs reflects the useful life and the programme of works as identified in the Commercial Case.

Table 11: Indicative Costs of Shortlisted Options

Cost (£m)	Option 1 Do Minimum	Option 2 New build in partnership with CEC	Option 3 NHS leased premises
Whole life capital costs	0	3,249	4,643
Whole life operating costs	0	759	759
Estimated Net Present Value (NPV) of Costs	0	4,008	5,402

3.4.4 Overall assessment and preferred way forward

The table below show the weighted benefit points for each shortlisted option, the NPV of costs and the calculated cost per benefit point. This calculated cost per benefit point has been used to rank the options and identified the preferred way forward.

Table 12: Economic Assessment Summary

Option Appraisal	Option 1 Do minimum	Option 2 New build in partnership with CEC	Option 3 NHS leased premises
Weighted benefits points	275	950	940
NPV of Costs (£k)	0	4,008	5,402
Cost per benefits point (£k)	0	4.22	5.75
Rank	**3**	**1**	**2**

3.4.5 The preferred solution was identified as Option 2 – New build with partnership with CEC. This was identified as the preferred option because it meets all the investment criteria identified in the Initial Agreement. Do minimum has been ranked last due to the inability to deliver any of the investment criteria.

It is recommended that NHS Lothian proceeds with this option to Standard Business Case stage where the implementation of the solution(s) shall be further developed and tested for value for money.

3.5 Design Quality Objectives

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

3.5.2 An AEDET (Achieving Excellence Design Evaluation Toolkit) workshop will be undertaken as the project progresses to Standard Business Case.

4 The Commercial Case

4.1 Procurement Strategy

4.1.1 The total indicative costs for the preferred option at this stage are £4.006m including VAT. It is anticipated that the procurement of the project will be led by CEC supported by Edinburgh Health and Social Care Partnership and NHSL

4.1.2 It is proposed that NHSL will provide a Capital Grant to CEC for the construction costs and then lease the completed facility from CEC.

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

4.2 Timetable

4.2.1 A detailed Project Plan will be produced for the SBC. At this stage the table below shows the proposed timetable for the progression of the business case and project delivery milestones:

Table 13: Project Timetable

Key Milestone	Date
Initial Agreement approved	August 2020
Standard Business Case approved	May 2021
Lease signed for the property	June 2021
HubCo Stage 2 Submission/Approval	October 2021
Construction starts	November 2021
Construction complete and handover begins	June 2023
Service commences	July 2023

4.2.2 The timescales outlined above are fully dependant on the development timescales. Any delays in the commercial/school developments will result in slippage in this programme,

5 The Financial Case

5.1 Capital Affordability

5.1.1 The estimated capital cost associated with each of the short listed options is detailed in the table below. Construction costs were provided by independent quantity surveyors. Option 1 does not require capital work therefore has not been included in the table below.

Table 14: Capital Costs

Capital Cost (£k)	Option 2: New Build in Partnership with CEC	Option 3: Fit out of Leased Premises
Construction	2,115	2,953
Professional Fees	378	680
Furniture, Fittings & Equipment	80	80
IT & Telephony	64	64
Inflation	89	123
Construction Risk	177	246
Optimism Bias	435	622
Total Cost (excl VAT)	**3,338**	**4,768**
VAT	668	954
Total Capital Cost	**4,006**	**5,722**

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

- Optimism bias has been calculated in line with SCIM guidance and is included at 15% of all costs
- Preliminaries are included within the total construction cost.
- An inflation allowance of 4% has been included using a base date of October 2022 and the construction timeline detailed in the Commercial Case
- VAT has been included at 20% on all costs. No VAT recovery has been assumed. VAT recovery will be further assessed in the SBC.
- Capital costs and programme will be reviewed as the project progresses

5.2 Revenue Affordability

5.2.1 The estimated recurring revenue costs associated with each of the short listed options are detailed in the table below. These represent the additional revenue costs when compared to the

'Do Nothing' option. There is no incremental increase for this project as there is no existing service provision.

Table 15: Annual Revenue Costs

Incremental Revenue Cost/year (£m)	Option 1 Do Minimum	Option 2 New build in partnership with CEDC	Option 3 NHS leased premises
Facilities	0	102	102
Premises Costs	0	18	18
Total Annual Revenue Cost	**0**	**120**	**120**

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

- Premises related costs have been estimated using a square metre rate from a similar type project, and is inclusive of rates, water and clinical waste.
- Facilities costs have been applied on the basis of annual costs of maintenance domestic services, and energy. These have been calculated on the basis of £39, £30 and £58 per sqm respectively, based on costs for similar type GP premises.
- In both options there will be a lease in place, either with CEC or commercial developer. At this stage no costs have been included for the lease and this will be assessed further at the SBC stage. For the purpose of comparison within the IA it is assumed that the lease cost would be the same in both options and would be fully funded by GMS in either option. It therefore does not affect the assessment of options

5.2.3 Staffing costs have not been included at this stage as they have not yet been fully assessed and it is anticipated these will be will be funded through GMS. There may also be a requirement for financial support in the establishment of a new practice. Both staffing and support requirements will be assess at SBC stage as well as the funding sources for these costs.

5.2.4 Recurring revenue costs in relation to facilities will be funded directly by the practices, subject to discussion and adjustment for any short term occupation considerations. Premises costs, including lease costs, will be fully funded via GMS payments.

All revenue costs detailed above will continue to be refined through the SBC process.

5.3 Overall Affordability

5.3.1 The capital costs detailed above are expected to be funded through traditional capital funding. This project has been prioritised by NHS Lothian and Edinburgh Health and Social Care Partnership. Availability of capital funding remains a key risk to the project. A high level of risk is included in the construction cost as the project is at a very early stage in the design process. Further work is scheduled to refine the cost estimates detailed above as part of the SBC process.

5.3.2 As the requirement for this project is driven primarily by population growth a specific capital allocation will be requested from the Scottish Government in order to fund the project

5.3.3 It is proposed that NHSL will provide a Capital Grant to CEC for the construction cost and then lease the completed facility from CEC.

5.3.4 Funding has been assumed for additional revenue costs from GMS and the practice itself, this will be refined in the SBC process and will then be reviewed and agreed by the relevant parties.

5.3.5 All costs will continue to be refined through the SBC process.

6 The Management Case

6.1 Readiness to proceed

6.1.1 A benefits register and initial high level risk register for the project are included in Appendix 3: Benefits Register and Appendix 4: Risk Register, respectively.

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

6.1.3 NHS Lothian and Edinburgh Health and Social Care Partnership are ready to proceed with this proposal and are committed to ensure the necessary resources are in place to manage it. Section 286.3 below details the project management arrangements. Section 6.2 outlines the governance support and reporting structure for the proposal.

6.2 Governance support for the proposal

6.2.1 Engagement with Stakeholder is detailed in the Strategic Case and includes information on how members of the proposal's governance arrangements have been involved in its development to date and will continue to support it.

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

6.3 Project Management

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

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

Table 16: Project Management Structure

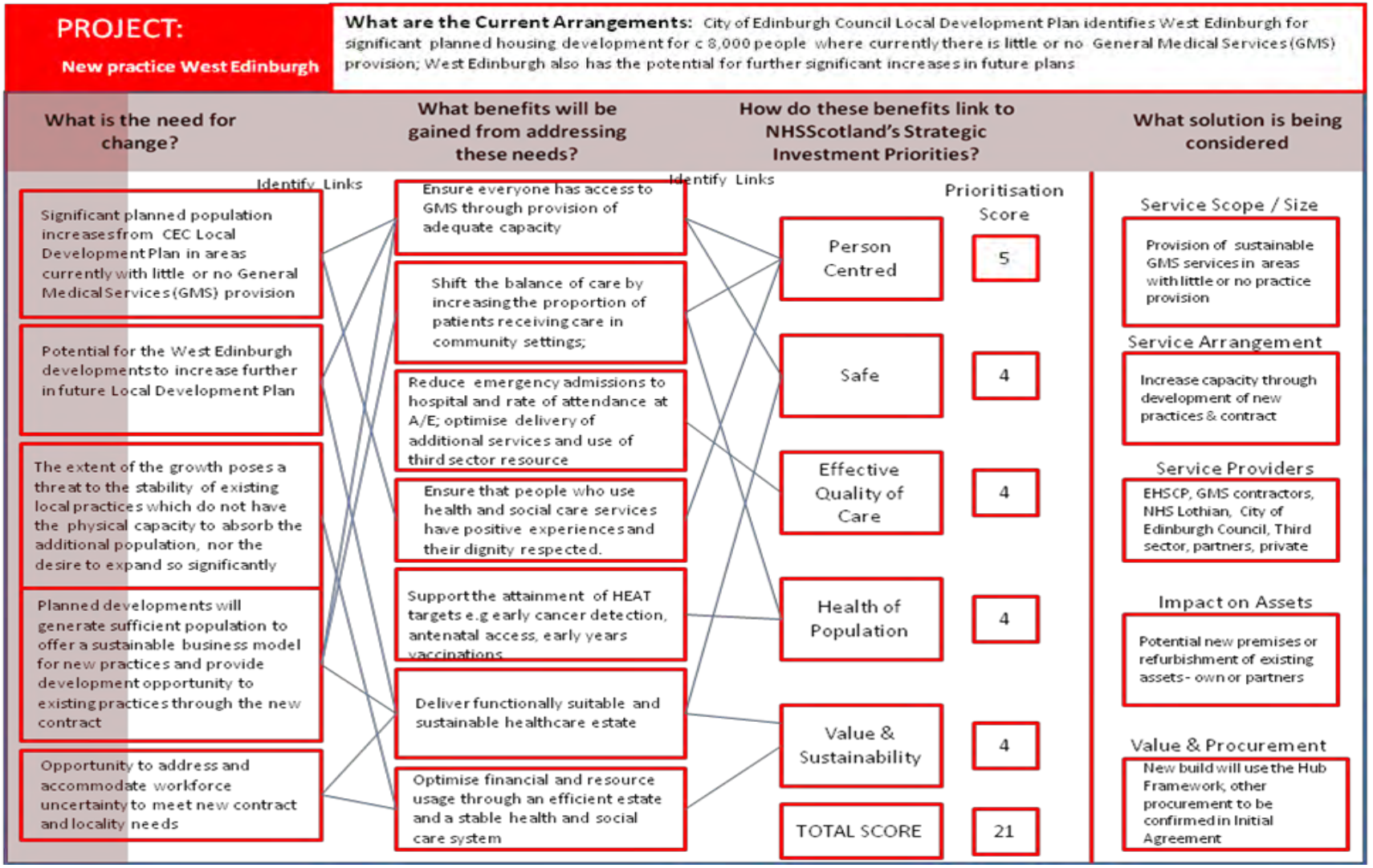
Role	Individual	Capability and Experience
Project Sponsor	David White, Strategy Planning & Quality Manger, primary Care and Public Health	Previous experience as Project Sponsor in primary care capital projects
Project Owner	Fiona Cowan	Previous experience of NHS capital projects
Project Manager	Campbell Kerr	Senior Project Manager in NHSL Capital Planning with extensive experience and responsibility for primary care projects
Capital Finance Support	Laura Smith	Experience supporting capital investment projects including similar primary care provisions
EHSCP Chief Finance Officer	Moira Pringle	Previous experience at Senior Manager level in similar projects, formerly Head of Capital Finance NHSL
NW Locality Lead	To be confirmed	Dependant on appointee
Clinical Lead	To be confirmed	Dependant on appointee
Communication Rep	To be confirmed	Dependant on appointee

7 Conclusion

7.1.1 The strategic assessment for this proposal (included in Appendix 1 Strategic Assessment) scored 21 (weighted score) out of a possible maximum score of 25.

7.1.2 The proposal has been prioritised by the relevant governance groups and identified as a priority for NHS Lothian as part of the NHS Capital Prioritisation Process 2020/21.

Appendix 1: Strategic Assessment



Appendix 2: Site Maps

Appendix 3: Benefits Register

Step 1: Identify desired benefits and include in the project benefits register

Project Name: West Edinburgh Primary Care Provision

1. Benefits Register						*2. Prioritisation*	*3. Realisation*					
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**	**Who Benefits?**	**Who is responsible?**	**Investment Objective**	**Dependencies**	**Support Needed**	**Date of Realisation**
Guidance	*Describe Benefit*	*Select from dropdown*	*How are you going to measure this?*	*Where you are now on this (baseline)*	*Where you want to get to*	*Select from dropdown*	*e.g. Public, patients, staff?*	*e.g. service manager*	*Which investment objective does this link to?*	*Does achieving this depend on anything else other than the project?*	*Is there any other support (not this project) required to achieve this?*	*When will you measure the realisation of this benefit (usually after 12 month of operation)*
1	Ensure everyone has access to GMS through provision of adequate capacity	Quantitatively	Capacity increase, restricted lists, patient assisgnments	No of patients resident assigned	No restricted lists, patients assigned	5 - Vital	Patients, GP Practices	GP/EHSCP/ NHSL	Improve service capacity to enable everyone to access GMS. Enable delivery of the Primary Care Improvement Plan as required for the implementation of the new GMS contract			24 months post project
2	Ensure that people who use health and social care services have positive experiences and their dignity respected	Qualitatively	Patient experience of GP practice, patient experience of Health and Social Care services	New practice - no current information	Results of post completion questionnaire	4 - Important	Patients	EHSCP/ NHSL	Improve service capacity to enable everyone to access GMS. Enable delivery of the Primary Care Improvement Plan as required for the implementation of the new GMS contract			24 months post project
3	Provides safe and easy access to GP services. Premises are DDA compliant	Qualitatively	Patients experience of travel options questionnaire	New practice - no current information	Results of post completion questionnaire and full DDA compliance achieved	4 - Important	Patients	EHSCP	Improve service capacity to enable everyone to access GMS. Enable delivery of the Primary Care Improvement Plan as required for the implementation of the new GMS contract			
4	Improve the functional suitability and sustainability of the healthcare estate	Quantitatively	Proportion of the estate categorised as either A or B for the functional suitability facet	New practice - no current information	A	4 - Important	EHSCP		Development of additional General Medical Practice			
5	Optimise financial and resource usage through an efficiant estate and a stable health and social care system	Quantitatively	Annual statutory appraisal	New practice - no current information	A	3 - Moderately important	Population / EHSCP / NHSL	EHSCP	Development of additional General Medical Practice			24 months post project

Appendix 4:
Risk Register

PROJECT TITLE **West Edinburgh (Maybury) Development**

PROJECT RISK REGISTER

Risk No.	Date Raised	Description of Project Risk	Potential Failure / Cause	Direct Consequence	Severity (1 - 5)	Probability (1 - 5)	Risk Factor	Risk Allowance £k	Comments	Trigger	Mitigation Response	Risk Controller	By when
1	07/07/2020	Delay in negotiations with CEC.	Failure to agree commercial terms (lease, construction, service charges) for the development with CEC.	Cost / Time	4	2	8	0.00	NHSL/HSCP sign off required on design, costs and operational agreements. These are still outstanding.		Capital Planning involvement with design to date including details of construction cost.	Capital Planning / Project Board	Ongoing
2	07/07/2020	NHSL Capital budget exceeded	NHS element of the costs exceed expectations due to higher than anticipated inflation/tender prices.	Cost	4	2	8	0.00	Costings included in the IA are based on the current information available from CEC.		Costs will be reviewed during the design process will be cinfirmed in the SBC.	Capital Planning	Ongoing
3	07/07/2020	Revenue costs exceeded and unaffordable	Revenue costs may exceed estimates in IA	Cost	4	2	8	0.00	Revenue costs (including those for setting up a new GP Practice) will be reviewed for the SBC.			Finance	Ongoing
4	07/07/2020	Passivhaus design not compatible with NHS design guidance	NHSL has yet to use the Passivhaus model, this will need to be checked throughout the design process.	Time	3	1	3	0.00			Capital Planning involvement with design to date.	Capital Planning	Ongoing
5	07/07/2020	Revenue/Running Costs not agreed with new GP Practices	New Practice unable to sign up to recurring running costs	Time	3	3	9	0.00	Requirement for practice to agree revenue costs prior to SBC submission.		SLA cost to be shared with practice when they are selected.	Project Board	Ongoing
6	07/07/2020	IT / Telecom costs	Issues with E Health briefing and initial costing information	Cost	3	2	6	0.00			E - Health to be include in the early design stages.	Capital Planning	Ongoing
7	07/07/2020	Design changes /variations following design freeze	Final brief/design not agreed by all parties. Changes to user group or working practices during detailed design and/or construction stages.	Cost / Time	4	2	8	0.00			Final SOA and layouts etc to be signed off by users and Project Board.	Capital Planning	Ongoing
8	07/07/2020	Delays/Difficulties with Statutory Approvals	Planning Permission/Building Warrant difficult to obtain causing delays	Cost / Time	3	1	3	0.00				Capital Planning / CEC	Ongoing
9	07/07/2020	Unforeseen building condition issues	Survey work incomplete or insufficient. Unknown issues discovered during construction stage.	Cost / Time	3	1	3	0.00				CEC	Ongoing
10	07/07/2020	Exceptional weather during construction	Adverse weather may affect programme.	Time	2	2	4	0.00				Capital Planning	Ongoing
11	07/07/2020	Communications/public engagement	Adverse publicity, failure to communicate with local community	Reputational	2	2	4	0.00				Project Board	Ongoing
TOTAL RECOMMENDED CONTINGENCY ALLOWANCE													

Key

Severity scored 1 Minor to 5 Severe.
Probability scored 1 very unlikely to 5 very likely.

0 to 5	**GREEN**
6 to 11	**AMBER**
12 & over	**RED**

Appendix 5: Non-Financial benefits Assessment

#	Benefit	Weighting (%)	Option 1 Do Minimum	Option 2 CEC	Option 3 Refurbishment of available property
1	Everyone has access to a GP	25%	0	10	10
2	Ensure that people who use health and social care services have positive experiences and their dignity respected	15%	2	10	10
3	Support the attainment of HEAT targets *Reduces the rate of emergency inpatient bed days for people aged 75 *Reduces the rate of attendance at A&E *Supports early cancer detection	15%	2	8	8
5	Provides safe and easy access to GP services	20%	2	9	9
5	Ensure the functional suitability of the healthcare estate	15%	7	10	10
6	Optimise financial and resource usage through an efficient estate	10%	7	10	9
	Total Weighted Benefits Points		**275**	**950**	**940**

Maximum possible benefits points -

LOTHIAN NHS BOARD

Board
14 October 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. This report, as requested at the previous Board Meeting, also includes contributions from Integration Joint Board Director's. 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

Director of Public Health Secondment

The Director of Public Health, Professor Alison McCallum, is leaving NHS Lothian to take up a 12 month secondment with the University of Edinburgh.

Professor McCallum will be working on SPECTRUM; a flagship multicentre collaboration looking at policy based interventions to reduce inequalities; an area of work for which Professor McCallum has long held a particular interest. The Board will doubtless join me in thanking Professor McCallum for her commitment and dedication during 15 years of service to NHS Lothian and send her very best wishes for her new role in this important sphere of public health.

The Deputy Director of Public Health, Katie Dee will step into the Interim Director role while Professor McCallum is on secondment.

Test and Protect: Over the last seven days NHS Lothian has seen a rise in the number of Covid cases to 943. This has resulted in us recruiting a further 84 contact tracers to work in the Test and Protect service. The system has also started to see an increase in admissions to the acute sites and after a period of no patients in ITU with Covid these are starting to rise. NHS Lothian is on average doing 3300 Covid tests per day. Some of the capacity is being used to support two of the IJBs. Work is underway with NSS to explore the potential of creating a Regional Covid 19 Testing Hub which could give an in increase in capacity of 6000 tests in the East per day.

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

Scottish Parliament Health and Sport Committee: On the 15 September 2020, Susan Goldsmith – Director of Finance and Calum Campbell – Chief Executive, attended the Scottish Parliament Health and Sport Committee to provide evidence on

the financial impact of Covid-19 for NHS Lothian. The Committee report is available to view on the Scottish Parliament website.

2. Deputy Chief Executive

Public Health: I am currently adding additional leadership resource to this team. Focus on stress testing and reviewing the operational outputs and performance of the health protection team, including contact tracing as well as the wider Public Health divisional team. This has involved reviewing the reporting mechanisms, intensively increasing the number of contact tracers and team leaders (through both external recruitment and internal redeployment/overtime) in line with Scottish Government requirements. This will allow us to respond to NHS Lothian cases and offer additional support nationally. In addition, an outbreak framework has been drafted and will have been agreed prior to the board meeting; this builds upon the existing Major Outbreak Plan. We have been engaging key stakeholders in the development of this whilst also considering the wider requirements needed for a robust response. I am using our learning from these meetings/reviews to strengthen and streamline the process and the performance monitoring of our response moving forwards to provide assurance.

Short Stay Elective Centre (SSEC): The previously reported design progression continues with a view to issuing contracts to the PSCP for Stage 3 technical design in October. The re-examination of design output has allowed the SSEC to cope with queries raised by national bodies with regard to future proofing against Covid type infection. The updated SSEC concept allows for:

- Future proofing against Covid or similar infections
- Minimal pathway strategy to ensure the patient uses the same room before and after surgical treatment
- Patient discussions and pre-operative checks carried out in their room to remove the need for theatre reception and waiting areas
- The Covid modifications will also deliver a better quality accommodation experience single room / privacy etc.
- Direct patient access to SSEC to minimise transit through main hospital
- Drop off points to allow private transport to be utilised
- Single room admissions for both day surgery and inpatient accommodation
- Revisions to ventilation strategy with IPCT consultation to accommodate mechanical ventilation

The revised footprint of the building has been used as an opportunity to unlock the potential of the southern areas of the St John's campus to improve traffic flow and parking with positive feedback received from the St John's Traffic Management Group and a matrix of risk and opportunity will be presented to Project Board and LCIG in October to seek approvals to link infrastructure solutions to the Project plans.

The Project Board has reviewed a communications plan and a further round of consultation is planned with events to wider stakeholder groups being scheduled for November.

Brexit: I chaired an initial re-grouping of previous members in early September. The purpose of this session was to reconvene the Brexit programme of work, talk about

impact assessment reporting, outside intelligence, the current position and agree our next steps.
Key points include:

- No specific response to Scottish Government had yet been requested and there had been nothing raised at the most recent tactical group.
- No further intelligence around the national stockpile. However, it was noted there had been discussion with NSS at a recent Chief Executives meeting around lessons learnt from COVID19.
- Prior to this meeting, no Brexit financial modelling had been requested and this was going to be raised by the Director of Finance at the Chief Executives meeting that day.
- Local IJB/ HSCP Brexit Groups had all either been re-convened or were scheduled to re-start.

Further meetings are scheduled in October and the COVID19 risk on the corporate risk register has been refreshed and will be continually reviewed as we near the final exit date.

Acute Car Parking: There was pre-existing pressure on parking across the acute campuses and these have been exacerbated by the Covid-19 climate. This involves a number of overlapping factors:

- The Scottish Government direction to make parking on the site free during the pandemic and during early remobilisation; increasing demand for parking from staff and visitors particularly on RIE site;
- Additional staff and patients visiting the campus as services migrate to the new RHCYP / DCN facility;
- Relaxation of permits to prevent limiting staff parking during this time across sites;
- Current limited public transport capacity, which some staff and visitors may be unwilling to use.
- Ongoing and upcoming works/builds to coordinate which may impact on temporary loss of parking or affect traffic flow in sites

Due to the increased pressures and capacity issues facing our acute sites, I established a Pan Lothian Acute Car Parking Group to agree a refreshed, standardised model of Traffic Management for NHS Lothian Acute sites. This includes; Royal Edinburgh Hospital, Royal Infirmary Edinburgh, St Johns and the Western General. This group will support sites and enable effective escalation as we remobilise services and manage increased traffic pressures across sites. A pan Lothian staff engagement plan has been developed for all sites to take a coordinated approach, this will include standardising the controls implemented across sites and aligning the timelines for these to go live.

This work will look to ensure;

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

3. Executive Director of Nursing, Midwifery & AHPs

Key amongst the work requiring to be done since the last update is the implementation of the 4 country guidance on infection prevention and control in health and care settings. This has been a significant amount of work and our position and key recommendations were taken to a special meeting of the Board on the 24 September 2020.

Care homes continue to be a key feature of my directorate and we have been participating in both a set of unscheduled visits to care homes across Lothian with the Care Inspectorate and Healthcare Improvement Scotland as well as supporting visits to all homes across Lothian. The Oversight Group for Care Homes that I chair continues to meet on a weekly basis and where any escalation is required this is done in partnership with chief officers and others.

At a national level work has been done with various statutory bodies including the care inspectorate, HIS and nursing and public health directors and chief officers to develop and roles and responsibilities framework for care homes.

We have recruited over 400 nursing and midwifery students and these will be coming in to our systems now and filling a significant number of our band 5 posts. This has taken our nursing vacancy levels to under 5% which is a positive position.

We are recruiting to our Director of Midwifery post and interviews will take place on the 29 September 2020 and I will update Board members on the appointment.

4. Medical Director

Since the August Board meeting I have been engaged with the national work on the Redesign of Urgent Care and considering the preparation for NHS Lothian to take part in this important work. I have made contact with a number of other colleagues working in this area across the UK. There has been great progress with electronic prescribing (HEPMA) at REAS and roll out will be complete by the end of October. The Quality directorate have engaged with site and service teams and we have agreed and presented to CMT on the priorities for the remainder of the year. My portfolio now incorporates R and D and professional responsibility for dentists.

5. Director of Finance

Over the last month or so I have been working with the Finance team, and Director of Finance colleagues, to try and refine our estimates on both the cost of COVID for the Boards and the costs of remobilisation. Although I have not been able to participate in all the Quarterly review meetings I know that the team have found them hugely informative in terms of understanding how the service has coped and adapted over the last 6 months. There has also been very positive sharing across the finance community both to understand all the cost drivers but also to compare assessments. The next significant challenge is to assess how all the changes and additional requirements to support the service function in a Covid world impact on the overall financial plan for 21/22 and beyond. Within that context the Chief Executive and I participated in an evidence giving session to the Health and Sports Committee on the 15 September as

part of their pre 21/22 Budget Scrutiny. This followed sessions with NHS Ayrshire and Arran and NHS Greater Glasgow and Clyde.

In the capital world we continue to press ahead with as many improvements and business cases as we can and I have chaired 2 Lothian Capital Investment groups since the last Board meeting. These included consideration of the Cancer Enabling works at the WGH and the Initial Agreement for the Cancer Centre, as well as progress on the Elective Centre at St Johns and how we address some of the infrastructure challenges in delivering the facility; and a discussion on the next phase of the Royal Edinburgh Hospital development in the light of limited capital, and what this means for other significant assets. On a smaller scale we are trying to progress work to support life cycle maintenance on the RIE site, and to enable the delivery of the Major trauma centre as required by Scottish government. At the meeting this month we also agreed a significant level of investment into the purchase of mobile hardware systems for Women's and Children's community services to facilitate system wide implementation of telehealth solutions, and the adoption of flexible working practices. The case had a clear articulation of benefits. We anticipate that there will be more of these cases coming forward as we encourage services to consider which aspects of their service could be delivered digitally, and how technology can support services in other ways.

I also met with some of the IHSL team this month to receive feedback on a review we had jointly commissioned to understand why SA2 (the contractual agreement to deliver the rectification of critical care in the RHCYP) took the time it did, and was so difficult. This review included interviews with not only representatives from IHSL and NHSL but advisers and Funders. There was learning for all and we committed to use this learning to develop the next SA and future ones. The review also helped to understand different perspectives. Meanwhile the work on site progresses well.

With the appointment of Counsel to support the Public inquiry agreed by the Board the introductory meeting with both Senior and Junior Counsel (and the CLO team) took place this month. This was helpful in putting names to faces and having a preliminary discussion about the scope and different aspects of the Inquiry, and specifically responding to the Public Inquiry's initial request for information.

6. Director of Human Resources and Organisational

The NHS Scotland '*Everyone Matters Pulse Survey'* opened on 1 September and closed on 22 September. This year's annual iMatter Survey was paused by Scottish Government due to the Covid response. However, the pulse survey has been designed to enable staff to provide feedback on their experience during the Covid response, particularly relating to health and wellbeing during this period. The full survey results will be available end of October and will be used to inform our Staff Health and Wellbeing Strategy.

Our Advancing Equalities Action plan has now been approved by the Lothian Partnership Forum and progress against the key commitments and outcomes will be monitored by the Staff Governance Committee. Our 4 staff networks are the cornerstone of this work supported and enabled by the senior leadership teams.

I hosted 2 virtual information events during August/September to provide information and access to immigration advice on EU withdrawal for our staff, ensuring that they and

their families have the most up to date information on the UK settlement scheme and citizenship. The sessions were supported by Morton Fraser Lawyers and Citizens Advice Edinburgh and were well received by staff.

Building on the success of our inaugural Leadership Conference – *Leadership Everyone's Chance to Shine*! last year, planning continues for a virtual leadership week 30 November – 4 December 2020. It will include external speakers and a question time with the Chief Executive session.

During September the 5th annual HR and OD event which is an opportunity for the whole HR and OD team to reflect, learn and connect with each other took place remotely over a 2 week period. Our theme this year was Equality and Diversity and included some really powerful conversations with members of our 4 staff networks.

7. Chief Officer Acute Services

Scheduled Care: Within the Acute Division the focus remains on remobilising services and optimising activity for out-patients, diagnostics and In-patient/day cases. I am currently looking at an option on how SJH can increase short stay and day case activity within designated green pathways.

Cancer: A case was submitted successfully to Scottish Government for the temporary placement of an additional robot to support prostatectomy procedures and free theatre capacity at the Western for additional bladder cancer surgery. As urology is one of the main services that contributes to our 62 day cancer performance it is anticipated that this will not only reduce waiting times for patients but increase our performance.

Unscheduled Care: A case for additional bed capacity within a modular building at RIE is being progressed to support winter capacity but on the longer-term basis this modular build will be used to support essential backlog maintenance.

Work continues to schedule unscheduled care with recruitment to the flow centre

Laboratories: Our NHS Lothian laboratories currently have capacity for 1500 covid-19 tests/ day and are currently recruiting additional staff and working on a case to expand existing footprint at RIE to increase internal testing capacity to 3000/ day.

8. Director of Improvement

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

Over the early Autumn period this has involved working with eHealth to define investment requirements in digital infrastructure, initially focusing on end user devices with an associated Programme Business Case to be brought forward. This links closely to work being progressed with outpatient teams across Lothian, including sessions I have been running with specialty teams at the WGH, St Johns, RHCYP, Lauriston and PAEP to help consider how best to redesign services, now and in the future, given physical distancing constraints.

Work progresses on the Unscheduled Care Programme with Jenny Long leading a complex programme of work to support the scheduling of unscheduled care via the 111 service. The Mental Health Programme has also been stepped up, with a focus returning to CAMHS and Psychological Therapy performance challenges as a result of the Covid pandemic.

9. Director of Strategic Planning

During August and September, key activities have included;

- Working with the Royal Society of the Arts on the design and delivery of our Strategy Development Framework;
- Redrafting and refreshing the Public Health Outbreak Plans to incorporate learning from Wave One of the pandemic;
- Heavy engagement and involvement in national work on contact tracing, winter planning, modelling for winter and for a revised national strategy;
- Work for Board Chief Executives on the national Mental Health agenda, including discussions with Scottish Government colleagues on their priorities;
- Finalising NHSL Physical Distancing work;
- Modelling for Wave Two.

10. Director of Primary Care Transformation

Flu Immunisation: The programme commenced on weekend of 26 and 27 September 2020. Many GP practices ran weekend clinics. Midlothian HSCP ran clinics at three locations for shielding households. Edinburgh HSCP ran "drive through" clinics for over and under 65's at 8 locations. At the time of writing (28/09/20) feedback from these clinics is that the numbers seen were at or above target. However, the first validated data through the national data extracts will be available to Lothian by 15 October. There has been a lot of media attention and some enquiries and complaints in the run up to the programme starting, largely focused on the changes in Edinburgh and that vaccination is not being offered at GP Practices there. It is the national agreement in the new GP Contract that vaccination work will be moved from away from GPs, Edinburgh is moving quicker to implement this, but all the HSCPs will have done this by next winter.

Covid Immunisation: A project team has been set up to plan for staff and mass public vaccination for Covid 19 in Lothian. There are major uncertainties including when a vaccine might be available, which vaccine and in what quantities. The team is planning on a set of assumptions, but will need flexible plans that can adapt to rapid change. There will be helpful learning from the different approaches to flu vaccination this year. National groups are planning for issues that have to be addressed for all of Scotland and NHS Lothian is well connected to them.

Dentistry: Reintroduction of aerosol generating procedures for urgent NHS patients has been progressing steadily. At the time of writing 81 practices have restarted. 43 had still to be face fit tested. 15 will be unable to restart. The Board is still in communication with others.

Community Covid Pathway: The service has continued to provide triage and face to face assessment for patients. The GP Out of Hours Service (LUCS) has taken over both triage and face to face assessment overnight. Activity was low all summer with 60 to 70 triage calls and 5 to 10 face to face assessments each day. From mid-August triage

activity increased to 130 to 140 call per day, but face to face assessment remained the same. This coincided with the return of schools. This dropped to 80 to 90 triage calls by the end of September and face to face assessment has not changed. If Covid 19 is accelerating again in Scotland we expect to see increasing demand through 111 coming to the Covid Pathway. Proposals to sustain the service and step it up again if necessary have been developed.

11. Director of Communications, Engagement and Public Affairs

COVID-10 – Outbreak Comms: A great deal of team resource is currently deployed managing communications relating to Covid-19 outbreaks in schools and universities. Anticipating these scenarios we had engaged before the start of the school term with comms colleagues in our 4 local authority areas and in Lothian's Universities and colleges to share our SOPs and ensure effective multi-agency working, in which NHSL takes the lead. This has undoubtedly helped us manage the response and ensure consistency but this remains an intense period. In particular it has been essential to support head teachers and university leaders with communications to their communities of pupils, students, parents and staff. We continue to work closely with the Health Protection Team and are preparing a comms strategy to support the 170-200 new recruits to our contract tracing team.

Redesign of Urgent Care: I have been participating in a national workstream tasked with developing a communication strategy to explain and promote the redesign of urgent care pathways this winter. The group has representation from Scottish Government, NHS 24, Emergency Medicine and Primary Care. The challenge is to ensure the requirement for behaviour change (to call 111 for telephone triage, rather than to self-present at the front door) does not get lost in a wealth of other messaging about how to access different parts of our services. We have been developing NHSL's own comms and stakeholder engagement strategy alongside this work which will support the national campaign but include localised information.

Flu Kills Too: The Staff Flu campaign launched on 28 September with a bold creative approach which underlines the seriousness of flu when minds have been occupied with Covid-19. The staff campaign will continue to be promoted widely across NHSL and our four HSCPs in the coming weeks to help reach an ambitious target of a 10% increase in uptake in Lothian, where uptake is already traditional high. The public campaign is also being promoted, emphasising new, easy access routes and increased eligibility for the free vaccination.

Infection Control Guidance: The introduction of the 'Four Nations' Infection Control Guidance' is being supported by a series of videos with the Infection Control Lead Nurse, posters, a patient information leaflet and multiple opportunities for staff to receive briefings and ask questions about the changes. We will also be working with media to help the public understand what to expect during a hospital visit or stay.

Board Recruitment – Non-Executive Directors: We made a concerted effort during the recent recruitment campaign to engage with stakeholders and influencers in diverse communities to attract a wide field of applicants to the Non-Executive Director roles. The process has generated 86 applicants. Around 3 times more than in previous recruitment rounds.

12. Director/Chief Officer, Edinburgh Integration Joint Board

Flu Vaccination Programme: The Flu Vaccination Programme for 2020 is the largest ever undertaken with the aim for us to increase the number of people vaccinated in Edinburgh from around 85,000 last year to 120,000. This includes the increased targets relating to the vaccine being made available to the over 55s as well as our ambition to offer to staff working in Social Care.

NHS members will be aware of the changes in the GP contract which envisaged the transfer of the programme out of GP premises over a 3 year period; due to the restrictions in place arising from Covid-19 in relation to social distancing, coupled with the increase in targeted numbers, we have accelerated plans to change the way that this is delivered for 2020. The programme in Edinburgh got underway over the weekend of the 26 and 27 of September and is being delivered through a series of drive through and walk-through clinics in sites across the city an 8 week period. Sites have been chosen to ensure safety of people accessing them and traffic management plans and support are in place for each of these.

Practices have been zoned to the sites and timeslots will be given to patients based on their practice and the first letter of their surname. The aim is to reduce waiting time and queues at the sites as far as possible.

Thrive Edinburgh: Thrive Edinburgh is the Health and Social Care Partnership's ambitious and far reaching programme of approaches to ensure that we address the underlying determinants of mental health and wellbeing as well as having in place the right support for people with mental health problems within our communities. Significant activity and action is underway under the Thrive Edinburgh banner including:

The Edinburgh Thrive Line will connect places and spaces which can promote and improve mental health and wellbeing across the city. From November online one-hour seminars Thriving Spaces and Places" aimed at people who may work, volunteer or spend time in these places and spaces. will be held focusing on how compassion and relationships are essential components of protecting and promoting our city's mental health and wellbeing.

The Thrive team with our Network Rail colleagues packed and delivered over 1,800 'Bags of Thrive' filled with self-care, activities and treats to Edinburgh citizens aged 6 months to 98! It also gave us the opportunity to raise awareness on the five ways to support your mental health and wellbeing – Connect; Be Active; Keep Learning' Give and Take Notice.

- On 12 October iThrive - The city's new online resource developed by our partner agency health in mind will be launched. This will ensure that people in Edinburgh have single "go to " website to find our abut all the services and supports available to them.

- Our new Thrive Exchange, bringing together over 50 people with an interest in research and development will have its first event in November 2020.

- Increased the workforce who can respond to people in distress in our A & E departments, police custody and Edinburgh Prison.

- Four new Thrive Welcome Teams, with experienced statutory and third sector staff are working with people in distress to create a Thrive plan informed by good conversations which focuses on what the person has identified is to important to them.

- These teams will be supported by our newly commissioned Thrive Collective. New 3rd sector services will provide a wide range of emotional, psychosocial, psychological and practical support for people in a ranges of places and spaces across the city. For the first time contracts have been awarded for a five-year period with an option to extend for a further three years and the total annual value is £2,596,645. These awards will help contribute to building a sustainable 3rd sector across the city, recognising the key role the sector has played in supporting communities in the pandemic to date.

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

Winter Planning: The partnership continues to adopt a 'home first' approach and work to maintain current performance on reducing delays to discharge. Our winter planning supplements the systems we have in place by increasing capacity in Hospital to Home Team, Discharge to Assess Team and Social Work Assessment Team. Available inpatient resource at East Lothian Community hospital to support winter pressure (44 beds) they are however not staffed. The Flu Vaccination Programme for 2020/21 is being delivered by East Lothian GP practices via an agreed delivery plan which is being supplemented by HSCP clinics.

Primary Care: One of our largest practices is reporting concern with their ability to respond to demand and will require significant partnership support. Discussions regarding this are at an early stage.

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

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

Social Care Capacity: Access to social care, particularly care at home for all client groups, i.e. over 65s, people with mental health needs, people with learning disability, people with physical disability/long-term conditions is monitored on a daily basis.

There is a concern about ongoing capacity. It is acknowledged that older adults, people with underlying health conditions and people with learning disability are all vulnerable.

The HSCP is providing increased support to Care at Home providers to ensure the maintenance of infection control and prevention through the establishment of a team to oversee social and clinical aspects of service delivery.

14. Director/Chief Officer, Midlothian Integration Joint Board

Work is well underway within Midlothian HSCP, working with Community Planning Partnership services, to prepare for winter pressures. The overarching Winter Plan is joined up to cover a wide range of areas – reducing delayed discharges, preventing admissions, increasing service capacity, gritting priority areas, implementing the flu programme, and resilience planning for severe weather, ongoing COVID-19 and potential local lockdowns, and staff absences. There is also an ongoing focus on supporting staff wellbeing and a winter communications plan both for staff and the public.

Efforts to ensure that people are discharged from hospital as soon as they are fit are progressing further. This includes the establishment of a single point of access to intermediate care services in Midlothian by December 2020 and improved working with the Flow Centre at the Royal Infirmary. To support this further, there is a recruitment drive to increase capacity in Midlothian's Care at Home service.

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

Winter Planning: The partnership is acutely aware of the risk posed by winter, combined this year with a potential second wave of Covid-19 and flu. Timely transfers of care remain a priority and work continues with colleagues in the acute and community sectors to refine operating procedures in the integrated discharge hub to ensure that potential barriers to discharge are removed. The partnership continues to concentrate on a 'home first' approach.

Winter planning has also involved the development of key tests of change such as:

- Intermediate care model for St Michaels Hospital (8 beds initially for palliative patients who do not require acute diagnostics)
- Extension of equipment stores/driver hours to deliver 7 day working
- Enhanced equipment provision and support for palliative care patients in care homes

The Flu Vaccination Programme for 2020/21 is being delivered by West Lothian GP practices via an agreed delivery plan with implementation and uptake monitored by senior managers.

Ongoing daily contact with care homes and oversight by senior will continue during the winter period. Enhanced support for care homes will also remain in place via the partnership's Care Home Team, Social Work teams and local links with Scottish Care.

Oral Health Remobilisation: Delivery of oral health services has been impacted considerably by the pandemic with most services ceasing in March 2020. Planning for remobilisation is complex and targeted work is being done on ventilation, water safety and demand and capacity modelling to inform mobilisation plans.

Many dental procedures result in the generation of aerosols and those procedures pose challenges in relation to clinic layout and ventilation. Two work streams have been established to inform decision making on ventilation safety.

Prior to the pandemic, work had begun on demand and capacity modelling to inform trajectories for each specialty but was interrupted as key analytical staff were diverted to support the pandemic response. Work will restart in October 2020 to ensure that modelling also includes the impact of services being unavailable for some time.

Integrated Performance Management Framework: Although there are arrangements in place for performance reporting across health and social care, it is recognised that a more integrated approach would enable a richer picture to be obtained of whole system performance. Work is underway, involving partnership colleagues and analytical staff from Public Health Scotland, to develop an integrated framework for West Lothian which captures performance data across all health and social care teams in a way which will help to identify the impact of good and poor performance on other parts of the system. The intention is to have a tiered approach to data reporting whereby a broad range of data is reported to the WLHSCP senior management team with more refined data sets being developed to support progress reporting on strategic commissioning plans. A review is also being undertaken on what is reported publicly via the IJB.

16. The Board is asked to receive the report;

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

Approved by

Name	Designation
Calum Campbell	Chief Executive

Author(s)

Name	Designation	Name	Designation

Calum Campbell	Chief Executive	Alison McCallum	Director of Public Health and Health Protection
Jim Crombie	Deputy Chief Executive	Jacquie Campbell	Chief Officer Acute Services
Alex McMahon	Executive Director Nursing, Midwifery and Allied Healthcare Professionals	Pete Lock	Director of Transformation
		Colin Briggs	Director of Strategic Planning
Tracey Gillies	Medical Director		
Susan Goldsmith	Director of Finance	David Small	Director of Primary Care Transformation
Janis Butler	Director of Human Resources and Organisational Development.	Judith Mackay	Director of Communications, Engagement and Public Affairs.
Morag Barrow	Director/Chief Officer Midlothian IJB/HSCP	Judith Proctor	Director/Chief Officer Edinburgh IJB/HSCP
Alison Macdonald	Director/Chief Officer East Lothian IJB/HSCP	Allister Short	Director/Chief Officer West Lothian IJB/HSCP

NHS LOTHIAN

Board Meeting
14 October 2020

Director of Public Health

COVID-19 PUBLIC HEALTH UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to brief the Board on current situation regarding the COVID-19 pandemic in the Lothian population. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 The Board agrees that it has been sufficiently briefed on the overview of the present situation for COVID-19 in the Lothian population.

3 Discussion of Key Issues

3.1 Patterns of transmission of the COVID-19 virus in Lothian have followed the same broad trends as in Scotland and the wider UK. Numbers of Lothian residents who have tested positive for COVID-19 are presented in Appendix 1 (over the pandemic), and in Appendix 2 (the past 4 weeks). Test results are an imperfect but useful proxy to track COVID-19 transmission in our communities. When comparing between numbers of positive tests now and those in Spring 2020, it is important to note the greatly increased testing which is now occurring in Scotland. More testing, will likely lead to the identification of a greater proportion of cases, hence the two peaks in Appendix 1 are not directly comparable.

3.2 Numbers and rates of hospitalisations, ICU admissions and deaths from COVID-19 are more readily comparable across time but lag behind indicators of community transmission. Presently there are very small numbers of hospitalisations for COVID-19, from which it is difficult to draw conclusions. Broadly these track the rates we saw in late February/early March 2020.

3.3 In the early stages of Scotland's pandemic, case numbers peaked during spring 2020 and fell into a plateau during the summer. The decline was associated with a suite of policy interventions (e.g. varying degrees of 'lockdown'), responses to contain and prevent spread and changes in public awareness and behaviours. Attributing causation is a matter of considerable debate and the most likely scenario is that a combination of interrelated factors have driven the various changes in transmission we have observed.

3.4 Since mid-August 2020, and consistent with the wider situation in Scotland the UK, Lothian has seen an increase in people testing positive for COVID-19. This was again associated with a complex combination of factors, as follows.

3.5 Following the gradual relaxation of national restrictions (e.g. visitors in homes, re-opening of hospitality settings) sporadic cases of COVID-19 have begun to rise from the summer 'plateau'. Through September 2020 has resulted in a significant rise in our rate of infection per 100,000 population (Appendix 3).

3.6 Soon after the return of children to school in mid-August 2020, NHS 24 experienced significant increases in their call volumes requesting advice and support around

COVID-19 and we observed a considerable increase in testing of children of school age. Since that time we have seen increases in sporadic cases, and some small clusters of cases in school settings (among both staff and young people). Unsurprisingly, given the challenges around social distancing in school settings, school cases often have considerable numbers of individuals identified as close contacts, resulting in those contacts needing to self-isolate for 14 days.

3.7 Likewise, the return of students to higher and further education was associated with significant increases in cases among young people in their late teens and early 20's throughout September 2020. As in other areas of the country, clusters and outbreaks have been observed within, but not limited to, social activities often focussed around student halls of residence.

3.8 NHS Lothian has worked locally and nationally in partnership with the education sector and relevant stakeholders to respond to such cases, clusters and outbreaks and to work to prevent future transmission.

3.9 It is important to note that, in recent months, UK behavioural surveys have demonstrated increases in the number of social contacts among younger people (e.g. under 40 years). Hence, while there have been clusters and outbreaks associated with higher/further educational settings, there are likely contributions from differences in behaviours between people of different ages.

3.10 Across the UK, Spring 2020 saw considerable transmission of COVID-19 within care homes. The intersection of challenges in this sector and social and physical vulnerabilities for care home residents are a matter of public record. As with trends in the wider Lothian population, the summer of 2020 saw cases in care home settings drop to at, or near 0. In recent weeks we have seen small increases in sporadic cases among care home staff and a number of cases among residents in a small number of homes. Given the vulnerabilities above, support for preventative efforts and responses to cases in care homes have been redoubled.

3.11 The following broad areas will be important contributors to our ongoing response to the COVID-19 pandemic as we head towards winter:

3.12 Planning and coordination – maintaining a nimble multi-stakeholder response to the situation as it evolves.

3.13 Situation monitoring and assessment – monitoring known areas of vulnerability (e.g. care homes and other vulnerable populations) and areas of higher transmission (e.g. educational institutions); and being vigilant for new priority areas of concern (e.g. manufacturing and warehouse settings where outbreaks have been seen elsewhere).

3.14 Reducing the spread of disease – through interventions: strengthening our response to cases, clusters and outbreaks to mitigate their impact and reduce onward spread. Using our test and protect contact tracing system to break chains of transmission; and thorough public support: reducing transmission through hand-washing, social distancing etc.

3.15 Continuity of healthcare provision.

3.16 Communications – working to ensure consistent, clear messaging across the public sector and beyond.

4 Key Risks

4.1 This paper does not identify new risks.

5 Risk Register

5.1 No new risks are identified in this paper

6 Impact on Inequality, Including Health Inequalities

6.1 This paper does not contain policy recommendations which would impact upon inequalities. It is important for to note that there is a body of emergent evidence which demonstrates that the impacts of COVID-19 are felt most keenly both among those from more deprived communities and among people of certain ethnicities.

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

7.1 Not applicable

8 Resource Implications

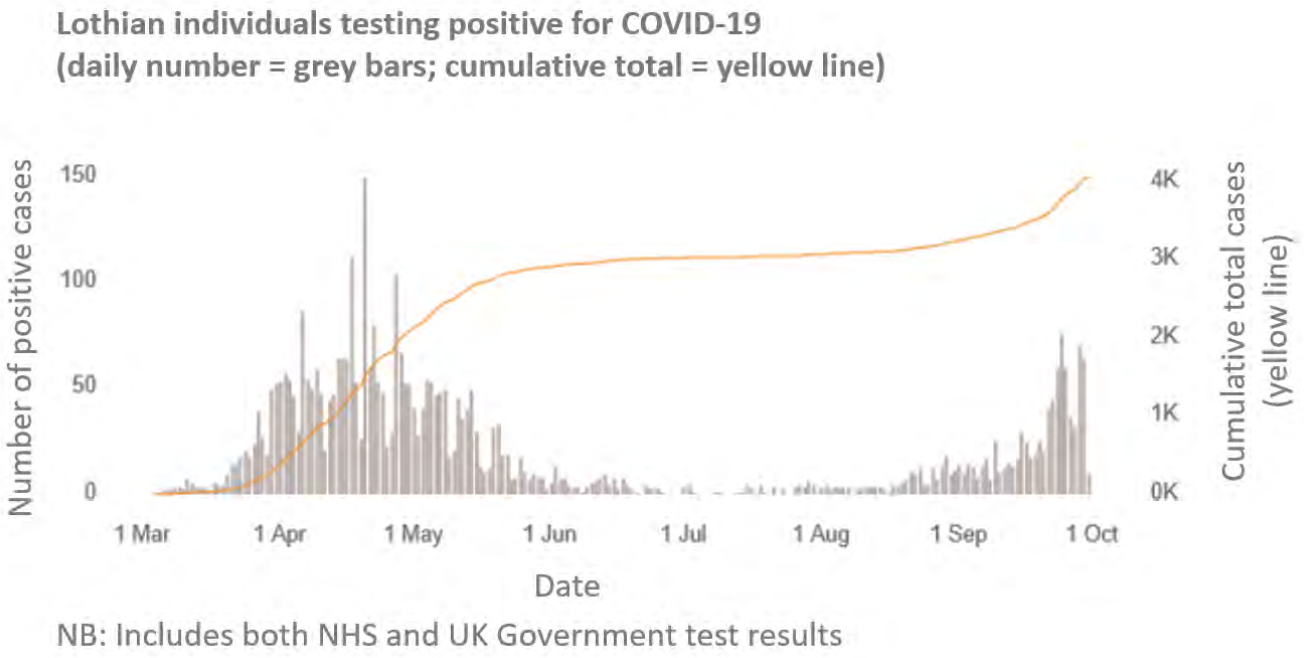
8.1 Not applicable

Philip Conaglen
Consultant in Public Health Medicine
01/10/2020
philip.conaglen@nhslothian.scot.nhs.uk

List of Appendices

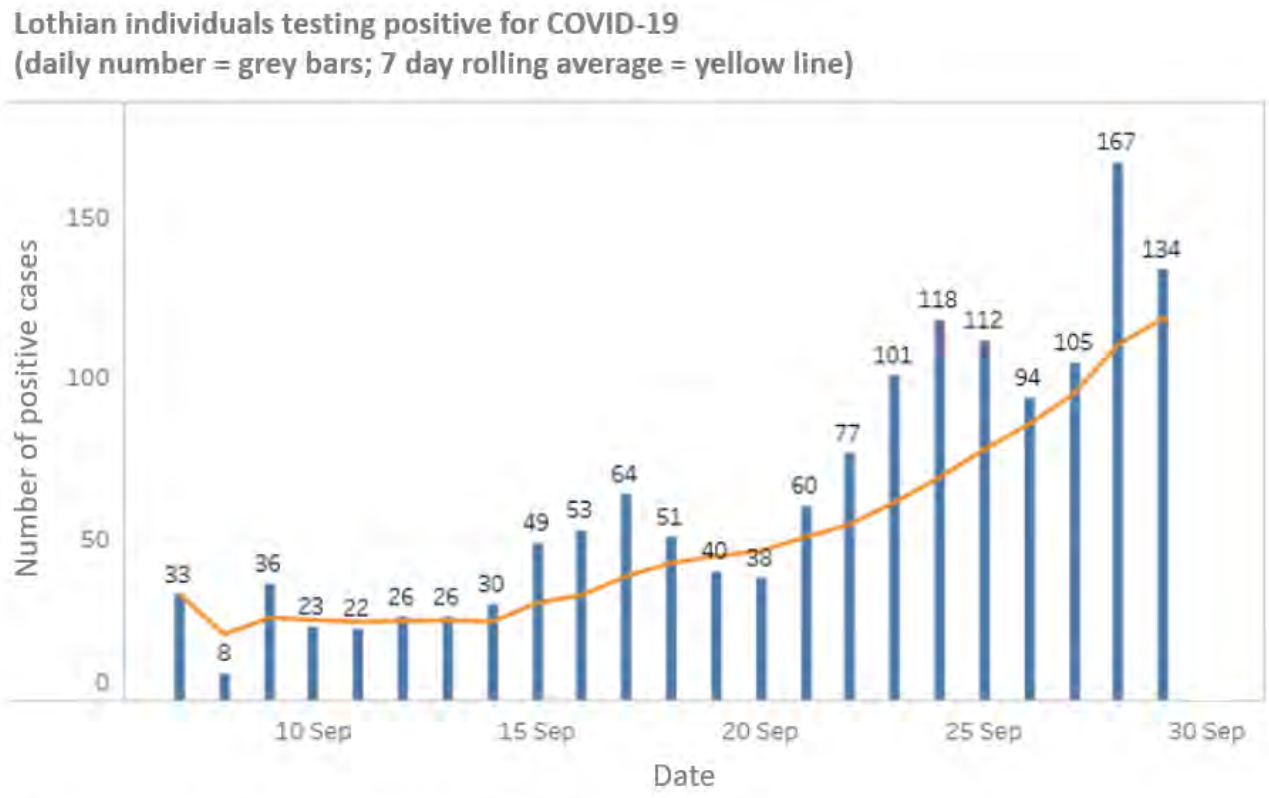
Appendix 1: Lothian individuals testing positive for COVID-19 (total)
Appendix 2: Lothian individuals testing positive for COVID-19 (last 4 weeks)
Appendix 3: Lothian 7 day rolling average of COVID-19 cases per 100,000 population

Appendix 1



NB: Includes both NHS and UK Government test results

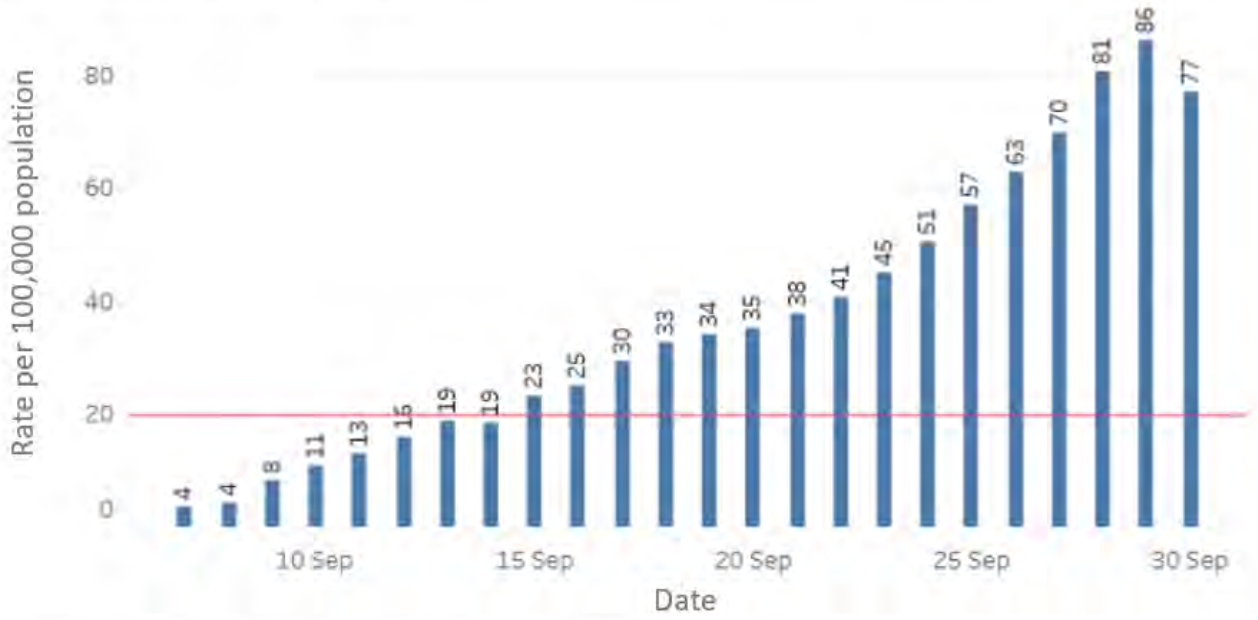
Appendix 2



NB: Includes both NHS and UK Government test results

Appendix 3

Lothian 7 day rolling average of the rate of COVID-19 cases per 100,000 population (most recent 4 weeks of data)



NB: Includes both NHS and UK Government test results

NHS LOTHIAN

Board Meeting
14th October 2020

Chief Officer, Acute Services

SCHEDULED & UNSCHEDULED CARE PERFORMANCE

1. Purpose of the Report

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

2. Recommendations

Board Members are recommended to:-

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

2.2 **Acknowledge** that management information indicates 63.8% of patients were seen within the Treatment Time Guarantee (TTG) in July 20. Provisional management information indicates that 9,890 inpatients were waiting longer than 12 weeks by end of August 20.

2.3 **Take limited assurance** that Remobilisation plans will mitigate growing volumes of long wait patients for scheduled care/ cancer services, against rising Covid infections & Winter;

2.4 **Acknowledge** that funding allocation letter has been received from the Scottish Government to improve patient access to scheduled care services; including establishing robotic prostatectomy procedures within Spire for up to 6 months, to support improved prostate & bladder cancer treatment times.

2.5 **Acknowledge** that 4 hour Emergency Access Standard performance is 88.9% for September 20 (up to 22 September). Further performance data is shown in Appendix 6.

2.6 **Recognise** the national redesign of urgent care programme is underway with delivery & oversight groups in place to provide strategic leadership and support areas of escalation. Please see 3.7.

2.7 **Recognise** that the initial Covid response from Health & Social Care Partnerships (HSCPs) was to increase community capacity focusing on Home First, significantly reducing delayed discharges. Delayed Discharge numbers on acute adult sites have increased since April 2020, but remain at a historic low - please see Appendix 6.

3. Discussion of Key Issues

3.1 A Scheduled Care Board has been established since August to oversee Remobilisation, Recovery and Redesign. Though outpatient demand remains lower than pre-Covid capacity has also reduced due to physical distancing and infection prevention & control

guidance. Activity has increased month on month since April (by 80% from April to August), when Covid was at its peak. The number of August Urgent new outpatient appointments (>4,600) has now almost returned to the pre-Covid number in February (4,900). Urgent Suspicion of Cancer outpatient appointments (>1,000) are higher than in February (900) and now around the number of appointments in August last year (1,100).

3.2 Mitigations for reduced face to face capacity include optimising virtual care such as telephone & video consultations to increase activity. Demand management includes active clinical referral triage, patient initiated follow up, email correspondence, patient-focussed booking and RefHelp. Performance focus is on clinical priority management – ensuring capacity for urgent/urgent suspicion of cancer referrals, increasing activity and re-triaging longest waiting patients. The number of patients waiting over 4 weeks for an Urgent Suspicion of Cancer new outpatient appointment increased in March to July, but has decreased in August as the number of appointments continue to increase and are targeted at these patients with the greatest clinical need. Similarly the number waiting over 12 weeks for an Urgent new outpatient appointment has almost halved (-45%) since May.

3.3 Surgical and diagnostics capacity is focussed on urgent, cancer and priority 2 patients i.e. those requiring surgery within 4 weeks. Remobilisation of inpatient and daycase surgical services continues, aligned to critical care and elective bed capacity. There is a month on month increase in remobilised theatre sessions with 84% by end August and a further rise to 88% by the end of September. Activity remains constrained due to increased turn-around time and IPCT guidance.

3.4 Cancer performance remains an area of significant focus but August saw improvement in both 31 and 62 days performance. Urology performance deteriorated slightly for both pathways. The number of patients waiting longer than 31 days for bladder cancer surgery rose through reduced theatre activity – down by one third for trans urethral resection of bladder tumour (TURBT), since Covid. Cancer bladder surgery will benefit from additional theatre access at the Western as part of an approved bid to implement an additional robot for prostatectomy surgery at Spire. 62 Day performance was impacted in the prostatectomy pathway by the length of the diagnostic pathway and surgical backlog. A short life working group comprising key stakeholders met to implement actions to reduce diagnostic waits, and the Spire additional robot will support surgical backlog. Additional Spire theatre capacity for urgent Colorectal, Urology, Breast and Neurosurgery ceased on 30th September.

3.5 Endoscopy diagnostic lists remain </=5 patients per session, due to physical distancing measures and PPE. Upper endoscopy still requires fallow time between procedures due to infection prevention control ventilation guidance. Fallow time has been removed from colonoscopy sessions, increasing patients from 3 to 5 per session where distancing can be accommodated pre- and post-procedure. Leith Community Treatment Centre and Regional Endoscopy Unit (QMH) access has recommenced, increasing capacity for high risk and Urgent/ Urgent Suspicion of Cancer patients to 56% of pre-Covid endoscopy capacity. The Faecal Immunochemical Test (qFIT) is used to prioritise patients appropriately, with high risk patients being expedited for investigation. Enhanced triage criteria have been embedded for upper endoscopy. National Bowel screening recommences on 12/10/20.

3.6 Core capacity to clear Radiology backlog and resume pre-Covid diagnostic and interventional capacity is impacted mainly by cleaning regimes. Improvement has been

seen from a 20% reduction, to between 10-20% in most modalities compared to pre-Covid. Remobilisation is underway, including full analysis of current service provision to modernise care models, maximise efficiency and meet new outpatient clinic demand. External provision of CT and MRI is being fully utilised. CT colon provision is being arranged at The Edinburgh Clinic. Recruitment is progressing to increase workforce to extend core scanner capacity at DCN/RHCYP, RIE and SJH, maximising existing scanner capacity. Preparations are also underway to manage the impact of an anticipated surge in Covid-related imaging activity, and Winter demand.

3.7 For unscheduled care, the national redesign of urgent care programme is underway. Work is taking a phased approach across acute sites and HSCPs. A project infrastructure has been established with an operational delivery group and new board meeting weekly to enable progress and decisions at pace. This reports to the Lothian Unscheduled Care Programme Board. Phase 1 concerns development of a 24/7 pathway via a national single point of access through NHS24/111, aimed at reducing and smoothing self-presenter attendance demand at acute hospital front doors, to minimise overcrowding and protect public, patients and staff. This will be supported by an expanded Flow Centre, required to manage a potential increase of around 127,000 additional referrals per year (approximately 348 per day) - if all current self-presenting demand (excluding triage categories 1 and 2 representing emergencies) is routed via NHS24. This expansion requires increased staffing and recruitment is in progress. Phase 2 will concern professional to professional referrals, including from the Scottish Ambulance Service, and also be accommodated by the Flow Centre. It will include access to same day community & secondary care services, and a review is underway to define and catalogue community pathways and referral criteria e.g. falls, frailty, respiratory, hospital at home teams, with agreed response times by HSCPs, and to understand what in-house services are available across rapid access & ambulatory care clinics to support scheduled treatment.

3.8 A test of change is underway at the RIE to expand the role of the ambulatory care clinic, aligned with the national redesign. The RIE team will contact patients at the point of referral from GPs to support scheduling. It is hoped that some attendances could then be averted, scheduled for later in the week or for same-day urgent attention, avoiding further overcrowding in the department through unscheduled attendance. The RIE are also progressing a case to utilise a Modular unit as part of their winter plans. This will help increase capacity by providing a temporary ward over winter, supporting social distancing and reducing overcrowding/congestion.

3.9 Alongside the developments above, aimed to be in place ahead of winter, routine unscheduled care winter planning across acute sites and HSCPs has been overseen by the Lothian Unscheduled Care Committee. This is taken forward through engagement with system colleagues incl. Acute, Partnership and Scottish Ambulance Service to ensure an inclusive and collaborative approach to prioritising winter proposals, and maximise impact over the period. Unscheduled care winter plan development has built on learning from the Covid-19 period as well as last winter's debrief. This year the planning process has been mobilised earlier than in previous years, and will be enacted from November onwards.

3.10 The RIE is the main driver of current unscheduled care performance (88.9%) and key mitigations they are undertaking include weekly front door debriefs to review performance trends and ongoing actions, with daily debriefs as required; review of Mental Health Assessment Service out-of-hours cover to reduce long waits, and of inter-site transfer pathways to ensure patients arrive timeously at sites for required specialties.

4. Key Risks

4.1 There is unknown risk for patient outcomes due to the impact of Covid on lengthening waiting times, reduced referral rates, delayed diagnosis/treatment and patient choice in not attending appointments, particularly where virtual care is not suitable.

4.2 Risks to scheduled care performance due to reduced capacity which is focussed on clinically prioritised care extending waits for routine demand. There is reduced access to our annual Golden Jubilee National Hospital allocation and independent sector and insource provider capacity. The requirement for Covid and non-Covid pathways, physical distancing, PPE and cleaning regimens, are all reducing capacity.

4.3 There is a risk to 4 hour EAS performance due to increasing unscheduled care demand whilst maintaining Covid and non-Covid pathways, increased elective activity and winter demand delayed discharges increase.

5. Risk Register

5.1 Corporate risk IDs 4191 (That patients will wait longer than described in relevant national standard & associated clinical risk); 3211 (That NHS Lothian will fail to achieve waiting time targets for inpatient/day case and outpatient appointments); 3203 (4-hr Target (Organisational)), and 4688 (4 Hour Emergency Access Standard (Patient)) reflect Covid.

6. Impact on Inequality, Including Health Inequalities

6.1 Capacity restrictions and waiting list delays may impact patient groups differentially. Covid's health impact will be reviewed within future public health work. The move to virtual healthcare could increase the 'digital care divide' for vulnerable groups with limited technology access. The development of new services e.g. monitoring services enables patients to have care closer to home, reducing travel, parking & time costs to attend an on-site appointment. 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 communications/ engagement events are ongoing & will inform models developed.

8. Resource Implications

8.1 Estimated additional costs associated with updates in this paper have been included within Quarter 1 submissions to the Scottish Government in Aug/Sept 2020. Specific proposals are approved through Management Teams, and an updated forecast will be reported to the Board and Scottish Government as part of financial planning.

Appendix 1 – Covid Impact on Performance

As part of the first wave of Covid, and in line with Scottish Government requirements, NHS Lothian ceased all non-urgent elective activity from 16th March this year. By the peak of the pandemic 72,000 outpatient appointments and 3,000 inpatient & day case procedures had been cancelled, resulting in a significant backlog. This along with reduced capacity means that provisional information indicates there were 36,210 patients waiting longer than 12 weeks for first new out-patient appointments at the end of August 20. This is a 72% increase from March 20, when Covid cancellations began, but Remobilisation plans have seen a month on month reduction in patients waiting more than 12 weeks since June – please see Appendix 2.

Provisional management information shows that 9,890 inpatients were waiting longer than 12 weeks by end of August 20 – please see Appendix 3.

Cancellations have significantly increased waits for key diagnostic tests including Endoscopy (the largest portion of Gastroenterology Diagnostics); and for Urology Diagnostics (Cystoscopy). However Radiology CT and MRI waits have decreased considerably since April 20 inclusive, and Radiology Ultrasound since May 20. 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 had fallen significantly in April 20, but are beginning to increase. They do however, remain historically low for the HB – please see Appendix 6.

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

Metric		*Sept 2020	Aug 2020	Jul 2020	Jun 2020	Target
Delayed Discharges	**Standard	160	141	136	92	95 by March 2021
	**Standard & Complex	206	182	180	133	-
4 Hour ED Waiting Time		88.9%	91.9%	94.7%	94.8%	95.0%
Outpatient >12 week waiting time [M]		N/A	36,210[P]	40,671	37,758	-
Treatment Time Guarantee [M]		N/A	9,890[P]	10,233	8,638	-
Cancer Waiting Times (31 day target) [M]		N/A	98.1%	96.8%	90.8%	95%
Cancer Waiting Times (62 day target) [M]		N/A	86.2%	83.9%	82.9%	95%

[M] Management information
[P] Provisional management information
* As of 22nd September 2020
** Standard (excl. code 9s and code 100s), Standard and Complex (incl. code 9s and code 100s

Appendix 2 - Outpatients

Outpatient performance is detailed below in terms of patients waiting over 12 weeks for a new outpatient appointment:-

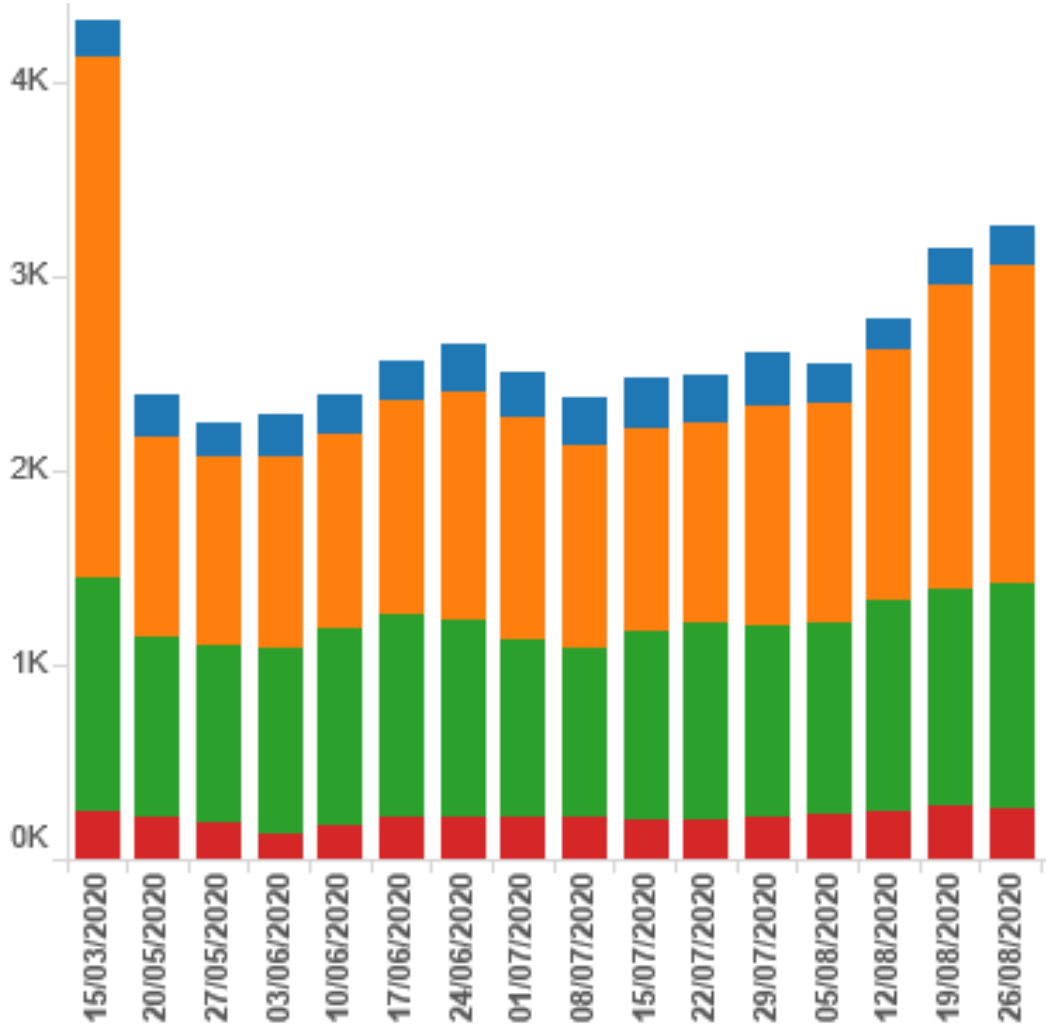
	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20 - *provisional*
NHSL OP >12 Wk Performance	**24,307**	**25,529**	**23,274**	**21,098**	**28,312**	**37,758**	**40,671**	**38,050**	**36,210**
OP Trajectory	26,269	25,051	20,393	18,100	-	-	-	-	-
Difference	-1,962	478	2,881	2,998	-	-	-	-	-

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

Impact of First Wave of Covid on Outpatient Waits:-

	Pre-Covid – Early March 20	Aug 20	% Change
Waiting List Size – Urgent & Urgent Suspicion of Cancer	7,618	8,037	5.5%
Waiting List Size – Routine	52,051	51,230	-1.6%
Referrals	6,303	4,949	-21.5%
>26 Week Breaches	6,886	24,840	+260.1%
>52 Week Breaches	334	2,686	**+704.2%**

Outpatient Weekly Removals Seen (Activity) by Priority:-



Key:- Red – Urgent Suspicion of Cancer; Green – Urgent; Orange – Routine; Blue– 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:-

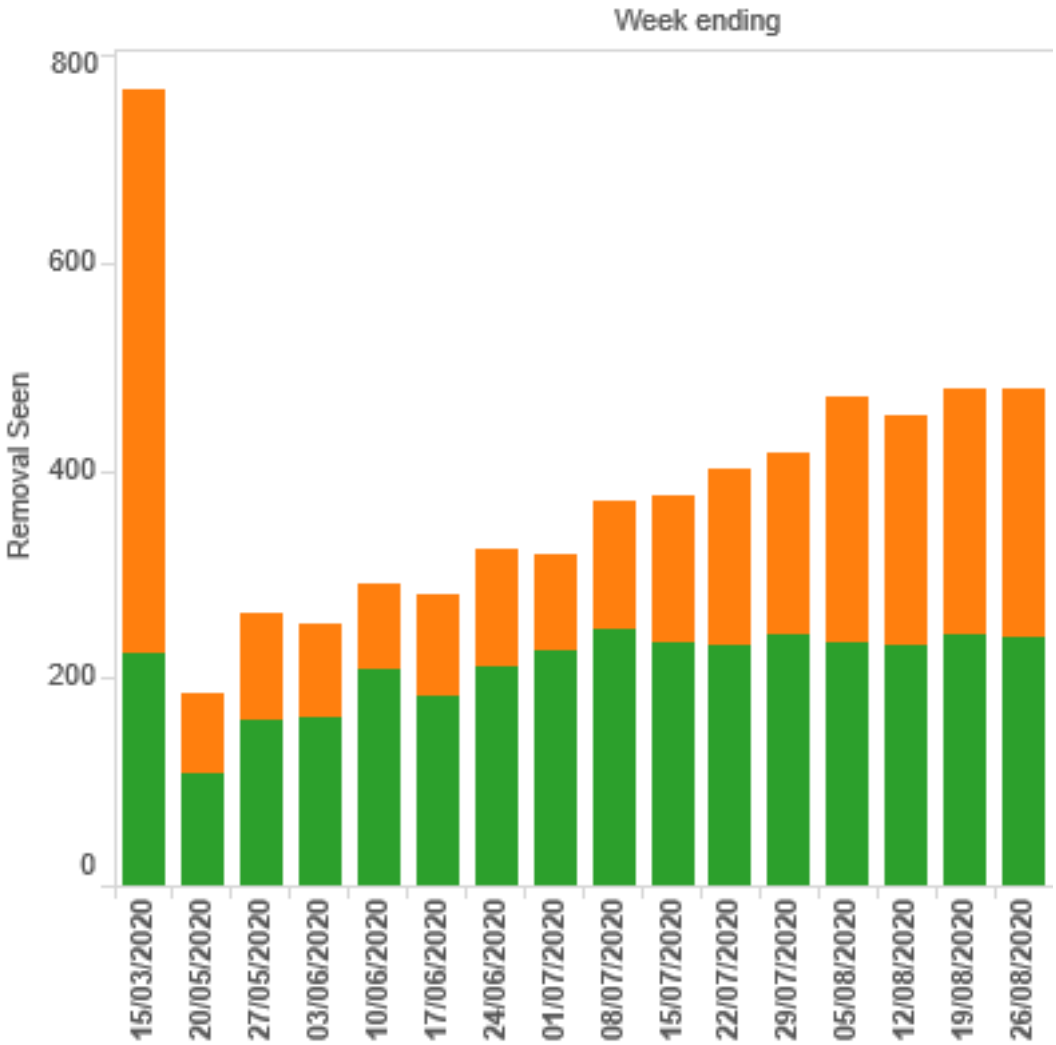
	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20 - *provisional*
NHSL TTG (IPDC) >12 Wk Performance	**2,622**	**2,788**	**2,753**	**3,404**	**5,750**	**8,638**	**10,233**	**10,328**	**9,890**
TTG (IPDC) Trajectory	2,839	3,190	2,922	3,100	-	-	-	-	-
Difference	-217	-402	-169	304	-	-	-	-	-
% of all patients seen, seen within the Treatment Time Guarantee	74.7%	74.2%	77.3%	80.2%	95.2%	89.2%	76.6%	63.8%	-

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

Covid Impact on Inpatient Waits:-

	Pre-Covid – Early March 20	Aug 20	% Change
Waiting List Size – Urgent & Urgent Suspicion of Cancer	1,677	2,424	+44.5%
Waiting List Size – Routine	9,699	11,626	+19.9%
>26 Week Breaches	810	6,340	**+682.7%**

Inpatient Weekly Removals Seen (Activity) by Priority:-



Key:- Orange – Routine; Green – 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	Jul 20	Aug 20
Upper Endoscopy	625	374	792	1,276	1,823	1,909	1,871	1,759	1,816
Colonoscopy patients waiting over 6 wks	933	521	879	884	1,406	1,517	1,476	1,325	1,372
Flexible Sigmoidoscopy (Lower Endoscopy) patients waiting over 6 wks	340	297	332	331	464	502	503	517	556
Gastroenterology Diagnostic Performance	1,898	1,192	2,003	2,491	3,693	3,928	3,850	3,601	3,744
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	Jul 20	Aug 20
Flexible Cystoscopy (Urology Diagnostic) Performance	323	340	362	599	765	792	846	896	877
Flexible Cystoscopy (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	Jul 20	Aug 20
CT Performance	101	112	97	203	1,049	1,000	743	394	219
Trajectory >6 weeks	100	40	0	0	200	200	100	100	100
Difference	1	72	97	203	849	800	643	294	119

Specialty Radiology - MRI Lothian	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20
MRI Performance	87	260	588	448	2,070	1,973	1,329	987	652
Trajectory >6 weeks	150	150	0	0	500	400	300	300	200
Difference	-63	110	588	448	1,570	1,573	1,029	687	452

Specialty Radiology - General Ultrasound (not Vasc)	Apr 20	May 20	Jun 20	Jul 20	Aug 20
General Ultrasound Performance	2,565	2,793	2,031	1,193	744
Trajectory >6 weeks	0	0	0	0	0
Difference	2,565	2,793	2,031	1,193	744

There were 10 breaches for Barium Studies in Aug 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	Jul 20	Aug 20
Urological	94.5%	91.2%	92.2%	90.3%	92.2%	89.4%	95.7%	71.8%	96.1%	93.9%
Colorectal (screened excluded)	85.7%	78.3%	88.6%	96.3%	87.1%	93.8%	92.6%	80.0%	97.0%	96.6%
Colorectal (screened only)	100.0%	100.0%	83.3%	55.6%	100.0%	60.0%	60.0%	50.0%	100.0%	50.0%
Melanoma	91.7%	95.7%	100.0%	100.0%	85.7%	83.3%	100.0%	100.0%	100.0%	100.0%
Breast (screened excluded)	98.1%	97.5%	100.0%	97.5%	98.0%	100.0%	100.0%	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	n/a	100.0%
Cervical (screened excluded)	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	66.7%	100.0%
Cervical (screened only)	100.0%	100.0%	n/a	n/a	n/a	n/a	n/a	100.0%	100.0%	n/a
Head & Neck	100.0%	100.0%	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%	95.4%	100.0%
Lymphoma	100.0%	100.0%	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%	100.0%	100.0%
Upper Gastro-Intestinal (GI)	97.7%	100.0%	100.0%	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%	97.6%	98.1%

62 Day performance	Mar 19	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20
Urological	50.0%	51.7%	47.8%	67.7%	58.1%	57.8%	56.5%	46.9%	57.1%	56.5%
Colorectal (screened excluded)	55.6%	41.7%	38.1%	68.8%	75.0%	82.6%	78.9%	84.6%	65.4%	76.9%
Colorectal (screened only)	0.0%	0.0%	10.0%	11.1%	50.0%	50.0%	40.0%	0.0%	0.0%	50.0%
Melanoma	80.0%	82.4%	94.8%	100.0%	100.0%	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%	100.0%	100.0%
Breast (screened only)	100.0%	97.7%	97.2%	100.0%	100.0%	100.0%	93.8%	n/a	n/a	100.0%
Cervical (screened excluded)	100.0%	100.0%	100.0%	n/a	50.0%	50.0%	50.0%	100.0%	n/a	0.0%
Cervical (screened only)	100.0%	0.0%	n/a	0.0%	n/a	n/a	100.0%	0.0%	0.0%	n/a
Head & Neck	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	71.4%	92.3%	100.0%	90.0%
Lung	92.9%	93.3%	83.3%	84.0%	82.8%	83.3%	93.3%	92.9%	88.9%	93.3%
Lymphoma	100.0%	75.0%	83.3%	33.3%	100.0%	100.0%	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%	100.0%	100.0%
Upper Gastro-Intestinal (GI)	90.5%	100.0%	94.7%	94.4%	100.0%	100.0%	100.0%	100.0%	94.4%	95.5%
All Cancer Types	79.3%	78.0%	78.5%	83.8%	83.0%	82.2%	83.9%	82.9%	82.1%	86.2%

Please note that data provided above are snapshots of management information and may be refreshed/differ from published statistics

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

4EAS performance

NHS Lothian reported compliance to the 4 hour Emergency Access Standard (4EAS) of 91.9% for August 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 22nd September 2020.

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

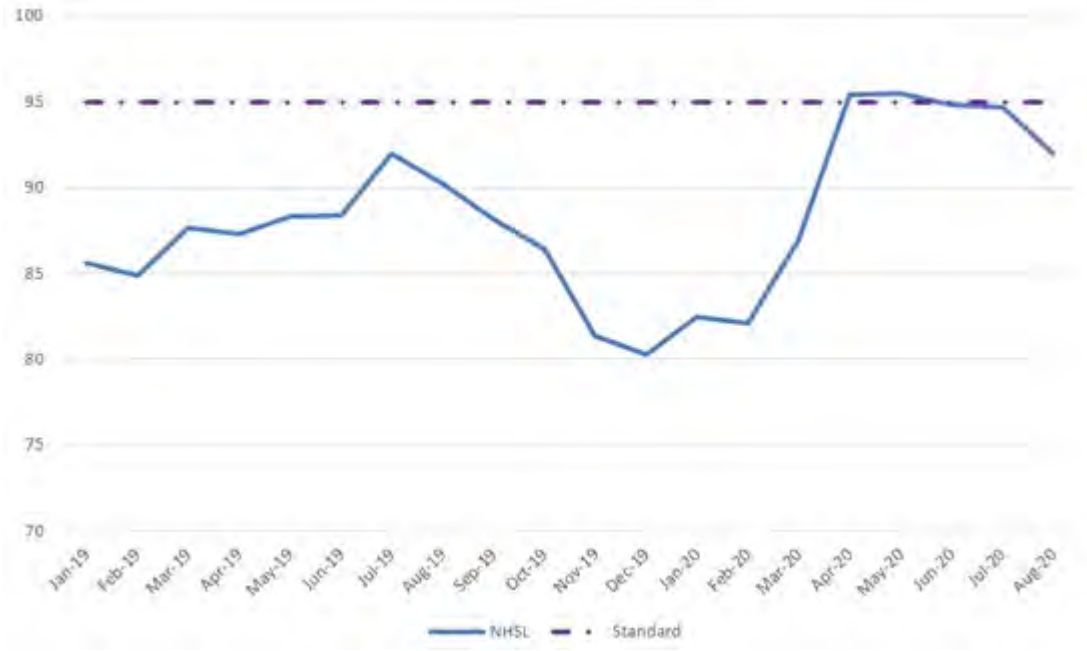


Table 1: 4 hour Emergency Access Standard September 2019 vs September 2020 (as at 22nd September 2020)

	September 19	September 20 MTD	Difference
Royal Infirmary of Edinburgh	83.1%	83.9%	0.8%
Western General Hospital	88.4%	89.7%	1.3%
St John's Hospital	92.3%	92.0%	-0.2%
Royal Hospital for Sick Children	96.1%	96.9%	0.8%
NHS Lothian	88.3%	88.9%	0.6%

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.

8 Hour Breaches

Chart 2: NHS Lothian 8 hour Breaches Jan 18 – Aug 20

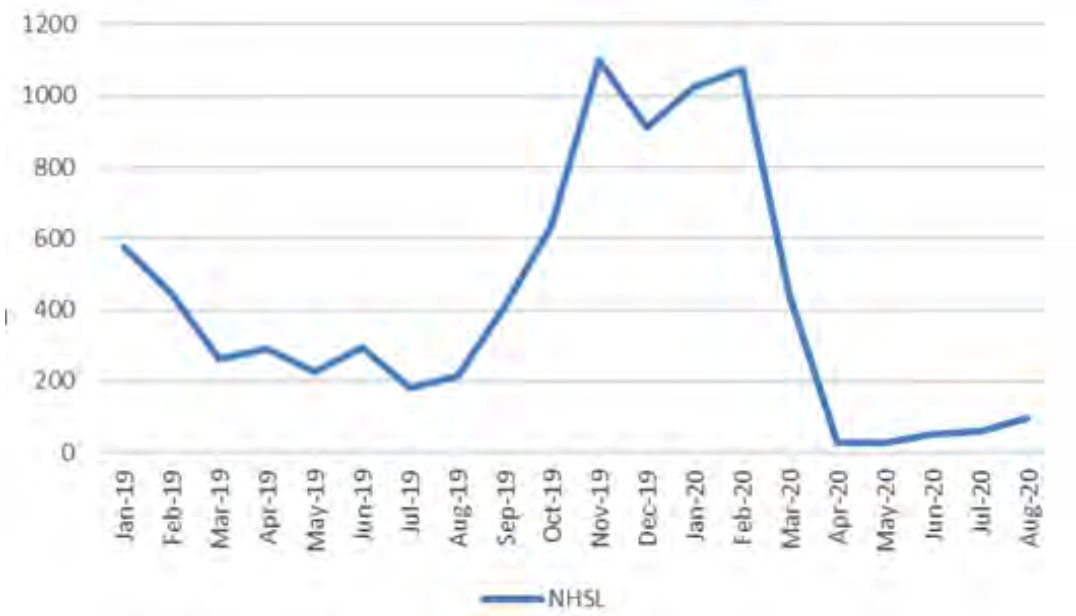


Table 2: *8 Hour Breaches September 2019 vs September 2020 (as at 22nd September 2020), by site

	September 19	September 20 MTD	Difference
Royal Infirmary of Edinburgh	236	114	122
Western General Hospital	89	15	74
St John's Hospital	77	23	54
Royal Hospital for Sick Children	3	2	1
NHS Lothian	405	154	251

*includes 8 hour breaches that went onto to become 12 hour breaches

12 Hour Breaches

Chart 3: NHS Lothian 12 hour Breaches Jan 18 – Aug 20

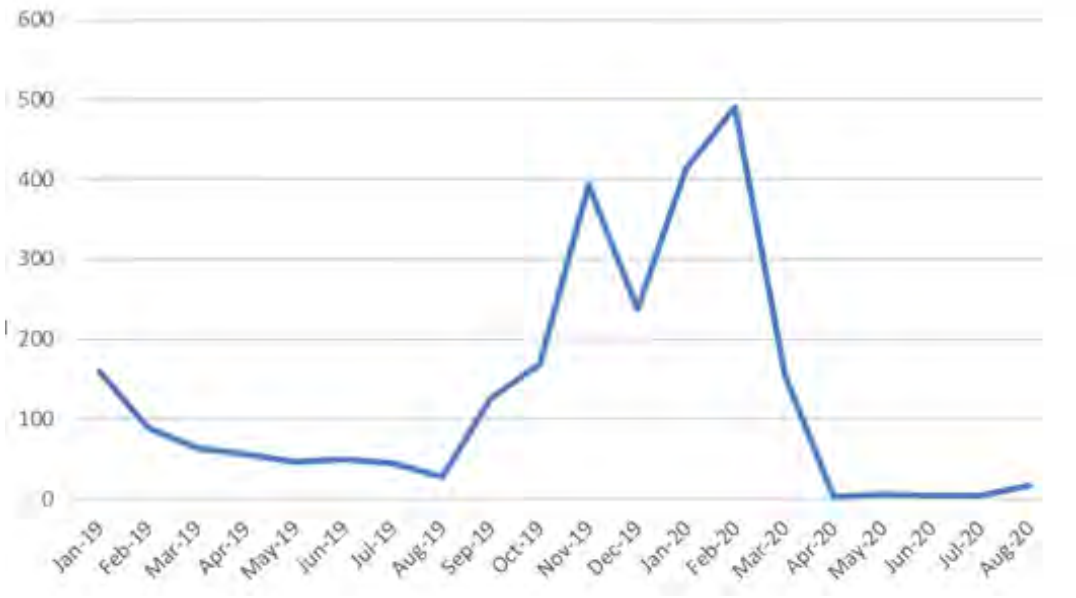


Table 3: 12 Hour Breaches September 2019 vs September 2020 (as at 22nd September 2020), by site

	September 19	September 20 MTD	Difference
Royal Infirmary of Edinburgh	39	30	9
Western General Hospital	54	0	54
St John's Hospital	32	6	26
Royal Hospital for Sick Children	1	0	1
NHS Lothian	126	36	90

Chart 4: NHS Lothian Attendances Jan 18 – Aug 20

Table 4: ED Attendances September 2019 vs September 2020 MTD

	September 19	September 20 MTD	Difference
Royal Infirmary of Edinburgh	11,067	6,261	4,806
Western General Hospital	4,021	2,072	1,949
St John's Hospital	5,355	2,951	2,404
Royal Hospital for Sick Children	4,561	2,518	2,043
NHS Lothian	25,004	13,802	11,202

Further information on Call MIA and SDEC pilots

Call MIA

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 August 16th Call MIA provided 1,138 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.

SDEC

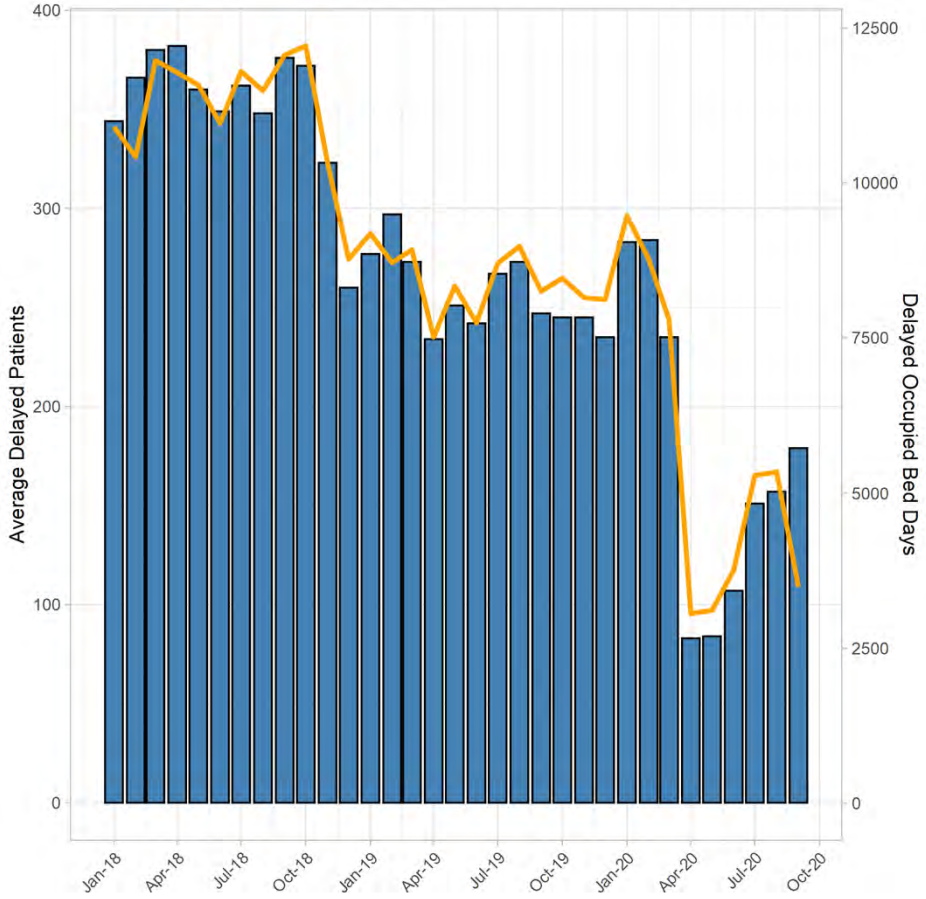
During the 6 week test of change at WGH (22 June – 31 July), there were 1,011 clinical episodes. There were 974 patients who were seen within SDEC. 478 visited for the existing ambulatory services, 483 visited for the new general medicine services, and 13 patients used the telephone/direct consultant link. In terms of patient count, there were more patients who used the new general medicine services. The 483 patients who utilised the new general medicine services would have gone to trolleys if SDEC did not exist. This is approximately 80 patients per week. Therefore, during the duration of this pilot, 25% of trolley attendances went through SDEC. During the pilot, 30% of patient went through the red pathway and 70% went through the green pathway. New appointments accounted for 60% and return appointments made up 40%. 55% of clinical episodes were discharged 'home,' 27% were provided with a return appointment to SDEC, 9% discharged to an alternative outpatient appointment, 7% were admitted to a ward and 2% were transferred to MAU Trolleys. There was a 10% average readmission rate for patients who attended SDEC in the last 7 days. This included patients who were admitted the same day or transferred to Trolleys. In existing SDEC literature, there is an expected 10-15% admission conversion rate; thus, the pilot's readmission rate is within the expected range[1]. 48% of appointments occurred between 9am-12pm, 30% between 12pm-3pm and 22% from 3pm onwards. 80% of patients were from the city of Edinburgh, 16% from East Lothian and 4% from Midlothian. Of all Flow Centre referrals in July 2020, 11.74% went to SDEC and 29.77% of WGH referrals went to SDEC. Patients were provided with a patient feedback form and 40 patients replied. 78% of patients gave the service 5 stars, 15% gave the service 4 starts and 7% did not rate the service. There were 23 staff respondents who provided unanimous consent that SDEC had a future at the WGH. The Unscheduled Care Programme Board has agreed to support the ongoing funding of SDEC as a 5 day service, with ongoing evaluation to determine if a 7 day service should be funded.

1. NHS England and NHS Improvement. *Same- Day Emergency care: clinical definition, patient selection and metrics*. 13 (2019).

Delayed Discharges

Chart 3 illustrates the significant reduction in delayed discharge numbers in April to date. While the number of delayed discharges have increased since the low in April 2020, the numbers are still historically low for Lothian and importantly the occupied bed days remains significantly lower than the pre-Covid level. HSCPs are continuing to make processes more efficient and are working with acute colleagues to implement a Home First approach.

Chart 5: NHS Lothian Average Delayed Discharges and Occupied Bed Days [1] Jan 18 – September 20 (MTD to 22nd September)



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

NHS LOTHIAN

Board Meeting
14 October 2020

Executive Director, Nursing, Midwifery and Allied Healthcare Professionals and REAS
Director of Improvement
Director of Psychology

LOTHIAN RECOVERY PLAN
PSYCHOLOGICAL THERAPIES UPDATE

1 Purpose of the Report

1.1. The purpose of this report is to update the Programme Board on progress in relation to improving performance against the Psychological Therapies LDP Access Standard and associated initiatives to strengthen the clinical governance and improve the effectiveness of services. It provides an overview of activities and actions already undertaken and the proposed further programme of work.

2 Recommendations

2.1. To note the recent and continuing challenges arising from the restrictions associated with Covid-19 and the actions taken to date to maintain services and improve performance.

2.2. Endorse the proposed further actions to improve waiting times recognising that individual staff and teams will be subject to increased accountability and performance management.

2.3. To support the implementation of scheduled capacity for taking on new patients and associated patient allocation and booking systems managed by administration, such as Patient Focused Booking, which will reduce the autonomy of individual practitioners.

2.4. Recognise and support the authority of the Clinical Standards, Governance and Training Board for Psychological Therapies to implement greater standardisation of clinical governance across each HSCP.

2.5. Recognise and support the consistent implementation of improved waiting list co-ordination and governance, including standardised and consistent application of policies relating to patient non-attendance.

3 Discussion of Key Issues

3.1. The Scottish Government's access standard for psychological therapies is that 90% of patients should commence treatment within 18 weeks of referral. Public Health Scotland has reported that for the quarter April - June 2020 NHS Lothian saw 2,868 people of whom 74.1% were seen within 18 weeks (down from 3,629 and 78% at end March 2020 but comparable to the current Scottish average of 74.3%) and ranked 5th of 12 NHS Boards.

3.2. Across Scotland during the April – June 2020 quarter activity levels fell dramatically (by 39.6% for new treatments and 44% for referrals) as a result of the impact of Covid-19. In Lothian there was a focus on the safety of those already on the waiting list and some primary care psychological therapy teams ceased taking on new patients for a time to support other community responses. However, activity levels were maintained across psychology teams as additional staff started work during this period. There remain ongoing, though reduced impacts from Covid-19, but activity levels have largely been restored albeit as digital consultations. Group work has not recommenced to the full extent due to the need for social distancing and this has had a significant impact in some services. Psychological therapy by videoconference has been facilitated when clinicians have access to suitable IT to use 'Near Me'. There is a shortage of equipment, so telephone still has the major role. However, this is being addressed with the rollout of a batch of new laptops being expected by the end of October 2020.

3.3. Internal reporting of performance for NHS Lothian for the period July – September shows that overall performance is 81.4%, however to a significant extent this performance is enabled by the high number of patients entering cCBT therapy within a matter of days. Over this period Learning Disabilities and Neuropsychology have faced particular challenges as they have not been able to conduct many aspects of psychological intervention / neurophysiological testing by remote working methods. The Learning Disabilities population also has a particular issue with digital poverty and engagement. However, General Adult Services continues to be the main challenge with only 34.6% of patients commencing treatment within 18 weeks.

	Jul-20		Aug-20		Sep-20		Jul- Sept Qrtr	
Service	Pts seen	% <18 wks	Pts seen	% < 18 wks	Pts seen	% < 18 wks	Pts seen	% < 18 wks
CAMHS	0	-	0	-	0	-		-
cCBT	529	100.0%	526	100.0%	379	100.0%	1,434	100.0%
General Adult Services	200	33.0%	273	32.2%	155	40.6%	628	34.6%
Learning Disabilities	9	44.4%	2	50.0%	3	100.0%	14	57.1%
Older Adult Services	51	94.1%	35	100.0%	23	100.0%	109	97.2%
Psychotherapy	7	100.0%	7	100.0%	8	87.5%	22	95.5%
Specialist Service [Adult]	101	82.2%	94	84.0%	46	80.4%	241	82.6%
Clinical Health Psychology	123	94.3%	129	85.3%	129	85.3%	381	88.2%
Neuropsychology	42	52.4%	34	73.5%	34	73.5%	110	65.5%
GSH (3rd Sector)	7	0	-	-	-	-	7	-
Overall Performance	**1,069**	**82.2%**	**1,100**	**79.2%**	**777**	**83.3%**	**2,946**	**81.4%**

3.4. The largest and most significant component of the waiting list relates to psychological therapies in Adult Mental Health outpatient services which are delivered across Lothian by 11 teams, where that has been a long term steady deterioration in performance.

3.5. Psychology has clinical governance responsibility for the delivery of psychological therapies across Lothian. Operational management is split with psychology teams managed by Psychology and the HSCPs managing the psychological therapists that they employ. Across Lothian 53.8 WTE psychology staff are currently employed with a further 22.2 WTE psychological therapists employed by the HSCPs. However, every effort is made to operate as a co-ordinated local team.

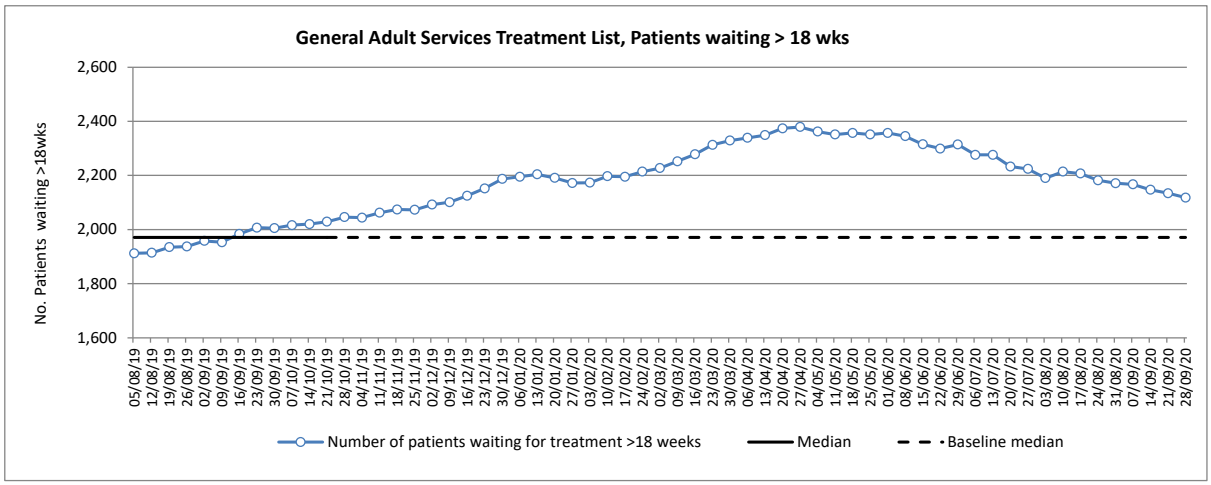
3.6. Waiting list trajectories were prepared in 2019 based on a broad assumption that one new patient could be taken into treatment from the waiting list per week for each WTE member of staff. This assumption proved inaccurate with subsequent analysis identifying that 0.7/ WTE/ Week was a more typical historic performance. The result was that the waiting list continued to rise until April 2020.

3.7. A key part of the recovery effort is an investment in additional temporary capacity for 18 months. This amounts to 17 WTE (5.1 still vacant) in Edinburgh, 6 WTE (2.9 still vacant) in Midlothian and 5 WTE (0.3 still vacant) in West Lothian.

3.8. The major part of that capacity commenced work in Edinburgh City during April 2019 with some additions to the other HSCPs, although recruitment proved challenging, particularly at Band 6. However, the workforce has a considerable part-time component and fairly high turnover. At present there are 8 WTE vacancies for permanent post psychological therapists in the primary care mental health teams. In addition, within the PCMHT component difficulty recruiting staff has led to the appointment of some 5.9 WTE staff and a possible further 2.7 WTE who are not trained to deliver psychological therapies and consequently are unable to take patients from the A12 psychological therapies treatment waiting list.

3.9. Since April 2020 there has been a gradual decline in the waiting list as shown below.

Adult Mental Health: Psychological Therapies Waiting List Aug. 2019 – Sept. 2020



3.10. The activity levels that underlie the above changes in the waiting list are shown in the table below reflecting three phases in the overall trend in the waiting list.

	Total	Aug 19-March 20	April – June 20	July – Sept 20
Period Length in Weeks	58	34	13	11
Additions to Wait List / Week	55	60	50	48
New Patient Appointments / Week	49	45	58	49
Change in Total No. Patients Waiting	+149	+354	-149	-56
Change in No. Patients Waiting > 18 Weeks	+255	+401	-14	-132

It should be noted that the April – June period covered the initial lockdown and the transition to digital consultation (note a significant number of patients have declined, to await face-to-face consultation). However, it was also during this period that the new temporary staff started coming into post. The July – September period included the summer holiday period.

3.11. Alongside the investment in additional capacity, data analysis and other considerations identified a number of key historical issues:

- Significant variation in the duration (number of appointments) of treatment provided to patients. Some variation is inevitable and expected based on individual patient circumstances and clinical judgement. However, the current ranges are significant, for example at Matrix Level 2 (mild to moderate mental health disorders) there is a range between 1 and 40 appointments with a mean of 9. At Matrix Level 4 (most severe) the range is between 1 and over 110 appointments with a mean of 17;

- Actual scheduled (offered) appointments are consistently less than the expected number based on job plans (a standard full time job plan at Bands 6, 7 and 8a is typically 18 appointments per week), i.e. some staff are consistently not undertaking their planned number of appointments each week. In addition, actual arrived appointments are historically some 25% lower (this has reduced since the shift to primarily digital consultation though it should be noted that the literature suggests a significant level, circa. 20%, should be expected in mental health);

- Insufficient standardisation of the therapies that are offered and the associated processes for referral, initial assessment, ongoing assessment and monitoring of progress and using standardised measures to review clinical outcomes with associated decision to discharge;

- Appointment scheduling and caseload sizes are managed by the individual practitioner in consultation with their supervisor. There is currently no forward scheduling of reserved capacity to take-on new treatment patients and consequently little basis on which to forecast capacity and waiting list trajectories;

- Activity reporting was fragmented with a lack of accepted 'norms' (performance standards) against which to monitor performance.

3.12. The Director of Psychology Services for Lothian was appointed in October 2019 and an interim Psychology Lead for Adult Mental Health has recently been appointed, starting on 22nd September 2020. Further recruitment is due to take place to leadership roles. To address the above issues various measures are being introduced as follows:

- A new weekly Manager's Report and a Caseload Report have been introduced, including expected 'norms' from job plans (expected appointment numbers and expected new patients at team and individual levels). This is intended to enable Team Leads to closely monitor and better manage activity and to support better informed clinical and management supervision;

- A model to estimate individual and team capacity to take on new treatment patients has been introduced to assist team leads in agreeing and setting expectations with their staff. Its use is relatively new, and it requires critical assumptions regarding mean durations of treatment which are still being agreed. Nevertheless, it provides a much sounder basis for planning, projecting capacity and managing performance. The present projection is that there is capacity across Lothian to offer 74 (compared to 58 during April to June period and 49 during July to September) new treatment appointments per week. However, at this point this modelling is still subject to review and refinement with the local team leads and finalisation of key assumptions;

- A new Psychological Therapies Governance, Standards and Training Board has been established which will lead the evaluation of selected therapies that have a less firm evidence base and also the refinement of treatment duration expectations and related processes such as assessment and expectations of supervision. The seniority and experience of this Board chaired by the Director of Psychology will provide the needed credibility to these judgements;

- New waiting list co-ordination and allocation processes are being designed with a focus on Edinburgh. This will include both clinical supervision and enhanced administrative support to relieve the administrative burden on clinical staff and to ensure the longest waits are addressed. Patients are now placed on the waiting list at the different matrix levels which enables better matching of provision with demand across each team. This approach combined with additional capacity has already resulted in the longest waits in Edinburgh being reduced from 134 weeks to 90 at Matrix Level 4 (most severe) and to 71 at Tier 3 (moderately severe).

- Patient Focused Booking which is currently utilised for assessment appointments is being introduced for first treatment appointments which typically have high DNA and short-term cancellation rates. New treatment patient slots will be reserved in advance on Trak for each therapist providing an agreed consistent pace for taking new treatment patients from the waiting list. This will be trialled in East and West Lothian commencing in October 2020 and is being considered in Edinburgh;

- A new psychological therapies website is in development and is expected to be launched circa. end November 2020. This site will be accessible to patients and will provide education and direction to statutory and third sector services. It will also provide the route to access the wide range of licensed SilverCloud online therapy modules that are now available and in due course will allow patients to sign-up for group courses.

3.13. Introduction of the above changes, which represent a significant increase in performance management, is challenging for team leads and for staff as they change long standing culture and practice around ways of working. Additionally, the service is still coming through the experience of Covid-19 which has involved staff transitioning to digital forms of treatment (which can be effective if both clinicians and patients have access to IT) and safeguarding their existing patients and those on the waiting list, as well as dealing with the personal challenges arising from the pandemic. The pace of change has therefore had to be appropriate and is still proceeding. In particular, a focus has been placed on supporting team leads and working together to develop activity expectations and forecasts that have local ownership within teams. Work is still ongoing to finalise waiting list trajectories for individual teams.

3.14. Further work remains to improve the processes of referral and assessment that precede addition to the psychological therapy treatment waiting list. Alternative options such as a range of supervised online cCBT options, group work, CMHT and third sector care, or other support through developments such as Mental Health Hubs may well be more effective for patients than a significant wait for individual therapy. The assessment process needs to be improved to ensure the right patients access psychological therapy whilst others are provided with alternative care appropriate to their needs.

3.15. The consistent use of outcome measures and goal-based interventions will facilitate treatment efficacy and reduce the number of appointments provided with appropriate discharge. Interventions to improve clinical governance and caseload management also have a critical role in improving performance, formalising these processes will be included in the Standards, Governance and Training Board.

4 Key Risks

4.1 The mixed operational management model with psychologists managed by the Director of Psychology (as part of the REAS SMT) and psychological therapists managed by the HSCPs can be a successful model with close cooperative working. However, maintaining the resource commitment to the psychological therapy waiting list and its access standard and supporting other clinical care and delivery of other mental health interventions needs to be balanced appropriately.

4.2 Whilst there has been a significant temporary addition to the psychology staff complement to provide increased capacity, staff retention is an issue. Vacancies remain amongst mainly the primary care teams and turnover is not insignificant, including movement between services in Lothian. In particular, the PCMHTs in Edinburgh find it difficult to recruit band 6 staff with requisite training and experience to take patients from the psychological therapies A12 waiting list. In a retained mixed operational management system, joint workforce planning and pathway mapping is important to consider how the resource is best configured to meet clinical demand and the delivery of psychological therapies.

4.3 Greater performance management is challenging for staff, in particular as it will lead to greater expectation of fulfilling agreed job plans and the associated increase in caseloads, which is a reasonable expectation, but it will also challenge cultural expectations and lead to greater clinical responsibility and accountability. Inevitably this means some adjustment for staff and will require support from psychology and team leads, through supervision and case management.

4.4 Achieving reduced variation in the duration of treatment needs to strike an appropriate balance between patient focused care, managing clinical risk and utilising scarce resource efficiently in the context of long waiting lists. The onus will need to be on the new Standards, Governance and Training Board to monitor progress of the quality of service provision and make pragmatic adjustments based on a shared view of evidence based psychological treatments and clinical standards.

4.5 Further progress is still required to raise capacity consistently across Lothian to the levels that have been modelled. This is achievable with shared ownership of the LDP Standard and associated cultural change to support adjusted work expectations. Nevertheless, it remains likely, though subject to further confirmation, that the temporary additional capacity that has been recruited will need to become permanent if demand and the Scottish Government's access targets are to be met.

4.6 The impact of Covid-19 on mental health has been widely reported and there is some reasonable evidence of its impact in delaying presentations which, as a consequence, are more severe. Lockdown reduced referrals to psychological therapies, but these are returning to previous levels. It is predicted that there will be a long-term impact on mental health that increases demand.

4.7 The impact of the shift to primarily digital consultation, a mix of telephone and Near Me (still limited by access to appropriate equipment), is not yet apparent in terms of the speed of efficacy of treatment as compared to face-to-face. There is evidence that it is as effective, but local experience and confidence in this is still to be established.

5 Risk Register

5.1 Lothian does not at present meet the Scottish Government's access standard (90%) for psychological therapies (September: 82%). The specific area of Adult Mental Health remains challenging. However, overall for the purposes of the standard this is offset by other adult psychology services and cCBT. It is proposed that a further report to the Board on the AMH improvement and projections will be made in six months when the rate of progress being achieved will be more apparent.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment has not been carried out and there are no significant concerns that have been identified related to the proposals above.

6.2 However, psychological therapies are subject to the wider concern as to whether digital consultation may disadvantage certain sectors of the community. A significant number of patients have declined digital consultation and to date have been retained on the waiting list, albeit with it noted that they have been made an 'offer'. Board, and possibly national, policy is awaited as to how this matter should be suitably addressed depending on the development of the pandemic.

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

7.1 The proposed changes relate to internal performance management of services and their redesign to better accommodate the needs of patients. However, they do not fundamentally change the Board's service offering.

7.2 The psychological therapies website for use by patients is a new service. Patient representation has been retained to advise on design matters.

8 Resource Implications

8.1 There are no resource implications at present. However, the matter will arise in due course as to whether to retain the additional capacity that has been secured beyond September 2021. The associated budget is approximately £1.5m. It remains important that vacancies are filled in a timely manner and maternity leave cover is funded

Belinda Hacking
Director of Psychology
05 October 2020
Belinda.Hacking@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
14th October 2020

Executive Director, Nursing, Midwifery and Allied Healthcare Professionals and REAS
Director of Improvement
General Manager, REAS

LOTHIAN RECOVERY PLAN
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress in relation to improving performance against the CAMHS LDP Access Standard and associated initiatives to improve the clinical governance and effectiveness of services. It provides an overview of activities and actions already undertaken and the proposed further programme of work.

2 Recommendations

2.1 To note the recent and continuing challenges arising from the restrictions associated with Covid-19 and the actions taken to safeguard children and young people while maintaining service delivery.

2.2 Endorse the proposed further actions to improve waiting times recognising that individual staff and teams will be subject to increased accountability and performance management.

2.3 Recognise and support the key requirement for multi-sector collaboration and solutions through the Children's Partnerships to allow CAMHS Tier 3 to focus on children and young people most in need of specialist skills, and ensure appropriate care is provided at Tier 2.

2.4 To support the implementation of scheduled capacity for taking on new patients and associated patient allocation and booking systems managed by administration, which will reduce the autonomy of individual practitioners.

2.5 Note that there remains some uncertainty on the date of meeting the Scottish Government's access standard and a further report will be made to the Board in six months.

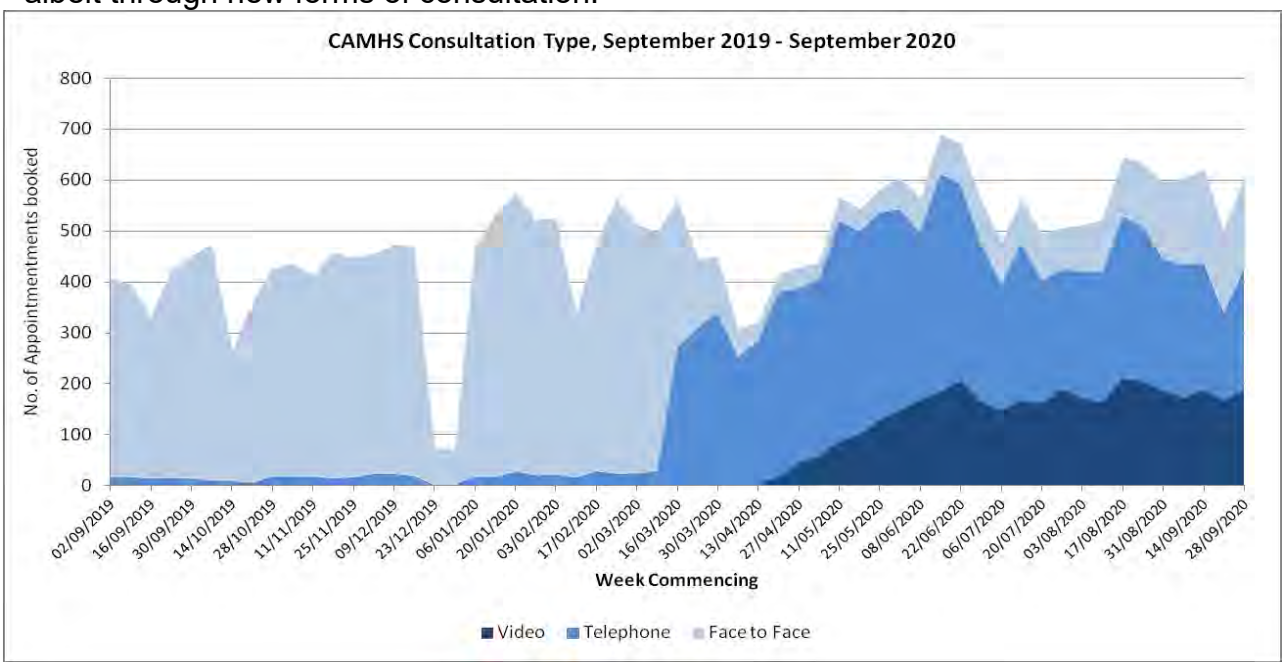
3 Discussion of Key Issues

3.1 The Scottish Government's access standard for CAMHS is that a minimum of 90% of patients should commence treatment within 18 weeks of referral. Public Health Scotland has reported that for the quarter April - June 2020 in NHS Lothian 546 children and young people started treatment of whom 51.7% were seen within 18 weeks (this was down from 865 and 54.6% at end March 2020 and below the current Scottish average of 59.3%).

3.2 Across Scotland during the April – June quarter activity levels fell dramatically (by circa. 56% for referrals and 14% for new treatments commencing) due to the impact of Covid-

19. In Lothian there was a fall in April and May in the total number of appointments offered. However, this recovered in June.

3.3 Throughout the Covid-19 National lockdown CAMHS in Lothian focussed resources in protecting and supporting the most vulnerable children and young people on the caseload and waiting list. A new Unscheduled Care service was established in May to respond to crises during the pandemic. This has recently been positively evaluated and will be commissioned to continue on a permanent basis. A rapid transition was made to digital consulting, initially by telephone but increasingly by videoconference (Near Me) as 153 laptops were rolled out to staff. CAMHS is a leading user of this technology within Lothian and this has enabled a continuation of services throughout Covid-19 albeit through new forms of consultation.

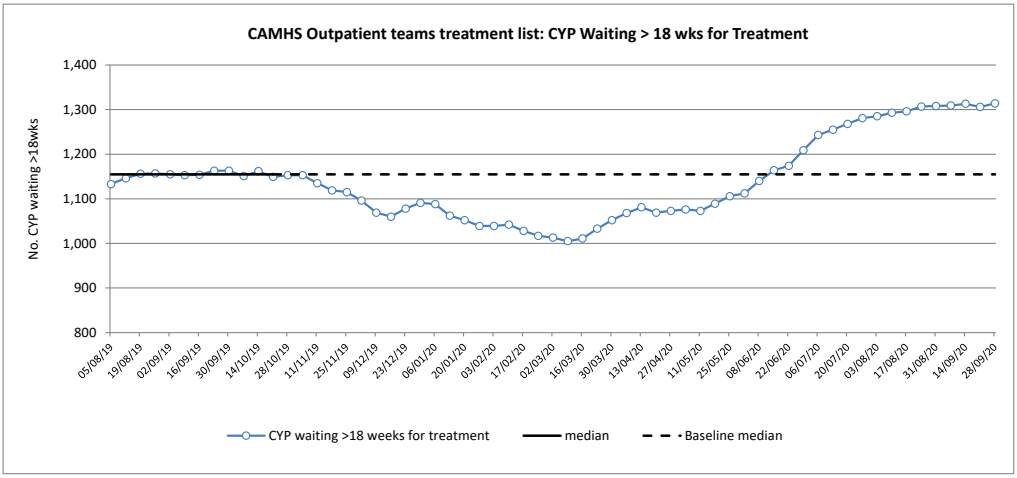


3.4 Internal reporting of performance for NHS Lothian for the period July to September shows an improvement with 56.9% of patients seen within 18 weeks.

3.5 NHS Lothian has had an ongoing improvement effort in CAMHS since late 2019 following a long-term steady deterioration in the waiting list. From 2019/20 there was an additional £3m per annum investment to recruit additional staff with a 12.3% rise in the workforce by April 2020.

3.6 From November 2019 this investment had a positive impact in reducing the waiting list. However, the Covid-19 lockdown in March 2020 has resulted in a reversal of the improvement trend and an increase in waiting list numbers as shown below.

3.7



3.8 The waiting list trajectory that was previously prepared in 2019 proved reasonably accurate up to lockdown but has since been disrupted. The key activity levels that underlie the changes in the waiting list are shown in the table below. They show a baseline from August to October 2019, highlight the progress made between November and March 2020, and the subsequent increases in the waiting list from April 20 to September 20.

	Total	Aug 19 – October 19	Nov 19 – March 20	April 20 – Sept 20
Period Length in Weeks	**57**	**13**	**21**	**23**
Additions to Treatment Waiting List per Week	**33**	**32**	**35**	**33**
New Patient Appointments Offered per Week	**29**	**28**	**39**	**21**
Change in Total No. Of Patients Waiting	128	9	-135	254
Change in Total No Of Patients Waiting per Week	**2**	**1**	**-6**	**11**
Change in No. of Patients Waiting > 18 Weeks	175	20	-120	275
Change in Patients Waiting > 18 Weeks per Week	**3**	**2**	**-6**	**12**
Discharges per Week	**18**	**23**	**20**	**13**

3.9 During the April 20 to September 20 period ADHD and Autism specialist assessments had to be paused due to the necessity of social distancing requirements and an inability to conduct school and home observation. Consequently, a backlog of uncompleted assessments has developed. Other discharges also slowed due to lack of availability of school follow-up and monitoring and third sector activity reduction. This difficulty with discharging patients has resulted in the slowdown in accepting new patients into treatment which has fallen significantly.

3.10 In the short-term further recruitment to CAMHS is planned. There remains 18.3 WTE posts funded under the investment programme. These individuals will be in post by December 2020.

3.11 Four nursing staff are now trained in non-medical prescribing and are currently supporting ADHD prescribing releasing psychiatry resource and improving the patient journey. All will shortly undertake further Clinical Decision Making training as part of the Advanced Nurse Practitioner pathway.

3.12 Data analysis and other consultation has also identified a number of key issues:

- All staff have job plans which identify an anticipated number of direct clinical care appointments to be delivered each month. Performance against plan is monitored monthly. However, the existing reports provide no differentiation between Choice (assessment) and treatment appointments, which have multiple forms in terms of duration and the number of staff involved. They also do not report the number of new patients taken on (though this is available separately). A new Manager's Report providing a more comprehensive overview of activity has been developed and will be fully rolled out following final validation;

- Further work is required to standardise standardised application of the DNA policy as it is important to ensuring equity and prioritisation of care when managing waiting lists. This is a challenge in CAMHS where the welfare of children and young people is at stake and it is important that the policy is clear and fairly applied with variation only in exceptional circumstances;

- Appointment scheduling and caseload sizes are managed by the individual practitioner subject to clinical and management supervision. Whilst there is typically reserved time in regular clinics for Choice (assessment) appointments there is no forward scheduling of reserved capacity to take-on new treatment patients;

- There is significant variation in the duration of treatment afforded to patients. Some variation is inevitable and expected based on individual circumstances and clinical judgement. However, the current ranges are significant and there is relatively little clinical classification of the data to allow categorisation to support forecasting. Work will commence with the intention to limit this unwarranted variation in conjunction with performance management. The newly formed Psychological Therapies Clinical Governance, Standards and Training Board covers the full age range and an evaluation of evidence based interventions and agreed standards for average duration of treatment is included in its remit and planned work;

- In the short term it is intended to remove ASD patients from the existing Core Outpatients waiting list and combine this category with ADHD to create a separate Neurodevelopmental waiting list. A corresponding development which will assist resource management will be ensuring all staff have job plans that distinguish between Neurodevelopmental and Core commitments.

3.13 Additionally, in East Lothian CAMHS a project originally initiated under the QI Access programme is underway. This was disrupted by lockdown however the process mapping of clinical pathways will shortly be completed and this will have a particular focus on safety processes including decision making and documentation. Work is underway to analyse associated data regarding activity volumes and durations for the

various tasks with a view to identifying the impact of Covid-19 adaptations and other opportunities for improvement.

3.14 Further work will be undertaken within CAMHS, drawing on the CAPA (Choice and Partnership Approach – a specialist CAMHS service organisation and delivery approach) methodology and any learning from the QI Access work. The aim will be to improve the capability to forecast individual practitioner and team capacity, to establish a revised waiting list trajectory, and to introduce the reporting and other supervision mechanisms required to manage performance. To deliver this it is intended to appoint four service managers at the level of individual geographic CAMHS teams to provide leadership and build on this work and reduce the administrative burden on clinical staff.

3.15 A significant matter is the relationship between Tier 3 and Tier 2 CAMHS and the various pathways available to children and young people. Tier 2 capacity was reduced approximately 3 years ago when a proportion of the time of Community Mental Health Workers was redirected to Tier 3 waiting list work. However, it is an important level where children and young people who do not need specialist care are supported as are those discharged from Tier 3. Importantly Tier 2 is delivered by a range of agencies as brought together in the Children's Partnerships including Education, Social Work, the Third Sector and CAMHS. Investment is taking place at present at Tier 2 with the introduction of school counsellors.

3.16 At present, a significant proportion of referrals to CAHMS are returned to the referrer at referral (29%, national benchmark is < 20%), the most common destination being 'Back to GP' (82%). CAMHS recognises that supporting and building the capacity of communities can, through early intervention, promote wellbeing in children and young people and potentially avoid the need for Tier 3 care. Various initiatives have been undertaken to address this issue of care at Tier 2 including:

- The Edinburgh Wellbeing Academy which is a joint project delivered collaboratively between Psychological Services and CAMHS. The aim of the project is to improve school-based capacity to deliver evidence based early supports in relation to emotional health and wellbeing. There are currently 37 Schools (10 secondary and 27 primary schools) involved in the project;

- CAMHS is currently building capacity in universal settings (i.e. Tier 1 including school nursing, education, general medical practices, health visiting) and supporting the availability of low-intensity community-based interventions in order to enable early access to services;

- CAMHS Tier 3 services are supporting the delivery of a Cognitive Behavioural Therapy informed low intensity intervention for anxiety by non-mental health professionals named Let's Introduce Anxiety Management (LIAM). Six two-day training events in LIAM were delivered between October 2017 and February 2019 to 94 non-mental health professional working in schools (school nurses, educational psychologists and pupil support officers). Outcome data from 90 Children and Young people who had completed the pilot LIAM programme showed statistically and clinically significant improvement;

- Building on the success of the LIAM programme, from October 20 CAMHS will support the development of a low intensity intervention for low mood, known as 'Behavioural Activation'. This will be delivered by practitioners in universal settings.

3.17 Further investment by the Scottish Government to Local Authorities for community support for mental health and wellbeing is also expected to offer early intervention and support discharges from CAMHS, as well as an alternative to referral to CAMHS. There will be an opportunity to test a multi-agency single point of referral in Midlothian which will provide data to inform such community developments. CAMHS will look to adopt a consultancy model and provide 'in-reach' to local authorities and 3rd sector organisations. This model of care not only provides early intervention for those with less complex disorders, it also provides input for those who are considered hardest to reach; those whose circumstances that do not allow the Children and Young People to benefit from formal CAMHS interventions. These Children and Young People are often considered the most in need of CAMHS input, therefore this consultancy model enables psychological/specialist CAMHS interventions to be delivered through others.

3.18 Overall it is clear that capacity at Tier 2 to ensure only those patients who need specialist services are referred to CAMHS Tier 3, and that at the right point they can be confidently discharged back to appropriate community support, is critical to the effective overall functioning and flow of the Tier 3 CAMHS service. This will ensure a focus on the most severely ill children and young people. This requires the combined efforts of local authority (education, social work), Health (CAMHS, Community Child Health) and the Third Sector, mediated through the Children's partnerships who all need to work to a common set of care pathways supported by strong relationships and communication.

3.19 CAMHS will continue its strategic programme which was interrupted by the Covid-19 pandemic and lead work with its partners to address this issue. The timing is appropriate with the current expansion of school counselling that is underway. Whilst accurate forecasting and performance management is a key requirement within Tier 3 CAMHS, resolving the issue of ensuring patients are cared for at the right level in a coordinated and integrated fashion is the answer to the long-term sustainability and effectiveness of the service. A project manager has been appointed to lead this work, including the digital support that can be provided for co-ordinating patient records and clinical and care communication.

4 Key Risks

4.1 Recruiting additional experienced staff to fill vacancies, and to cover leave and absences, without drawing from other Lothian services or indeed from within CAMHS itself will remain challenging.

4.2 Greater performance management is challenging for staff, in particular as it leads to greater expectation of fulfilling job plans and is likely to include a more formal commitment to the rate at which new patients will be taken onto caseloads with additional unexpected demands and greater clinical responsibility. Inevitably this means some adjustment for staff and will require support from team leads. It is unlikely that significantly greater flow can be achieved without resolving the current slowdown in capacity to discharge in a safe and appropriate manner. One option may be to increasingly retain patients on caseloads, for a period of three months, without a further appointment but with the option to request one. This may help avoid the issue of

reluctance to discharge due to the current length of the waiting list and the limitations of digital consultation.

4.3 Achieving a reduction in variation in the duration of treatment needs to strike an appropriate balance between patient focused care, managing clinical risk and utilising limited resource efficiently in the context of long waiting lists. The variety of care within CAMHS makes this a challenging balance to achieve.

4.4 Each local authority area will need its own multi-agency solution. An appropriate balance will have to be struck between meeting local needs through a local multi-agency approach and ensuring a consistent pan-Lothian approach across Tier 2 and 3 CAMHS services.

4.5 The impact of Covid-19 on mental health has been widely reported and there is some accredited evidence of its impact in delaying presentations which as a consequence creates a more complex caseload. The Tier 3 teams report an increase in more severe illness such as eating disorders and a need to focus on urgent cases, and those at clinical risk. Lockdown reduced referrals to CAMHS, but these are slowly returning to previous levels. It is not yet clear whether demand will increase due to the individual experiences of the public throughout the lockdown period and ongoing social distancing measures.

4.6 The impact of the shift to digital consultation and a blended model of telephone and Near Me, is not yet apparent in terms of the speed of efficacy of treatment as compared to face-to-face. There is evidence that it is effective but local experience and confidence in this is still to be fully established; some staff may need additional support, and it may prove / remain sub-optimal for some patients.

5 Risk Register

5.1 Lothian does not at present meet the Scottish Government's access standard for CAMHS and it has not been possible as yet to project a satisfactory revised trajectory. New locally owned projections will be developed and a further formal report to the Board will be made in six months when the degree of recovery being achieved will be more apparent.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment has not been carried out and there are no significant concerns that have been identified related to the proposals above.

6.2 However, CAMHS is subject to the wider concern as to whether digital consultation may disadvantage certain sectors of the community. Monitoring is being undertaken as to the extent of patients declining digital consultation. CAMHS is continuing to provide Face to Face consultation where required for reasons of clinical risk.

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

7.1 The proposed changes relate to internal performance management of services and their redesign to better accommodate the needs of patients. However, they do not fundamentally change the Board's service offering.

8 Resource Implications

8.1 There are no resource implications at present and CAMHS has a number of posts to fill which are budgeted. At this point it is not clear whether there are resource implications for NHS Lothian or Councils in respect of any changes required to capacity and the delivery of care at Tier 2.

David Pickering-Gummer
General Manager, REAS
5th October 2020
d.pickering-gummer@nhslothian.scot.nhs.uk

NHS LOTHIAN

NHS Lothian Board
14th October 2020

Deputy Chief Executive, NHS Lothian

EDINBURGH CANCER CENTRE CAPITAL DEVELOPMENT INITIAL AGREEMENT

1 Purpose of the Report

1.1 The purpose of this report is to provide the NHS Lothian Board with an overview of the Edinburgh Cancer Centre Capital Development and present the Initial Agreement (IA) for approval.

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

2 Recommendations

The Board is requested to:

2.1 Recognise that the Capital Investment in Cancer Services through Haematology, Oncology and Clinical Trials projects to date supports service sustainability to ~2025. This however does not support the cancer pathway transformation that is required to meet the needs of future cancer service delivery for the region. To achieve this, a re-provision of the Edinburgh Cancer Centre (ECC) is required which also delivers on the strategic vision articulated in the NHS Lothian Hospitals Plan (LHP).

2.2 Note that the IA articulates a vision and outlines the approach taken to the development of a proposed Clinical Model, confirmed through regional engagement and that implementation of this model will be collaboratively developed by NHS Lothian, NHS Fife, NHS Borders and NHS Dumfries and Galloway as part of the Full Business Case (FBC) process.

2.3 Note the three key messages to Scottish Government regarding the importance of this proposal:

- The re-provision of the Edinburgh Cancer Centre is essential for the patients of South East Scotland;
- The development will generate a wide range of regional and national benefits;
- The development will stimulate the economy of Scotland - creating jobs from construction workers to care workers to clinical research professionals.

2.4 Consider the indicative range of estimated capital and revenue costs contained in this IA, and the assumptions that underpin them.

2.5 Note the opportunity to fulfil the Board's ambition of delivery of a sustainable and net zero carbon position aligned with Scottish Government objectives.

2.6 Recognise that the IA received Acute Senior Management Team (SMT) approval in July 2020, Corporate Management Team (CMT) approval on 1st September 2020 and Finance and Resource Committee (F&RC) approval on 23rd September 2020. The IA was also supported by the East Region Directors of Finance at their 2nd September 2020 meeting and the Regional Cancer Advisory Group (RCAG) on 4th September 2020.

2.7 Approve the IA for submission to the Scottish Capital Investment Group (SG CIG) in November 2020.

3 Discussion of Key Issues

3.1 *Roadmap to new Cancer Centre*

3.2 NHS Lothian is part of the South-East Scotland Cancer Network (SCAN) and works collaboratively with NHS Borders, NHS Fife, and NHS Dumfries and Galloway to plan and deliver cancer services across the South East of Scotland.

3.3 As part of this, NHS Lothian hosts the Edinburgh Cancer Centre (ECC), located on the Western General Hospital (WGH) site, which provides specialist haemato-oncology services to adult cancer patients on behalf of the region.

3.4 The IA describes the background of how over several years, from as early as 2010, Healthcare Environment Inspectorate (HEI) inspections and Scottish Patient Safety Programme (SPSP) visits have highlighted that Cancer Services on the Western General Hospital site are not sustainable in their current configuration.

3.5 This has been acknowledged by Scottish Government Capital Investment Group (SG CIG) approval of the Full Business Case in 2020.This programme addresses the priority areas for service sustainability:

- Refurbishment of Oncology inpatient wards 2-4 (£2m)
- Relocation of Cancer Assessment unit (£3.5m)
- Expansion of Pharmacy in Ward 1(£3m)
- New-build LINACS and Admin block (£12m)

3.6 Oncology Enabling alongside Haematology (£13m) and Clinical Trials (£1m) capital programmes, will support service sustainability and resilience, with modelling completed at the outset of these programmes (in 2015 for Oncology Enabling) demonstrating that these programmes will support service sustainability until 2025.

3.7 With submission to SG CIG of the IA for the Edinburgh Cancer Centre re-provision scheduled for November 2020, a draft timeline has been constructed to show a realistic timeframe for ECC delivery. This, however, will be subject to Scottish Government confirmation of procurement route and gateway reviews:

Table 1: Edinburgh Cancer Centre Delivery Programme

Key Milestone / Activity	Date
Initial Agreement submitted & approved by SGCIG	October 2020 - December 2020
Development of Information (Clinical Brief / Technical Brief) for Lead Advisor / Technical Advisor Appointment	October 2020 – September 2021
Contractor and Advisor Procurement and Design development	October 2020 – September 2021
Outline Business Case submitted & approved by SGCIG	October 2022 - December 2022
Full Business Case submitted & approved by SGCIG	January 2024 - March 2024
Enabling Works (DCN Site Clearance / Infrastructure inc roads and car parking	January 2021 - February 2024
Essential Services Centre (separate business case)	April 2025 - April 2028
Cancer Centre (Assuming no phasing)	January 2024 - December 2027
Commissioning	January 2028 - September 2028
Service Migration	April 2028 - March 2029

3.8 Based on these timings, a reasonable question is how the service will be sustained from 2025 until the transformed regional service models have been implemented and specialist services have been migrated to a new facility.

3.9 Demand for cancer services has been rising annually in response to a number of key drivers. It is too early to project what the impact of the COVID-19 pandemic will be on demand (for example what impact this will have on stage of patient presentations) however, in the longer term, it is anticipated that the underlying trends will continue:

- Increasing population within Lothian and the South East Region;
- Aging demographic;
- Increased cancer incidence, across the SCAN region which is projected to increase by a further 22% by 2025;
- Earlier detection of cancer through improved diagnostics and increased screening;
- Increased number of effective treatment options licensed and SMC approved;
- Increased duration of use of multiple regimes of SACT in individual patients as a result of better efficacy and greater tolerability of modern SACT agents;

- Improved Radiotherapy modalities and techniques – increased indications for Radiotherapy;
- Increased use of lifelong Supportive Therapies

3.10 Against the backdrop of these key drivers, the impact on patients from the South East Region of not re-providing the ECC will inevitably lead to capacity constraints for Systemic Anti Cancer Treatment (SACT), Radiotherapy and specialist cancer care. This will lead to delayed access to treatment and risk of negative impact on patient outcomes. In addition, the risk associated with ageing building and facilities in the longer term will increase and the opportunity will have been missed to increase pandemic resilience with 100% single room provision.

3.11 Ongoing service transformation work is crucial to mitigate against the growing demand for cancer services but is also a critical part of the roadmap to the re-provision of the ECC.

3.12 To support this, NHS Lothian will develop a strategic service plan – underpinned by a clear financial plan – to describe the activity projections leading up to the new facility, the proposals to deliver additional activity/mitigate against growing demand and the financial implications of those actions. This will provide a roadmap for the Board and its regional partners.

3.13 A regional approach to transformation will support a sustainable service in the short to medium term and the delivery of the vision for this programme and transformed clinical model by the time a new ECC is constructed.

3.14 <u>Essential Services Hub</u>

3.15 The schedule of accommodation, and indicative costings, include allowances for the elements of key support services that are required for the ECC. In addition, through the WGH Masterplan, a proposal is being developed for an Essential Services Hub with components to support services across the whole of the WGH site, including Colorectal and Urology services which are central to provision of cancer care to the South East region.

3.16 An Essential Services Hub is vital not only as an enabler to the ECC, but also provides an opportunity to improve the cancer patients pathway across NHS Lothian by offering improved diagnostic access (potentially encompassing the concept of a Rapid Diagnostic/Early Diagnostic Centre), subsequently improving performance around cancer waiting times (CWT) and improving patient outcomes.

3.17 It is proposed that further development of the ‘Essential Services Hub’ proposal and how this relates to the development of the Edinburgh Cancer Centre and the broader Western General Hospital site masterplan is required in order for this proposal to be progressed via a separate, parallel Business Case which is likely to include;

- Imaging/Radiology
- Laboratories
- Nuclear Medicine Physics
- Critical Care capacity (potential for future expansion)

3.18 *Summary of Proposal*

3.19 An Initial Agreement has been developed in line with the Scottish Capital Investment Manual (SCIM) Guidance.

3.20 The existing arrangements, drivers for change, investment objectives and benefits are described leading into the long list of options.

3.21 Four of these options have been identified as meeting the Investment Objectives and shortlisted for further assessment. These will be carried forward into OBC:

Table 2: Shortlisted Options

Option	Descriptor	Further Information
'Do Minimum' (baseline)	Cancer services remain at the WGH in their current location with some upgrade works (Oncology Enabling, Haematology upgrade and Clinical Trials Expansion) to provide service sustainability until a new cancer centre is established.	These projects have received internal and external endorsement via separate Business Cases and are in the process of being implemented in order to support service sustainability. This option does not support the cancer pathway transformation that is required to meet the needs of future cancer service delivery for the region.
Re-provision: New build at WGH	This option seeks to replicate existing service provision providing core cancer services whilst allowing for adjustments in department areas to meet modern healthcare standards. This option does not seek to address future projected demand and capacity issues relating to the service.	
Enhanced Re-provision: New build at WGH	This option represents a purpose built *'Regional Specialist Cancer Centre'* with accommodation/infrastructure designed to meet current applicable clinical standards - including design/technical requirements and incorporating transformational redesign of patient pathways.	Range of specialist cancer therapies available for the patients of South East Scotland. Internationally leading Clinical Research and Trials providing most innovative cancer therapies for people of Scotland. Rapid Diagnostic Centre and Essential Service Hub supporting transformation of cancer pathways (*components to be developed separately*). Innovation, role re-design and

		Workforce Development/training for staff regionally and nationally, potentially including a Centre for Cancer Education (*to be developed separately).* Support for patients living with and beyond cancer in managing long term conditions.
Enhanced Regional re-provision: New build at WGH with Regional Satellite / Outreach Facilities	As Option 5 above but additionally seeks to integrate the service regionally through satellite and outreach facilities. As the proposal progresses towards OBC, ongoing regional discussions and collaboration will result in potential sustainable service delivery options being scoped and defined. Options will subsequently be refined and costed in more detail allowing an objective scored option appraisal to be undertaken with relevant stakeholders.	At the Option Assessment workshop held on 30 April 2019 this option was scored as the preferred option.

3.22 The graphic attached at Appendix 2 depicts:

- What is included within the scope of this IA;
- Areas to be developed further and progressed via a separate Business Case(s) as part of the Western General Hospital Masterplan to support services across the WGH site;
- Regional elements to be developed further in collaboration with Regional partners and progressed via a separate Business Case(s);

3.23 A vision and proposed Clinical Model have been developed with key stakeholders from across the South East Region. This is described at a high level with regional service delivery and workforce models to be developed as the business case progresses.

3.24 The proposed Clinical Model aligns with various local and national strategies including the recently refreshed Scottish Government Strategy Beating Cancer Ambition and Action, 2016 and emerging Scottish Government Cancer Recovery Plan (currently in draft form) has been discussed with Scottish Government Cancer Policy colleagues who are supportive of the approach.

3.25 The IA also describes the benefits of addressing the need for change through implementation of the proposed clinical model, which will have a significant impact on patients, staff and other project stakeholders alongside the wider economy, environment and communities.

3.26 As the proposal progresses, cognisance will be taken of lessons learned from other capital projects in NHS Lothian (e.g. Royal Hospital for Children and Young People/Department of Clinical Neurosciences and the Surgical Elective Centre

process) and beyond (e.g. findings/recommendations from the enquiry into the Queen Elizabeth University Hospital, Glasgow).

3.27 The Cabinet Secretary has announced the establishment of a Centre for Expertise to provide additional assurance to government. The blueprint for this is with government but it is anticipated that the Centre will undertake frequent assessments during the lifecycle of a project. These will be akin to that undertaken on RHCYP / DCN last year. These are in addition to the existing National Design Assessment Process, undertaken by Health Facilities Scotland on behalf of the Capital Investment Group. The Centre will also be undertaking an update to guidance and other activities such as research and development. The liability and accountabilities from the review assessments has not yet been confirmed.

3.28 *Sustainability Support and Ambition*

3.29 NHS Lothian has declared a need for delivery of a sustainable and net zero carbon position aligned with the Scottish Government objectives. This direction of travel is also reflected in the NHS Scotland position led by Health Facilities Scotland. Following the current guidance across the range of technical areas for new facilities requires targets to be included in the design brief and business case.

3.30 The business case process for the Edinburgh Cancer Centre presents a substantial opportunity to fulfil the Board's ambition, building upon on the support already for infrastructure improvements at the Western General Hospital. It is not, however, without challenges.

3.31 The attached Initial Agreement establishes the base parameters and strategic briefing for the reprovision project going forward. The Committee may also wish to consider enhancing this with direction from the Board to prioritise specific areas of future project and site briefs. The Board may wish this project - and other capital investments - to reinforce or prioritise the sustainability requirements over other investment criteria.

3.32 For example;

- Site selection can heavily influence the sustainability of a future development through positioning and natural light etc. The Board's support for the WGH location should present advantages in terms of reuse and connections within an existing site but could be prioritised despite potentially constraining some aspects of the design for the building.

- Ongoing Board support for improving the sustainability of the site infrastructure (outwith the Edinburgh Cancer Centre business case) will facilitate the decarbonisation of the project.

- The highly technical equipment for the Edinburgh Cancer Centre will be energy hungry and therefore presents a real challenge. The Board may consider prioritising criteria in the future procurement processes which support holistic / sustainable lifecycle costs over capital costs alone.

- Design focus and ambition around sustainability can be embedded in the selection, design and construction processes. For example, the Board's design brief could prioritise natural ventilation and similar measures over systems designed to be fully mechanical and thus reduce carbon and energy costs but may not guarantee, for example, room air change rates.

- Digital use rather than creating buildings is now more embedded in clinical ways of working. The Board could consider this as a priority for investment as part of the project despite it being outwith the scope of the measures to achieve net zero carbon.

3.33 At the next stage of Business Case development, ambitious stretch targets for the project, beyond extant guidance, could be set by the Board to cover: Energy, Waste, Transport, and lifecycle / whole life real costs. Baseline information will require to be obtained and appropriate modelling commissioned as part of the development of the Edinburgh Cancer Centre.

3.34 At the next stage of Business Case development, ambitious stretch targets for the project, beyond extant guidance could be set to cover: Energy, Waste, Transport, and lifecycle / whole life real costs. Baseline information will require to be obtained and appropriate modelling commissioned as part of the development of the Edinburgh Cancer Centre.

3.35 *Financial Case*

3.36 An estimated capital cost range has been calculated for each of the three short listed options (as above) which will be carried forward to OBC stage. This is included in the table below and notes a capital cost range for the preferred option of £635 - £700m. A range of costs was developed for each option in recognition of the uncertainty inherent within the cost estimates.

Table 2: Capital Costs of Shortlisted Options

Capital Cost Range (£m)	Option 2 Do Minimum (baseline)	Option 3 Re-provision: New build at WGH	Option 5 Enhanced re-provision: New build at WGH	Option 6 Enhanced regional re-provision: New build at WGH with regional satellite/outreach facilities
Low	26	428	616	635
Mid	28	446	644	663
High	29	468	678	700

3.37 Initial costings are based upon a Schedule of Accommodation (SOA), which has been developed based on a high level data review conducted by HG Health and

Care Planning, using assumptions established from similar projects alongside activity data provided by the clinical and service teams.

3.38 Option 3 represents the estimated capital cost of delivering the current activity within fully compliant facility - £446m at the mid point of the range. The £216m additional estimated capital cost for Option 6 reflects the increase in demand for services, as well as the expansion in clinical trials, education, staff wellbeing and other elements of delivering the vision.

3.39 Incremental revenue costs (which represent the additional revenue costs when compared to the baseline 'Do Minimum' option) have been identified as £19.5 - £33.1m. This is a high level calculation based on the centre operating at full capacity. Work is being undertaken on these to articulate the costs on opening day, increasing as the centre reaches full capacity, and this will be incorporated into a detailed 'Strategic Plan' for Cancer Services, working with regional partners to forecast activity, costs and impact of transformation up to the proposed new facility and beyond.

3.40 Regional collaboration will continue to develop regional service delivery models and workforce plans for implementation of these models as the business case progresses.

3.41 It is proposed that additional revenue costs are shared across the Regional Boards based on activity levels. Proposed costings will be shared with Regional Boards as they are developed, through existing groups (primarily the Regional DoFs Operational Group) to ensure full engagement and understanding throughout the process.

Next Steps

3.42 The IA is planned to be submitted to the Scottish Government Capital Investment Group (SG CIG) on 11th November 2020.

3.43 Plan for the development of the OBC in collaboration with regional partners.

3.44 The OBC and subsequent FBC will;

- Articulate an appreciation of the challenges around the extraordinary gestation period and likely changes to the model of care in order to ensure the environment remains fit for purpose.
- Incorporate lessons learned from previous capital projects (e.g. Royal Hospital for Children and Young People/Department of Clinical Neurosciences project and the Elective Centre process).
- Align with a 5-7 year strategic service plan for Cancer Services in it's entirety.

4 Key Risks

4.1 Delivery within a reasonable timeframe is essential to ensure that the need for change are addressed and associated benefits are realised whilst mitigating ongoing risks connected with service delivery within existing infrastructure as demand for services continues to grow.

4.2 Progression to OBC not approved by NHS Lothian Board or SG CIG.

4.3 Sufficient capital and revenue funding not available.

4.4 A Risk Register for the programme is attached as Appendix 3 of the IA.

5 Risk Register

5.1 No changes to NHS Lothian's Corporate Risk Register are proposed as part of this paper.

6 Impact on Inequality, Including Health Inequalities

6.1 An Integrated Impact Assessment (IIA) has been completed with the Action Plan included as Appendix 7 of the IA.

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

7.1 Patient, staff and key stakeholder engagement has been an integral part of this programme of work from the outset. This will continue as the proposal progresses. The Stakeholder Engagement Process is detailed in the relevant section of the IA.

8 Resource Implications

8.1 The resource implications for are detailed in section 3 above and represent:

- A capital cost range for the preferred option of £635 - £700m
- An incremental annual revenue cost range of £19.5 - £33.1m – when all aspects of the provision are fully utilised.

Lyndsay Cameron
Strategic Programme Manager, Cancer Services
Lyndsay.Cameron@nhslothian.scot.nhs.uk

Nick Bradbury
Finance Business Partner
Nick.Bradbury@nhslothian.scot.nhs.uk

1st October 2020

Appendix 1: Edinburgh Cancer Centre Initial Agreement

Appendix 2: ECC, Essential Services, Satellite and Regional Graphic

Edinburgh
Cancer Centre
Capital Development

NHS Lothian
Initial Agreement

Project Owner: Chris Stirling, Site Director WGH

Project Sponsor: James Crombie, Deputy Chief Executive, NHS Lothian

Date: 1st October 2020

Version: 41

Document Control

Title:	Initial Agreement, Edinburgh Cancer Centre Capital Development at the Western General Hospital
Owner:	Lyndsay Cameron, Strategic Programme Manager, Cancer Services, NHS Lothian

Version History

Version	Date	Author(s)	Comments:
1	19/07/2018	Lyndsay Cameron	Set up of IA Template
2	13/08/2018	Lyndsay Cameron	Initial comments
3	27/12/2018	Lyndsay Cameron	Strategic case and CS comments
4	16/01/2019	Lyndsay Cameron	Updates
5	12/03/2019	Lyndsay Cameron	Insertion of revised strategic case
6	11/04/2019	Lyndsay Cameron	Development of Strategic Case
7	15/04/2019	Lyndsay Cameron	Essential Services
8	15/04/2019	Lyndsay Cameron	Transformation
9	17/04/2019	Lyndsay Cameron Nicola McCloskey-Sellars	Settings of Care Review-outreach opportunities
10	25/04/2019	Lyndsay Cameron, Wilma Jack, Heather Tait, Steve Elliott	Review of Strategic and Economic case for additional info and points of accuracy
11	10/05/2019	Lyndsay Cameron Audrey Campbell	Updates on Strategic and Economic Case for additional info and points of accuracy
12	15/05/2019	Lyndsay Cameron	Incorporation of comments from LH. Update on Stakeholder Engagement
13	28/05/2019	Lyndsay Cameron	Options Assessment included
14	04/06/2019	Lyndsay Cameron	Incorporation of comments following May CCPB
15	23/07/2019	Lyndsay Cameron Victoria Bassett Smith	Updates to Medical physics/Nuclear Medicine Physics section
16	17/09/2019	Lyndsay Cameron	Update to Proton Beam statement following SG Cancer Policy Team meeting
17	12/02/2020	Lyndsay Cameron	Updates to Clinical Model, Transformation and Stakeholder Engagement sections
18	16/04/2020	Lyndsay Cameron David Walker	Review of Strategic Case and associated data.
19	20/04/2020	Lyndsay Cameron Melanie McKean	Incorporation of comments into Strategic Case from MM
20	20/04/2020	Karolina Gibula	Formatting
21	22/04/2020	Lyndsay Cameron Immy Tricker	Review of structure
22	04/05/2020	Immy Tricker Lyndsay Cameron	Wider Economic Benefits added Economic Case updated Population Figures Update
23	05/05/2020	Karolina Gibula	Appendices inserted
24	12/05/2020	Lyndsay Cameron	Incorporation of comments from Cancer Management Team,
25	20/05/2020	Lyndsay Cameron Thomson Gray	Draft Commercial and Management case inserted
26	02/06/2020	Lyndsay Cameron	Incorporation of further comments
27	29/06/2020	Lyndsay Cameron	Executive Summary
28	30/06/2020	Immy Tricker	Benefits Updated

Version	Date	Author(s)	Comments:
29	07/07/2020	Lyndsay Cameron	Risks and constraints updated
30	14/07/2020	Lyndsay Cameron	Executive Summary Updated
31	21/07/2020	Lyndsay Cameron	Stakeholder Engagement Update
32	30/07/2020	Lyndsay Cameron Karolina Gibula	Insertion of Appendix 9
33	17/08/2020	Lyndsay Cameron	Updated with comments from Denise Calder and Larry Hayward
34	19/08/2020	Karolina Gibula	Insertion of new Commercial and Management Case; tables and figures numbering
35	19/08/2020	Immy Tricker Karolina Gibula	Financial and Economic Case updates Insertion of new Appendices: 5, 6, 12-15
36	23/08/2020	Lyndsay Cameron	Amendments
37	28/08/2020	Nick Bradbury	Adjustments to Financial Case
38	01/09/2020	Lyndsay Cameron Emma Amor	Amendments Adjustments to Financial and Economic Case
39	09/09/2020	Lyndsay Cameron Emma Amor Karolina Gibula	Amendments to Stakeholder Engagement Adjustments to Financial and Economic Case Adjustments to Figures and appendices
40	24/09/2020	Karolina Gibula	Amendments and formatting Insertion of Appendices: 2 and 16 and updated benefits section
41	01/10/2020	Lyndsay Cameron	Amendments following F&RC feedback

Contents

Table of Contents: Tables

Table of Contents: Figures

1 Executive Summary and Purpose

1.1 Purpose

Vision

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

An ambitious programme of work commenced in 2018 with the agreement of this vision by key stakeholders and a commitment to achieving this through transformation of the cancer pathway for patients from across the South East Region.

This Initial Agreement (IA) outlines the approach taken to the development of a Proposed Clinical Model – with a focus on confirming the service model through regional engagement and understanding the scope of the infrastructure requirements. The practical implementation of the preferred service model will be developed as a South East Region service delivery model and detailed as part of the Outline Business Case process.

Specifically, the purpose of this IA is:

- To seek approval from the Scottish Government Capital Investment Group (CIG) to develop an Outline Business Case (OBC) for the reprovision of the Edinburgh Cancer Centre (ECC), a South East Scotland Development hosted and led by NHS Lothian on behalf of the SCAN region, on the Western General Hospital (WGH) site with a capital cost estimated to range from £635 - £700m.

- To demonstrate that the Capital Investment in Cancer Services through Haematology, Oncology and Clinical Trials projects to date supports service sustainability to ~2025, however does not support the cancer pathway transformation that is required to meet the needs of future cancer service delivery for the region. To achieve this, a reprovision of the Edinburgh Cancer Centre (ECC) is required.

- To demonstrate the need for change and to describe how addressing this which will have a significant impact on patients, staff and other project stakeholders alongside the wider economy, environment and communities.The Scottish Government's National Performance Framework provides a structure to the identification, incorporation and assessment of these wider economic benefits, to demonstrate the benefit of the project to communities and the economy of South East Scotland with the identification of economic opportunities and benefits contributing to a socially inclusive 'net zero carbon' economy.

1.2 Background and Strategic Context

NHS Lothian is part of the South-East Scotland Cancer Network (SCAN) and works collaboratively with NHS Borders, NHS Fife, and NHS Dumfries and Galloway to plan and deliver cancer services across the South East of Scotland. As part of this, NHS Lothian hosts the Edinburgh Cancer Centre (ECC), located on the Western General Hospital (WGH) site, which provides the most specialist haemato-oncology services to adult cancer patients on behalf of the region.Paediatric radiotherapy is provided in the ECC,otherwise paediatric cancer services are provided at the Royal Hospital for Sick Children (RHSC).

Over several years,from as early as 2010, Healthcare Environment Inspectorate (HEI) inspections and Scottish Patient Safety Programme (SPSP) visits have highlighted that Cancer Services on the Western General Hospital site are not sustainable in their current configuration.

This was further acknowledged through Scottish Government approval of the Initial Agreement for the Cancer Enabling Projects in 2016 (subsequently renamed as Oncology Enabling) and approval of the Full Business Case in September 2020.

In the knowledge that development of a new Edinburgh Cancer Centre will take several years, three capital programmes of work are currently underway in order to sustain Cancer Services until ~2025.

These projects are:

1/The **Haematology Capital Programme (£13m)** which began in 2019 (with a completion date of early 2021) is the redesign and upgrade of the Haematology facilities at the Western General Hospital (WGH) into a purpose built, modern facility which co-locates both inpatient and day case work streams within the Edinburgh Cancer Centre.

2/ The **Oncology Enabling Capital Programme (£20.6m)** which (pending FBC approval from Scottish Government Capital Investment Group) is scheduled to begin construction in September/October 2020 and includes:

- Refurbishment of Oncology Inpatient Wards 2 and 4
- Relocation of Cancer Assessment Unit (CAU)
- Expansion of Pharmacy in Ward 1
- New build Linac bunkers and Admin block

3/ The **Clinical Trials Capital Programme (£1m)** which commenced in June 2020 will move non-clinical research staff to a separate facility to allow relocation of Ward 1 staff downstairs and release space to expand trials capacity within Ward 1.

Although these projects will improve current facilities they are largely within existing infrastructure and therefore require NHS Lothian (and subsequently the Scottish Government) to agree derogations from current applicable SHTM healthcare building standards and other relevant guidance that cannot be met within the scope of these options.

In order to meet all applicable building and clinical standards as well as respond to a rapidly increasing demand for cancer services by delivering a transformed model of care, a full reprovision of the ECC is required.

Furthermore, if necessary changes implemented during the COVID-19 pandemic (e.g. reduction in inpatient capacity to allow adequate physical distancing) are not able to be reverted, this presents a further significant challenge to delivering care which further accelerates the urgent requirement for change.

In recognition that, due to the complexity of the proposal, the construction of a new cancer centre is likely to be beyond the 2025 timeframe, NHS Lothian will continue to work in collaboration with regional partners to transform service delivery and mitigate against the impact of increasing demand for cancer services.

The capital investment made in the building infrastructure by the projects outlined above will continue to be realised, post-Cancer Centre construction, as part of the wider site masterplan for the Western General Hospital Site.

1.3 Need for Change

1.3.1 Rising Demand for Cancer Services

Demand for cancer services has risen annually in response to a number of key drivers. It is too early to know how these will be impacted by the COVID-19 pandemic, however in the longer term it is anticipated that the underlying trends will continue:

- Increasing population within Lothian (10% between 2010-2019) and the SCAN region (6% between 2010-2019) with growth expected to increase by a further 15% (Lothian) and 7% (SCAN) in the next 25 years
- Aging demographic
- Increased cancer incidence, across the SCAN region which is projected to increase by a further 22% by 2025
- Improved diagnostic techniques and capabilities
- Improved detection and increased uptake of screening
- Increased number of effective treatment options licensed and SMC approved
- Increased duration of use of multiple regimes of SACT as a result of better efficacy and greater tolerability of modern SACT agents
- Improved Radiotherapy modalities and techniques – increased indications for Radiotherapy and development of advance techniques as alternatives to surgery
- Increased use of lifelong Supportive Therapies

Many more people are also living with and beyond cancer resulting in a need to focus on early prevention and detection to optimise treatment and minimise morbidity and mortality. The increase in the number of patiets surviving cancer, adds substantially to the complexity of care planning and delivery for those who are living with the consequences of cancer or cancer treatment.

Achieving the vision of transformed and improved cancer services and pathways for adult patients from across the South East Region will:

- Provide a response to rapidly increasing demand and increasing cancer incidence across the South-East Region;
- Streamline patient pathways and maximise efficiencies based on a patient focused, holistic approach;
- Offer a range of specialist cancer therapies to patients in the South-East Region;
- Provide facilities to deliver safe and effective, high quality clinical care, designed to optimise efficiencies and new technologies;
- Provide Care Closer to Home where clinically appropriate and financially viable;
- Make opportunities available to ensure recruitment and retention of specialist staff; including teaching, training, research and academic opportunities;
- Provide equitable access to the most innovative therapies, optimise resource utilisation and patient outcomes by integrating Cancer Research with core services across the South East Region.

1.3.2 National Strategic Context

This vision aligns with national strategies (details of which are contained within Table 22 of this document) however, of particular significance is the alignment with the Scottish Government *Beating Cancer, Ambition and Action Strategy (2016)* and the recent 2020 refresh of this strategy.

The proposed Clinical Model specifically addresses the following aspects:

Smoother patient journeys - A focus on early cancer diagnosis through direct access to diagnostics and the role of imaging in accurate and timely diagnosis of cancer.

'Prehabilitation' – Holistic patient approach through a wellness programme, patient education and empowerment.

Treatment - Consistency and equity of treatment access for patients across the South East of Scotland with services planned and delivered locally wherever possible.

Best care and support for all people with and beyond cancer – Working closely with third sector organisations to provide access to individually tailored patient information, support and advice, patient education and timely access to palliative care where appropriate in the patient pathway.

Whole system actions - Integration of clinical research and trials with cancer services through physical co-location and service model collaboration.

Using data for improvement – Develop Phase II of the South East Scotland Cancer Information Programme from 2021 to provide a detailed, comprehensive Regional Cancer Information Service to facilitate smooth and efficient data driven innovation.

With the timing of a further cancer strategy update expected in 2021 there is ample opportunity during the next stages of the Business Case process to ensure alignment with this and other emerging strategies.

1.3.3 Local Strategic Context

The vision also aligns with NHS Lothian strategies including;

- Better Cancer Outcomes in Lothian 2015-2020

- NHS Lothian Corporate Objectives 2018-19 to 2022-23

- Living and Dying Well in Lothian – Lothian's Palliative and End of Life Care Strategy 2010-2015

A major challenge to the delivery of cancer services on the Western General Hospital (WGH) Site is the outdated infra-structure of the Edinburgh Cancer Centre (ECC).The main buildings were constructed in the 1950s and no longer meet the needs and expectations of modern healthcare.

Through Scottish Government approval of the Initial Agreement for the Cancer Enabling Projects in 2016 (subsequently renamed as Oncology Enabling) and approval of the Outline Business Case in 2020 (with Full Business Case now pending approval) it was acknowledged that Cancer Services on the Western General Hospital site are not sustainable in their current configuration.

This proposal also delivers on the strategic vision articulated in the Lothian Hospitals Plan (LHP) which set out NHS Lothian's strategic intent for each of the acute sites, providing a framework for development and a focus for investment on each site.

As identified in the LHP, across NHS Lothian Acute Services there is a need to address service configuration and allocation of space according to clinical priority.This plan seeks to address the challenges of changing demography, clinical demand, workforce, condition of estate and provide an organisational focus to investment decision and management effort.

The strategic headline for each of the three acute hospitals is presented in the table below;

Table 1: Lothian Hospitals Plan

Site	Strategic Headline
Royal Infirmary of Edinburgh	South-East Scotland's emergency care centre, incorporating a major trauma centre, orthopaedic services, neurosurgery, and children's tertiary care
St John's Hospital	An elective care centre for Lothian and for the South-East Scotland region, incorporating highly specialist head and neck, plastics and ENT services
Western General Hospital	**The Cancer Hospital for South-East Scotland, incorporating**

Site	Strategic Headline
	breast, urology and colorectal surgery and Critical Care

A long list of options for the location of a new cancer centre was generated for the Lothian Hospitals Plan and the preferred location was designated as the Western General Hospital (WGH) site.

Demolition works at the WGH following the relocation of the Department of Clinical Neurosciences (DCN) services to the Royal Infirmary site in 2020 will help rationalisation of the estate and remove many of the more problematic buildings from the portfolio as well as providing land for the building of a new ECC.

1.4 Investment Objectives

By assessing the existing situation and the drivers for change, the changes required to deliver the vision were identified and defined as the investment objectives.

These were discussed and developed with key stakeholders at an early stage of the process and development of the proposed Clinical Model addresses these objectives as outlined below:

Table 2: Investment Objectives

Effect of the need for change on the organisation:	What has to be achieved to deliver the necessary change? (Investment Objectives)
Facilities and existing capacity unable to cope with projected demand resulting in patient treatment delays	Increase service capacity and sustainability to meet demand and provide timely service access for patients
Safety issues highlighted in Healthcare Environment Inspectorate (HEI) reports Patient experience not optimum in current accommodation Split locations result in inefficiencies in service provision, duplication of work, loss of possible collaboration	Design buildings to provide appropriate facilities for clinical care that meet all required standards, allow service collaboration and provide an improved patient experience
Workforce challenges causing detrimental effect on service provision and capacity	Improve recruitment and retention of specialist staff Offer a range of education,training, research and academic opportunities for professional development
Patients travelling to other UK centres/ abroad for certain treatments	Offer a wide range of specialist cancer therapies to the patients of South East Scotland
NHS Lothian unable to participate in full complement of trials	Integration of Clinical Research and Trials with Cancer Services to enable access to an expanded range of trials and improve patient outcomes

1.5 Options Assessment and Preferred Option

A workshop to assess the potential options identified for the implementation of a new proposed Clinical Model for Cancer Services in support of the Initial Agreement for the new Cancer Centre was held in April 2019.

Options were assessed at a high level in line with Scottish Government Capital Investment Manual (SCIM) guidance relevant to this Initial Agreement (IA) stage of the business case process.

During this workshop an emphasis was placed on the Clinical Model of Care and how it could be delivered rather than on the specifics of a new cancer centre building design.

This event was attended by 55 stakeholders including patients, staff, charity representatives, clinicians and managers from across NHS Lothian and the SCAN Regional Boards.

Following a presentation of the proposed Cancer Centre Clinical model, six potential options were described with a Strengths, Weakness, Opportunities and Threats (SWOT) analysis which was discussed in detail and added to by participants.

The Investment Objectives were described to the group and discussed before each group was asked to assess the options against these objectives and provide a consensus.

A full report of this event is available upon request, however the short listed options are below:

1.5.1 Option 2 – Do Minimum

The 'Do Minimum' option relates to cancer services remaining at the WGH in their current location but with some upgrade works (Oncology Enabling, Haematology and Clinical Trials projects) to support service sustainability and resilience to ~2025 (based on modelling that commenced in 2015).

These works consist of:

- Refurbishment of Oncology inpatient wards 2-4
- Relocation of Cancer Assessment unit
- Expansion of Pharmacy in Ward 1
- New build Linac bunkers and Admin block
- Haematology refurbishment of Wards 7 and 8 East/West
- Relocation of Clinical Trials Staff and expansion of Trials footprint

The above noted projects have received internal and external endorsement via separate Business Cases and are at various stages of implementation.

1.5.2 Option 3 – Re-provision: New Build at WGH

This option seeks to replicate existing service provision providing core cancer services whilst allowing for adjustments in department areas to meet modern healthcare standards. This option does not seek to address future projected demand and capacity issues relating to the service.

1.5.3 Option 5 – Enhanced Re-provision: New build at WGH

This option represents a purpose built *'Regional Specialist Cancer Centre'* with accommodation/infrastructure designed to meet current applicable clinical standards - including design and technical requirements and incorporating transformational redesign of patient pathways.

Key characteristics

- Wide range of specialist cancer therapies available for the patients of South East Scotland
- Internationally leading Clinical Research and Trials providing most innovative cancer therapies for people of Scotland

- Essential Services Hub (potentially incorporating the Rapid Diagnostic Centre concept) supporting transformation of cancer pathways (components to be costed separately)
- Innovation, role re-design and Workforce Development/training for staff regionally and nationally, potentially including a centre for cancer education
- Support for patients living with and beyond cancer in managing long term conditions

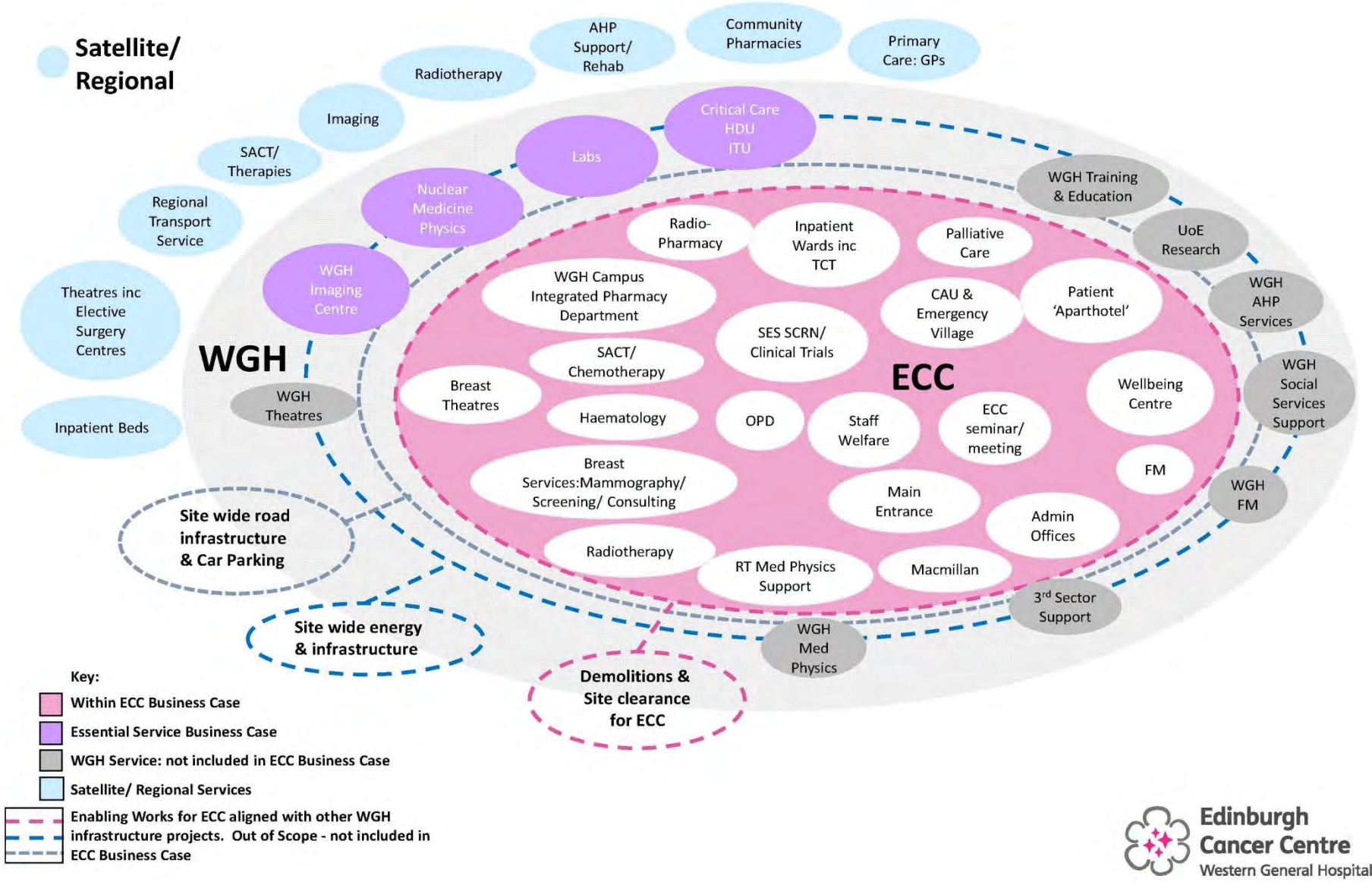
1.5.4 Option 6 – Enhanced Regional Re-provision: New build at WGH with Regional satellite / outreach facilities

As Option 5 but additionally seeks to integrate the service regionally through satellite and outreach facilities.

As the proposal progresses towards OBC, regional discussions and collaboration will result in potential sustainable service delivery options being scoped and defined. Options will subsequently be refined and costed in more detail allowing an objective scored option appraisal to be undertaken with relevant stakeholders.

Figure 1 overleaf graphically depicts what is included in scope for the ECC (this IA),what is included in the Essential Services Hub concept for the WGH site (to be developed separately) and what potential outreach (satellite/regional) proposals could be developed and taken forward as this proposal progresses.

Figure 1: ECC, Essential Services,WGH Whole Site Requirements and Regional Services



Edinburgh Cancer Centre
Western General Hospital

1.6 Readiness to Proceed

The Board's preferred procurement strategy is that of a capital funded project utilising the established Health Facilities Scotland Framework (HFS3). This should facilitate the earliest start on site. However, the Board acknowledge that should the funding arrangement be of revenue nature a form of private/ public finance initiative would be employed.

Professional services could likewise be procured via the HFS3 Framework for all lead appointments and for more specialist services such as clerk of works and validating engineers indirectly via lead appointments. It is the Board's view that provision of independent assurance via NSS is essential and that NSS may consider the need to outsource some or all of this assurance via a shadow design team who would be able to scrutinise in sufficient depth the design and execution of that design during construction and commissioning. Further work will be required to determine the cost and programme impact of these additional assurance requirements.

The current estimate for service migration, based on an approved IA in early 2021, is Q1 2029.

A clear distinction between those delivering or providing the facility (the project team) and those who will use the facility (project sponsor and project owner) is seen as essential to ensure the level of governance and assurance necessary. In addition, independent assurance that all current and relevant HFS and HPS requirements are being met should be given to the Board and Scottish Government by NSS as the accountable gatekeeper and that they are represented at Programme Board level.

The project team delivery model from the RHCYP + DCN project is proposed which includes internal support from IPCT, Fire, Health + Safety, eHealth and Estates and Facilities amongst others as the project develops. It is hoped that continuity of staff over the proposed timeline can be given sufficient priority to ensure knowledge transfer through the various phases from specification through design and construction to commissioning and final completion.

1.7 Conclusion

The reprovision of the Edinburgh Cancer Centre presents the opportunity to transform pathways for adult cancer patients across the South East Region by developing a robust, sustainable Regional Service Delivery Model to respond to the rising demand for cancer services across the region,ultimately improving timely access to services and improving patient outcomes.

Addressing the need for change through implementation of the proposed clinical model with its wide range of associated benefits,will have a significant positive impact on patients, staff and other project stakeholders alongside the wider economy, environment and communities.

It will also address key strategic aims as outlined in the 2020 refresh of the Scottish Goverment Cancer Policy *Beating Cancer, Ambition and Action Strategy (2016).*

Ongoing collaborative regional service transformation work is critical in delivering a transformed clinical model by the time a new Edinburgh Cancer Centre is constructed alongside supporting sustainable services in the short to medium term. NHS Lothian, Fife, Borders and Dumfries and Galloway will continue to work together to deliver an ambitious 'Regional Transformation Programme' with a commitment to developing this as part of the 'roadmap' to Edinburgh Cancer Centre reprovision.

Delivery of the reprovision programme in a reasonable timeframe is essential to ensure that the articulated needs for change are addressed and associated benefits realised, whilst mitigating against ongoing risks connected with current service delivery as demand continues to grow.

2 The Strategic Case

2.1 Existing Arrangements

2.1.1 Background

NHS Lothian is part of the South-East Scotland Cancer Network (SCAN) and works collaboratively with NHS Borders, NHS Fife, and NHS Dumfries and Galloway to plan and deliver cancer services across the South East of Scotland. As part of this, NHS Lothian hosts the Edinburgh Cancer Centre (ECC), located on the Western General Hospital (WGH) site, which provides the most specialist haemato-oncology services on behalf of the region.

2.1.1.1 Edinburgh Cancer Centre

Photo 1: Edinburgh Cancer Centre Entrance

The Edinburgh Cancer Centre (ECC) delivers Haematology and non-surgical Oncology including Radiotherapy (RT) and Systemic Anti-Cancer Therapy (SACT) for adult patients from a catchment of 1.4 million people[1] across the SCAN region.

Breast Surgery, Specialist Hospital Based Palliative Care and Supportive Care are also provided with some referrals received from other Health Boards for specialist services.

Specialist Radiotherapy services are provided for paediatric patients whose care is otherwise managed by Paediatric Oncologists and Haemotologists at the Royal Hospital for Sick Children (RHSC). The ECC also provides the national Benign Intracranial Stereotactic Radiotherapy Service.

All highly specialist non-surgical cancer care is provided to SCAN Region patients in NHS Lothian, with the exception of some nationally designated services and those not currently provided in Scotland.

Where possible, assessment and diagnosis is undertaken locally in the NHS Board of the patients residence however some regional patients will be referred to NHS Lothian for clinical assessment and diagnosis of suspected cancer. Some treatment services (such as radiotherapy, highly complex SACT provision and phase 1 and 2 clinical trials) are exclusively provided by NHS Lothian.

With the exception of Breast Surgery (which currently sits within the existing Edinburgh Cancer Centre footprint), Surgical Oncology is provided by Surgical Services across NHS Lothian with regional and national service provision in place for selected specialties and is outwith the scope of this proposal.

[1] SCAN website, April 2020

2.1.1.2 NHS Lothian Outreach

Outwith the ECC, SACT is provided for West Lothian patients in a recently expanded satellite unit (Ward 15) at St Johns Hospital in Livingston.

The NHS Lothian Breast service is provided over two sites, at the Western General Hospital (WGH) and St John's Hospital (SJH).

2.1.1.3 Regional Outreach

The ECC Consultant Team provides Oncology Outreach Services across the region which include regular face to face outpatient clinics, Acute Oncology (AO) and Cancer of Unknown Primary (CUP) Services.

2.1.1.4 Regional Services

SACT is provided regionally by the Boards in NHS Fife, NHS Borders and NHS Dumfries and Galloway.

There is regional provision for Breast Surgery in Borders General Hospital, Queen Margaret Hospital in Fife and at Dumfries and Galloway Royal Infirmary.

Some inpatient provision is provided for Haematology and Oncology patients in the Regional Boards however not in designated Haematology/Oncology wards.

Table 3: Regional Service Provision

Service	RT	SACT	Outpatient			Breast Surgery	Haem Stem Cell Transplants	Inpatient		
			Haem	Onc	Breast			Haem	Onc	Breast
Lothian	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Borders	X	✓	✓	✓	✓	✓	X	X	X	✓
Fife	X	✓	✓	✓	✓	✓	X	✓	✓	✓
D&G[2]	X	✓	X	✓	✓	✓	X	✓	X	✓

2.1.1.5 ECC Facilities

Facilities in the ECC have previously been recognised as being critically overcrowded and not meeting modern standards. Some of the current issues will be addressed through a series of Capital projects (see Table 4 below) however full re-provision is required in order to have a facility that meets modern healthcare needs and standards whilst achieving the vision of transformed and improved cancer services and pathways for adult cancer patients from across the SCAN Region.

This IA will focus on the reprovision of a Specialist Regional Cancer Centre hosted by NHS Lothian. Central to the clinical service model is the continuing importance of partnership working across the region, to provide care closer to home wherever a sustainable regional service delivery model is possible.

[2] Some services provided through the SCAN network and others through the West of Scotland (WOSCAN)

Although NHS Dumfries and Galloway have previously stated their intention to align their services with the West of Scotland, the timescales for this are uncertain and therefore dialogue between NHS Lothian and Dumfries and Galloway will continue as this proposal develops.

On the journey from IA to Outline Business Case NHS Lothian, Fife, Borders and Dumfries and Galloway will continue to work together to deliver an ambitious 'Regional Transformation Programme' and are committed to this as part of the roadmap to Edinburgh Cancer Centre reprovision.

2.1.2 Ongoing Capital Projects

There are presently three other major (>£250k) capital projects in progress within NHS Lothian for Cancer Services. These are summarised below:

Table 4: Cancer Capital projects

Project Name	Stage of Project	Planned Completion Date	Est. Capital Cost	Service Area(s) Impacted
Haematology Capital Project	Construction	2021	£13m	Haematology inpatient wards Haematology Daycase Daycase SACT (Ward 1)
Oncology Enabling Projects	Final Business Case in Progress	2022	£20m	Daycase SACT (Ward 1) Radiotherapy Inpatient Wards Cancer Assessment Unit Cancer Admin Accommodation
Clinical Trials Project	Construction	2021	£1m	Clinical Trials Daycase SACT (Ward 1)

Further detail of the specific works included in these projects are included in the descriptions of the current arrangements and drivers for change for the relevant service areas. All of these projects relate to the adaptation, improvement and reallocation of space within the constraints of the existing estate, with the exception of the Radiotherapy element of Oncology Enabling which is a new build.

2.1.3 Existing Service Provision

Existing cancer service provision within the ECC on the Western General Hospital (WGH) site for the patients of South East Scotland can be categorised as follows:

Table 5: Edinburgh Cancer Centre Service Provision

Inpatient Ward Accommodation (Oncology, Haematology, Breast Surgery and Teenage Cancer Trust)	Cancer Assessment Unit	Outpatient Services
Daycase Procedures	SACT – Inpatient and Daycase	Radiotherapy (including Brachytherapy)
Specialist Haematology and Stem Cell Transplants	Stereotactic Radiotherapy/Radiosurgery (including National Benign Conditions Service)	Supportive and Rehabilitative Therapies
Palliative Care	Breast Services (including Breast Surgery)	Clinical Trials

The current Edinburgh Cancer Centre (ECC) comprises of:

- Seven inpatient wards (five Oncology wards, one incorporating Teenage and Young Adults (TYAC) inpatient and daycase capacity plus one general Haematology ward and one Stem Cell Unit
- Cancer Assessment Unit (CAU)
- Radioactive Iodine Room (RAI Room)

- Oncology Outpatient Department
- Two daybed areas
- Four Systemic Anti-Cancer Treatment (SACT) daycase areas and one SACT inpatient ward (Ward 3)
- Specialist Haematology and Stem Cell Transplants
- Radiotherapy Services (including pre-treatment imaging, planning, brachytherapy and Stereotactic Radiotherapy/surgery)
- Supportive and Rehabilitative Therapies with input from Dietetics, Speech and Language Therapy, Physiotherapy and Occupational Therapy
- Two Theatres for Breast Surgery (including some provision for Brachytherapy)
- Palliative Care
- Breast Clinic
- Clinical Trials Facilities

There is also some provision for overnight patient accommodation for those travelling from the region for a course of treatment (e.g. Radiotherapy) in the form of patient rooms and communal living space in Pentland Lodge.

Across NHS Lothian:

- Specialist Hospital Based Palliative Care (Cancer and non-Cancer) is provided across all Lothian sites.
- Breast Surgery is also provided at St John's Hospital, Livingston.
- An expanding range of SACT and Supportive Therapies are delivered at St John's Hospital (SJH) Livingston.
- Monitoring clinics for Haematology patients including phlebotomy services are provided at Lauriston Buildings, St John's Hospital (SJH) and East Lothian Community Hospital (ELCH).
- The Regional Haemophilia Comprehensive Care Centre, Benign Haematology Unit and Regional Clinical Immunology Service are delivered from the Royal Infirmary of Edinburgh (RIE).
- The Scottish Breast Screening Programme for South East Scotland is based at Ardmillan Terrace and has mobile units working across the region.
- Neuro-Oncology Reviews are provided at the Royal Infirmary of Edinburgh (RIE).
- Paediatric Radiotherapy Reviews are provided at the Royal Hospital for Children and Young People (RHCYP).
- Apheresis is delivered from the Royal Infirmary of Edinburgh (RIE) by the Scottish National Blood Transfusion Service (SNBTS).

Although the current Edinburgh Cancer Centre (ECC) delivers a significant proportion of cancer services, there are cancer diagnostics and treatments delivered across NHS Lothian that **are not managed** by the Oncology Management Team including (but not limited to);

- Radiology
- Endoscopy
- Colorectal
- Urology
- Gastrointestinal (GI)
- Thoracic Surgery
- Upper Gastrointestinal (UGI)
- Melanoma
- Plastics
- Cervical

Regionally, NHS Fife, NHS Borders and NHS Dumfries and Galloway provide a range of cancer services for their patients including SACT delivery and Breast Surgery across the regional boards as well as some

general Haematology services. The level of provision varies across the region according to facilities and availability of specialist staff groups.

Current arrangements within the Edinburgh Cancer Centre are described below.

2.1.3.1 Inpatient Ward Accommodation

The current Edinburgh Cancer Centre inpatient ward accommodation comprises of seven inpatient wards - five Oncology wards, one incorporating Teenage and Young Adults (TYAC) inpatient and daycase capacity plus two Haematology wards.

The bed numbers contained in each of these are detailed below including the specialities to which they relate.

Table 6: Existing Inpatient Ward bed numbers*

	Total Beds	Single Rooms (inc in total bed numbers)	Specialty
Ward 8	14	6	Haematology
Ward 8 Unit	10	10	
Ward 6	11	5	Breast
Ward 3	9	1	Oncology
Ward 4	22	2	
Ward 11	23	3	
Teenage Cancer Trust (TCT) Unit	4	4	Haematology and Oncology
Total in patient Ward Beds	**93**	**31**	

** Bed numbers have decreased from the numbers above to allow adequate physical distancing during the COVID-19 pandemic. It is anticipated that these will revert to the numbers above post-pandemic however if this is not possible it presents a significant challenge with delivering care which further accelerates the urgent requirement for change.*

The images below depict the current facilities - the issues of which have been well documented over several years within both Business Cases for capital funding and in Healthcare Environment Inspectorate (HEI) reports and will be further explained within the '*Drivers for Change'* section of this case.

Photo 2: Inpatient Ward (Ward 4) corridor

Photo 3: Inpatient Ward - restricted access to the single wash hand basin in a 4 bedded room

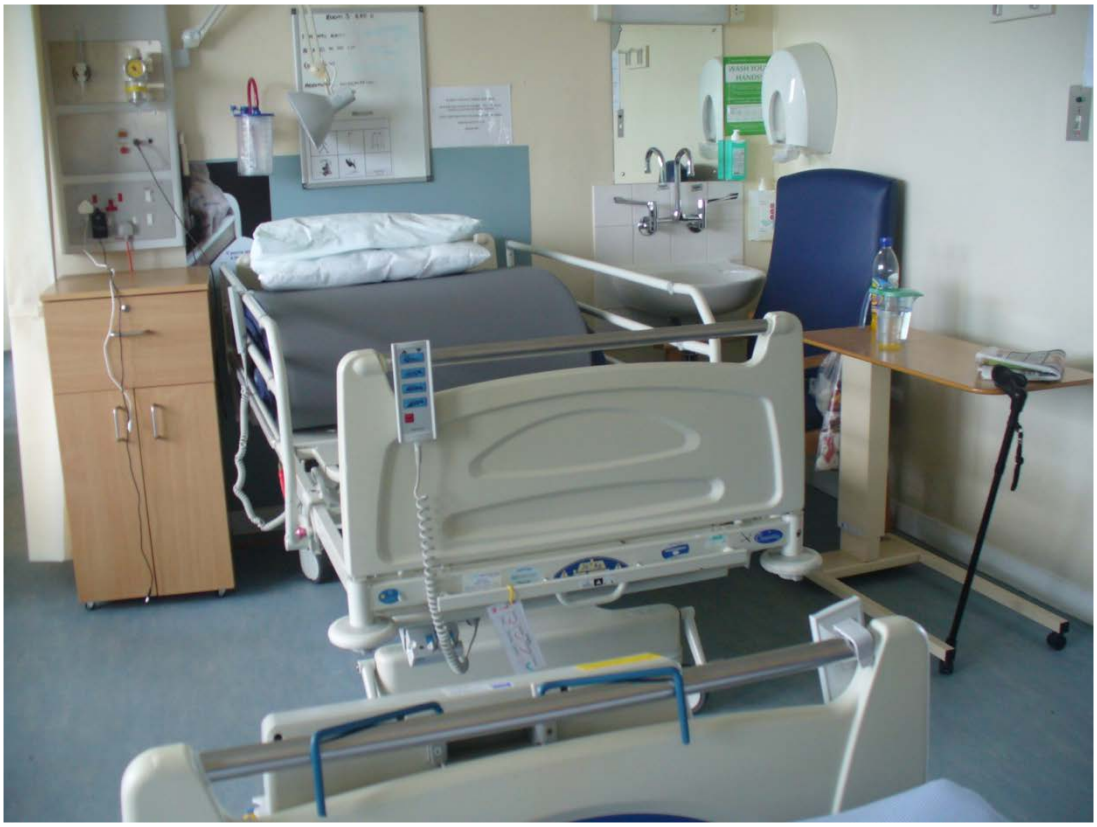


Photo 4: Inpatient Wards: One toilet for 8 inpatients

Photo 5: Inpatient Wards: One small shower for 8 patients

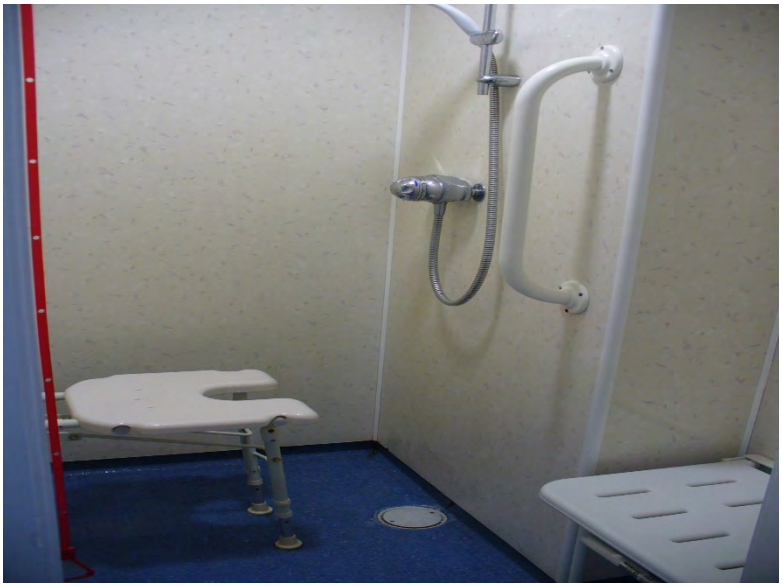
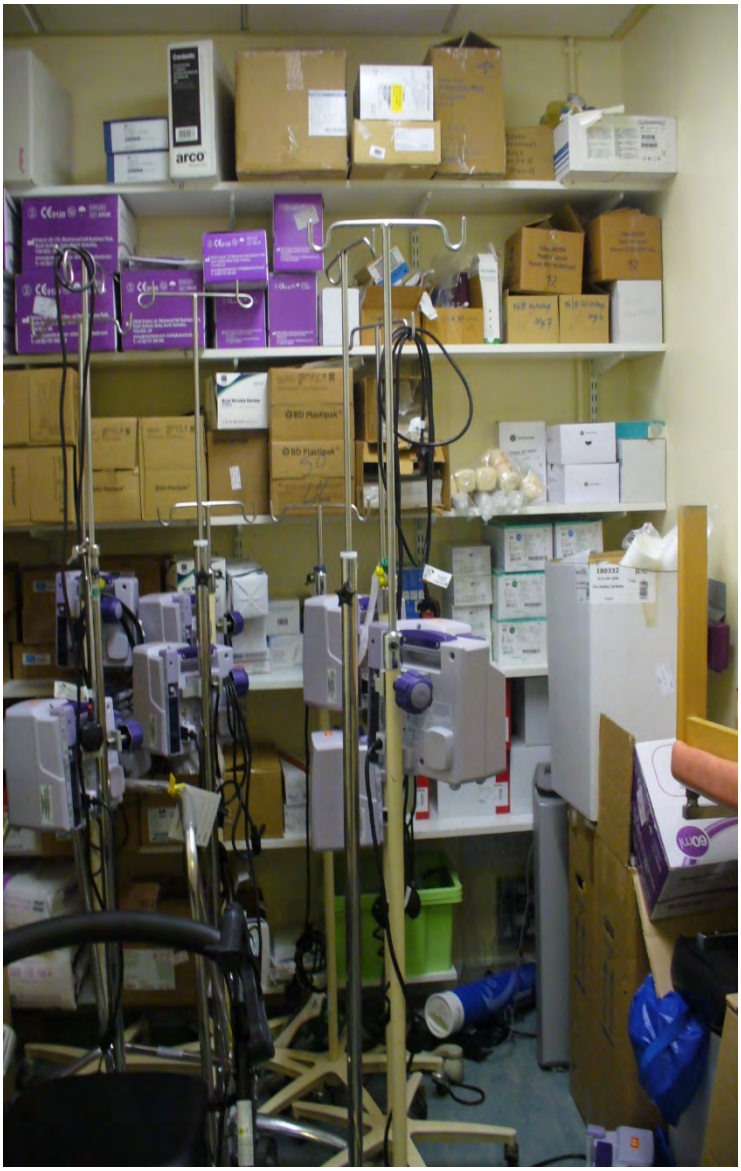


Photo 6: Inpatient Ward (Ward 4) Storage



2.1.3.2 Cancer Assessment Unit (CAU)

The Cancer Assessment Unit (CAU) is located within the Edinburgh Cancer Centre and provides unscheduled care for adult Haematology and Oncology patients who have developed acute problems while on active cancer treatment or who have recently completed therapy. The CAU also provides facilities for a range of activities that cannot be accommodated elsewhere on the WGH site including Supportive Therapies, central line care, recovery from biopsies and from interventional radiology procedures.

Patients are referred through the Cancer Treatment Helpline (CTH), as well as from the treatment floors and outpatient clinics, by GP's and also from other departments and hospitals in NHS Lothian and across the SCAN Region.

It is a service which has evolved and expanded over several years and is still developing. Over a six year period CAU has expanded from an area accommodating 3 trolleys to now occupying the space of a full inpatient ward. This growth is related to the overall increase in demand and activity in oncology as well as to the development of acute oncology services alongside the Cancer Treatment Helpline (CTH) triage service.

There are currently four work streams going through CAU;

1) Triage Assessment (may or may not lead to admission)
2) Short stay patients
3) Supportive Therapies
4) Post procedure recovery (diagnostic and supportive)

The area is also used as flexible capacity for inpatient stays when demand for Cancer Services exceeds the existing inpatient capacity.

Table 7: CAU

	Total Beds	Single Rooms (inc in total bed numbers)
Cancer Assessment Unit* (CAU)	20	3

While CAU is primarily an assessment unit, there is the ability in times of peak demand to flex some of the trolley spaces as bed spaces which adds to the work streams going through the unit.

Trolley numbers have decreased from the numbers above to allow adequate physical distancing during the COVID-19 pandemic. It is anticipated that these will revert to the numbers above post-pandemic however if this is not possible it presents a significant challenge with delivering care which further accelerates the urgent requirement for change.

The **Cancer Treatment Helpline (CTH)** is a Scotland wide service that offers patient triage which may result in a CAU attendance. Patients with solid tumours are given the CTH alert card if receiving systemic anti cancer therapy (SACT) or Radiotherapy treatment and can contact the CTH during their treatment and for six weeks thereafter.

This is a national service which is open 24 hours a day, 7 days a week and provides a triage assessment to patients who are receiving or have received specific cancer treatment if they feel unwell, ensuring that they access the most appropriate, effective and timely care if their condition is deteriorating.

Triaged calls are then re-directed to specialist staff on site for input when required. Currently in Lothian there is a Triage Team from 9am to 5pm, staff in the Cancer Assessment Unit take the calls from 5-9pm then the Hospital at Night Team (HAN) receives triaged calls overnight.

2.1.3.3 Outpatients

A variety of Haematology, Oncology and Breast outpatient clinics are provided including Consultant, Nurse Led clinics, Allied Health Professional clinics (e.g. Dietetics), multidisciplinary joint clinics and Pharmacist led clinics for both new and return patients.

Outpatient appointments are conducted in separate locations across the WGH site (Oncology Outpatients Department, Edinburgh Breast Unit and in the Anne Ferguson Building). Clinics are also held at St Johns Hospital (SJH) in Livingston for Oncology (Lung and Breast Tumour Groups) and Haematology (new and return patients).

Oncology clinics are also provided in the SCAN Regional Boards (NHS Fife, NHS Borders and NHS Dumfries and Galloway)by NHS Lothian Oncologists with Haematology clinics provided by the local health boards in NHS Fife, NHS Borders and NHS Dumfries and Galloway.

Some follow up clinics are provided virtually by Consultants,Specialist Nurses and Pharmacists by telephone or video, these are also delivered across the SCAN Region. There has been a recent increase in the number of appointments delivered virtually during the COVID 19 pandemic. These will continue to be delivered remotely in the future where it has been proven that a safe and effective service has been delivered.

Photo 7: Outpatient Consultation Room

2.1.3.4 Haematology and Oncology Day Treatment

Day case procedures for cancer services take place in various locations across the WGH site.

Haematology daycase procedures including a pilot for Ambulatory Infusion pumps are undertaken in Ward 8 unit (currently Ward 71 while the Haematology construction works are ongoing).

Breast daycase procedures are undertaken in Breast Theatres with recovery in Ward 6.

Ascitic Drainage and Peripherally Inserted Central Catheter (PICC) line insertions are undertaken in CAU. Patients requiring procedures carried out by the interventional radiology team (including biopsies, Hickmann Line Insertion and Portcath insertion) are pre-assessed and recovered in CAU.

Supportive Therapies including IV fluids, blood and platelet transfusions, management of central venous access devices (CVADS) and magnesium infusions can be administered independently or as a package of care for patients already undergoing SACT.

Currently Supportive Therapies for Cancer patients are delivered across several areas of the Cancer Centre:

- Ward 1
- Cancer Assessment Unit (CAU)
- Ward 8 Unit for Haematology

There is also some Supportive Therapy provision for West Lothian patients at St Johns Hospital (SJH).

Daycase procedures for Haematology are also undertaken at St Johns Hospital (SJH).

Day case SACT for adult patients in NHS Lothian is predominantly delivered in Ward 1 at the Western General Hospital. SACT regimens are also delivered in the inpatient setting within the ECC as necessary.

Expanded in 2019, a satellite day case facility provides an increasingWnumber of regimens at St John's Hospital in Livingston - an expanded range of gynaecological, lung, acute oncology and Enhanced Supportive Care services are now provided. West Lothian now provides a wide range of Haematology and Oncology SACT and Cancer Trials closer to home in a much improved 21 chaired facility. This development has allowed 6 chairs to be moved out of Ward 1 at WGH to improve spacing between chairs and efficiency of workflow.

Consultants from the Edinburgh Cancer Centre also provide a regional SACT delivery service working with administrative, nursing and pharmacy colleagues in the partner Boards in dedicated SACT delivery units in NHS Fife (at Queen Margaret Hospital), in NHS Borders (Borders General Hospital) and in NHS Dumfries and Galloway (Dumfries and Galloway Royal Infirmary) with a further small satellite unit at the Galloway Community Hospital in Stranraer.

Patients attend the Edinburgh Cancer Centre from other regional health boards where SACT cannot be delivered locally (e.g. the most complex cases) however in 2019, 93.5% of the SACT and Supportive Therapies delivered across NHS Lothian were for NHS Lothian domiciled patients.

The existing Ward 1 service provides:

- Day case SACT and supportive therapies for Oncology patients
- Day case SACT and supportive therapies for Haematology patients
- Daycase SACT trials delivery
- Pharmacy (aseptic and oral dispensing units and clinical verification area) for the above, and also for inpatients in the Oncology and Haematology wards, and as required for outpatients attending Oncology clinics, the Breast Unit and Haematology clinics.

The images below depict the current facilities - the issues of which have been well documented over several years and will be explained within the '*Drivers for Change*' section of this case.

Photo 8: Daycase (SACT) - Ward 1 Oral Dispensing Area

Photo 9: Daycase (SACT) - Ward 1 Storage

Photo 10: Daycase SACT - Ward 1 chairs area

2.1.3.5 Inpatient SACT

Inpatient SACT is delivered to patients in Oncology and Haematology wards for regimens that take longer to deliver (e.g. 24 hour or overnight infusions).

2.1.3.6 Haematology

Inpatient Haematology care is provided on Ward 8 (General Haematology) and Ward 8 Stem Cell Unit at the Western General Hospital with SACT also being administered within these areas. Ward 8 Unit accommodates the regional autologous haematopoietic stem cell transplant service for NHS Lothian, NHS Borders, NHS Fife and NHS Highland.

The bed numbers for these wards are included in the table below:

Table 8: Haematology Bed Numbers (pre-Haematology Capital Development)

	Total Beds	Single Rooms (inc in total bed numbers)	Specialty
Ward 8	14	6	Haematology
Ward 8 Unit	10	10	

**Post-Capital Development there will be creation of single rooms throughout,with a reduction of five inpatient beds from the numbers above, accompanied by an increase in daycase provision*

The wards provide care for patients with both non malignant and malignant haematological conditions which require intensive medical and nursing interventions including Stem Cell Transplants, systemic anti-cancer therapies (SACT) and supportive therapies such as blood and/or platelet transfusions. The patients are highly susceptible to infection therefore the treatment of sepsis is a large part of the workload.

In 2018, a substantial anonymous charitable donation of ~£13m was received by NHS Lothian, specifically to upgrade the Haematology service and facilities within the Western General Hospital. This donation was received and managed on behalf of NHS Lothian by the Edinburgh and Lothian Health Foundation (ELHF).

This work, which is due to complete in early 2021, will provide full refurbishment of Ward 8 and 8 Unit creating single rooms throughout (with a reduction of five inpatient beds from the numbers above, accompanied by an increase in daycase provision) and allows the design of a significantly improved, modern environment for day-case and in-patients, as well as allowing the integration and co-location of the Haematology services within the Edinburgh Cancer Centre.

It is important to note that this programme of work will require a number of derogations as, though a significant improvement on the current arrangement, the facility will still not meet modern HEI standards (e.g. around room sizes and facilities) as the available space is restricted within current infrastructure. The donor is aware of this and during the NHS Lothian governance process leading to approval of the project, it was recognised that the upgrades are only intended to temporarily improve the environment for patients whilst awaiting the development of a new cancer centre.

The images below depict the current facilities - the issues of which have been well documented over several years and will be explained within the '*Drivers for Change*' section of this case:

Photo 11: Haematology - Ward 8

Photo 12: Haematology - Ward 8 Corridor

Photo 13: Haematology Day Unit

2.1.3.7 Radiotherapy

The Radiotherapy department is currently in a self-contained unit comprising;

- 6 linear accelerators (Linacs)
- 7 Linac bunkers (mixed age, size, radiation protection)
- Wide-bore CT simulators,
- Pre-treatment imaging rooms suitable for CT scanners
- 1 HDR suite (control area, prep room and treatment delivery room)
- 8 outpatient clinic rooms
- Patient Interview Rooms (non-clinical information/support giving rooms)
- 1 Mould Room for patient setup
- Radiotherapy planning rooms
- 1 Image contouring room
- 1 ARIA (Oncology Information System) room
- 1 Bookings and Trials office
- 2 teaching/education room for staff
- 1 Mechanical workshop (supporting Cancer Services & Medical Physics)
- 1 Electronics workshop
- 1 Computing workshop
- 1 Dosimetry laboratory
- Staff offices, including research offices with computer links to University of Edinburgh
- 2 Staff Rooms
- 1 kV (Superficial) treatment room
- 1 Secure Sealed Sources Laboratory (alarmed)
- Shielded single bed areas on Ward 2
- Waiting areas (main area supported with cafe, and local rooms closer to Linacs)

The ECC provides a comprehensive Radiotherapy service to the South East Region, and some specialist services to patients from all over Scotland including the national Benign Intracranial Stereotactic Radiotherapy Service.There is an active research program and a significant provision of clinical trials, though little capacity for further expansion of this within the current footprint.The department sees 200-240 patients per day who are usually having a course of treatment which is delivered over multiple days which means that patients can attend daily for up to 7 weeks.

The current suite of Linac bunkers do not provide the space and flexibility to install and accommodate the full range of modern radiotherapy treatment machines, and the associated technical equipment essential for clinical operation.

The photographs below show the current facility:

Photo 14 and 15: Some Linac bunkers are too small to allow full range of movement of the Linac couch, and are overcrowded with equipment.

Photo 14: Radiotherapy – Linac bunker

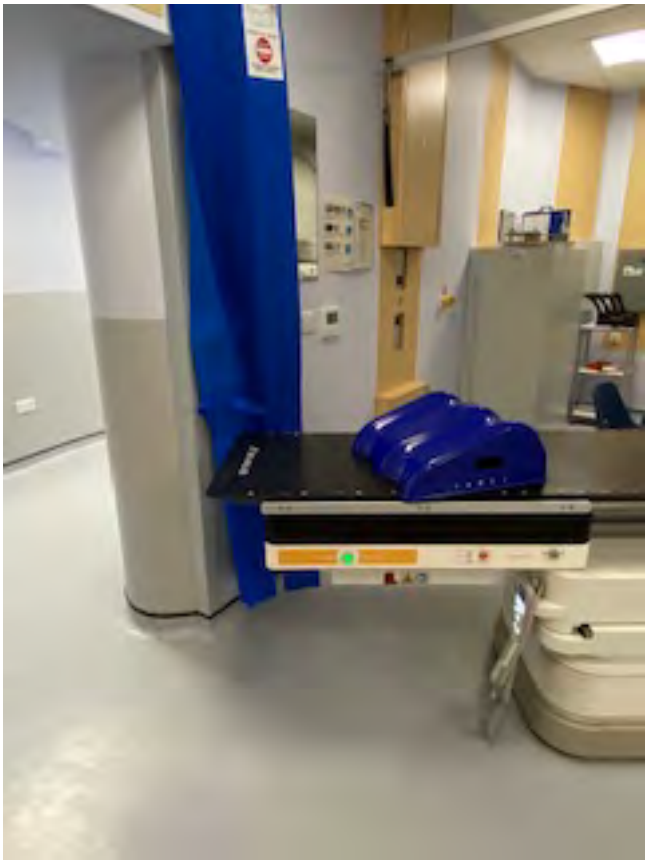


Photo 15: Radiotherapy - Linac bunker

Photo 16: Main entrance into the treatment area is narrow and often results in queues at the patient check-in desk, which is at the entrance to one of the machine. It is difficult to get a bed through this area.

Photo 16: Radiotherapy – Main entrance into the treatment area, narrow access

Photo 17:: Radiotherapy – Limited Storage

Photo 18: Radiotherapy – Corridor

2.1.3.8 Brachytherapy

The Edinburgh Cancer Centre provides a prostate brachytherapy service for patients across Scotland alongside NHS Greater Glasgow and Clyde (NHS GG&C).

Currently High Dose Radiation (HDR) Brachytherapy for Gynaecological Cancers requires access to Theatre 15 for treatment preparation and is delivered in the Radiotherapy HDR Suite. Patients also require access to CT for treatment planning purposes.

Prostate Low Dose Radiation (LDR) Brachytherapy is delivered in Theatre J and Breast Theatre with some patients requiring overnight stays. This requires storage facilities for radioactive seeds, and specialist treatment planning equipment and software.

2.1.3.9 Breast Services

The NHS Lothian Breast service is provided over two sites, at the Western General Hospital (WGH) and St John's Hospital (SJH).

Within WGH the Edinburgh Breast Unit (EBU) consists of Ward 6 inpatient ward,which includes a day surgery unit with 6 trolley spaces, two operating theatres (Theatres 14 and 15), an outpatient clinic area which includes Breast Care Nurse interview rooms as well as nine clinic rooms, two treatment rooms, an administration corridor and a seminar room with video-conferencing facilities.

Furthermore EBU has a designated mammography department, situated on the south corridor on the floor directly below the clinic, where breast imaging is carried out.

Bed numbers in the Breast Unit are included in the Table below:

Table 9: Inpatient Breast Unit - Bed numbers

	Total Beds	Single Rooms (inc in total bed numbers)	Specialty
Ward 6	11	5	Breast

At SJH, outpatient clinics are held in OPD 4 with 2/3 clinic rooms allocated to morning sessions on Wednesday and Thursday. Operations are carried out in main theatres located on the ground floor within the main hospital building. The Breast Care Nursing Team offices are located within the oncology

outpatients department on the ground floor and breast imaging is carried out in the main x-ray department. Long term post cancer surveillance and high risk clinic (nurse led) currently runs from the outpatient department on a Thursday morning.

Annually ~1,700 operations are carried at WGH with ~200 operations carried out at SJH. A percentage of these are revisional/ reconstructive procedures but the majority are cancer operations.

The unit works in partnership with the South East Scotland Breast Screening Programme based at Ardmillan Terrace and covers Lothian, Fife, Borders and Forth Valley. The Edinburgh Breast Unit (EBU) is the tertiary referral centre and supports the SCAN regional services in Fife and Borders seeing ~8000 new patients per year (the majority of which are not found to have cancer), diagnosing approximately 400 new cancers annually in addition to a similar number detected through the national breast screening programme.

Following a positive screening result patients return to their host board for treatment and follow up wherever possible.

2.1.3.10 Clinical Trials

The Edinburgh Cancer Centre continuously strives to improve quality, learning and innovation in order to provide the highest standards of cancer care. A main driver of these efforts is a centre wide commitment to cancer research and to providing access to the most innovative therapies through clinical trials. This is considered to be core business for the centre. Consequently there has been a very significant growth in trials activity over the last 3 years and the number of NRS clinicians has tripled in this time. This is in contrast with a trend of decline seen elsewhere in Scotland and the UK.

There is an active Clinical Trials program in both Haematology and Oncology and there has been a very significant growth in trials activity over the last three years. The number of NHS Research Scotland (NRS) fellowhips and research funded clinicians has tripled in this time.Improved opportunities for professional development and research, for academic and for NHS clinicians has improved the prospects for recruitment and retention of staff.

These endeavours are supported and managed by the South-East Scotland Cancer Research Network (SES SCRN). SES SCRN was established in 2004 and is based in the Edinburgh Cancer Centre. Its main function is to co-ordinate trials activity as well as support and encourage cancer clinicians to deliver clinical trials across all tumour types in order to give patients across South-East Scotland access to the most innovative therapies and more treatment options. SCRN has 50 whole time equivalent (WTE) staff delivering and recording research to patients and receives core funding from the Chief Scientist's Office (CSO) as well as funding from Research & Development, Cancer Research UK (CRUK) and commercial income.

Clinical trials delivered at the Edinburgh Cancer Centre provide access to novel therapies that are not available through any other route, as well as providing funded trials treatment opportunities which lead to significant cost savings for the NHS. Involvement in clinical trials also provides funding for trained staff leading to an increase in capacity of the ECC to deliver anti-cancer therapies and contributes to the development and implementation of state-of-the-art radiotherapy.

In 2018 over 1,000 patients within the SESCRN area consented to take part in a clinical study either as part of a randomised trial or by donating blood or tissue for further research purposes. In 2019 in Lothian there were 141 trials open or in follow up and a further 12 in set up, with a large number of treatments being delivered by the clinical trials teams.

Currently the clinical trials team work in Area 1 of Ward 1 with 11 chairs designated to deliver trial therapy.

Data Managers and Research Nurses are currently accommodated on the Lower Ground Floor level of Ward 1 and in the Oncology management corridor.

Radiotherapy has designated Clinical Trials radiography and physics staff integral to the department to support an expanding portfolio of trials involving Radiotherapy.

The Clinical Trials Pharmacy service has 3.0 WTE pharmacists designated to the pharmaceutical input to Cancer Clinical Trials service with some support from 2 Pharmacy Technicians from the wider Clinical Trials service. The Pharmacy team work in close collaboration with the research MDT to support the delivery of SACT within Clinical Trials. Investigational medicines are stored and dispensed between the main pharmacy and satellite pharmacy.

A lack of space (including lack of space for the storage and preparation of clinical trial medication) serves as a physical constraint on the growth of this exciting research programme.The integration of research, innovation and service elements would be achieved more efficiently with the correct adjacencies in place,allowing expanded access to the benefits of clinical research for patients, staff and service.

2.1.4 Existing Workforce

The number of staff directly involved in delivering cancer services are detailed below:

Table 10: Staff Numbers within Cancer Services

Staff Group	Number	Comments
Consultant Clinical Oncologists	23 WTE	Delivering Radiotherapy and SACT
Consultant Medical Oncologists	16 WTE	Delivering SACT, Acute Oncology and CUP Services
Oncology Specialist Drs	3 WTE	
Oncologists are based in the Edinburgh Cancer Centre with 12 travelling to peripheral clinics (in Fife, Borders and Dumfries and Galloway) to support locally delivered clinics, multi-disciplinary meetings, and SACT delivery close to patients homes.		
Consultant Haematologists	10 WTE	
Haematology Specialist Drs	2 WTE	
Consultant Breast Surgeons	6.75 WTE	
Breast Specialty Drs	3.25 WTE	
Consultants in Palliative Medicine	4.2 WTE	Across Lothian Acute Hospitals
Palliative Care Clinical Nurse Specialists	7.8 WTE	
Registered Nurses (Band 5/6/7)	170.5 WTE	
Non-Registered Nurses (Clinical Support Workers, B2)	62 WTE	
Clinical Nurse Specialists (CNS) and Advanced Nurse Practitioners (ANP)	52.6 WTE	
Oncology Physics (Band 5/6/7/8/9) Registered Clinical Scientists Clinical Technologists	 17.2 WTE 24.3 WTE	Includes brachytherapy, Stereotactic Radiosurgery, Clinical Trials
Registered Therapeutic Radiographers (Band 5/6/7/8)	70.1 WTE	
Non-registered therapeutic radiography staff (Band 2/3)	4.6 WTE	Radiography/Radiotherapy Helpers
Pharmacists (B6-8)	18.5 WTE	Resource allocated to Cancer Services
Pharmacy Technicians (B4-7)	15.5 WTE	
Pharmacy Support workers (B2-3)	5.6 WTE	
Pharmacy Admin (B2-4)	0.5 WTE	
Research Nurses	25.8 WTE	Clinical Trials
Tissue Consenters	2.0 WTE	
Data Managers	24.0 WTE	
Clinical Trials Pharmacists	3 WTE	
Administrative Services (based on WGH site)	99 WTE	Includes Cancer Performance Team, Ward Clerks, Clerical Officers, Medical Secretaries, Multi Disciplinary Meeting Co-ordinators and managers
There are an additional 9 WTE and 7 WTE admin staff that support Cancer Services based at the Royal Infirmary of Edinburgh and St John's Hospital respectively.		

2.1.5 Estates Strategy and EAMS

NHS Lothian has produced a Property and Asset Management Strategy (PAMS) since 2011 in line with the Scottish Government's requirements as scheduled in CEL 35 (2010) 'Policy for Property and Asset Management in NHS Scotland'. This reporting has generally been provided as a full report every two years with updates in the intervening years.

The PAMS reflects the following policy aims:

- To ensure that NHS Scotland assets are used efficiently, coherently and strategically to support Scottish Government's plans and priorities and identified clinical strategies and models of care;
- To provide, maintain and develop a high quality, sustainable asset base that supports and facilitates the provision of high--quality health care and better health outcomes;
- To ensure that the operational performance of assets is appropriately recorded, monitored, reported and reviewed and, where appropriate, improved;
- To ensure an effective asset planning and management with other public sector organisations.

Much of the PAMS reporting is supported by information held centrally via Health Facilities Scotland (HFS) within the Estates and Asset Management System (EAMS) database. HFS also host the Capital Planning System (CPS) tool which interfaces with EAMS and integrates data sets to scenario model investment needs, develop life cycle models for each property, generate informative, graphical reports and with relevant outputs supports the prioritisation of projects across Boards and Regions.

The data sets within EAMS are based on the findings from building condition surveys carried out on a rolling programme and further reviewed on a quarterly basis. The last update for the Western General Hospital site for inclusion here was issued in May 2020. This data is supplemented by other surveys and desktop reviews carried out by NHS Lothian which include Functional suitability, Space utilisation, Quality and Statutory Compliance. This information is refreshed on a regular basis in line with PAMS reporting.

As part of the property review supporting this IA, information from the Capital Planning System and the EAMS data base has been reviewed in conjunction with real world evidence from general site familiarity to help further inform more detailed views on functional suitability, space utilisation and physical condition.

The following facilities at the Western General Hospital are relevant to this IA:

- Existing DCN Zone
- Existing Edinburgh Cancer Centre (ECC) Zone

See the WGH Block Plan below for reference.

Figure 2: WGH Block Plan

Backlog maintenance and life cycle data has been reviewed for the whole hospital including external areas. Two site zones are principally affected by current Cancer Centre proposals. These are the existing Cancer Centre – located within multiple blocks to the South East of the site and the DCN zone on the South West which is the preferred location of the new Edinburgh Cancer Centre at the Western General Hospital.

The backlog costs indicated for the ECC Zone in the table below are based on the existing Cancer Centre and don't take account of any potential backlog reduction as a result of the Oncology Enabling and Haematology works as no refresh reporting will be available until after these works are complete. Due to the limitations of these refurbishment works and the fact that they are for only relatively small parts of the existing ECC, it is considered that there will not be a significant reduction in the quoted backlog figures below.

The DCN Zone has blocks associated with DCN services that have relocated to Little France and also includes other blocks which will require to be vacated and demolished to clear the required extent of the preferred Cancer Centre site.

Based on a review of the blocks associated with these zones the tables below confirm the relevant current backlog maintenance costs. These are base elemental costs and do not reflect the real costs of projects required to deliver the backlog reduction. It is generally accepted that a 3 times multiplier should be used to determine a more realistic cost for the relevant backlog removal.

It should also be noted that the costs also include a relative proportion of the identified costs for external site areas including key infrastructure.

Table 11: DCN Backlog Maintenance

	Currently Recorded Backlog Maintenance (£m)				
	Low	Moderate	Significant	High	Total
DCN Zone Totals	£1.04	£0.687	£2.619	£ -	£4.348

Table 12: ECC Backlog Maintenance

	Currently Recorded Backlog Maintenance (£m)				
	Low	Moderate	Significant	High	Total
Existing ECC Zone Totals	£0.030	£0.314	£2.590	£ -	£2.,934

The backlog priorities include:

- Electrical
- Fire Prevention
- Internal repairs – HAI related in particular
- External repairs

Life Cycle Costs

The Life Cycle Costs are reported through the CPS managed models which synchronise all data gathering and collation which NHS Lothian are required to collate through EAMS.

Life cycle replacement is a major factor in the appraisal of the investment required to maintain the facility to an acceptable standard. The replacement of key components and particularly services infrastructure will affect other components. The relevant work required to be carried out will impact on facility operations and involve significant out of hours working and potentially complex phasing strategies.

A review of the life cycle modelling has been carried out in collaboration with Health Facilities Scotland. The models which have been run from the CPS have highlighted some issues that will be required to be addressed through the next phase of refresh surveys and across the whole site within a relatively short timeframe to ensure that data for all blocks is as concurrent as possible and this will provide more up to date and manageable data outputs.

There are around 100 separate blocks of various scales and vintages recorded on the CPS for the WGH site. This underlines the complexity of both the site and the challenges associated with managing the estate where NHS Lothian have a very detailed strategy that addresses all high-risk issues that affect business continuity as key priorities.

2.1.5.1 Space Utilisation

As part of the clinical data review carried out in support of the development of a Draft Schedule of Accommodation, there has been a clearer understanding gained of the current space utilisation performance of the existing parts of the estate. This is effectively a more “real world” view of utilisation that supplements the approach required in the Property Appraisal Manual as it is based on hard evidence, where available, from actual clinical throughput.

The existing facilities are generally being fully utilised but with significant compromises as highlighted in the section on Functional Suitability below.

The existing estate is not capable of being adapted or extended to support the longer-term activity projections that have also been assessed as part of the schedule of accommodation development.

As also can be seen in the Block reference diagram above, the existing Cancer Centre Zone takes up a relatively large area of the Western General site and that the proposed DCN Zone occupies a smaller portion of the overall site area. This is an important factor that is further articulated in the Functional Suitability and Quality Sections below.

2.1.5.2 Functional Suitability

The existing facilities are, in the greater part, not functionally suitable and have many noted deficiencies which will only be addressed in part through the Oncology Enabling and Haematology projects.

These include:

- Chair spacing - there is an insufficient number of treatment chairs to meet current and future demand. Current chair spacing is circa 2.0m2/chair with the recommended chair area being 10m2/chair. This results in a poor patient experience illustrated by the fact that return patients are no longer permitted to bring a relative or friend for support due to space constraints.
- Infection Control – a range of measures required to improve infection control.
- Safety concerns – constraints imposed by configuration can cause difficulties in treating patients safely.
- Pharmacy Space – very constrained and requires reconfiguration. Essential Pharmacy support is at the limit of its capacity- evidenced by increased incidence reporting in the clinical area and in pharmacy.
- Storage Space - There is inadequate storage for pharmacy, ward supplies and linen.
- Support facilities - There is a lack of facilities for relatives and patients e.g. waiting areas and toilets
- Clinical Rooms - There is an insufficient number of consulting, procedure and isolation rooms.
- Toilets - Ward 1 does not have an adequate number of toilets, nor does it have toilets that are built to a specification to meet patient needs.
- Configuration – Layout and adjacencies does not support effective patient flows in many areas.
- Insufficient space to develop Trials - There is a lack of space to develop Clinical Trials resulting in that service rejecting offers limiting the revenue benefits to the hospital and any potential clinical benefits for patients. This is being addressed through the redevelopment of the Lower Ground Floor of the Scottish Health Service Centre (SHSC) to provide suitable clinical trials facilities in line with the development of the Oncology Enabling projects.
- Room sizes – particularly patient bedrooms – multi bed and single rooms. These are considerably below current recommended standards which impacts on bed spacing and accessibility including hoisting and space for testing and monitoring equipment around the bed.
- Percentage of single bedrooms – 31 out of 93 – ie 30%. This is particularly low given the patient groups being treated as inpatients within the Cancer Centre itself.

In addition to the range of issues associated with clinical and non-clinical rooms and spaces within the buildings the following are key factors which affect the functional suitability of the facilities.

- Disparate buildings that are linked – this factor impacts on the efficiency of the facilities and including patient care and staffing.
- Link bridge – The Ward 1 Block is located on the South of the main hospital drive and is connected physically by a link bridge. Lift and stair access is required at either end of the bridge and this further compromises patient care and staffing efficiency alongside being a physical constraint for vehicular movement. NB: There was a recent case of a Lothian Buses double decker bus hitting the bridge. Fortunately, there were no injuries or major damage to the bridge itself.

- The above factors create access issues for patients, visitors, carers and staff and including FM efficiency.
- Efficient and effective FM support is compromised by the inefficient building configuration.
- Car parking is limited and will be more so on conclusion of the enabling projects. This allied with relatively poor public transport also further increasing pressure on the spaces available.

The projected activity growth is significant, and the existing estate is not adaptable or flexible enough to deal with this level of change. In addition the Western General Hospital site is very constrained at the moment and this situation will not be improved until the DCN Zone is fully cleared and preparatory works carried out prior to the development of the new Edinburgh Cancer Centre in this preferred location.

2.1.5.3 Quality

The existing Cancer Centre facilities have been recognised as not being fit for purpose, and although improvements are scoped within the Oncology Enabling, Haematology and Clinical Trials projects, these will not resolve many of the issues which are fundamental to the qualitative aspects of how the facilities are perceived by the range of users.

The AEDET process has highlighted a number of issues relating to the quality of the facilities in particular and this is a useful reference point as the review process involved a wide range of stakeholders including clinical, administrative and facilities staff along with members of the patient group.

The key issues raised included:

- Fragmented services – difficult to deliver the model of care across both the Cancer Centre and wider WGH campus,poor wayfinding/ signage, complex levels,lone working raising security concerns.
- Fragmentation of facilities - especially over different levels across services. Difficulties in using wheelchairs across site.
- Lack of proper pavement access routes from Crewe Road South and difficulties in using wheelchairs across the site due to complexity of levels.
- Entrances to Radiotherapy and Ward 1 are situated on the road and also directly opposite each other and can get congested.
- Reception and waiting areas in Ward 1 described as 'miserable.'
- Sensory impairment considerations required (e.g. lighting).
- No space for Palliative Care that is contemplative, peaceful etc.
- Lack of physical space, for both current and potential future expansion. Facilities have reached their limit.
- Facilitating the enablement of new treatments is fundamental to future service. Future-proofing from 'expansion' perspective also. Flexibility in use of space.
- Quantity and access to parking poor. Accessing staff parking can also be stressful and time consuming.
- Very tight spaces for ambulances and due to fragmentation of services patients not always dropped off at correct location (e.g. dropped off at inpatient wards instead of Cancer Centre).
- FM problems in Outpatients in particular - no segregation and can be disruptive to the service.
- Lack of good quality external amenity space.
- No secure bicycle storage, showers etc for staff. No safe cycle routes.
- Being able to see daylight is beneficial - too many long dim corridors. Important to staff as well as patients.
- IT infrastructure requires upgrade.
- Frequent problems with overheating - can't relieve this with fans due to infection control regulations.
- One lift to access services - requires long detour if it is not working.

- Not enough WC facilities for patients. Staff wellbeing facilities not fit for purpose. This is a priority for morale and encouraging staff retainment and recruitment.

2.1.5.4 Overall Facility Related Challenges

In summary there are a number of existing facility related challenges which do not support the implementation of new models of care for cancer treatment at the Western General Hospital.

Although the Oncology Enabling project (at FBC stage) and the separately funded Haematology and Clinical Trials projects urgently address priority areas for safe service sustainability, they are unable to address most of the challenges that impact on the ability to future proof cancer services by implementing new treatments and models of care.

2.1.5.5 Conclusions of Reviews of the Estate relevant to the development of the proposed New Edinburgh Cancer Centre

The conclusions from the above reviews were that:

- Backlog and Life Cycle performance will be improved in part through the Oncology Enabling and Haematology projects but not proportionately to the investment required relative to full replacement by new facilities.
- The reported backlog and overall life cycle investments requirements will be, in reality, at least three times, based on generally accepted national norms, of those as reported to deliver the relevant improvements through actual projects.
- Oncology Enabling and Haematology projects are a relatively short-term solution and do not support the implementation of new models of care or have the flexibility to deal with new treatments and technologies asthey become available.
- External areas on the hospital site are tight for all types of vehicle access and manoeuvring generally. As such this presents risks to the public and staff. This is being addressed through the masterplan development but the problems are particularly evident in the existing Cancer Centre Zone.
- The Cancer Centre blocks are fully utilised and generally functionally unsuitable.
- There are a significant number of Functional Suitability issues noted with the facility that cannot be addressed within the existing floor plate and overall configuration constraints.
- Feasible improvements will be carried out to improve functional suitability and utilisation through the enabling projects but within a constrained footprint and tight overall site zone.
- Patient flows are generally poor, and this is due mainly to cramped conditions with poor adjacencies. This is further reflected in privacy and dignity issues for patients visiting many areas of the facility.
- Further expansion options in this zone of the site are extremely limited, and the potential benefits would be difficult and expensive to realise while still potentially creating other complex issues that would need to be resolved.
- Even with the additional single rooms created through the Oncology Enabling and Haematology projects, single bed provision continues to be very limited without significant investment in a compliant new build – which is not feasible with the current site zone constraints.
- Improvements proposed generally mean only relatively small gains due to the ageing and inflexible building arrangement but require to be carried out due to the urgent nature of a number of issues.

2.2 Drivers for Change

2.2.1 Population and Cancer Incidence Data

Demand has been rising annually in response to a number of key drivers. It is too early to project whether these estimates will be impacted by the COVID-19 pandemic, however in the longer term it is anticipated that the underlying trends will continue:

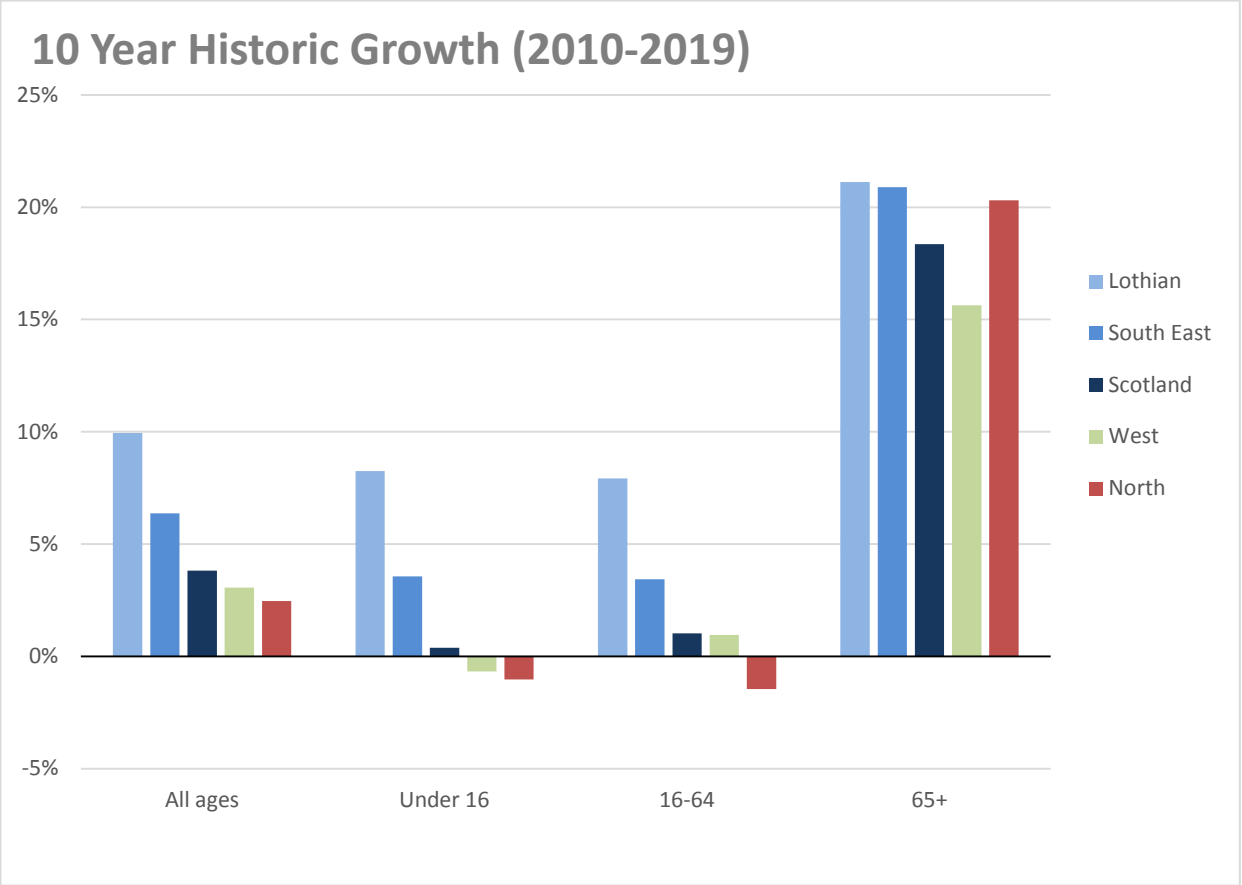
- Increasing population within Lothian (10% between 2010-2019) and the SCAN region (6% between 2010-2019) with growth expected to increase by a further 15% (Lothian) and 7% (SCAN) in the next 25 years;
- Aging demographic;
- Increased cancer incidence, across the SCAN region which is projected to increase by a further 22% by 2025;
- Earlier detection of cancer through improved diagnostics and increased screening;
- Increased number of effective treatment options licensed and SMC approved;
- Increased duration of use of multiple regimes of SACT in individual patients as a result of better efficacy and greater tolerability of modern SACT agents;
- Improved Radiotherapy modalities and techniques – increased indications for Radiotherapy;
- Increased use of lifelong Supportive Therapies

Many more people are also living with and beyond cancer resulting in a need to focus on early prevention and detection to optimise treatment and minimise morbidity and mortality. The increase in the number of patients surviving cancer, adds substantially to the complexity to care planning and delivery for those who are living with the consequences of cancer or cancer treatment.

2.2.1.1 Increasing Population

The population of Scotland, the SCAN region and Lothian has increased since 2010 with older age groups seeing the greatest increase.

Figure 3: Population Growth in Scotland



The graph above and table below demonstrate that Lothian's historic growth rate is the highest in Scotland across all age bands displayed.

Table 13: 10 Year Historic Growth 2010-2019[3]

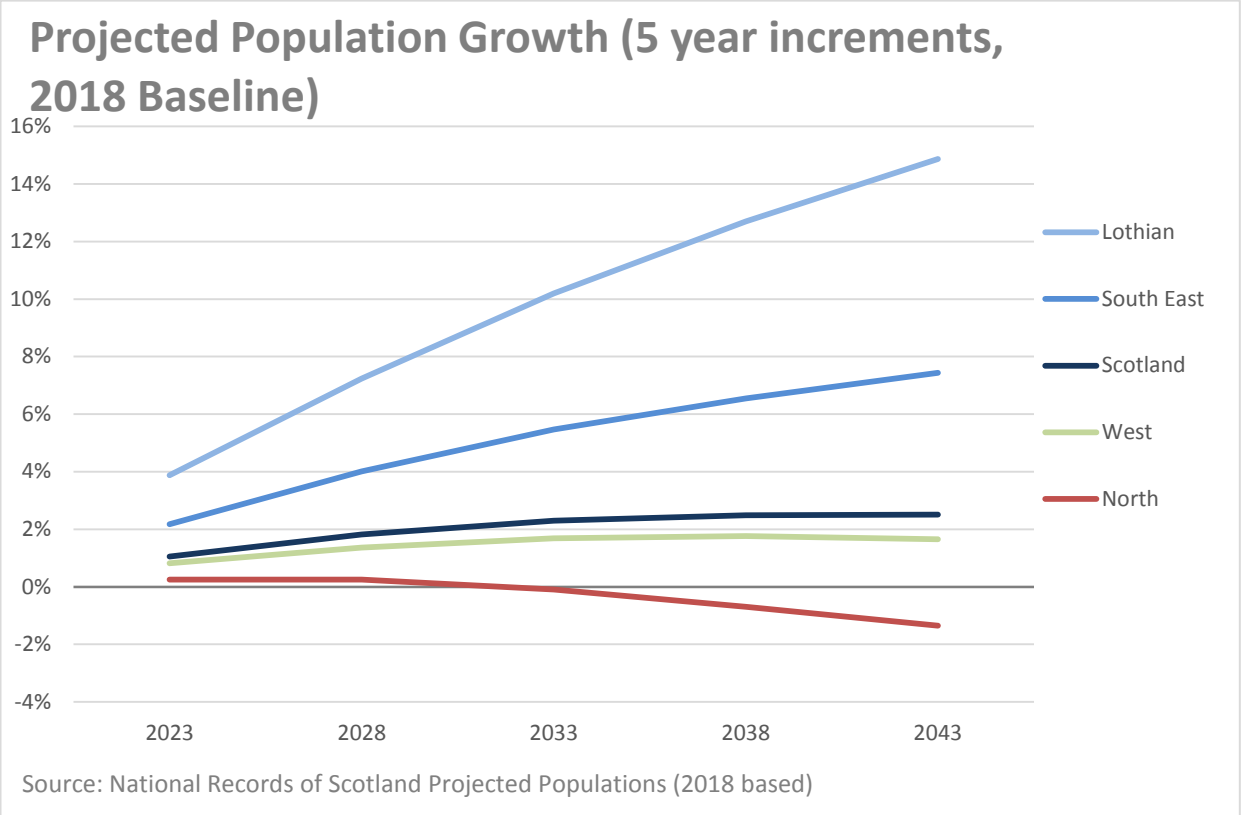
	All ages	Under 16	16-64	65+
Lothian	**10%**	**8%**	**8%**	**21%**
South East	6%	4%	3%	21%
Scotland	4%	0%	1%	18%
West	3%	-1%	1%	16%
North	2%	-1%	-1%	20%

This trend is forecast to continue, with the population of Scotland, the SCAN region and Lothian predicted to increase over the next 25 years. Lothian has the largest predicted increase for all of Scotland (see Figure 4 and Table 14 below).

Older age groups are predicted to see the largest increase with Lothian having the largest increase across all age ranges.

[3] Time Period of Dataset: Mid year 2010-2019
Geographic Coverage: Scotland, Cancer Region, Lothian
National Records of Scotland (NRS)

Figure 4: Forecast Population Growth in Scotland



- The East Region is expected to grow over four times faster than any other region in the next 25 years.
- The Lothian growth rate is projected to be 12% higher than the Scottish average over the same period.
- Lothian is expected to show the highest rate of growth in the over 65s age group over the same period.

Table 14: Projected Population change over 25 years (2018-2043) [4]

	2023	2028	2033	2038	2043
Lothian	**4%**	**7%**	**10%**	**13%**	**15%**
South East	2%	4%	5%	7%	7%
Scotland	1%	2%	2%	2%	3%

[4]

Time Period of Dataset: Mid year 2018-2043

Geographic Coverage: Scotland, NHS Board areas

Supplier: National Records of Scotland (NRS)

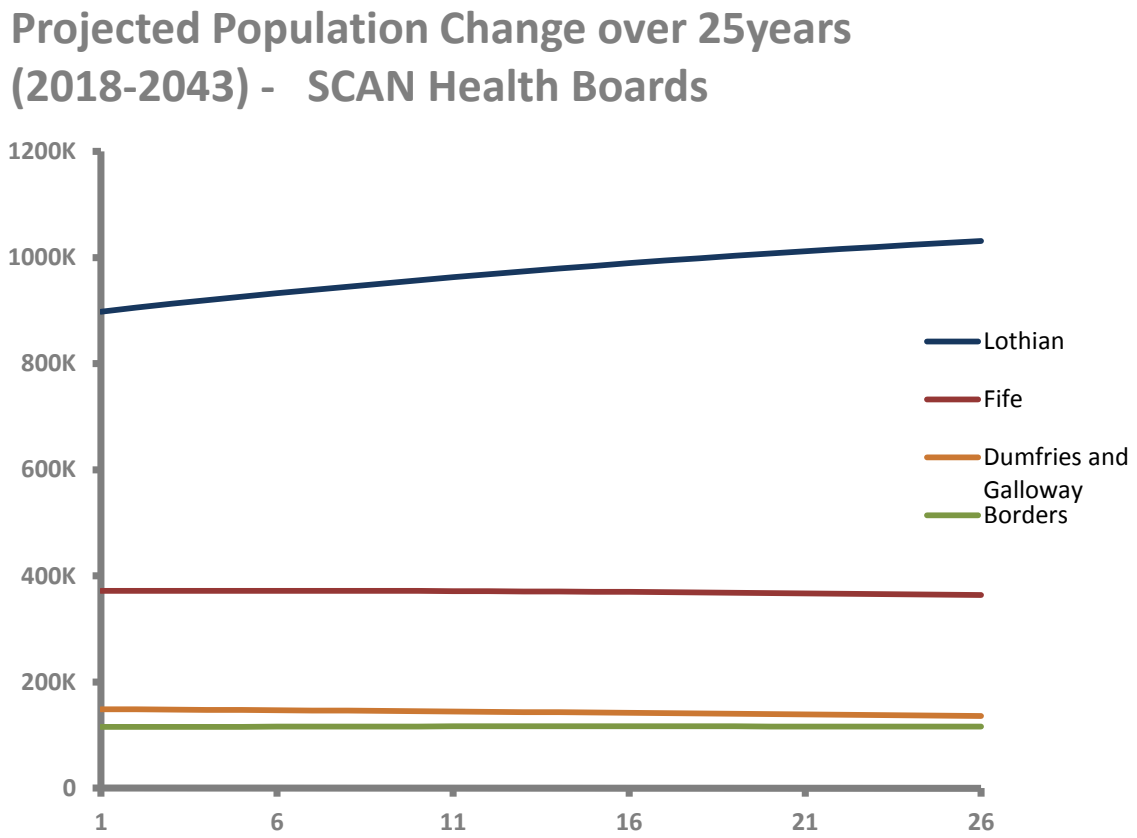
Department: Demographic Statistics, Population and Migration Statistics Branch

West	1%	1%	2%	2%	2%
North	0%	0%	0%	-1%	-1%

Table 15: Predicted Population over 25 years (2018-2043)

	2018	2023	2028	2033	2038	2043
Lothian	**897,770**	**932,555**	**962,745**	**989,285**	**1,011,757**	**1,031,266**
South East	1,533,740	1,567,172	1,595,185	1,617,532	1,634,137	1,647,854
Scotland	5,438,100	5,495,578	5,537,116	5,562,901	5,573,181	5,574,819
West	2,509,920	2,530,536	2,544,012	2,552,234	2,554,280	2,551,302
North	1,394,440	1,397,870	1,397,919	1,393,135	1,384,764	1,375,663

Figure 5: Projected Population Change Over 25 years (SCAN Region)



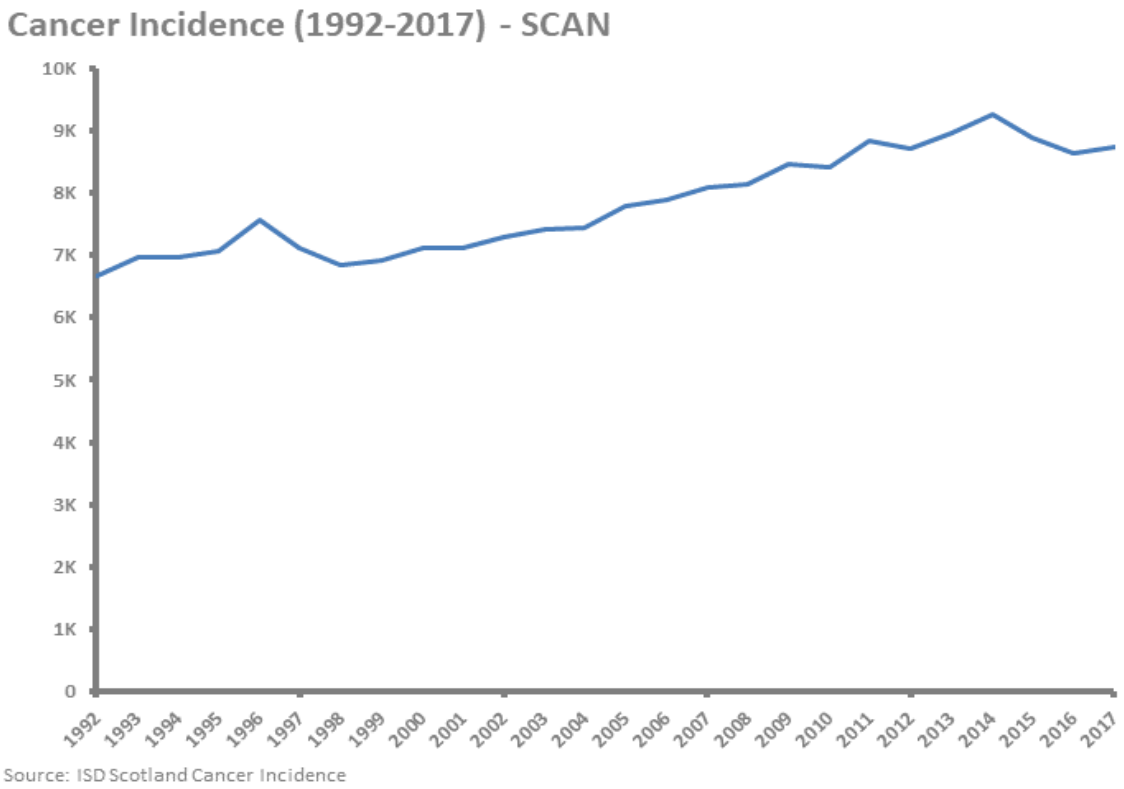
Source: National Records of Scotland Projected Populations (2018 based)

2.2.1.2 *Increasing Cancer Incidence*[5]

Age standardised cancer incidence in Lothian, South East Scotland and in Scotland overall is significantly higher than the UK average[6]. The most common cancers in the South East region are prostate, lung, colorectal and breast cancers.

The graph below shows the increase in cancer incidence (across all cancers) in the SCAN region from **1992 to 2017**.

Figure 6: Cancer Incidence (SCAN Region)



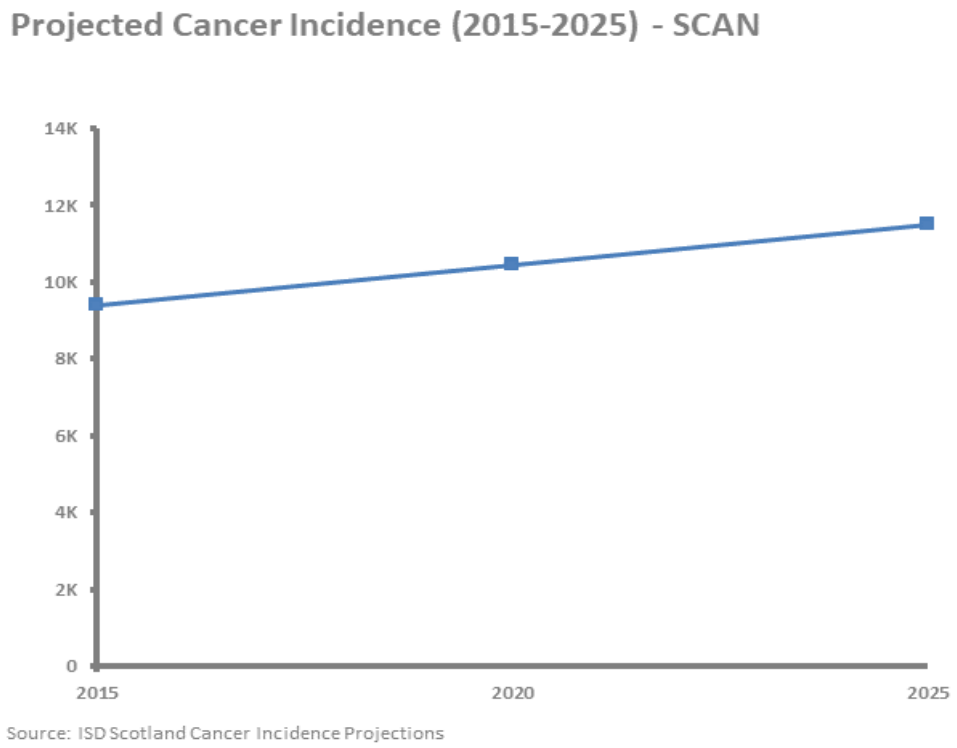
Future projections for Cancer incidence were last forecast by ISD in 2014. At that time Cancer incidence in Scotland was predicted to increase by 33% between ~2010 and ~2025.

Cancer Incidence in the SCAN Region is projected to grow by 22% - from 9,391 in 2015 to 11,479 by 2025.

[5] Source: Scottish Cancer Registry, ISD Data extracted: March 2018
Notes: Cancer registration is a dynamic process: the data presented here may differ from other published data relating to the same time period.

[6] Better Cancer Outcomes in Lothian – A Strategy for Cancer 2015-2020, November 2014

Figure 7: Projected Cancer incidence (SCAN Region)

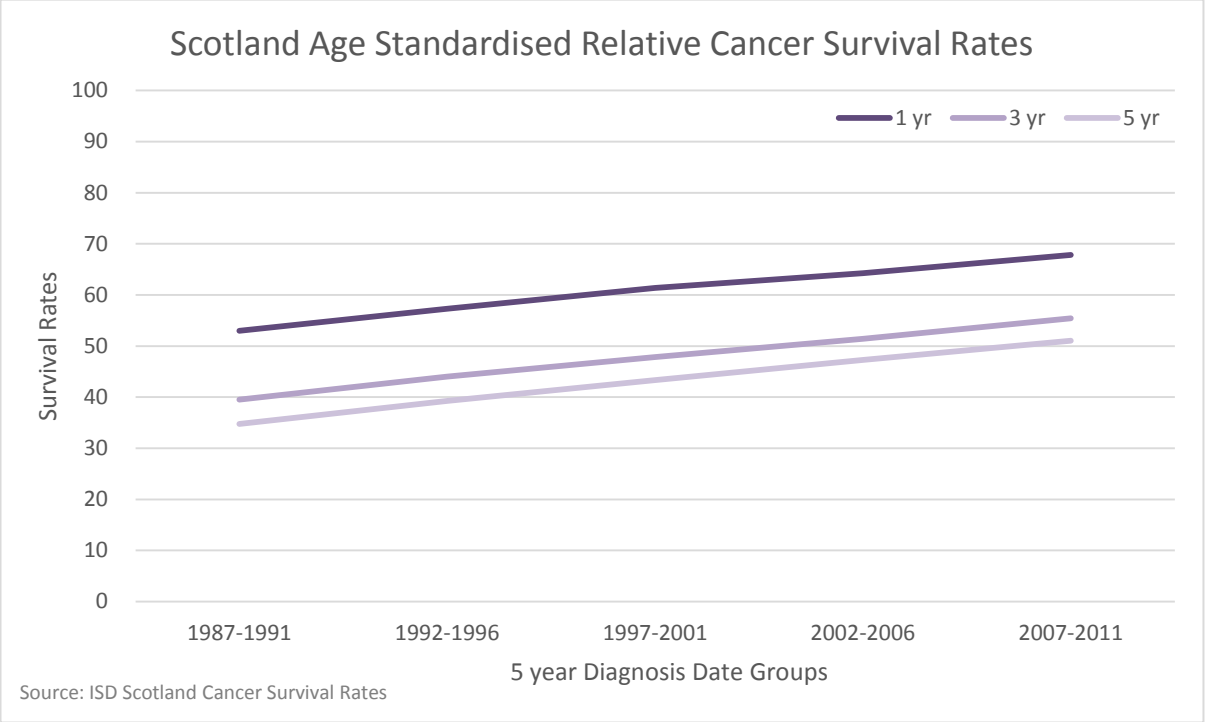


The projected population growth combined with an aging population contributes to a projected increase in cancer incidence in the SCAN region, and highlights the need for delivery of a sustainable service to meet the needs of cancer patients in South East Scotland.

2.2.1.3 Cancer Survival Rates

As demonstrated in the graph below,across all age groups, in Scotland,the relative five year survival rate has increased.

Figure 8: Age Standardised Relative Cancer Survival Rates[7]



The actual percentage increase is highest in the 65-74 age group and it is also the largest cohort of patients accounting for 25-30% of admissions and Length Of Stay (LOS) currently.

The fact that more people are living with and beyond cancer also highlights the need for a service that supports cancer patients on a long term basis as they continue to live longer.

[7] ISD Scotland Cancer Survival Rates

2.2.2 Challenges with Current Arrangements and Potential Opportunities

Historically, service development and transformation work has been and continues to be undertaken to counteract the rising demand for Cancer services.

Many of the challenges have been recognised through approval of Business Cases for capital investment within NHS Lothian, including the Haematology project (£13m), Oncology Enabling Programme of works (£20m) and Clinical Trials Project (£1m) and expansion of the St Johns Hospital Satellite Unit (£160k).

However, NHS Lothian continues to face challenges with regards to meeting Scottish Government targets for Cancer Performance as summarised below:

Table 16: Key Performance Indicators (KPIs)

	Key Performance Indicator	Relevance of KPI	Target	Jan to Mar 2020
Cancer Waiting Times	**31-day target** from decision to treat until first treatment, regardless of the route of referral.	How quickly patients are treated	95%	96.2%
	62-day target from urgent referral with suspicion of cancer, including referrals from national cancer screening programmes, until first treatment.	How quickly patients are treated	95%	83.5%

Against the backdrop of increasing population and cancer incidence as demonstrated above, plus the impact of service changes due to the recent COVID pandemic, these targets will become ever more challenging to meet in the future.

Challenges exist across diagnostic and treatment pathways with specific challenges described below in 'Drivers for Change'. Addressing these challenges will improve compliance with the National Cancer Waiting Times Standards as outlined above, alongside other key performance metrics,whilst improving patient experience and outcomes.

2.2.3 Drivers for Change - Inpatients

The Edinburgh Cancer Centre inpatient facilities for both Oncology and Haematology patients are currently non-compliant by Health Environment Inspectorate (HEI) standards– leading to issues around infection control, patient privacy and dignity and increased falls.

The Oncology Enabling Programme of works (due to complete in 2022) will deliver an improved (but not fully compliant) inpatient care environment for Oncology patients, with the Cancer Assessment Unit (CAU) moving out of Ward 2, allowing the inpatient wards to spread over two floors (Wards 2 and 4). This will allow treatment and care to be provided in a more suitable environment. There will also be fire compartmentalisation and detection systems upgrades along with general flooring upgrades and building fabric works.

As detailed above in s2.1.3, in 2018 the Haematology service received a substantial anonymous charitable donation of £13m to upgrade the Haematology service and facilities within the Western General Hospital.

Although the Project Team undertook an exhaustive Options Appraisal exercise to maximise improvements in capacity and environment, within the current infrastructure both of these programmes of work require significant derogations (e.g. around room sizes and facilities) and they will still not meet modern HEI standards.There is also no allowance for any growth in numbers of single rooms.

Based on robust service modelling as part of the Oncology Enabling Full Business Case,it is expected that the refurbished facility will cope with growing demand for the next ~ five years, thereafter further investment will be required to facilitate essential continued transformation of service.

There is also currently no inpatient provision for Cancer Trials which limits the trials that can be offered to patients in the South East Region, causing a negative impact on patient outcomes.

2.2.3.1 Admissions and Length of Stay

Admissions to Haematology and Oncology have increased by 44% from 2009-2019 (from 4657 patients in 2009 to 6746 patients in 2019) however the length of stay has decreased over the same period by 7.8% (from 34868 days in 2009 to 32,152 days in 2019).

The increase in admissions reflects the increasing cancer incidence and increasing complexity of treatment as well as the increased use of the Cancer Treatment helpline - meaning more patients are directed into the cancer centre rather than to their GP. Decreased length of stay is likely to be the result of better tolerated modern SACT treatment along with improved outpatient support, triage, inpatient care, supportive and palliative services resulting in patients being treated in specialist secondary care settings where appropriate more rapidly and effectively and being discharged home more quickly.These trends demonstate the potential for continued transformation of services to manage increased demand.

Similarly, admissions for Breast have decreased by 46% from 2009-2019 (1211 patients in 2009 to 655 patients in 2019) with length of stay also decreasing over the same period by almost 35% (2827 days in 2009 decreasing to 1841 days in 2019). This reflects a significant change in practice over this time , for example the majority of wide excision cases being done as daycases (previously an overnight stay) and earlier discharge of mastectomy patients.

2.2.3.2 Transformation Opportunities

- **Deliver early intervention and alternatives to admission** (e.g. pre-habilitation, and self care) and rapid access to diagnostics
- **Provide improved access to scheduled opportunities for Enhanced Supportive Care (ESC) Acute Oncology** multi-disciplinary team with urgent outpatient capacity to minimise unscheduled care episodes and readmissions

- **Workforce optimisation** to provide a sustainable modernised medical workforce to optimise efficiencies from pre-admission and throughout admission to the point of discharge
- **Robust links with partners** including Regional Boards, Third Sector, Integrated Joint Boards and Primary Care colleagues to providecare closer to home, minimise admission and facilitate safe and timely discharge and rehabilitation
- **Optimisation of Allied Health Professionals** to expedite discharge, reduce admissions and optimise use of discharge to assess and hospital at home
- **Oncology outreach service** to patients in Regional Boards to prevent unnecessary admission and re-admission
- **Provide an expanded range of Clinical Trials** by providing access to dedicated trials Inpatient beds

2.2.4 Drivers for Change - Cancer Assessment Unit (CAU)

In the context of increasing cancer incidence and therefore increasing patient activity, the need for acute oncology will expand.

Currently, physical space to provide this in the Cancer Assessment Unit is the critical constraint. The Oncology Enabling programme of works will partially address this by constructing a Cancer Assessment Unit which moves offices from the south end of the Oncology Management Corridor to a modular building in Car Park 3 (above Linac bunkers – see Radiotherapy below) and creating an 'acute' CAU with reduced office accommodation in the south end of the existing Oncology Management Corridor.

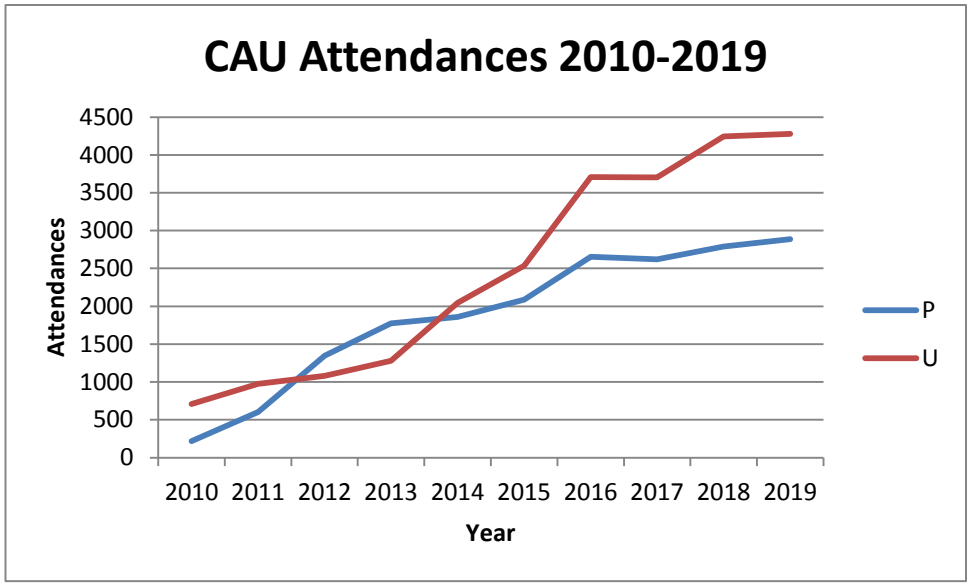
This programme of work requires derogations (e.g. around room sizes and facilities) as the work is within current building footprint, and though a significant improvement on the current arrangement, will not meet modern HEI requirements.It is also not expected that this facility will provide sufficient space post-2025, if the service continues to be delivered in the same way.

Transformation of this service to provide more effective triage, outpatient management and prevention of admission strategies could also help to manage the demand for inpatient facilities.

2.2.4.1 Attendances

The graph below shows number of planned (P) and unplanned (U) attendances to CAU from 2010-2019. This shows a marked increase over the time period.[8]

Figure 9: CAU Attendances 2010-2019



The increase in planned attendances in 2015-16 is due to a change in practice for administering of Supportive Therapies with patients who historically had received these in Ward 1 being redirected to CAU.This additional workflow was necessitated by space constraints within Ward 1, and adds to the pressure on CAU which was originally planned to provide a robust facility and process for the management of unscheduled cancer care.

2.2.4.2 Transformation Opportunities

- **Adjacencies with essential services** (e.g. Imaging and Labs) to optimise efficiencies and streamline the patient journey (Essential Services Hub concept)
- **Stratification of workflow** – distinct Supportive Therapies unit and separate planned procedure unit for lower risk activities

[8] TRAK Data 2020

- **Enhanced Supportive Care and Acute Oncology 'front door' clinics at WGH** to reduce admissions and improve the patient pathway and experience

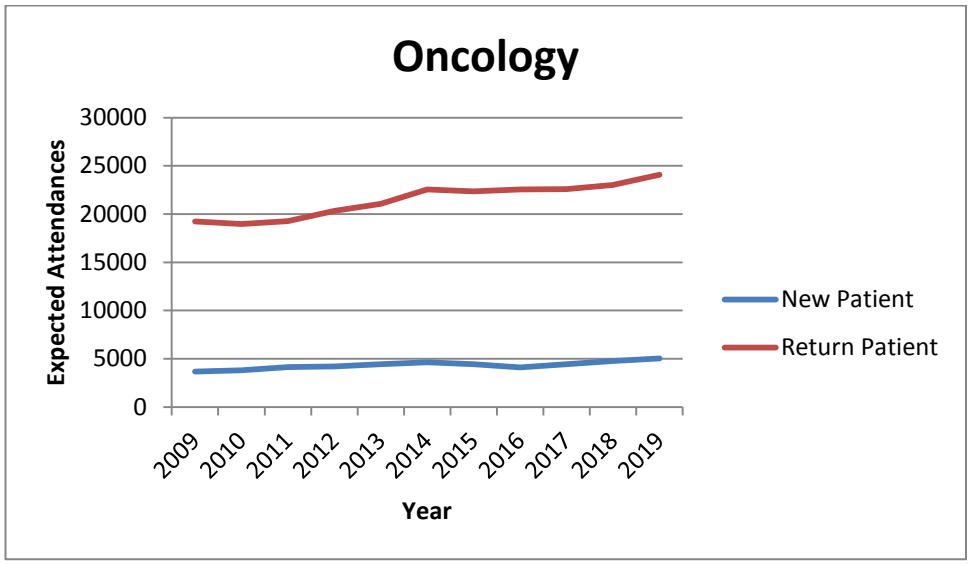
2.2.5 Drivers for Change - Outpatients

Oncology and Haematology outpatient clinics are conducted in separate locations across the WGH site (Cancer Centre and Anne Ferguson Building) leading to inefficiencies in working practices for the medical, nursing and administrative teams and confusion for patients who are unsure of which area they should be attending.

2.2.5.1 Service Demand

The demand for outpatient services has increased over the last few years as demonstrated by the graphs below:

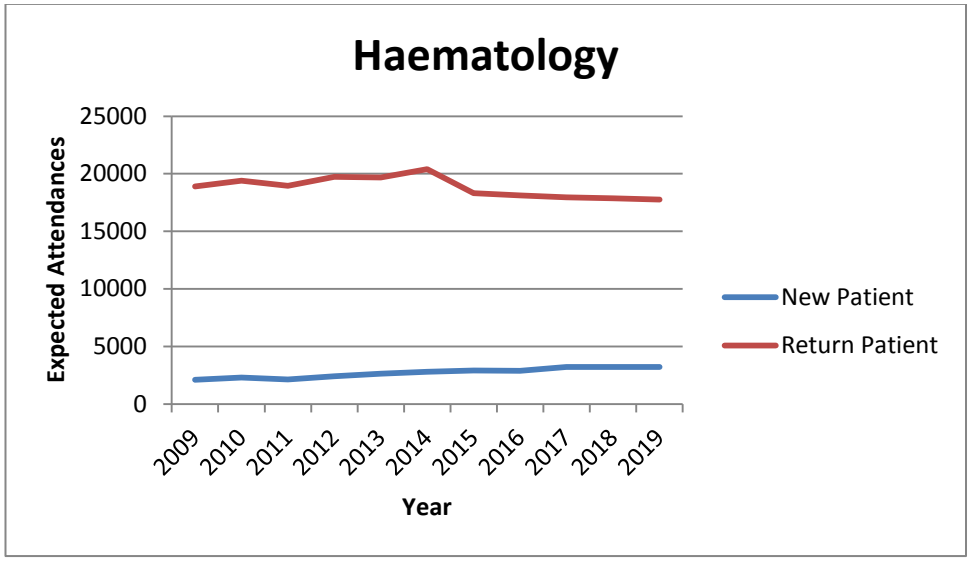
Figure 10: Expected Attendances (new and review) for Clinical/ Medical Oncology [9]



The demand for Oncology Outpatients has increased overall by 27% from 2009 to 2019 (37% increase for new patients and 25% for return patients).

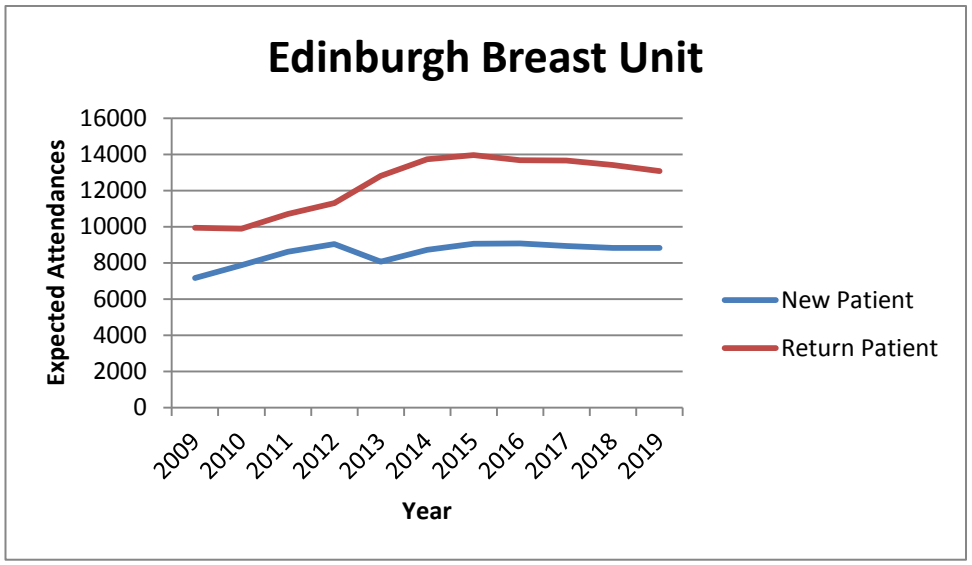
[9] TRAK Data, extracted June 2020 for 2009-2019

Figure 11: Expected Attendances (new and Review) Haematology [10]



The demand for Haematology new Outpatients has increased by 52% for new patients.The graph aboves shows a decrease of 6% for return patients attending the ECC,this is due to a change in practice in 2015 whereby return patients began to be seen virtually reducing the need for them to attend in person.

Figure 12: Expected Attendances (new and Review) Breast



The demand for Breast Outpatients has increased overall by 28% from 2009 to 2019 (23% increase for new patients and 31% for return patients).

With numbers projected to increase by a further 26% for new patients and 7% for return patients (across medical oncology, clinical oncology and haematology) by 2030, reprovision of facilities to allow improved efficiencies and transformed service delivery will be essential to manage the demand,and to improve patient experience and outcome.

It will also be necessary to continue to offer virtual/remote consulations where these have been proven during the COVID-19 pandemic to deliver a safe and effective service.

[10] TRAK Data, extracted June 2020 for 2009-2019

2.2.5.2 Transformation Opportunities

- **Deliver care in the most appropriate setting** e.g. maximise repatriation to peripheral clinics (to provide care closer to home), move non acute clinics out of the acute setting,utilise outpatient facilities for oral SACT delivery,managing acute oncology and Enhanced Supportive Care activities in a scheduled manner.
- **Utilising clinics in different ways** - e.g. having group follow up clinics in different locations (e.g. closer to home) and increasing joint clinic arrangements with other specialties (as exemplified by joint breast cancer follow up clinics)
- **Demand Management** –continue to practice Realistic Medicine, ensure consistency with national standards, minimise variation in practice and review models of care. Use data on efficacy and outcome of management practices from the Cancer Information Programme to inform practice review.
- **Continue to use genetics and genomics** to stratify treatment and follow-up – optimise personalised treatment.
- **Utilising available technology** continue to use virtual clinics for approriate patients (NHS Near Me) and learning from changes in practice during the COVID-19 pandemic, use smart scheduling to optimise urilisation of capacity, electronic support for outreach services to potentially reduce the requirement for specialist staff, telephone and video consultations to support delivery at home or in the community.
- **Optimise workforce development** offer opportunities (e.g. research,continued professional development) to improve recruitment and retention of specialist staff across the South East Region for all professions.

2.2.6 Drivers for Change – Daycase SACT

Over the past ten years, SACT Services have seen a shift towards greater use of day case facilities. Service redesign was undertaken 10 years ago with the aim of treating more as outpatients and therefore reducing the length of inpatient stays.

This shift brought new challenges in managing demand for SACT and Supportive Therapies in the Edinburgh Cancer Centre with additional chairs required in an already crowded environment. Long daycase regimens were accommodated, limiting patient flow through the department. Additionally, some patients continued to require their SACT treatment as an inpatient resulting in SACT Trained Nurses and pharmacy provision being required across multiple service areas, geographically separated across the ECC.

To mitigate some of this overcrowding and staffing pressure, in 2015 an an area was developed within CAU to cope with the demand for Supportive Therapies. Despite this,the overcrowding situation has further deteriorated over time, as demand has continued to rise, resulting in a detriment to patient experience. For example, patients are no longer able to bring a companion to support them during treatments.Time to treatment starting, waits within the unit for treatment delivery and patient experience have all been adversely affected.

Furthermore,current chair spacing does not meet current guidelines for the safe administration of SACT (chair spacing currently circa 2.0m^2/chair against the recommended 10m^2 chair [Health Building Note 02-01 Cancer Treatment Facilities]). The area also does not have isolation facilities for immuno-compromised patients. All of the above have significant implications for safety, quality and efficiency of care.

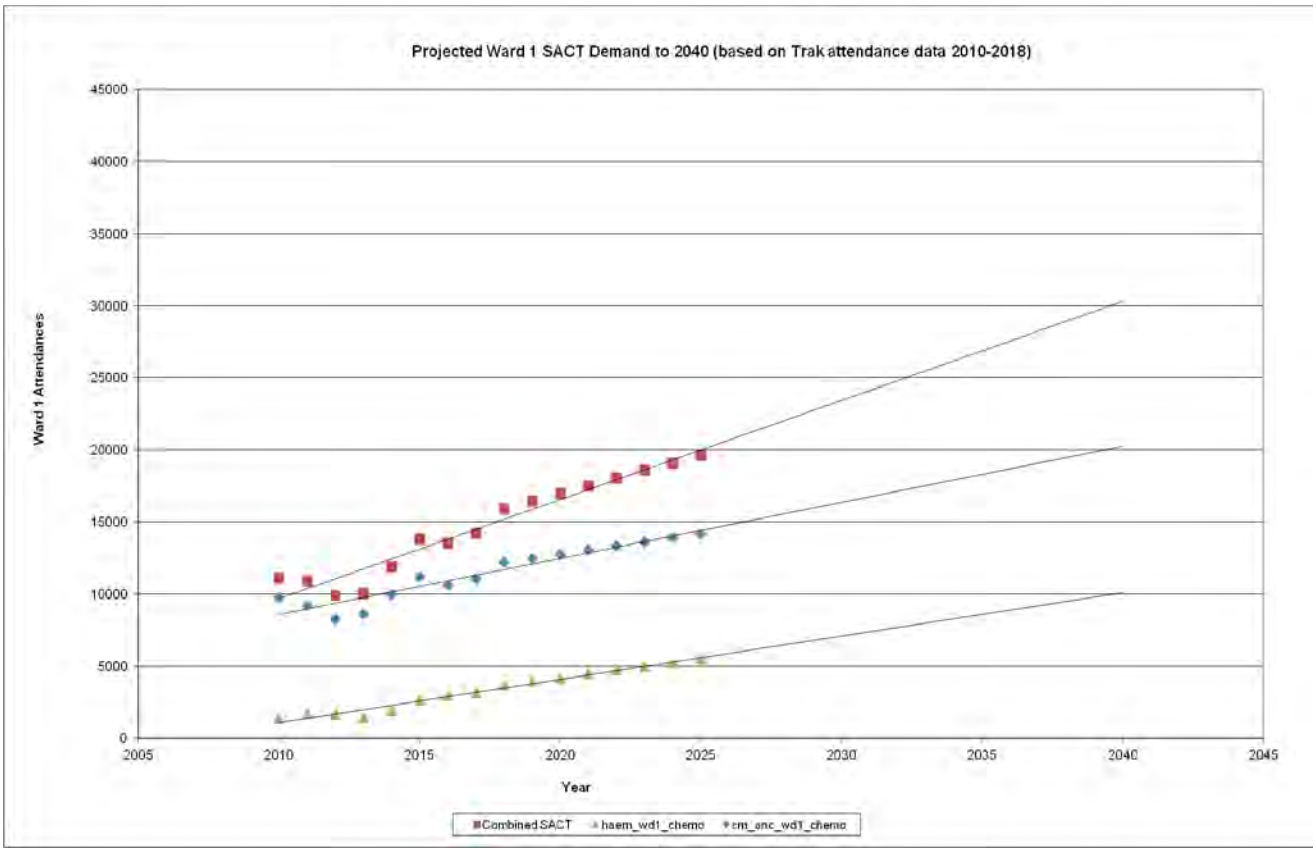
A critical incident due to overcrowding in the area underpinned the decision that to ensure patient safety no additional chair capacity would be added to Ward 1. There is simply no further ability to expand to accommodate growth within the current footprint or to implement more efficient ways of working.

The Oncology Enabling Programme of work prioritised Pharmacy expansion in Ward 1 to allow a sustainable service to be provided in the short to medium term. These works will result in a slightly improved environment but remains sub-optimal in terms of space required.

Moving Haematology capacity out of Ward 1 (currently Area 4 of Ward 1 delivers daycase SACT and Supportive Therapies to Haematology patients) as part of Haematology's relocation in 2021, will create some space for an aseptic/satellite pharmacy expansion (and additionally releases some space within Ward 1 treatment areas) however the minimum chair spacing standard will not be met and further capacity to accommodate increasing demand beyond ~2025 will require reprovision of the ECC.

Data shows SACT service demand is projected to increase by a further 20% by 2025 with further growth projected to 2040, the graph below is based on TRAK data:

Figure 13: Forecast rise in demand for Ward 1 services to 2040[11]



The activity historically undertaken in Ward 1 can also be separated into the patient's healthboard of origin:

Table 17: Ward 1 activity by Health Board/origin (SACT and Supportive Therapies)

2019	Others	Borders	Fife	Lothian	Total
Grand Total (Chair Time in Hours)	**1,102**	**539**	**1,568**	**46,153**	**49,361**
Percentage Split	2.23%	1.09%	3.18%	93.50%	100.00%
Chair Time (days)	138	67	196	5,769	6,170

There is more detailed analysis of this chair time by Tumour Type and regimen to inform conversations amongst the Regional Boards regarding options for more Care Closer to Home and forms part of the transformation work described below.

As illustrated in Table 17 above, the majority of the work undertaken is for NHS Lothian patients.

[11] TRAK Data March 2019 – data to 2025 is a projection, from 2025-2040 is a linear trend line

Further analysis is required, in collaboration with regional partners, to ascertain which of the remaining regional patients are undergoing complex regimes which cannot be provided closer to home.

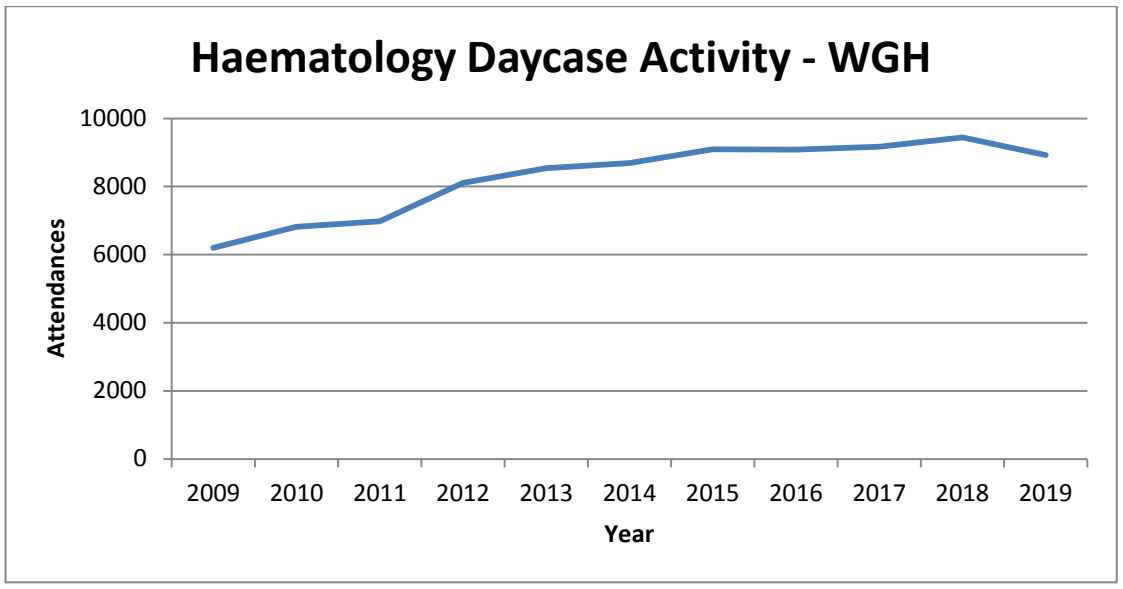
2.2.6.1 Transformation Opportunities

- **Deliver more Care Closer to Home** Additional treatments delivered at St John's Hospital, in other locations within Lothian and in the regional boards based on a risk assessment of what can be delivered where. Develop home delivery of SACT and community dispensing of oral SACT.Develop ambulatory care service and maximise the management of post-transplant and post-treatment care in outpatient scheduled settings.
- **Manage demand** Continue to practice Realistic Medicine,ensure consistency with national standards, minimise variation in practice and review models of care, including the value of treatment, imaging and frequency of attendance.
- **Data driven innovation** Use data on efficacy and outcome of management practices from the Cancer Information Programme to inform practice review.
- **Continue to use genetics and genomics** to stratify treatment and follow up - optimise personalised treatment.
- **Utilising available technology,** use smart scheduling to optimise utilisation of existing capacity,electronic support for outreach services to potentially reduce specialist staff required in outreach facilities, telephone and video consultations to support SACT delivery at home or in the community.
- **Optimise workforce development** offer opportunities (e.g. research,continued professional development)to improve recruitment and retention of specialist staff across the South East Region for all professions.

2.2.7 Drivers for Change - Haematology Daycase

There has been a significant annual increase in demand for the Haematology daycase service since 2009, with a 44% increase from 2009-2019 as demonstrated in the graph below:

Figure 14: Haematology Day Case Activity[12]



Part of the charitable donation received by NHS Lothian in 2018 to upgrade the Haematology service and facilities within the Western General Hospital allows for the design of a significantly improved, environment for daycase patients.

[12] TRAK Data, June 2020

A benefit of this development will be the release of space within Ward 1 which, as described in the SACT section above, is currently experiencing challenges due to lack of capacity, non conformity with current guidelines regarding spacing between therapy chairs and has a pharmacy department which is currently too small to meet the ever increasing demands for its services. Therefore, relocating this element of the Haematology service will also allow expansion of the Pharmacy Department.

The new environment will also allow clinicians to transform the way Haematological care is provided with an environment to administer some treatments traditionally delivered in the in-patient setting in an extended day case facility.

Due to the constraints of the existing footprint, the chair spacing in this daycase area will be increased from $2m^2$ to $8m^2$ though a derogation will continue to apply as the current recommendations are $10m^2$. This means that there is already insufficient space to accommodate future demand.

The location of the facility will also present significant challenges in terms of ensuring an efficient service as it will be remote from the Cancer Pharmacy and the Cancer Clinical Trials team.

- **Deliver more Care Closer to Home** Additional treatments delivered at St John's Hospital, in other locations within Lothian and in the regional boards based on a risk assessment of what can be delivered where. Develop home delivery of SACT and community dispensing of oral SACT.Develop ambulatory care service and maximise the management of post-transplant and post-treatment care in outpatient scheduled settings.
- **Manage demand** Continue to practice Realistic Medicine,ensure consistency with national standards,minimise variation in practice and review models of care, including the value of treatment, imaging and frequency of attendance.
- **Data driven innovation** use data on efficacy and outcome of management practices from the Cancer Information Programme to inform practice review.
- **Continue to use genetics and genomics** to stratify treatment and follow up-optimise personalised treatment.
- **Utilising available technology,** use smart scheduling to optimise utilisation of existing capacity,electronic support for outreach services to potentially reduce specialist staff required in outreach facilities, telephone and video consultations to support SACT delivery at home or in the community.
- **Optimise workforce development** offer opportunities (e.g. research,continued professional development) to improve recruitment and retention of specialist staff across the South East Region for all professions.

2.2.8 Drivers for Change - Supportive Therapies

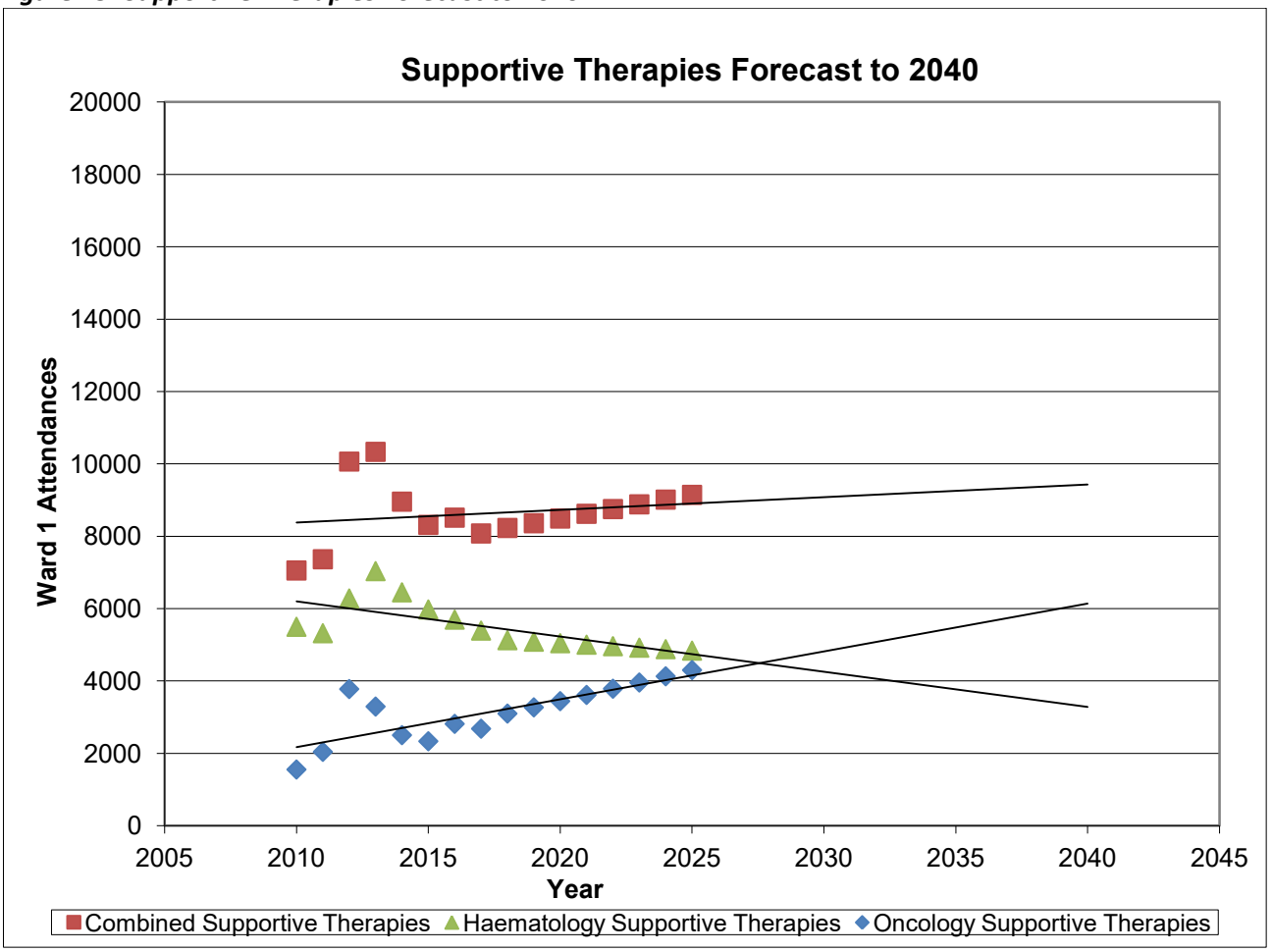
Supportive Therapies for Cancer patients are currently delivered in various areas areas across the WGH campus, often in shared areas where SACT, inpatient and unscheduled care are also delivered. As a consequnece of these mixed pathways, these treatments are delivered inefficiently. It also results in patients receiving Supportive Therapies in a suboptimal environment,alongside patients receving active treatment.

The graph below shows the volume of Supportive Therapies that have been delivered historically in Ward 1 of the Edinburgh Cancer Centre - a combined increase of 17% since 2010.

This figure does not refect the entire volume of Supportive Therapies delivered as in 2015 the service delivery model changed with many of the therapies traditionally delivered in Ward 1 subsequently being delivered from CAU.

Continued growth is expected with a further 11% growth projected to 2025.

Figure 15: Supportive Therapies Forecast to 2040[13]



2.2.8.1 *Transformation Opportunities*

- **Deliver more Care Closer to Home** Additional treatments delivered at St John's Hospital, in other locations within Lothian and in the regional boards based on a risk assessment of what can be delivered where. Develop home delivery of SACT and community dispensing of oral SACT.Develop ambulatory care service and maximise the management of post-transplant and post-treatment care in outpatient scheduled settings.
- **Manage demand** Continue to practice Realistic Medicine,ensure consistency with national standards,, minimise variation in practice and review models of care, including the value of treatment, imaging and frequency of attendance.
- **Data driven innovation** use data on efficacy and outcome of management practices from the Cancer Information Programme to inform practice review
- **Continue to use genetics and genomics** to stratify treatment and follow up - optimise personalised treatment.
- **Utilising available technology,** use smart scheduling to optimise utilisation of existing capacity,electronic support for outreach services to potentially reduce specialist staff required in outreach facilities, telephone and video consultations to support SACT delivery at home or in the community.
- **Optimise workforce development** offer opportunities (e.g. research,continued professional development) to improve recruitment and retention of specialist staff across the South East Region for all professions.

[13] *TRAK attendance data 2010-2018'*

2.2.9 Drivers for Change – Radiotherapy

A robust modelling exercise has previously been completed for Radiotherapy and informed the Oncology Enabling Business Case which prioritises Radiotherapy service sustainability by funding the build of a new unit to house two additional linear accelerator (Linac) bunkers (with associated accommodation) to meet demand by avoiding future in-room swaps and giving capacity for an increase in clinical Linacs.

Administrative offices will also be re-provided in the new build which will be connected to the Edinburgh Cancer Centre. This also allows for the move of the Cancer Assessment Unit into what is currently the Oncology Management Corridor.

This modelling work projects required capacity to 2025 and articulates that 8 Linacs will be required at this point to work at 81% capacity. However this will be impacted by changes to numbers of fractions per course and complexity of delivery in each fraction. This is changing constantly.

This modelling will be repeated and the timeframe extended as the business case progresses to Outline Business Case in order to accurately predict the required future Radiotherapy capacity.

This modelling will be refreshed in accordance with changes in practice, complexity of treatment and the impact of new screening programmes (particulary for Breast, Prostate and Lung which are our largest patient groups).

The current suite Linac bunkers do not provide the space and flexibility to install and accommodate the full range of modern radiotherapy treatment machines, and the associated technical equipment essential for clinical operation.

Continuing to develop the prostate Sterotactic Body Radiotherapy Treatment (SBRT) service will relieve the pressures on Linac capacity due to the reduction in treatment fractions (from 20 to 5). Although each fraction takes longer, the overall treatment time is greatly reduced.

For this treatment to be considered routine, the results of the UK PACE Study (comparing surgery,conventional radiotherapy and stereotactic radiotherapy for localised prostate cancer) need to be published. It is anticipated that this will be within the next 1-2 years and in the interim period prostate SBRT remains available through existing clinical trials.

2.2.9.1 Brachytherapy

Unlike most other large UK Cancer Centres, the Edinburgh Cancer Centre does not have a dedicated Brachytherapy Theatre. This is a limiting factor resulting in waiting times for the procedure having been 5-6 months consistently for a number of years, a situation further exacerbated by the COVID-19 pandemic. The treatment alternative is Robotic Assisted Radical Prostatectomy (RARP) which also has a waiting time of around 6 months.

A dedicated theatre for brachytherapy for Lothian's second largest tumour group could significantly impact on Cancer Waiting Times (CWT) performance and provide an opportunity to channel more patients into the brachytherapy route thereby alleviating pressure on surgical services.

In addition, the introduction of High Dose Rate (HDR) brachytherapy will benefit patients who require pelvic and nodal radiotherapy for high risk disease.

To enable an increased range of treatments to be developed and offered to our patients, accommodation is required to be designed for streamlined patient and service pathways.

A specially designed facility will incorporate all the facilities and resources required to provide a comprehensive brachytherapy service with consideration on co- dependencies and adjacencies to minimise risks and maximise efficiency (e.g. theatre standard preparation rooms adjacent to the treatment rooms and to the radioactive sealed source lab, designed with input from the Counter Terrorism unit) to:

- Minimise transportation of radioactive sources; minimise transfer of patients with applicators in situ.
- Increase capacity due to limited co-dependencies on other services/areas.

This will enable an increased range of treatments to be developed and offered to patients, in a specialist state of the art facility.

2.2.9.2 Transformation Opportunities

- **Radiotherapy unit** capable of housing a wider range of developing technologies to enable us to stay at the forefront of radiotherapy treatment delivery (e.g. MR Sim, CT-PET, MR Linac, Stereotactic Linacs).
- **Development of comprehensive cancer services** for example, prostate where the pathway and waiting times performance could be transformed by providing the full range of available therapies including Robotic Assisted Radical Prostatectomy (RARP), Stereotactic Ablative Radiotherapy (SABR) Prostate, Low Dose Radiation (LDR) Brachytherapy and High Dose Radiation (HDR) Brachytherapy. This would be facilitated by the provision of a dedicated Brachytherapy Theatre with benefits as described above.
- **Provision of a capacity Linac** to provide continuity of service to enable maintenance and quality assurance without reducing treatment capacity.
- **Research Linac** to enable us to be at the forefront of radiotherapy research and innovation to develop and offer new treatment options in Scotland. This will also help Scotland to recruit and retain highly specialist staff by offering opportunities to be at the forefront of cancer care and fulfil career ambitions.
- **Use of state of the art technology and innovation through research** to offer alternatives to cancer surgery to patients where viable.
- **Streamlining and optimising use of imaging in the diagnostic and therapeutic pathways** to model the need for additional imaging modalities (CT, MRI, PET) and to deal with increased capacity demands.
- **Optimise Adjacencies** co-located Imaging Centre and Radiopharmacy dept will provide the ability to flex staffing and machine capacity across the treatment and diagnostic service areas. This will also allow staff to develop extended roles and pursue specialist interests in cancer which will support improvement in recruitment and retention of diagnostic staff.
- **Scoping of a Satellite Radiotherapy Centre** – Modelling required to ascertain demand,location and workforce model viability.

2.2.10 Drivers for Change - Breast Services

Breast Cancer Incidence in the SCAN Region is expected to increase from 2008/12 to 2023/27[14]

Table 18: Breast Cancer Incidence 2008/12 to 2023/27

2008/12	2023/27	% Increase
6,266	7,968	27.15%

Meeting this demand will require optimum service efficiency to be achieved through further transformation of the service.

The current daycase area is not fit for purpose and does not include pre-operative, post-operative and discharge areas.

Transformation opportunities include:

- **Optimise the location of surgery –** to provide care in the most appropriate facility,closest to home.Potentially increasing the breast surgery that is undertaken at St John's Hospital or moving cosmetic surgery from WGH site.
- **Provide co-location of symptomatic and screening services** to maximise workforce efficiency and equipment usage.
- **Continue to improve triage processes**
- **Review/redesign outpatient and inpatient pathways**
- **Modelling theatre capacity** to anticipate future demand.
- **Manage demand** continue to practice Realistic Medicine, ensure consistency with national standards, minimise variation in practice and review models of care, including the value of treatment, imaging and frequency of attendance.
- **Data driven innovation** use data on efficacy and outcome of management practices from the Cancer Information Programme to inform practice review.
- **Continue to use genetics and genomics** to stratify treatment and follow up-optimise personalised treatment.
- **Reviewing roles and optimise skill mix** e.g. radiology, advanced nursing roles, radiography roles, consultant radiographers etc.
- **Utilising available technology,** e.g. virtual clinics for relevant patients via NHS Near Me (implemented during the COVID-19 pandemic).
- **Optimise workforce development** offer opportunities (e.g. research, continued professional development) to improve recruitment and retention of specialist staff across the South East Region for all professions.

2.2.11 Drivers for Change - Clinical Trials

Currently Area 1 of Ward 1 delivers Clinical Trials. As described in the SACT and Haematology daycase sections above , current accommodation is extremely overcrowded with spacing of less than $2m^2$ per chair.

As with all SACT, the delivery of trial treatments requires enough space to safely deal with any possible interventions if a patient has a reaction to the drug. These reactions may be less predictable with newer treatments, which is especially the case in Phase 1 (first in man) trials. Newer types of treatments may also require novel modes of administration or isolated delivery areas, which require dedicated facilities and space.

[14] Where 2008/12 was the actual 5 year incidence and 2023/27 is the forecasted 5 year incidence produced by ISD.

The current footprint does not provide sufficient capacity for the volume of Clinical Trials that are available, limiting the number of patients that can be treated on trials. Furthermore, there are no ringfenced inpatient beds for overnight stays, which further limits the types of trials that can be opened for South East of Scotland patients, especially accessing newer treatments in Phase 1 trials.

In summary, these space constraints reduce access for patients to the most innovative therapies that could otherwise be safely provided by our experienced trials teams.

A Capital Investment of ~£1m has been received from the Edinburgh and Lothian Health Foundation (ELHF) to relocate Clinical Trials Data Managers from the lower ground floor of Ward 1 to the Scottish Health Service Centre (SHSC). There will also be a-reconfiguration of Ward 1 to allow a slightly larger footprint for Clinical Trials.

There will still be no ringfenced inpatient beds available for overnight stays and the service will be fragmented with Clinical Trials Nurses in one area and Data Managers in another.

Further opportunities could exist in the future with expanded capacity to develop an internationally leading Clinical Research and Trials facility providing the most innovative cancer therapies for the people of Scotland. This would also attract experts in their fields from across the world and contribute to retention of existing staff that would be able to participate in a wide range of trials activity.

Transformation opportunities include:

- **Integrated Clinical Research** by placing research at the heart of standard of care services,improving access to clinical trials by providing a range of trials' closer to home, improving patient experience and outcomes. Co-located facilities for Consultants and Research Partners, Pharmacy, access to WGH site ITU and HDU facilities to support a range of early and late phase clinical trials including cellular therapies.
- **Continue to use genetics and genomics** to stratify treatment and follow up,improve access to targeted therapies and personalised medicine through expansion of trials programme.
- **Utilising available technology,** use smart scheduling to optimise utilisation of existing capacity, electronic support for outreach services to potentially reduce specialist staff required in outreach facilities, telephone and video consultations to support SACT delivery at home or in the community.
- **Optimise workforce development** offer opportunities (e.g. research, continued professional development) to improve recruitment and retention of specialist staff across the South East Region for all professions.

2.2.12 Drivers for Change Workforce

The table below details the challenges with workforce from the current arrangements:

Table 19: Current Workforce Pressures

Staff Group	Comments
Oncology	Small numbers of Oncologists completing training so not always able to recruit to needed sub-specialty. Recent challenges in recruiting Breast medical oncologists and GI Clinical Oncologists. Clinical Oncology has nationally recognised deficit in training places – recent announcement to increase number of training places by 2 to manage future retirement – large number of Clinical and Medical Oncologists in 50+ age group.
Haematology	National challenges around availability of Consultant staff
Breast Surgeons	Dependent on number of trainees coming through and can be competitive to attract candidates.
Specialty	Nationally challenging to find good quality applicants across all specialties.

Staff Group	Comments
Doctor Posts	
Physicians Associates	NHS Lothian currently developing a training programme for these roles.
Oncology Physics	Highly specialist staff group, can be challenging to attract candidates with UK wide difficulties in recruitment.
General Nursing	National shortage of registered nurses with future challenges expected due to a significant volume being expected to retire due to changes in public sector pension scheme over the next 5 years.
SACT trained nurses	Ongoing difficulty in recruiting SACT trained nurses – reliant upon training from existing staff.
Advanced Nurse Practitioners (ANP) and Clinical Nurse Specialists (CNS)	Usually have to recruit to trainee posts which take approx 2-3 years to become fully qualified ANP. Often promote from within the service which is positive in terms fo career progression however this leaves subsequent gaps.
Radiologists	National shortage of Radiologists including Breast Radiologists
Pathologists	National shortage of Pathologists
Cancer Pharmacists	National shortage of available qualified staff
Pharmacy Technicians	
Therapeutic Radiographers	

Addressing these workforce challenges is discussed in s3.3.2 of this IA.

With an increase in workload and complexity of work, there requires to be an environment to facilitate innovation and change, efficiency and productivity with meeting rooms and offices designed to allow adequate space for Quality Improvement to take place.

2.2.13 Drivers For Change Site Masterplan

2.2.13.1 The Western General Hospital Site Generally

The Western General Hospital is located to the North West side of Edinburgh, just South of Ferry Road. The main site Access is off either Crewe Road South from the East or from Telford Road to the West.

The hospital sits in a suburban context with many houses located to the North and South with playing fields and parkland to the East around the Fettes College site.

The detailed site analysis identified constraints and opportunities, topography, climate aspects, green space, roads and car parking, servicing and associated operational issues, site history and infrastructure issues.

The site itself is of mixed density with various scales of buildings that have been developed and redeveloped over the years. The largest buildings on the site are the Anne Ferguson Building (AFB), the Royal Victoria Building (RVB), the Alexander Donald Building (ADB) and the historic Clock Tower. These are all approximately between three and four stories high.

The site slopes down to the South and then further down to the East, with a change in level of around two floors. Overall, the level changes across site together with the actual building form means that there is the equivalent of at least 8 stories of building from the lowest part of the site to the highest floor level in the historic clock tower.

2.2.13.2 Site History

The Western General Hospital has a long, rich and varied history and has its origins in the poorhouse for the parish of St. Cuthbert's and it was in 1761 that the poorhouse was opened on the site of the present Waldorf Astoria (Caledonian Hotel).

In 1868 a new poorhouse was opened on land purchased from the Fettes Trust. The new building was known as Craigleith Hospital and Poorhouse. It continued to serve the needs of the parish's paupers until 1914 when the hospital was taken over by the Army and used for the treatment of forces casualties. At the end of the war, the institution continued for several years to be administered by the Ministry of Pensions. It then returned to the control of the parish council and the west wing was reconditioned and re-equipped to accommodate 120 sick poor under the name of Craigleith Hospital.

In 1929 the Local Government (Scotland) Act was passed, becoming operative on 16 May 1930.

This Act discontinued the parish councils and transferred their poorhouses and poorlaw hospitals to the counties and large burghs. It also empowered these authorities to upgrade the former poorlaw hospitals and make them available to the general public. Edinburgh Town Council took over Craigleith Hospital among others and a scheme of renovation and improvement was begun with the aim being to equip and staff it as a fully efficient teaching hospital.

As a municipal hospital, Craigleith changed its name to the Western General Hospital with 280 beds available. In 1933 it was provided with a residence for 12 medical students, and in 1936 a nurses' home was built.

A high proportion of the patients referred to the municipal hospitals were the chronically sick and elderly. The local authority was legally empowered to charge patients for their accommodation and treatment. Members of the Royal Infirmary of Edinburgh's (RIE) League of Subscribers were admitted free from 1945, their maintenance being paid out of RIE funds.

In 1941, as a result of World War II, many members of the Polish army found their way to Britain. Among them were some medical specialists from Polish medical schools, and a number of medical students. On 24 February 1941 the President of the Polish Republic, then in exile in London, issued a decree officially instituting the Polish School of Medicine at Edinburgh, and on the same day Edinburgh University signed an agreement with the exiled Polish government.

Part of the Western General was set apart as the Polish, or "Paderewski", Hospital. After 1945 the school was no longer needed as Polish universities were able to reopen. The last students from it graduated in 1949. The following year the Paderewski building became the casualty and out-patients building, used until 1968 when the current OPD block was completed.

In 1948 the Western became part of the Edinburgh Northern Hospitals group of the South Eastern Regional Hospital Board, coming in turn under the control of the North Lothian District of Lothian Health Board in 1974. In 1986 it formed part of the Royal Victoria, Western and Northern General Unit of Lothian Health Board. At this time departments of Leith Hospital began to be transferred to it as Leith was closed down. In 1994 the Western became an NHS Trust hospital.

The Western General Hospital (WGH) has been more recently developed through provision of a number of specialist units including the coronary and gastro-intestinal units. It also currently hosts the regional unit for Radiotherapy.

The most recent buildings have provided modern accommodation on the site with the construction of the AFB and RVB. There have also been a number of smaller scale temporary buildings added on site to satisfy urgent accommodation requirements. These have ranged from 2 storey modular buildings to individual portable cabins. Although temporary in nature, they have tended to be used beyond their intended lifespan due to capacity pressures on the site. The site layout of the early 1960's can still be seen under these overlays of newer accommodation which now make navigating the site difficult and developing the site for the future in a controlled manner challenging. The green spaces which were an

integral part of the original layout and an aid to recovery and well-being are all but gone, replaced with buildings and tarmac.

2.2.13.3 Drivers for change

The future of the Western General Hospital (WGH) campus is embodied in a Masterplan which is effectively the development strategy for the site up to 2045. Central to these proposals is the new Edinburgh Cancer Centre (ECC) which will be a significant stepping stone in the journey to create a more modern, compact and efficient estate capable of responding to the needs of modern healthcare and the Scottish Government's ambitions of net zero carbon by 2045.

As currently scoped, and within the context of the Western General Hospital Site Development Strategy - Masterplan, the proposed new Edinburgh Cancer Centre will be circa 30% of the overall footprint as currently projected in ~2045.

There are a number of key and strategic drivers for the Masterplan and the development framework effectively addresses these. They can be summarised as:

- Support the vision for the clinical service model on site
- Improve clinical adjacencies and pathways
- Provide flexibility in development sites and sequencing of potential projects
- Incorporate the co-location of other organisations and services on site
- Improve infrastructure
- Demolition of sub-standard estate (condition and functional suitability)
- Reduce backlog maintenance requirements
- Provide a future development framework for the site that can be supported by all key
- Stakeholders
- Provide a suitable context for town planning dialogue and future planning approvals

In order to support and sustain the delivery of Cancer Services at the Western General Hospital until the new Edinburgh Cancer Centre is delivered, a range of interim works are due to be delivered within the existing estate:

- Refurbishment of Oncology inpatient wards 2-4
- Relocation of Cancer Assessment unit
- Expansion of Pharmacy in Ward 1
- New build Linac bunkers and Admin block
- Haematology refurbishment of Wards 7 and 8 East/West
- Relocation of Clinical Trials Staff and expansion of Trials footprint

The above projects are effectively a 'Do Minimum' to support service delivery within and around the ageing Cancer Centre facilities. It is proposed that in order to maximise the use of facilities and minimise sunk costs following the opening of the new facility, that they provide useful decant space required during the longer term site development plus additional winter capacity and support facilities to ease seasonal pressures.

In parallel with the development of the existing cancer centre zone of the site, there has been recent investment in Energy Infrastructure to enable the start of a de-steaming and new energy provision programme of works across the site. The main Energy Infrastructure programme of works will be phased over a number of years and is described in a separate Business Case which is currently at Outline Business Case (OBC) Stage.

The Existing Arrangements and associated Drivers for Change relating to the facilities used for cancer services at the Western General Hospital are outlined in Sections 2.1 and 2.2.

2.2.13.4 Masterplan - Context and Development

The Masterplan – or more appropriately referred to as the Site Development Framework – has been developed over a number of years. It has evolved through various levels of detail and with projects now being delivered on site within this overarching development planning context, there is a real understanding of the key issues required to ensure that this type of complex acute healthcare campus site originating from the 19th century is prepared for the 22nd century.

Masterplan review and development has been supported by separate site analysis, including a review of existing estates data and clinical adjacencies on site. As highlighted above, there are significant level changes across the site and these together with the campus nature of the site – ie a huge number of effectively separate buildings - impacts on clinical adjacencies and associated FM support in particular.

In reviewing the information available for the existing site and in response to the key drivers while taking cognisance of other key issues, four strategic options were developed with a range of scenarios to create the current masterplan framework for the sustainable redevelopment of the site. This development framework responds to the overall requirement for significant upgrades to site wide services and transportation infrastructure as well as the principal driver of creating a better functioning, more flexible and adaptable hospital for the future.

There has been a real drive within whole site proposals to ensure that the clinical adjacencies are simplified with departments consolidated where feasible to achieve a more integrated campus development which is easier to navigate for all users.

The proposed new Edinburgh Cancer Centre (ECC) in its preferred location within the 'DCN Zone' of the site will provide a strategic zone to facilitate site wide rationalisation and consolidation along with vastly improved departmental adjacencies and in-use flexibility. The new ECC will effectively be the key building block for the 'new' Western General Hospital and the proposed phases to follow will require to be delivered timeously to provide the essential Services to support cancer care delivery and the delivery of effective clinical care across the wider site.

The supporting infrastructure strategies for the site are being designed to work seamlessly with the redevelopment through timeous rationalisation that will allow the new buildings to benefit from a plug and play philosophy that aims to be based on a 'do things once' approach and avoid interim temporary works and diversions.

New technologies will be integral to the phased development and will include energy efficiencies to reduce the overall site load on services. The Energy Infrastructure project, currently at OBC stage, is being progressed to ensure that there is a clear strategy for the de-steaming of the site with replacement lower temperature hot water systems, renewable energy solutions and improvements to the performance of existing plant to be retained alongside the upgrades to the whole site High Voltage power networks and including a new incoming transformer.

Transport issues within the site have been addressed to date within the confines of the existing site layout and operational requirements however, improvements can only be achieved by the redevelopment of the site. The proposals address this and allow for the road infrastructure to be upgraded in a controlled manner and align with the redevelopment within each phase. While it is recognised that during construction there will be disruption, when each phase is complete, the new and old road network interfaces should be seamless and complement each other. Car parking on the site is a major issue and the redevelopment will ensure that an agreed level of replacement parking is available as phases are complete. The introduction of better public transport links to the site and routes through it, should also help provide the public parking requirements.

A strategy to allow cycling to be more integral to the road network and give access across the site has been developed in conjunction with provision for cycle parking in appropriate locations.

In summary the site development framework for the Western General Hospital:

- Provides a Masterplan overview for a 30 year plus development timescale – i.e. 2045 Vision.
- Has a timescale which aligns with a major building replacement programme on a phased basis.
- Aligns with Scottish Government's net zero Carbon strategy to 2045.
- Provides increased flexibility in site / building zones to support strategic pan Lothian Service Planning.
- Addresses Affordability and supports better long-term Capital Planning .
- Has options to provide longer term flexibility for decision making for Capital Investment.
- Ensures that development opportunities are deliverable through options which create capacity and have improved adjacencies to other clinical accommodation through an embedded zonal template.
- Has options that can facilitate phased development.
- Has a developing list of projects tested, or that will be tested, through robust feasibility studies.
- Supports the enablement of projects and backlog maintenance that has to happen.
- "Do – Ability" - Creates a flexible template for rational and affordable site development.
- Provides a framework for ongoing dialogue with City of Edinburgh Council as planning authority through an agreed Place Brief.

2.2.14 Summary of Need for Change

The table below summarises the need for changes described in detail above and outlines why action should be taken now to address these needs.

Table 20: Summary of Need for Change

What is the cause of the need for change?	What effect is it having, or likely to have, on the organisation?	Why action now:
Existing service model unable to cope with increasing demand	Facilities and existing capacity unable to cope with projected demand resulting in patient treatment delays	Future service sustainability at risk
Current environment does not meet recommended standards for patient care	Safety issues highlighted in Healthcare Environment Inspectorate (HEI) reports Patient experience not optimum in current accommodation	To mitigate safety risk To improve patient experience
Challenging to recruit and retain specialist staff due to lack of opportunities	Workforce challenges causing detrimental effect on service provision and capacity	Future service sustainability at risk
All cancer treatments not available in Scotland	Patients travelling to other UK centres/ abroad for certain treatments	Where possible: Reduce financial impact Improve patient experience – care closer to home
Restricted Clinical Research and Trials portfolio	NHS Lothian unable to participate in full complement of trials	Increase financial income from commercial trials Provide access to most innovative treatment options – expanding patient options and allowing optimum outcomes Drugs cost avoidance Opportunity in early phase drug cell therapy production
Services, which should be co-located split over multiple locations on the WGH site	Split locations result in inefficiencies in service provision, duplication of work, loss of possible collaboration	Increase collaboration and improve patient experience

2.3 Opportunities

The opportunities vafforded by this proposal are far reaching and link into the Benefits and Investment Objectives as outlined below.

The key opportunities are:

- Transformation of cancer services within the Edinburgh Cancer Centre, across the South East Region and the cancer pathway as a whole;
- Opportunity to provide care closer to home through collaborative working with regional partners and provide a consistent model and quality of care across the South East Region with a patient focused/ holistic approach;
- Ability to be at the forefront of innovation through Cancer Research being integral to core services across the region;
- Alignment with local and national cancer strategies (as outlined in Table 22 below);
- Development of facilities to retain existing staff, encourage recruitment into the South East Region from across the UK/internationally and promote internal training and education.

The opportunities around service transformation, regional service delivery and delivery of trials and research are articulated in more detail as part of the proposed Clinical Model below.

2.3.1 Service Transformation

Rather than simply re-providing the existing accommodation including an uplift to cope with future service demand, this proposal describes an opportunity to contemplate the arrangement of services and ensure that efficiencies are optimised.

Work in developing and transforming cancer services has been ongoing for several years with departmental working groups being established to develop Clinical Output Specifications. Information for some departments is more mature than others, however enough information has been developed to inform initial schedules of accommodation for the identified shortlisted options.

Prior to the commencement of OBC, a Clinical Brief will be developed to articulate baseline service requirements in advance of any conceptual design work taking place.

2.3.2 Regional Collaboration and Transformation

NHS Lothian is part of the South-East Scotland Cancer Network (SCAN) and works collaboratively with NHS Borders, NHS Fife, and NHS Dumfries and Galloway to plan and deliver cancer services across the South East of Scotland. The project offers real opportunity to collaboratively transform service delivery across the Region ensuring that the correct services are provided in the best place offering sustainable cancer services to local populations.

Regional collaboration has been ongoing for several years.This work has fed into the development of options and the service scope included within these options – this is covered in greater detail within the Economic Case.

2.3.3 Technology

Optimisation of efficiencies and new technologies within service and building design is also an opportunity which was explored during a cross stakeholder technology and innovation workshop held on 9th October 2019 and discussed:

- NHS Lothian – recent and future innovations
- Technical innovations – led by Design Consultant WSP

The workshop helped to identify existing challenges and how these might be able to be overcome using new technology and innovations. Some aspects can be improved without the necessity of a new

building, whilst others are intrinsic to the construction and infrastructure associated with new facilities. Some of the proposed initiatives require further dialogue at a local, regional and national level.

The key themes to be carried forward for further development are summarised within the workshop report which is available upon request.

2.3.4 Cancer Information Programme

This proposal also affords the opportunity to provide a world-leading clinical data system for service planning, audit, and modern data-driven patient care via the development of a Regional Cancer Information system.

The provision of cancer services in the South East Scotland Cancer Network uses diverse clinical systems amongst NHS Lothian, partner Regional Health Boards and central NHS Scotland services. As the regional tertiary referral centre, the Edinburgh Cancer Centre has, for 46 years, maintained a treatment and outcomes database. Brought together, using modern data gathering and analytical tools, these assets provide a rich data resource that is currently underused.

The Cancer Information Programme has established approved governance processes for using NHS Lothian, Regional and National data for improved patient care.

A Business Case for Phase II of the South East Scotland Cancer Information Programme is currently being developed which will ultimately provide a comprehensive Regional Cancer Information Service.

Phase II will build upon the significant progress made since the Cancer Information Programme began in 2015.

The recent COVID-19 pandemic has highlighted the demand for, and the value of, real-time data intelligence to support delivery and to monitor the impact of the service on patient outcomes.

The pandemic has also driven forward regional and national cancer intelligence collaborations, highlighting the necessity and the value of national, regional and local level analysis conducted in parallel.

With detailed knowledge of its data and development in-house of workforce skill sets and academic links, the Edinburgh Cancer Centre is in a strong position to host an internationally recognised Cancer Information programme.

A strong data platform will attract investment from potential academic and commercial partners which will be key in achieving the vision for the ECC.

Alongside this, the COVID-19 pandemic has highlighted the demand for real-time data intelligence to support delivery and to monitor the impact of the service on patient outcomes.

2.4 Investment Objectives

2.4.1 Local Strategic Context

This proposal delivers on the strategic vision articulated in the Lothian Hospitals Plan (LHP) which identifies that across NHS Lothian Acute Services there is a need to address service configuration and allocation of space according to clinical priority.

This plan seeks to address the challenges of changing demography, clinical demand, workforce, condition of estate and provide an organisational focus to investment decisions and management effort.

It describes the purpose of the hospital sites in Lothian as follows:

Table 21: Summary of Lothian Hospitals Plan

Site	Strategic Headline
Royal Infirmary of Edinburgh	South-East Scotland's emergency care centre, incorporating a major trauma centre, orthopaedic services, neurosurgery, and children's tertiary care
St John's Hospital	An elective care centre for Lothian and for the South-East Scotland region, incorporating highly specialist head and neck, plastics and ENT services
Western General Hospital	**The Cancer Hospital for South-East Scotland, incorporating breast, urology and colorectal surgery and Critical Care**
Royal Edinburgh Hospital	Edinburgh's inpatient centre for highly specialist mental health, physical rehabilitation and learning disability services, incorporating regional and national services

The Western General Hospital (WGH) Site is a complex campus with site infrastructure requiring urgent development to allow both the Oncology Enabling projects and potential cancer centre reprovision to take place.

The outdated infrastructure of the Edinburgh Cancer Centre (ECC), with its main buildings constructed in the 1950s, no longer meet the needs and expectations of modern healthcare.

Through Scottish Government approval of the Initial Agreement for the Cancer Bridging Projects in 2016 (subsequently renamed as Oncology Enabling) and approval of the Outline Business Case in 2020, containing the reduced proposals as agreed in March 2018, it has been acknowledged that cancer services are not sustainable in their current configuration.

The potential scope of associated demolition works at the WGH following the relocation of the Department of Clinical Neurosciences (DCN) services to the Royal Infirmary Hospital site in 2020 will help the rationalisation of the Western General Hospital estate and remove many of the more problematic buildings from the portfolio as well as providing space onsite to build a new Cancer Centre, should this be identified as the preferred option.

2.4.2 Vision

Through a series of workshops with wide representation from multi-disciplinary staff from across the South East Region, a vision for the future of cancer services was developed and agreed:

Vision

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

This was also agreed by Regional Representatives at a series of meetings held in November 2018 and by the Cancer Capital Programme Board, NHS Lothian as the steering group for this proposal.

This vision and the proposed clinical model as articulated below aligns with national,regional and NHS Lothian strategies:

Table 22: Summary of Relevant Strategies

National Strategies	
Quality Strategy, 2010	**Safe –** Any building design will provide adequate space for safe treatment that meets all applicable healthcare standards. **Person Centred -** Patient focused/holistic approach to providing cancer care. Where possible, providing care as daycase/outpatient (rather than inpatient) to benefit the patient by allowing them to return home during or after their treatment, increasing the time they can spend with family and allowing them the opportunity to self care in a non-clinical environment whilst having the support of the service should they require it. Providing care closer to home where clinically appropriate and financially viable to do so – high quality service model provided across the region. **Effective -** Reducing the cost of treatment by providing it as daycase/outpatient and therefore reducing bed occupancy. Reducing current inefficiencies of working and maximising on economies of scale by designing a building around a redesigned service model to support the delivery of waiting times targets. **Efficient-** Improvement in patient pathways by reducing length of wait through re-designed patient pathways and optimum service adjacencies. Future proofed service with improved service capacity and performance. **Equitable-** Reducing health inequalities by providing timely access to a wide range of specialty therapies and trials closer to home for patients in the South East Region. Providing equitable access to the most innovative cancer therapies for patients in the South East Region. **Timely -** Improvement in patient pathways by reducing length of wait through re-designed patient pathways and optimum service adjacencies. Providing access to early diagnostics, detection and treatment to improve cancer outcomes.
2020 Vision for Health and Social Care, 2011	Transformation of Cancer service delivery for the patients of South East Scotland, with a focus on prevention, anticipation and supported self-management.

National Strategies	
	Treatment will be delivered in a daycase setting whenever possible.Where this is not possible there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission . Whatever the setting, care will be provided to the highest standards of quality and safety, with the patient at the centre of all decisions.
Beating Cancer, Ambition and Action 2016	A transformed clinical model will have a focus on early cancer detection and diagnosis through direct access to diagnostics and a focus on the role of imaging in accurate and timely diagnosis of cancer.Improved capacity will provide better access to timely safe and effective care for patients across the Region. Services and clinical trials will be planned and delivered locally wherever possible.Collaborative approach to expansion of services and trials available locally for patients in the South East region. A diverse sustainable workforce is key to service delivery across the region. Recruitment and retention strategies to be developedto include career development opportunities and potential inclusion of a training and education facility. Focus on living with and beyond cancer with access to individually tailored patient information, support and advice, patient education and access to palliative care. Results of the National Cancer Patient Experience Survey will be used to inform the way services are provided including a focus on the availability of emotional and psychological patient support. Access to high quality, accurate data via an integrated Regional Cancer Information Programme will be an essential part of patient centred care. Research will be embedded into the service to give patients access to and opportunity to participate in appropriate clinical trials. Overall there will be a focus on reducing health inequalities and providing patient centred care.
Beating Cancer, Ambition and Action 2016 (Updated, 2020)	**Smoother patient journeys** - a transformed clinical model with a focus on early cancer diagnosis through direct access to diagnostics and the role of imaging in accurate and timely diagnosis of cancer. Improved capacity will provide better access to timely safe and effective care for patients across the Region. **'Prehabilitation'** – Holistic patient approach through a wellness programme, patient education and empowerment. **Treatment** - Consistency and equity of treatment access for patients across the South East of Scotland with services planned and delivered locally wherever possible. **Best care and support for all people with and beyond cancer** – working closely with third sector organisations to provide

National Strategies	
	access to individually tailored patient information, support and advice, patient education and access to palliative care. **Whole system actions** - Integration of clinical research and trials with cancer services through physical co-location and service model collaboration. **Using data for improvement** – Develop Phase II of the South East Scotland Cancer Information Programme from 2021 to provide a comprehensive Regional Cancer Information Service.
A Fairer, Healthier Scotland: 2017-2022	The transformed clinical model focuses on the need for long term prevention of health conditions,better equity and better access to services across the region to reduce health inequalities. By adopting a holistic patient approach inequalities in health can be reduced through a wellness programme, patient education and empowerment. The service provided will continue to be of high quality, continually improving, efficient and responsive to patients needs. The building design and construction will improve access to green space and reduce Scotland's carbon footprint. The service will be redesigned bearing in mind the principle of everyone having a fairer share of the opportunities, resources and confidence to live longer, healthier lives.
Realistic Medicine 2015/16,Realising Realistic Medicine 2016/17,Personalising Realistic Medicine 2017/18	Transformation of the clinical service across the region provides an opportunity to build a personalised approach to care and reduce unnecessary variation in practice and outcomes. Continuous improvement and innovation are key components of an efficient and sustainable service model. Service models designed around the person/patient to achieve a better understanding of their preferences and values, then using our experience and clinical judgement to deliver true evidence-based medicine in a personalised way. Creating environments where staff feel valued, respected and supported. Understanding the challenges faced by our staff to improve recruitment and retention.
The Modern Outpatient 2017-2020	The importance of harnessing digital technology, promoting collaboration between primary and secondary care and redesigning patient pathways will be highlighted through any re-design. A reduction in the number of outpatient appointments delivered in hospital will allow resource to be diverted to more efficient use as well as allowing patients to be seen in the right place at the right time.
Scottish Government	This proposal assists in the delivery of the four priorities for sustainable growth; Investment, Innovation, Inclusive Growth,

National Strategies	
Economic Strategy 2015	Internalisation Specific links with this are articulated in the wider benefits section of this document using the Scottish Government's National Performance Framework to provide a structure to the identification, incorporation and assessment of the wider economic benefits and demonstrate the benefit of the proposal to the communities and economy of South East Scotland.
NHS Scotland Staff Governance Standard 2012	A diverse sustainable workforce is key to service delivery across the Region. This will be achieved by ensuring that staff are; • well informed; • appropriately trained and developed; • involved in decisions; • treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and • provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community. Future workforce models will be designed around these principles with the input of the local Partnership Forum alongside the appropriate Board Committees.

NHS Lothian	
Better Cancer Outcomes in Lothian 2015-2020	The proposed clinical model takes account of the increasing demand for cancer services across the South East of Scotland with a focus on prevention and tackling cancer inequalities as well as the need for integrated care to be delivered across primary, secondary and social care and regionally across the South East Region. Service changes will take into account the rapid pace of technological change and need to modernise cancer care based on evidence, best practice and innovation. Models will be developed to deliver care in the right place and in a way that is appropriate to particular needs with mechanisms for continued patient involvement in cancer service planning.
NHS Lothian Corporate Objectives 2018-19 to 2022-23	This programme of work seeks to address the following: o *Improve quality, safety and patient experience* by providing services in a clinically appropriate environment o *Improve Access to Care and Treatment* by meeting the 62 and 31 day targets o *Improve the experience of our staff* by designing a facility which takes the holistic needs of staff into account and prioritising staff development through training and career planning

NHS Lothian	
	o *Achieve greater financial sustainability and value* by maximising the opportunities from working with our Regional Partners to deliver a sustainable resource model o *Develop workforce plans including workforce supply* by attracting specialist staff to Scotland with the promise of a career, not just a job, highlighting workforce challenges to gain support from Scottish Government regarding training needs and providing a training and education hub for the benefit of the region and Scotland o *Maximise the potential for innovation and technology to deliver transformational change* by incorporating the opportunities offered by innovation and technology into the service and building design o *Work with Regional and National partners to support transformational change* on national service planning, workforce planning, service sustainability and outreach models of care
NHS Lothian Quality Strategy 2018 – 2023	During the process of transforming pathways for cancer patients we will ensure that; • Improvement ideas can be tested • Leaders devote time to encouraging local testing and development • All staff are involved in developing improvement priorities and ideas • There is a focus on patient and population needs and wishes in all improvement work • There is constant learning, sharing and embedding of new knowledge from all improvement activities • We explicitly measure and realise the financial gains of better quality • We move to more integrated health and social care quality management • We adopt quality management universally to support everything we do.
Living and Dying Well in Lothian – Lothian's Palliative and End of Life Care Strategy 2010-2015	The proposed Clinical Model will support the approach to Palliative Care planning and delivery by; • Working with people with **Long Term Conditions** to make sure that the need for palliative care is identified as part of routine care at the earliest stage appropriate, helping people to plan, direct and be actively involved their own care • Adopting the **Palliative Care Approach** from as early a stage as is agreed appropriate. The palliative care approach seeks to maximise quality of life, by maintaining good symptom control, offering holistic assessment including family and carers needs, and seeks to agree choices around treatment options, place of care and preferred place of death. • Planning for and managing **end of life care** in the last days of life in a tightly co-ordinated and structured manner. Two specific elements of the model that support this are: 1/Enhanced Supportive Care – routine involvement of Hospital Specialist Palliative Care Services (HSPCS) for all patients across the region living with metastatic cancer whether currently receiving anti-cancer treatments or best supportive care

NHS Lothian	
	including active management of difficult symptoms and sufficient access to interventional anaesthetics and radiology. 2/ Proactive identification of patients with palliative care needs via MDT attendance, joint ward rounds, and involvement in acute admissions and oncology assessment areas to extend the reach and impact of the HSPCS on improved quality of patient care and experience.

2.4.3 Investment Objectives

The assessment of the existing situation and the drivers for change have been used to identify what has to be achieved to deliver the changes required to deliver the vision.

These are defined as the investment objectives and are summarised in the table below with further information to follow:

Table 23: Investment Objectives

Effect of the need for change on the organisation:	What has to be achieved to deliver the necessary change? (Investment Objectives)
Facilities and existing capacity unable to cope with projected demand resulting in patient treatment delays	Increase service capacity and sustainability to meet demand and provide timely service access for patients
Safety issues highlighted in Healthcare Environment Inspectorate (HEI) reports Patient experience not optimum in current accommodation Split locations result in inefficiencies in service provision, duplication of work, loss of possible collaboration	Design buildings to provide appropriate facilities for clinical care that meet all required standards, allow service collaboration and provide an improved patient experience
Workforce challenges causing detrimental effect on service provision and capacity	Improve recruitment and retention of specialist staff Offer a range of education,training, research and academic opportunities for professional development
Patients travelling to other UK centres/ abroad for certain treatments	Offer a wide range of specialist cancer therapies to the patients of South East Scotland
NHS Lothian unable to participate in full complement of trials	Integration of Clinical Research and Trials with Cancer Services to enable access to an expanded range of trials and improve patient outcomes

1. **Increase service capacity and sustainability to meet demand**

The preferred option will provide increased service capacity to meet the demand as predicted by the forecasting detailed in the Strategic Case. A consistent timeframe will be used to determine the capacity requirements for each service area. Innovative service redesign will continue to be undertaken to provide a service model that is sustainable and delivers excellent patient care and efficient pathways for patients across the region.

2. **Building designs will provide appropriate facilities for clinical care that meet all required standards**

The design and specification of the built environment for the preferred option will meet current standards such as room sizing and chair spacing as far as is possible within the identified footprint. Further, the preferred options should deliver co-location benefits that allow an integrated cancer service promoting collaboration between services to drive efficiencies and excellent patient care.

3. Opportunities available to ensure recruitment and retention of specialist staff. Offering a range of education and training for professional development

The preferred option will enable the recruitment and retention of specialist staff through four key areas:

- Providing a range of education,innovation,research and training opportunities for professional development across the South East Region.
- Providing safe, appealing physical working environment that meets required standards (linked to Obj 2)
- Collaboratively developing a sustainable service model that allows staff to continue to provide excellent patient care and a wide range of cancer treatments across the region (linked to Objs 1 and 4)
- Provide a strong research and clinical trials model to support staff in their research & development aspirations (linked to Obj 5)

4. Wide range of specialist cancer therapies available for the patients of South East Scotland

The preferred option will include a service model and build environment that allows the provision of a wide range of cancer therapies current available in the UK, at the Edinburgh Cancer Centre (ECC) and across the South East Region. This will:

- Reduce the patient travel by providing treatment closer to home
- Allow staff to gain experience and develop their skills and knowledge in the delivery of a wider range of treatments
- Allow the ECC and South East Region Cancer Service provision to be at the forefront of cancer treatment in the UK.

5. Integration of Clinical Research and Trials with Cancer Services

The preferred option will enable the integration of clinical research and trials with cancer services through physical co -location and service model collaboration.

In assessing the options against the investment objectives described above, preferred options will be identified that can deliver benefits to patients, staff, NHS Lothian, Regional Boards, local communities and the wider economy. Consideration of the desired benefits to all stakeholders, and wider economic benefits, are outlined in the following sections.

2.5 Benefits

2.5.1 Benefits Identification Methodology

The identification of benefits is a key part of both the business case and project process as this allows options to be assessed to determine the preferred solution but also provides a framework against which the success of a project can be measured.

A Strategic Assessment (SA) was completed identifying the need for change, benefits of addressing these needs and their link to NHS Scotland's five Strategic Investment Priorities below:

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

In developing the Initial Agreement, a dedicated Stakeholder workshop was held on 30 July 2019 to explore the proposed investment objectives in detail and to consider the associated benefits that may be realised. Through group working sessions, the benefits listed within the SA were endorsed and additional applicable benefits were suggested and have been incorporated as noted in the following section.

The reprovision of the Edinburgh Cancer Centre will have a significant positive impact on project stakeholders (NHS Lothian, Regional Boards, patients, staff and partners) and on the wider economy, environment and communities. The identification of benefits contributing to a socially inclusive, 'net zero carbon economy' is key in the decision making process.

The Scottish Government's National Performance Framework has been used to provide a structure to the identification, incorporation and assessment of these wider economic benefits to demonstrate the benefit of the project to communities and economy of South East Scotland. The benefits have also been considered in the context of Scottish Government plans and documents including: the refreshed Scottish Government Economic Action Plan (2019-20), the Infrastructure Investment Plan and "Exploring the Rationale for Infrastructure Investment" (December 2018).

Feedback from stakeholders has highlighted vital links between benefits to the health of the population and wider communities and benefits to the economy such as improved national, social and economic resilience in face of potential future pandemics.

A reprovided ECC will create resilience in Scotland's health system through greater capacity to manage disease outbreaks safely and swiftly would minimise otherwise immensely expensive disruption to the wider economy.

Reprovision of the ECC will provide a series of new opportunities for local businesses and manufacturers, with opportunities to build local resilience, manufacturing capacity, employment opportunities and profitability in the health care sector in Scotland. Manufacturing opportunities for healthcare products severely restricted in supply (such as PPE) arose in the local economy during the current pandemic, showing the key interaction between local economy and healthcare provision.

Reprovision of the ECC would also offer many more traditional economic opportunities to local businesses in Scotland and the UK, including in innovative building design and construction, clean energy and transport, and in the supply chain.

A reprovided ECC and a transformed service providing 'Care Closer to Home' will provide employment opportunities both in the construction phase and in the health care sector for the long term. These employment opportunities will exist both within the Centre itself and across the South East Region through the transformed regional model. There will also be opportunities to upskill health workers across primary and secondary care. This will not only support effective wrap around care closer to home but allow non cancer specialists to pursue cancer interests and participate in research, supporting more attractive and rewarding careers.

Innovation is at the core of the strategic case for a reprovided ECC with a transformed regional service and integrated research model able to leverage synergies and adjacencies that optimise opportunities for research and innovation. The provision of world class cancer care and related academic health science opportunities will provide unique opportunities for bench to bedside medicine, enhancing Scotland's reputation on the world stage. In the clinical field, economic opportunities intrinsic to a reprovided ECC will exist in all the aspects of digital innovation, as well as in more traditional aspects of clinical innovation and research with potential for associated intellectual property benefits for the local economy and research institutions throughout the region. Access to world leading research and data science opportunities on the Cancer Campus will support the University's active role in business innovation and encourage closer links between the NHS, academia and industry.

The economic opportunities in digital innovation (e.g. in data collection, remote working, and responsive management systems) are also core to the reprovision of Cancer Services. A reprovision of the ECC will support the development of a world leading Cancer Informatics Programme harnessing Edinburgh's unique data assets, cancer data science expertise and evolving Academic Health Science Campus creating greater opportunity for University supported business development opportunities, spin-offs and entrepreneurial ventures.

The ECC is already working to develop international research collaborations with other leading centres and industry. This will continue to develop with international research exchange programmes and formal international partnerships. Opportunities for international collaboration will be greatly enhanced by state of the art facilities and technologies. This in turn will create greater opportunities for inward international investment, enhancing Scotland's reputation and drawing top global talent to Scotland.

The following methodology has been followed to identify the numerous possible benefits from the project. Due to the scale of the project and the wider ranging benefits that could accrue from it steps 1-5 have been undertaken as part of the IA, steps 6-7 will be undertaken through the OBC and step 8 as part of the Post Project Evaluation (PPE) process.

1. Identification of benefits to project stakeholders (e.g. NHS Lothian staff, patients and partners)
2. Identification of wider inclusive net zero economy benefits (e.g. drivers of economic growth or reduced emissions)
3. Mapping of identified benefits to NHS Scotland Strategic Priorities and the Scottish Government National Performance Framework Outcome and Indicators.
4. Review of benefits in the context of the above mapping to determine how these benefits could be measured (quantitatively or qualitatively).
5. Review of benefits to identify where a financial benefit would be accrued that should be included within the financial options appraisal and assessment of how this financial benefit would be measured.
6. Engagement with stakeholders to weight benefits to confirm relative importance to the success of the project
7. Scoring of each shortlisted option against the identified benefits by stakeholders to determined the preferred option
8. Review of delivery against identified benefits by the preferred option.

Due to the significance of the project and the changing economic, policy and healthcare landscape the key benefits will be continually reviewed at each stage of the business case process to ensure they are still those most vital to the success of the project.

2.5.2 Benefits

A summary of the key desired benefits from the project are detailed in the first below and mapped to the investment objectives and both the NHS Scotland Strategic Priorities and the Scottish Government

National Performance Framework. The mapping also indicates the impact and the certainty/ measurability of these benefits indicated using the colour matrix below:

		Impact	
		H	L
Certainty/ measurability	H		
	L		

These benefits cover the direct healthcare benefits, benefits to the project stakeholder and wider benefits to a net zero inclusive economy. Further detail behind each of the 13 key benefits on the individual aspects that have been highlighted and considered in developing these is contained in Appendix 2. This Appendix also provides further detail on how the benefits look to both address the SG National Outcomes (as mapped on the table below) and underlying indicators.

Table 24: Key Benefits and Mapping

#	Benefit	Related Investment Objective(s)	Mapping to SG Performance Framework National Outcome											Mapping to NHS Scotland Strategic Priorities				
			Children and Young People	Communities	Culture	Economy	Education	Environment	Fair Work and Business	Health	Human Rights	International	Poverty	Safe	Person Centred	Effective Quality of Care	Health of Population	Efficient: Value and Sustainability
1	Provision of **care closer to home** improves the **patient experience, reduces emissions, provides skilled employment opportunities in the region** and **reduces health inequalities**	Wide range of specialist cancer therapies available for the patients of South East Scotland	X			X	X		X	X	X		X		X	X	X	X
2	An **improved environment for staff** results in improved **staff recruitment, retention** and **well being,** enhancing **economic participation**	- Building designs will provide appropriate facilities for clinical care that meet all required standards - Opportunities available to ensure recruitment and retention of specialist staff - Offering a range of education and training for professional development		X	X		X	X		X	X			X	X			X
3	A flexible building that can be adapted to safely manage and treat different patient cohorts provides improved **service resilience** and supports a **transformed service model**	Building designs will provide appropriate facilities for clinical care that meet all required standards	X			X			X	X				X		X	X	X
4	Increased ability to provide **precision medicine** through further collaboration with genomic services, building on University relationships and increasing clinical trials - resulting in **better patient outcomes and clinical innovation**	Wide range of specialist cancer therapies available for the patients of South East Scotland	X			X	X		X	X	X				X	X		X
5	Increased opportunities for **clinical trials** leading to **improved outcomes, equitable access ,better patient** and **staff experience** and **closer links between the NHS, academia and industry**	- Integration of Clinical Research and Trials with Cancer Services - Opportunities available to ensure recruitment and retention of specialist staff				X	X		X	X		X	X		X	X	X	X
6	**Collocating services** helps streamline patient pathways and aids staff collaboration improving the **patient experience** and **patient outcomes,** and provides synergies and adjacencies that optimise opportunities for research and innovation	- Wide range of specialist cancer therapies available for the patients of South East Scotland - Integration of Clinical Research and Trials with Cancer Services		X		X	X		X	X					X			X
7	An **improved physical environment** for patients benefits **safety** and **the patient experience**	Building designs will provide appropriate facilities for clinical care that meet all required standards	X	X	X			X		X	X			X	X	X		X
8	More efficient buildings and reduced travel for treatment drives a **reduction in emissions**	Building designs will provide appropriate facilities for clinical care that meet all required standards		X		X				X							X	X
9	A national infrastructure project drives increased **skilled job opportunities** in the region from construction, R&D and clinical trials activity and associated innovative business growth	- Opportunities available to ensure recruitment and retention of specialist staff - Offering a range of education and training for professional development	X	X		X	X		X	X			X					X
10	An increase in **research and development** provides opportunities which **attract staff, drive economic innovation** and provide innovative treatments that **benefit patient experience and outcomes**	- Integration of Clinical Research and Trials with Cancer Services - Opportunities available to ensure recruitment and retention of specialist staff - Offering a range of education and training for professional development				X	X		X	X		X	X		X			X

Strategic Case: Benefits

#	Benefit	Related Investment Objective(s)	Mapping to SG Performance Framework National Outcome										Mapping to NHS Scotland Strategic Priorities				
			Children and Young People	Communities	Culture	Economy	Education	Environment	Fair Work and Business	Health	Human Rights	International	Poverty	Safe	Person Centred	Effective Quality of Care	Health of Population	Efficient: Value and Sustainability
11	Future proofed **sustainable service** with capacity to provide **equitable access to healthcare**	Increase service capacity and sustainability to meet demand		X		X			X	X	X				X	X	X	X
12	Redesigned patient pathways **improve the patient experience** and **clinical outcomes** and provide **unique opportunities for science and bench to bedside medicine.**	- Wide range of specialist cancer therapies available for the patients of South East Scotland - Integration of Clinical Research and Trials with Cancer Services	X			X			X	X	X				X	X		X
13	Ability to use **data driven innovation** to improve patient experience and outcomes through a more linked up data driven service model and provide **innovative business development opportunities**	- Wide range of specialist cancer therapies available for the patients of South East Scotland - Integration of Clinical Research and Trials with Cancer Services	X			X	X		X	X	X	X			X	X		X

A key feature of the benefits outlined above is their ability to be measured in order to assess achievement and to utilise them in the options appraisal process. Measurement criteria have been identified for each benefit and these have also been flagged where benefits will a financial benefit to allow appropriate incorporation of financial benefits in the financial options appraisal. This information is summarised below:

Table 25: Measurement Criteria for Benefits

#	Benefit	Key Measures	Input to Financial Options Appraisal?
1	Provision of **care closer to home** improves the **patient experience, reduces emissions, provides skilled employment opportunities in the region** and **reduces health inequalities**	1. Change in number of remote consultations 2. Change in service provision throughout the Region 3. Change in number and distance of patient journeys for treatment 4. Patient satisfaction audits before and after reprovision	YES
2	An **improved environment for staff** results in improved **staff recruitment, retention** and **well being,** enhancing **economic participation**	1. Staff absence, turnover and bank and agency usage 2. Staff satisfaction audits before and after reprovision 3. Monitor environmental / facilities complaints before and after reprovision 4. SG National Indicator: Education/ Work place learning	YES
3	A flexible building that can be adapted to safely manage and treat different patient cohorts provides improved **service resilience** and supports a **transformed service model**	1. Diagnostic capacity and capability 2. Building flexibility (single rooms and adaptable wards)	NO
4	Increased ability to provide **precision medicine** through further collaboration with genomic services, building on University relationships and increasing clinical trials - resulting in **better patient outcomes and clinical innovation**	1. Specialities using genetic treatments and target cellular therapies 2. Offering access to novel treatment options through expansion of early phase trials programme 3. Change in patient outcomes for those treated using precision medicine	YES
5	Increased opportunities for **clinical trials** leading to **improved outcomes, equitable access ,better patient** and **staff experience** and **closer links between the NHS, academia and industry**	1. Increase in number of clinical trials undertaken at ECC and across the region 2. Increase in number of NHS patients taking part in clinical trials 3. External investment received before and after reprovision	YES
6	**Collocating services** helps streamline patient pathways and aids staff collaboration improving the **patient experience** and **patient outcomes,** and provides synergies and adjacencies that optimise opportunities for research and innovation	1. Impact on waiting times performance 2. Impact in pathways involving multiple disciplines	YES

#	Benefit	Key Measures	Input to Financial Options Appraisal?
7	An **improved physical environment** for patients benefits **safety** and **the patient experience**	1. Reduction in DATIX incidents 2. Patient satisfaction audits before and after reprovision 3. Compliance with HEI and other relevant standards 4. Comparative levels of Healthcare Associated Infection (HAI) – Infection Control Reports and Audits	YES
8	More efficient buildings and reduced travel for treatment drives a **reduction in emissions**	1. SG National Indicator: Economy/ Carbon footprint 2. SG National Indicator: Economy/ Greenhouse gas emissions 3. Reduction in building energy usage 4. Reduction in patient journeys	YES
9	A national infrastructure project drives increased **skilled job opportunities** in the region from construction, R&D and clinical trials activity and associated innovative business growth	1. SG National Indicator: Fair work and business/ Economic participation 2. Increase in skilled roles	YES
10	An increase in **research and development** provides opportunities which **attract staff, drive economic innovation** and provide innovative treatments that **benefit patient experience and outcomes**	1. SG National Indicator: Fair work and business/ High growth businesses 2. SG National Indicator: Fair work and business/ Innovative Businesses 3. SG National Indicator: Economy/ Spend on Research and Development 4. Cancer Services research portfolio	YES
11	Future proofed **sustainable service** with capacity to provide **equitable access to healthcare**	1. Impact on waiting times performance 2. Reduced number of appointment cancellations	NO
12	Redesigned patient pathways **improve the patient experience** and **clinical outcomes** and provide **unique opportunities for science and bench to bedside medicine.**	1. Patient satisfaction audits before and after reprovision 2. Impact on length of stay an number of treatments delivered as in/ outpatient	YES
13	Ability to use **data driven innovation** to improve patient experience and outcomes through a more linked up data driven service model and provide **innovative business development opportunities**	1. Change in patient outcomes 2. Change in time to progress through patient pathway	YES

For the benefits where there are financial aspects that should be included in the financial options assessment flagged above – how these can be incorporated is detailed below. This will be included in the financial options appraisal as detailed in the Economic Case section of this document.

Table 26: Financial benefits and measures

#	Benefit	Financial Benefit	Financial Measurement for inclusion in Economic Case
1	Provision of **care closer to home** improves the **patient experience, reduces emissions, provides skilled employment opportunities in the region** and **reduces health inequalities**	Financial benefits of delivering care closer to home (e.g. within SE Region) and digitally. Highly skilled construction research and health sector employment opportunities throughout the region: 'Care Closer to Home' implies 'Work Closer to Home'.	Reduction in out of area charges. Reduction in cost to patient and relatives associated with need to regularly travel to access care. Increased tax base/ contributions to economy.
2	An **improved environment for staff** results in improved **staff recruitment, retention** and **well being,** enhancing **economic participation**	A reduction in staff costs (less Bank, Locum and Agency staff).	Staffing cost savings identified and included in the proposed staffing model(s). Reduction in maintenance costs.
4	Increased ability to provide **precision medicine** through further collaboration with genomic services, building on University relationships and increasing clinical trials - resulting in **better patient outcomes and clinical innovation**	Targeted treatments can lead to a reduction in the number and time of treatments required, improved patient outcomes reduce lost economic contributions. Ability to generate income and create employment in a range of sectors through development of product manufacture through partnership between NHS, Academia and Industry. Economic opportunities for local research institutions and businesses in clinical research and clinical trials activity, with potential to secure intellectual property.	Reduction in high costs drugs expenditure. Reduction in lost economic contributions through better patient outcomes. Income generation and wealth creation through innovation across NHS, Academic and Science/ Industrial sectors.
5	Increased opportunities for **clinical trials** leading to **improved outcomes, equitable access ,better patient** and **staff experience** and **closer links between the NHS, academia and industry**	Clinical trials reduce drug costs as treatments are provided through the trials, improved patient outcomes reduce lost economic contributions for patients. Innovative treatment development provides economic opportunities for local research institutions and	Reduction in drug costs. Staffing cost savings (improved retention) identified and included in the proposed staffing model(s). Reduction in lost economic contributions through better patient outcomes.

#	Benefit	Financial Benefit	Financial Measurement for inclusion in Economic Case
		businesses in clinical research and clinical trials activity, with potential to secure intellectual property..	Income generation and wealth creation through innovation across NHS, Academic and Science/ Industrial sectors.
6	**Collocating services** helps streamline patient pathways and aids staff collaboration improving the **patient experience** and **patient outcomes,** and provides synergies and adjacencies that optimise opportunities for research and innovation	Internal efficiencies from co-location (e.g. reduction in portering costs) and economies of scale from collocating, reduction in costs associated with complaints, clinical risk, adverse events and poor patient outcomes	Staffing cost savings identified and included in the proposed staffing model(s) Benefits to non-pays, equipment etc will be included in the revenue/ capital cost model(s) Reduction in costs associated with complaints, clinical risk, adverse events, and reduction in lost employment through better patient outcomes.
7	An **improved physical environment** for patients benefits **safety** and **the patient experience**	Reduced building maintenance costs due to improved condition of estate, reduction in costs associated with complaints, clinical risk and adverse events.	Reduction in maintenance and energy costs. Reduction in costs associated with complaints, clinical risk and adverse events, including in indemnity costs.
8	More efficient buildings and reduced travel for treatment drives a **reduction in emissions**	Reduced building maintenance costs due to improved condition of estate. Lower energy costs from reduced footprint and more efficient technologies.	Reduction in maintenance costs. Reduction in energy costs. Reduction in travel costs.
10	An increase in **research and development** provides opportunities which **attract staff, drive economic innovation** and provide innovative treatments that **benefit patient experience and outcomes**	Reduced staff costs through better retention and easier recruitment due to opportunities on offer. Innovative R&D provides economic opportunities for local research institutions and businesses in clinical research and clinical trials activity, with potential to secure intellectual property..	Staffing cost savings (improved retention) identified and included in the proposed staffing model(s). Reduction in lost economic contributions through better patient outcomes. Income generation and wealth creation through innovation across NHS, Academic and Science/ Industrial sectors.
12	Redesigned patient pathways **improve the patient experience** and **clinical outcomes** and provide	Reducing the cost of treatment by providing it as daycase/outpatient and therefore reducing bed	Staffing cost savings identified and included in the proposed staffing model(s).

#	Benefit	Financial Benefit	Financial Measurement for inclusion in Economic Case
	unique opportunities for science and bench to bedside medicine.	occupancy. See items above for other financial benefits associated with improved patient experience and outcomes.	See items above for measurement of benefits associated with improved patient experience and outcomes.
13	Ability to use **data driven innovation** to improve patient experience and outcomes through a more linked up data driven service model and provide **innovative business development opportunities**	Reducing the cost of treatment through relying on better data to support more efficient pathways. See items above for other financial benefits associated with improved patient experience and outcomes.	Staffing/ non-pays cost savings identified and included in the proposed staffing model(s). See items above for measurement of benefits associated with improved patient experience and outcomes.

The benefit work outlines above have led to the development of a benefits register which is included in Appendix 2.

2.5.3 Benefits Next Steps

The above sections detail the key benefits that could be derived from the redevelopment of the Edinburgh Cancer Centre both internally to NHS Lothian and to support growth in a socially inclusive net zero economy.

This work will be further developed through the OBC using a collaborative process working with stakeholders to refresh the benefits in light of the changing healthcare, economic and policy environment and in the context of the development of the preferred option.

Key next steps will include

- Quantification of financial benefits and inclusion within the financial options appraisal
- Quantification or qualitative assessment of benefits to confirm measurement techniques and baseline values.
- Weighting and scoring of benefits as part of the options appraisal process

The development of a means by which to measure socially inclusive net zero economic benefits and incorporate these into business cases is in its infancy and therefore we will continue to engage and work with the Scottish Government and Health Facilities Scotland (HFS) to develop a consistent process for application across all NHS Lothian business cases.

2.6 Strategic Risks

To identify and understand some of the key risks which could affect the investment proposal, a Stakeholder Risk Workshop was undertaken on 12 August 2019.

The workshop facilitated the development of an initial Risk Register which is located at Appendix 3. Key strategic risks emerging that may undermine the realisation of benefits and the achievement of the investment objectives are summarised below.

These are described thematically alongside potential safeguards and actions in place to mitigate against these:

Table 27: Key Risks

Theme	Risk	Safeguard
Workforce	Availability of workforce across various professional groups and distributed across the South East region.	Clearly outline the workforce required identifying current challenges and considering sustainability of current services across the South East region. Review skill mix and staff roles to adapt to known workforce shortages. Develop a comprehensive risk assessed workforce plan for the South East Region as part of Full Business Case.
	Potential issues with training pipeline (e.g. increased places required and timeframe for achieving desired staffing levels)	Provide staff training and education for the region to focus on workforce development and role redesign.
	Risk that attractive jobs in new Edinburgh cancer Centre have the potential to de-stabilise services elsewhere in the SCAN Region (and potentially across Scotland)	Provide employment opportunities across the region - provide services closer to home Plan recruitment on local, regional, national and international levels so as to minimise de-stabilisation.
Funding	Capital funding not approved by SG	Initial Agreement clearly articulating the wide reaching benefits of a world class cancer facility in Edinburgh. Transformed ways of working to show best use of public monies.
	Revenue funding not approved by	Transformed services based on most efficient use of workforce

Theme	Risk	Safeguard
	NHS Lothian and Regional Partners Reduced funding in the Third Sector impacting on delivery of patient holistic approach	to demonstrate value for money – affordability a key consideration. Continue to develop relationships with Third Sector partners to understand financial constraints as proposal develops.
Capacity	Rapidly growing and ageing population, increase in cancer incidence and increase in treatment options exacerbating service pressures	Robust data analysis undertaken to project future demand. Accommodation designed flexibility that can adapt to changing patient needs.
Regional Commitment	Regions not in agreement with the preferred option or unable to quantify their future requirements impacting upon the scope and success of a regional service delivery model	Continuous dialogue with the regions to ensure full discussion of the plans proposed and alignment with individual Boards strategic vision. Develop collaborative service models to enable patient access to high quality care across the region
Capital Projects	Lessons from other Capital Projects not considered at appropriate stage in the process	Process being reviewed through LCIG and implemented across projects going forward to ensure lessons are learned from other recent capital projects

The risk register will be updated for the project at OBC stage.

2.7 Constraints and Dependencies

There are a number of constraints on both the delivery of the clinical model and delivery of the programme.

The key constraints to be considered are:

- **Financial** - Availability of sufficient capital, revenue and Third Sector funding to deliver the transformed vision.
- **Timeframe for proposal** – Delivery within a reasonable timeframe is essential to ensure that the need for change and associated benefits are realised whilst mitigating ongoing risks connected with service delivery within existing infrastructure as demand for services continues to grow.
- **Regional Collaboration** - To enable the likely preferred option to be delivered, collaborative Regional working will be required to agree on service requirements and delivery.
- **Regional Workforce Availability** – Availability of specialist staff across the region and all of the services that contribute to the cancer patients pathway will be required. Development of robust workforce plans is essential to ensure robust and sustainable services can be provided across the South East Region.
- **Quality** – Quality constraints and expectations will be referenced within the project's Clinical and Technical briefs which will be developed upon approval of this IA but in advance of any design activity taking place. Importantly the technical brief will make it clear that all current and appropriate healthcare guidance should be followed unless specific derogations are proposed and signed-off by the Project Board. The project will also be subject to independent gateway reviews where recommendations and instructions will be issued helping to manage and control the process and eventual outcome.
- **Briefing** – as described under 'quality' above, the project will develop clear Clinical and Technical briefing – once complete and endorsed by the Project Board, the briefing will help to control development of the project within agreed parameters.
- **Sustainability** – Sustainability criteria for the project has yet to be established, however this will be developed and confirmed within the Technical Brief. Given current policy, it is likely that the project will require to demonstrate net zero carbon credentials.
- **Site** – The preferred option is likely to involve significant works at the WGH. Given that the WGH is a live site, there will be multiple site constraints affecting safe delivery of the project together with operational continuity of the site. In addition, given the congested nature of the site and the agreed WGH master-plan framework, the facilities will be constrained in respect to agreed development zones.
- **Procurement** – given the size and complexity of the project, possible procurement options are likely to be constrained. Procurement options are outlined within the Commercial Case (refer to Section 4).
- **Statutory** – The project will be subject to statutory consents (planning and building warrant).
- **Governance** – The project will be subject to internal and external governance monitoring and approvals. Refer to the Management Case (Section 6) for further details in respect to project governance.

The key dependencies to be considered are:

- **Site -** the WGH site is currently a congested site following years of reactive development. To unlock the masterplan framework a significant area of the site (Department of Clinical Neurosciences) requires to be cleared following the service move to Little France (In July 2020). As part of the site clearance, quite significant service diversions are envisaged. In addition, other parties (Edinburgh University) and services require to be decanted to alternate accommodation to unlock the site. In summary, all new-build options under consideration at the WGH are likely to involve a series of enabling works to generate a suitable site for development.

- **Other WGH projects** – the project will be dependant upon other relevant ongoing projects at the WGH. A key dependency is the WGH Energy Infrastructure Project which will rationalise the primary infrastructure on the site, improving energy efficiency and future flexibility to support the master-plan framework. With the Cancer Centre potentially being the first significant development on the site, it will be important to ensure that the WGH Energy Infrastructure Project is able to support this major development in respect to capacity of supplies and primary service nodes/connection points. In tandem with the Energy Infrastructure improvements, there will also be associated non energy infrastucture works associated with the projects / phases planned for the wider site development.
- **Regional Agreement**– the preferred option will involve a review of the South East Region Service model. Any changes will be agreed through regional collaboration however these will be dependent upon the availability of specialist workforce required to provide a robust sustainable service and potentially investment in infrastructure within NHS Fife,NHS Borders and NHS Dumfries and Galloway.
- **Enhanced Options** – the Economic Case considers enhanced options where in addition to core cancer services, services serving the cancer centre,wider Western General Hospital site and South East region are included within the scope. It is anticipated that some of the site wide services may require to be delivered in advance, in parallel or after the core cancer centre to protect operational continuity and adjacencies. Further work will be required to map out these dependencies in greater detail for inclusion in the OBC.
- **Other Clinical Services** – the success of the proposed clinical model is dependent on the Western General Hospital remaining a viable 'hot' site (full list of services available at Table 32)with sustainable services to support Specialist Cancer Care and other services on the WGH site including Critical Care capacity, Pharmacy (inc Radiopharmacy), Laboratories, Radiology and Nuclear Medicine Physics.These services have been described as Essential Services in s3.3.3.

3 The Economic Case

This section will identify the preferred strategic and service solutions suitable for further assessment at Outline Business Case stage.

3.1 Do minimum/baseline

The table below summarises the baseline option which is fully detailed in the strategic case section 'existing arrangements' above.

A do minimum option has been included as a baseline, as opposed to a do nothing option, due to the ongoing capital projects in the existing Edinburgh Cancer Centre agreed by Scottish Government to address immediate capacity and clinical safety issues. These are the Oncology Enabling Project (Full Business Case awaiting approval), Haematology Project (under construction) and Clinical Trials Project (under construction). Further details of these are included in the Strategic Case.

Table 28: Do minimum/ baseline

Strategic Scope of Option	Do Minimum
Service provision	Cancer Services remain in existing accommodation with upgrade work completed (Oncology Enabling, Haematology and Clinical Trials Projects). Service provision remains as described in the existing arrangements.
Service arrangements	The enabling works consisting of the below are completed: • Refurbishment of Oncology Inpatient Wards 2 and 4 • Relocation of Cancer Assessment Unit • Expansion of Pharmacy in Ward 1 • New build Linac bunkers and Admin block Plus: • Haematology refurbishment of Ward 8 and 8 Unit • Relocation of Clinical Trials office and expansion of trials footprint The service model continues in the improved environment as described in the existing arrangements.
Service provider and workforce arrangements	Existing workforce will be used to deliver the service as detailed in the strategic case.
Supporting assets	Existing buildings and equipment at WGH will be used to deliver the service with noted issues as described in the strategic case.
Public & service user expectations	This work requires the Scottish Government to agree derogations (opt outs) from current applicable clinical standards that will not be met within the scope of this option. The capital projects presently underway provide significant improvements to the physical environment for delivery of services in the medium term, however full transformational redesign and delivery of cutting edge research and innovation are not possible within the 'do minimum' footprint.

3.2 Engagement with Stakeholders

This section provides details of the stakeholder engagement that has taken place confirming support for the proposal. Engagement events consisted of:

- Clinical Workshops
- Experience Based Co-Design (EBCD) (subsequently revisited in 2020)
- Place Brief
- Branding
- Options Assessment
- Design Statement
- Integrated Impact Assessment (IIA)
- Regional Engagement
- Engagement with Young People
- Third Sector Engagement

A full list of stakeholders is available in Appendix 4.

3.2.1 Engagement Process

The Scottish Government Health Directorate guidance, CEL 4 (2010) *'Informing, Engaging and Consulting People in Developing Health and Community Care Services'* provides a step-by-step guide through the process of informing, engaging and consulting with the public in service change proposals.

It specifies that the public involvement process should be applied in a realistic, manageable and proportionate way to any service development or change and recommends regular communication with stakeholders. It also defines the role of the Scottish Health Council in ensuring NHS Boards meet their patient focus and public involvement responsibilities whilst supporting them in doing so.

The NHS Lothian Quality Strategy 2018 – 2023 states a commitment to provide a greater focus on patient and population needs and wishes in improvement work, and to understand what matters to NHS Lothian staff.

In order to meet all of these obligations, in 2018 NHS Lothian employed a Public Involvement and Engagement Manager to support various streams of work with development of a new Cancer Centre being one of the key priorities.

Initial contact was made with the Scottish Health Council in August 2018 which included discussion of the approach to involving, engaging and consulting with stakeholders throughout the process of Business Case development, beginning with engagement at the earliest possible stage as the Initial Agreement (IA) is developed.

The stakeholder engagement process for the Edinburgh Cancer Centre proposal is described below.

3.2.1.1 Clinical Workshops

A Clinical Model to underpin the development of a new Cancer Centre was developed through a series of clinical workshops held in October 2018.

Workshops were held for each of the following areas which facilitated meaningful discussion and input from a wide range of stakeholders;

- Radiotherapy
- Inpatient and Cancer Assessment Unit
- Breast Services
- Outpatient and Daycase
- Haematology
- Clinical Trials

During these events, representatives from Regional Boards (NHS Borders and NHS Fife) worked alongside NHS Lothian service teams including Consultants, nursing staff, AHPs and service management to design a proposed Clinical Service Model.

Discussion focused around the 'fork in the road' strategic questions/decisions that the group felt should be considered for inclusion within the IA. The workshops also generated a list of '*Principles, Dependencies and Assumptions*' - critical elements which will underpin the proposal for a new Cancer Centre.

The Clinical Model was discussed and agreed initially by the Cancer Clinical Management Team (CMT) then by the Cancer Capital Programme Board (CCPB) in December 2019. This was reviewed in January 2020 by the various clinical and management groups listed above to ensure accuracy and continued support.

The proposed Clinical Model and '*Principles, Dependencies and Assumptions*' are included in Section 3.3 below.

3.2.1.2 Experience Based Co-Design (EBCD)

Alongside the clinical sessions, in October 2018, a comprehensive programme of wider stakeholder engagement began based on an adapted model of Experience Based Co-Design (EBCD) https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/

The use of this model is approved and encouraged by Healthcare Improvement Scotland as an effective means of ensuring that patients and staff can influence decisions throughout the design process.

The EBCD process follows the principles of '*What matters to you?*' and ensures a clear focus on relevant patient and staff experience.

The first stage of the process involved patients and frontline staff being interviewed about what they like/would keep and would change about the current cancer services. The themes from these interviews were collected together in video format to become the starting point for discussions on future design principles for the new cancer centre.

The video was shown to staff and patients during phase two, an Experience Based Co-Design Workshop in January 2019. This workshop brought together patients, carers, charity representatives and staff (including representation from the Regional Boards) to look more closely at the emerging themes and work on common principles of design to be incorporated into the development of the new centre.

The video has provided helpful insights into how patients experience services and how their future experience could be improved and can be seen here:

- https://vimeo.com/318729227
- Password: CodesignECC

Key themes emerging from the interviews were:

- Access
- Holistic Wellbeing
- Design Improvements
- Futureproofing

These provided a starting point for discussions on future design principles for the new cancer centre which were further developed at a second Experience Based Co-Design workshop in March 2019.

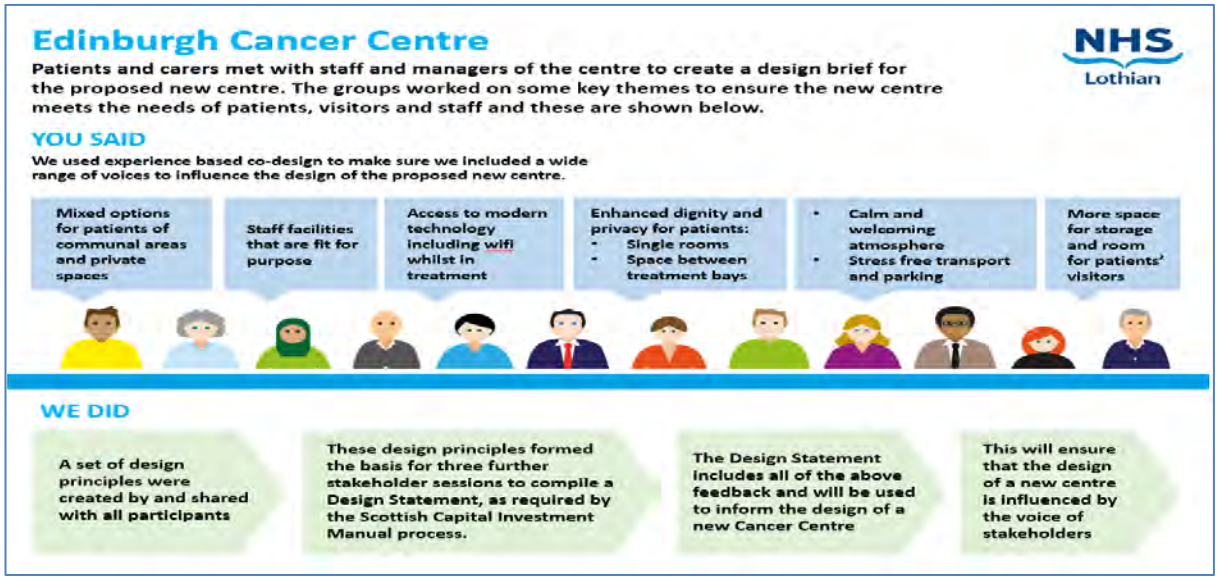
The second workshop was attended by patients, carers, charity representatives and staff (including representatives from the Regional Boards) as well as an advisor from the Scottish Health Council (SHC).

The workshop included an explanation and discussion of the proposed Cancer Centre Clinical model and an opportunity for non-clinical stakeholders to have their views included. The representative from the Scottish Health Council provided feedback that it '*was a useful opportunity for people to be introduced to the complexities of the different services that are delivered as part of the cancer treatment centre'* and that *'people were encouraged to contribute to the discussions and ideas and thoughts that were shared or discussed were noted'*.

Discussion in the workshop then focused around further developing the themes identified above into design principles. These are available as Appendix 5, the Scottish Capital Investment Manual (SCIM) Design Statement is available upon request.

The graphic below captures the general themes which emerged from the engagement work and describes how NHS Lothian are responding to these:

Figure 16: Engagement Process Outcomes



The work of the co-design groups provided key discussion points for the Achieving Excellence Design Evaluation Toolkit (AEDET) and NHS Scotland Design Assessment Process (NDAP) processes which began with a workshop in June 2019 and will be integral to the wider design process.

As the business case progresses and models of care for the new cancer centre become fully defined, key stakeholders will be invited to participate again in more specific discussions around how services will be delivered.

3.2.1.3 Place Brief

The 'Place Brief' forms part of the council planning process. Drop-in events for patients, staff and members of the public were held in November 2018 and were attended by a total of 136 people.

The events provided a display showing the high level strategy for the Western General Hospital site giving people the chance to share their views and ideas on how the site should develop in the future, help shape plans for the site and have their say on what the hospital should look and feel like.

Surveys were also distributed which asked specific questions on the layout of the Western General Hospital site. 159 of these were completed and views were also given through social media using the hashtag #MySayWGH

Alongside ensuring engagement with patients, staff and the community during early planning stages, the process should help to facilitate timely planning approval for each development on site in alignment with the site masterplan.

3.2.1.4 Branding

NHS Lothian's Strategic Planning Committee (SPC) endorsed the development of a branding exercise for the Cancer Centre on 12 October 2017. This was in recognition that there are lessons to be learned in this area from other Cancer Centres and opportunities to coordinate effectively with the Edinburgh & Lothian Health Foundation (ELHF) as a fundraising partner.

The continuing evolution of the Edinburgh Cancer Centre throughout the enabling works as well as the plan for redevelopment and re-provision of the cancer centre are fundamental changes that necessitate a review of 'brand identity' in order to ensure that 'the brand' appropriately represents the evolving centre and resonates with its growing catchment population.

Brand Agency Morton Ward were appointed through Procurement Contracts Scotland in December 2018 and from January to March 2019,stakeholders were consulted on the brand for the new Cancer Centre including a name and graphic design upon which the brand will be based.

The first stage of the Morton Ward proposal included a 'Discovery' element comprising of a brand review, research, stakeholder engagement, positioning strategy, naming and creative brief.

Activities related to this included a:

1) Branding Inception workshop held on 17th January 2019
2) Range of one to one stakeholder interviews
3) Discussion of name options with several,small focus groups to gauge opinion

Initial activities allowed information gathering and input from a wide range of stakeholders in order to direct the team towards a series of options for a name. This list was subsequently reduced to three shortlisted names through discussion with smaller focus groups then wider discussion with Oncology Clinicians resulted in the addition of a fourth name option.

Brand Identity Concepts were developed for these four proposed names which were presented to the Cancer Capital Programme Board in March 2019 and were subsequently tested by the following groups:

- Patient cohort - patients who were involved in the EBCD process;
- Regional patients contacted by SCAN public involvement managers;
- Staff cohort including regional NHS staff;
- Cancer CMT;
- WGH Hospital Management Group

Following feedback, 'Edinburgh Cancer Centre' was confirmed as the preferred name.This name was then attached to four graphic design evolutions which were distributed to the same stakeholder groups for further feedback.

The final result of this process is below:

Figure 17: Edinburgh Cancer Centre Graphic Design

It is envisaged that both the name and graphic design will be used across the SCAN Region as a marker of high quality patient service and experience which, as the brand is developed, patients and the public will become more familiar with.

3.2.1.5 Options Assessment

A workshop to appraise the potential options identified for the implementation of a new proposed Clinical Model for Cancer Services in support of the Initial Agreement for the new Cancer Centre was held in April 2019.

Options were assessed at a high level in line with Scottish Government Capital Investment Manual (SCIM) guidance relevant to this Initial Agreement (IA) stage of the business case process.

During this workshop it was emphasised that the assessment was of the Clinical Model of Care and how it could be delivered - not on the specifics of a building design.

This event was well attended by 55 stakeholders including patients, staff, charity representatives, clinicians and managers from across NHS Lothian and the Regional Boards.

The session began with a presentation on Session Objectives and explanation of the current situation and need for change. Following a summary of the proposed Cancer Centre Clinical model, the six potential options were described with a Strengths, Weakness, Opportunities and Threats analysis which was discussed in detail and added to by participants.

The Investment Objectives were described to the group and discussed before each group was asked to assess the options against these objectives and provide a consensus.

A summary of this event is available at Appendix 6 with a full report of the Options Assessment Workshop available upon request. The IA outlines the short listed options and preferred way forward as scored by this group of key stakeholders.

3.2.1.6 Integrated Impact Assessment (IIA)

It is vital in developing any proposal to understand how the needs of different groups in the population may differ. Assessing impact is an important part of NHS Lothian's decision making process and the IIA is a mechanism which enables the needs of different groups to be considered.

An Integrated Impact Assessment (IIA) stakeholder event in relation to the Edinburgh Cancer Centre Capital Redevelopment was held on 28th November 2019.

NHS Lothian is committed to 3 core objectives in relation to equality and rights:

- To plan services and policies which promote equality of opportunity; eliminate discrimination and harassment; and promote good relations between those with protected characteristics and those with none.
- To address broader inequalities. This means we want to ensure that policies meet the needs of all people including children and young people , especially those from population groups that are known to have poorer outcomes.
- To identify and address wider impacts on poverty, health and health inequalities in our policies, plans and strategies. For example employment, education, transport, the built environment, purchasing policies, public safety, waste disposal all have wider impacts on people's health, wellbeing and life experience.

The session consisted of detailed discussion amongst the stakeholder group to critically consider the possible impacts (both positive and negative)of the Cancer Centre Re-provision on different groups within the community. Following this, the group discussed and agreed a summary of the impacts identified and made some recommendations to be included within a detailed action plan and built into the implementation of the proposal.

The action plan is available at Appendix 7.

Further IIA events will take place as the Business Case progresses and service models are more clearly defined to ensure the needs of different population groups are addressed.

3.2.1.7 Regional Engagement

At the infancy of the engagement process, NHS Lothian made a pledge to our regional partners that we would work alongside them to ensure that there was effective communication and two-way dialogue as this IA is developed.

The level of engagement to date gives assurance that this proposal accurately articulates an agreed strategic regional position on the future of cancer service provision for the patients of South East Scotland. The detail and implementation of a future regional service delivery model will be developed jointly as the proposal progresses to OBC.

Early meetings were held with all of the Regional Health Boards to agree specified Key Principles which underpin the content of the Cancer Centre proposal. It was discussed and agreed at these meetings that equity of service across the region was of utmost importance to ensure a consistent, high quality patient experience.

A robust and interactive communication process has been vital in ensuring that the views of all of Regional Boards have been considered and included. It was requested from an early stage that the representatives from each Board took responsibility for communication and dissemination of this proposal to key colleagues within their individual Boards to ensure that feedback from a wide range of stakeholders could be incorporated at the right stage in the process and ensure that key colleagues at all appropriate levels of their organisation were suitably engaged in the process.

As the proposal continues to develop, the views of stakeholders across Lothian and the SCAN Region will continue to be sought in order to influence and support the development of the proposal.

3.2.1.8 Engagement with Young People

This proposal has been discussed with the NHS Lothian Young People's Panel as part of the engagement process. The word cloud below summarises how they would like to feel on arrival at the cancer centre.

Figure 18: NHS Lothian Young People's Panel

Many of these aspirations ar shared by the wider patient stakeholder group and will be taken into consideration as the building design progresses.

3.2.1.9 Third Sector Engagement

Re-provision of the Edinburgh Cancer Centre is an opportunity to deliver services with a patient focused, holistic approach and to meet the aspiration of the refreshed Scottish Government Cancer Strategy ' *Beating Cancer:Ambition and Action (2016)*'[15] around '*best care and support for all people with and beyond cancer*'[16].

There are a wide range of Third Sector partners who currently provide vital support services for cancer patients.It is the ambition of the proposal that this support is strengthened in order to provide a holistic patient experience.

NHS Lothian Third Sector Voluntary Services is currently undertaking a mapping exercise of 3rd sector service provision to cancer patients across the South East Region.The outputs of this exercise will be used to engage with Third Sector Partners (existing and potential future) to plan a regionally co-ordinated approach to Third Sector service provision with the overall aim of enhancing the patient experience.

This work will be further developed and the outcomes articulated as part of the OBC.

3.2.1.10 Experience Based Co-Design (EBCD) Revisited

Almost two years following the start of the initial EBCD stakeholder engagement process, we sought additional patient views as an assurance that the key themes identified at the start of the process remain valid.

We asked '*What could be done to improve/make a difference to your experience within Cancer Services'*, and patients responded with;

[15] Refreshed in April 2020: An update: achievements, new action and testing change
[16] Beating Cancer:Ambition and Action (2016), refreshed in April 2020 p.13

- *Purpose built space, fresh, clean environment*
- *Variety of seating areas*
- *Building facade being important*

- *How the building looks and feels instils confidence and makes you feel more relaxed*
- *Good signposting – bad signposting adds to patient stress levels*
- *Waiting areas/spaces. Having the option to sit in area where more private/quiet or be social with other patients*

This feedback re-affirms the themes as captured within the Design Statement, that this proposal will seek to address, and provides reassurance that what matters to cancer patients has not changed since the earlier engagement work.

3.2.2 Summary of Engagement with Stakeholders

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

Table 29: Summary of Engagement with Stakeholders

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
Patients/ Service users	Patients and service users affected by this proposal include current and previous cancer patients. Their involvement has included participation in the EBCD process, Branding Consultation, Options Assessment, Design Statement and IIA. Their input has influenced the proposal's development in various ways as described in the narrative above.	Feedback has been incorporated into the final version of this document and into the overall proposal for the Cancer Centre through incorporation into the proposed Clinical Model and the Design Statement.
General Public	The general public will be affected by this proposal by the proposed change in service configuration on the Western General Hospital site. This has required public consultation events in the form of the Place Brief as described in the narrative above.	Outcomes from the Place Brief event have been incorporated into the future vision for the Western General Hospital site overall. This will be demonstrated at OBC stage through the output of an exemplar design for a new cancer facility. The level of support from the general public for this proposal is positive and is demonstrated through feedback from patients in the EBCD video and during the Options Assessment event.
Staff	Staff affected by this proposal include Cancer Centre staff and staff across the WGH site and Region including but not limited to Pharmacists, AHPs, Critical Care staff, Imaging and Labs staff. Their involvement in its development includes consultation and discussion on what the requirements are for their services are to support a new Cancer centre as well as continuing to support other specialties across the WGH site and Region. Increasing population and cancer incidence is likely to put additional	Feedback from these 'Essential Services' , adjacencies and support functions has been incorporated into the final version of this document in the 'Essential Services' section and into the overall proposal for the Cancer Centre through incorporation into the proposed Clinical Model and adjacencies noted within the Schedule of Accommodation to be incorporated into the final design.Continued close engagement with Regional Boards will ensure close alignment with local Boards workforce

Stakeholder Group	Engagement that has taken place	Confirmed support for the proposal
	pressure on their services for the future.	planning.
Regional Stakeholders	Regional patients, service users and staff affected by this proposal include current and future cancer patients and staff from across NHS Borders and NHS Fife. Involvement has included participation in the Clinical Workshops, EBCD process, Branding Consultation, Options Assessment, Design Statement and IIA. Their input has impacted the proposal's development in various ways as described in the narrative above.	Feedback has been incorporated into the final version of this document and into the overall proposal for the Cancer Centre through incorporation into the proposed Clinical Model and the Design Statement. Continued close engagement with Regional Boards will ensure close alignment with local Boards workforce planning.
University of Edinburgh & Cancer Research UK (CRUK) Governance Board	This proposal was presented to CRUK Governance Board 18 months ago with University, Academic and patient representatives in attendance. Comments were provided regarding the need to develop greater strategic alignment between the NHS and University at the WGH and Edinburgh Bioquarter and the development of a strong complimentary partnership between Edinburgh and Glasgow's NHS and academic institutions and industry.	Support has been formalised through the creation of a joint management post to support greater integration, strategic alignment, and through academic representation on the Cancer Capital Programme Board. Feedback has been incorporated into the final version of this document and integrated service model.
Third Sector	Third sector involvement to date has included participation in the Branding Consultation, Options Assessment, Design Statement and IIA. The undertaking of a regional Third Sector audit will inform the next steps of engagement with these stakeholders.	Feedback has been incorporated into the final version of this document and into the overall proposal for the Cancer Centre. Continued close engagement with Third Sector partners is vital as the proposal develops.
Healthcare Improvement Scotland (HIS) – Community Engagement (Formerly Scottish Health Council)	Representatives have been involved from the beginning of this programme. As well as attendance at workshops, regular meetings have been held to discuss best practice for engagement and next steps as the proposal has progressed.	A letter received on 28th August 2020 provides confirmation on the view of HIS that this proposal does not meet the threshold for 'major service change'. It also confirms that HIS consider the approach to engagement to be proportionate.

3.3 Service Change Proposals

As detailed in the 'Engagement with Stakeholders' section above In October 2018 a series of workshops were held to look at clinical service model delivery.

Following the workshops a list of '*Principles, Assumptions and Dependencies*' was produced. These have been discussed and ratified by a variety of key stakeholders and subsequently been used to generate a long list of options for cancer centre re-provision. These principles and assumptions are detailed below.

Table 30: Principles, Assumptions and Dependencies

Guiding Principles
All key partners will develop strategies throughout the life cycle of this programme that support delivery of the vision
As a world class centre, a range of specialist cancer therapies will be delivered
Care should be delivered closer to home wherever clinically appropriate and financially viable
Patient experience, service model and quality of care should be consistent across all regional centres delivering cancer services
There will be a patient focused/ holistic approach to the design of a transformed regional service
Service and building designs will optimise efficiencies and new technologies
The service design will be aligned with SG national cancer strategies
We will lead innovation ensuring Cancer Research is integral to core services across the region
We will learn lessons from similar developments in the UK and beyond to ensure that the above vision can be realised
Assumptions
Workforce challenges will continue across the UK in line with the present position. The workforce plan must be bold and ambitious offering rewarding and well supported careers to support service delivery across the region
Demand for Cancer Services will continue to grow at current rates– anything built must be future proofed
There will be no structural changes to SCAN Regional Health Economy
All necessary supporting infrastructure will be effectively planned and in place within planning time horizon
Subject specific expertise will inform the future service model based on reasoned assumptions and horizon scanning
Essential state of the art equipment and co-dependent services necessary to support regional treatment delivery will be available on WGH site and/or in the partner boards

The WGH will remain a 'hot site' with a fully viable ITU

Patients requiring advanced therapeutics will be cared for in a cellular therapies unit which will include capacity for Early Phase Trials

The design of all services will be evidence based, data driven and linked to measurable outcomes

Based on the 'Principles, Assumptions and Dependencies' a proposed clinical model was developed. This has also been discussed and ratified by a variety of key stakeholders as included in the 'Engagement with Stakeholders' section (s3.2).

3.3.1 Proposed Clinical Model

This is a South East Scotland Development hosted and led by NHS Lothian on behalf of the SCAN region. The key principles of Person Centred, Safe, Effective Quality of Care, Value and Sustainability have been considered throughout.

Re-provision of the Edinburgh Cancer Centre is an opportunity to transform the way cancer services are delivered and to transform patient pathways. It is also an opportunity to deliver improved services with a patient focused, holistic approach.

The opportunities for improvement are in the transformational re-design of services resulting in optimum patient experience and outcomes,improved efficiency of service and better staff experience while realising economic and financial benefits as described in previous sections.

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 service and research infrastructure and workforce are already in place.

The Proposed Clinical Model High Level Diagram can be found at Appendix 8 and the essential components of this Clinical Model which will be delivered on the WGH campus are detailed in the table below.

The detailed development of the current Schedule of Accommodation began in May 2019 and is based on the available service data which has been reviewed and supported by the clinical team. It also encompasses work done in developing clinical briefs for the Oncology Enabling and Haematology projects to inform numbers of clinical treatment areas and consequently provide an estimate of square footage which in turn informs the estimated capital cost range.

A descriptor of this process alongside area sizes and a summary of the Primary Clinical Delivery Areas by scheduled zone and room type can be found in Appendix 9.

As the Outline Business Case develops,options for outreach models of care will be developed and agreed in collaboration with regional partners.

Table 31: Proposed Clinical Model

Critical Care

- Capacity in appropriate facilities for Level 2 High Dependency and for Level 3 Critical Care Breast Surgery/Haematology/Oncology patients (including capacity for patients being treated by licensed and investigational advanced therapeutic medicinal products)

Inpatient

- Cellular Therapies Unit (Level 1 and 2)
- Clinical Trials Inpatient beds (Level 0 and 1)
- Acute Oncology Inpatient beds (Level 0 and 1)
- Breast Surgical Inpatient beds (Level 0 and 1)
- Acute Haematology Inpatient beds (Level 0 and 1)
- Teenage and Young Adult Inpatient beds

Daycase

- Breast Daybed Unit
- Extended Hours Oncology Daycase SACT Unit
- Extended Hours Haematology Daycase Unit
- Teenage and Young Adult Services
- Clinical Research and Trials Facilities

Outpatient Department

Supportive Therapies Facilities

Theatres

- For Breast Surgery and Brachytherapy

Breast Screening and Breast Radiology Facilities

Emergency Village

- Cancer Assessment Unit (trolleys and short stay)
- Acute Oncology Outreach Service
- Enhanced Supportive Care Clinic
- Cancer Treatment Helpline/Booking Hub

Radiotherapy Department

Clinical Pharmacy

Multi-disciplinary Hospital Specialist Palliative Care Support (HSPCS)

Office Accommodation

Staff Facilities

Patient and Staff Wellness Centre

Patient Accommodation and Transport Hub

3.3.1.1 Critical Care Capacity

Requirement: Level 3 ITU and Level 2 HDU capacity for Haematology/Oncology/Breast Surgery patients integrated with WGH critical care and high dependency provision (including capacity for patients being treated by licensed and investigational advanced therapeutic medicinal products).

Over the next few years, a predicted increase in Advanced Therapeutics such as CAR-T (and potentially others) in Cancer services means the number of Level 3 and 2 beds required by Haematology and Oncology patients is likely to increase, over and above that already provided by the existing Stem Cell Transplant, High Dependency and Critical Care Facilities.

The opportunity to re-provide a Critical Care facility of the highest standard on the Western General Hospital site would continue to support the growing needs of all services on the site and will be designed with enough capacity to accommodate the predicted increase in Cancer services patients who require care in a high dependency unit.

Data produced during the Western General Hospital Dependency Audit (May-June 2018) will be factored into the review of future high dependency capacity requirements for Cancer Services.

Discussions with the NHS Lothian Critical Care Team regarding how best to provide a critical care facility on site generated the list below of needs that must be met:

- The need to ensure patients requiring multi-organ support and specialist care are cared for by appropriately experienced staff. It was agreed that this should remain the remit of Intensivists and critical care experienced nursing staff. Given the national shortfalls of critical care medical and nursing staff, it is important that the critical mass is retained in a single service.
- High Dependency (HDU) facilities suitable to the provision of Stem Cell Transplant services and Advanced Cellular Therapeutics (including patients with single organ bone marrow failure), should be managed by specialty services, as at present, with access to Level 2/3 Critical Care remaining adjacent and on site.
- Location of Intensive Treatment Unit (ITU)/High Dependency Unit (HDU) facilities will remain in a central location on the WGH campus. All relevant adjacencies will be taken into consideration at the planning stage.

Some upgrade work is planned to the current ITU/HDU facilities on the Western General Hospital site which will happen in the short term,to be completed in 2021/22 at the earliest.

Any further re-provision of facilities as part of the Cancer Centre programme of work will be consulted upon with relevant teams as the business case progresses.

3.3.1.2 Adult Inpatient Beds

Requirement: Inpatient beds for those requiring specialist oncology care. Regional patients, will continue to be repatriated back to their regional hospitals as per current practice when they no longer require specialist oncology care.

- Cellular Therapies Unit (Level 1 and 2)
- Clinical Trials Inpatient beds (Level 0 and 1)
- Acute Oncology Inpatient beds (Level 0 and 1)
- Breast Surgical Inpatient beds (Level 0 and 1)
- Acute Haematology Inpatient beds (Level 0 and 1)
- Teenage and Young Adult Inpatient beds

Adult inpatient beds will be managed as follows:

- Admissions beds for the care of patients within the first 24-48 hours in a Cancer Assessment Unit (CAU)
- Step Up (Level 1) beds for the care of the more acutely unwell patients or those at risk of rapid deterioration

- General oncology beds for the care of the remainder of the patients
- The allocation of inpatient beds will focus on the admission of only those patients who cannot safely be managed in an outpatient setting and whose care needs can only be met in the Edinburgh Cancer Centre rather than their general local acute hospital – this may include some provision for inpatient SACT delivery.
- Breast Services inpatient beds for elective and emergency admissions (these will be reduced in number from the current complement and will be co-located within an inpatient ward area to ensure a viable footprint)
- Specific provision for Early Phase Clinical Trials unit for low risk trials patients (inpatient capacity for higher risk clinical trial patients (such as those pursuing Advanced Cellular Therapeutics trials) will be provided in the WGH site ITU/HDU facility.
- Specific provision for teenagers and young adults (aged 16-24)
- Cellular Therapies Unit to reprovide the existing Stem Cell unit with additional capacity to meet the growing demand for cellular therapies for cancer trials and within core services in Haematology, Oncology, Neurology and other specialities.It is proposed that this facility be led by Haematology but serve multiple specialties as all patient receiving cellular therapies will require access to a core specialist skill set and standard of facilities.The additional capacity to be built into this unit will be scoped and agreed at OBC stage following national planning discussions.

3.3.1.3 Breast Services

Daycase Unit

Requirement: **Adequate daycase footprint to allow for increased capacity and an improved workflow model, resulting in:**

- Improved privacy for patients
- Surgical teaching opportunities for clinicians and other health professional students
- Adequate accommodation for patient flow (pre-op and pre-discharge areas)
- Time efficiency for medical staff
- Minimisation of inpatient stays

With an adequate footprint to accommodate demand, staffing hours and numbers could be increased to allow patients to receive follow-up care as an Outpatient rather than an Inpatient, improving patient experience and reducing inpatient demand.

Outpatient Clinic space in close proximity to breast imaging facilities would allow growth in the one stop model already in operation within the current Cancer Centre and available as an outreach service for patients closer to Livingston at St John's Hospital. This is the preferred patient model which is dependent upon surgeon and radiologist job planning to ensure clinics are sustainable.

Theatres

Requirement: Dedicated theatres for Breast surgery (for cancer and non-cancer breast surgery cases only, with plastics support when required) and Brachytherapy co-located with the Breast IP ward, Daycase Unit. Breast OPD and Mammography would allow:

- High case throughput – increase in capacity for breast surgery
- Efficient use of multi-disciplinary staff
- Increased time efficiency

Theatres are currently shared by breast surgery, melanoma and plastics specialties and accessed by Gynae-oncology and Genitourinary-oncology brachytherapy. Repatriation of melanoma and plastics surgery (excluding joint cases) would also improve continuity and the patient pathways for these patients. Discussions are underway regarding these proposed changes.

Breast surgery is the only surgical service which is located within the current footprint of the Cancer Centre and is managed by the Cancer Services management team.It is envisaged that this arrangement will continue and therefore breast surgery is included as part of the Clinical Model.

Co-located Breast Screening/Symptomatic

Requirement: Relocation of the existing Ardmillan Screening Service to a site adjacent to the Symptomatic Breast Service on the Western General Hospital site would allow efficiencies to be gained from single site working including;

- Streamlined patient pathway with potential to reduce time to diagnosis and improve waiting times, improved patient flow with reduction in appointments for surgical treatment
- Potential to further develop the rapid reporting diagnostic service
- Combined staffing model with no travel between sites and flexible cover during periods of leave
- Simpler transfer of patient information between services, improved clinical communication and data collection
- More efficient Multi Disciplinary Meeting process
- Cross cover of equipment at times of breakdown or downtime for servicing
- Future proofing of screening service to meet increasing demand
- Potential for expanded teaching and training and sharing of expertise and good practice
- Increased opportunities for research projects/trials and innovation

This relocation would also would allow the screening service to better support post cancer surveillance follow up and provide consistency for patients.

Further discussion is required to fully understand the impact of co-location on patient volumes onto the WGH site and the necessary infrastructure required for this.

3.3.1.4 Extended Hours SACT Daycase Units – Oncology and Haematology

Requirement: Appropriate daycase footprint to operate extended hours clinics to allow for increased capacity and an improved workflow model, resulting in:

- Improved efficiency of SACT delivery
- For Haematology, the provision of autologous transplants as out-patient rather than inpatient
- Optimise SACT delivery to ensure that this is delivered in an outpatient or community setting wherever possible
- Dedicated area for supportive therapies with clear patient pathways and optimised workforce skills mix
- Facilities that adhere to HEI requirements with adequate chair spacing, isolation facilities, chemo prep/checking and nurse admin areas
- A fully integrated, safer and improved patient journey

3.3.1.5 Teenage and Young Adult Services

Requirement: Dedicated Inpatient beds for teenagers and young adults as well as designated areas for them to receive treatment and socialise with each other to ensure that the needs of this patient group are met.

This provision already exists within the current Edinburgh Cancer Centre and is well utilised.The Clinical Team have requested that this model continue within the proposed Clinical Model for the future.

3.3.1.6 Palliative Care

Requirement: Aligned review of specialist palliative care provision across hospital sites, and robust service planning towards 2026 and beyond

Within the existing Hospital Specialist Palliative Care Support (HSPCS) resource and service model, it is not possible to meet the projected clinical demand from acute hospital specialties across Lothian, nor the requirements of a world class cancer centre and regional service.

The future vision includes resilient multi-professional Specialist Palliative Care Teams with sufficiently resourced staffing to cover core service activity as well as admin and data management support. A CNS team will require the skills to reflect evolving caseload requirements and new service models. This includes advanced practice skills and non-medical prescribing, supported by robust succession planning, leadership & cross-site development programme.Continued Professional Development (CPD) opportunities will be provided for all HSPCS staff reflecting specialist role requirements and core skills e.g. Quality Improvement, Teaching.

A workforce plan will be developed further to inform an outline business case. This is likely to include requirements for pharmacy, social work and AHP resource.

Future models of HSPCS will be developed in conjunction with workforce plans and tested using QI methodology. These are likely to include;

- Enhanced Supportive Care – routine involvement of HSPCS to all patients with metastatic cancer currently receiving anti-cancer treatments including active management of difficult symptoms and sufficient access to interventional anaesthetics and radiology.

-Proactive identification of patients with palliative care needs via MDT attendance, joint ward rounds, and involvement in acute admissions and oncology assessment areas to extend the reach of the HSPCS.

-Earlier HSPCS involvement in care, supporting patient priorities and realistic treatment decisions for in-patients and out-patient populations.

-Seven day per week specialist palliative care review available via a CNS, supported by the palliative medicine on call rota.

3.3.1.7 Clinical Research and Trials

Requirement: Inclusion of a Clinical Trials facility is integral to the aim of leading innovation through Cancer Research.

The vision is to continue to offer the best standard of treatments to patients whilst providing comprehensive equitable opportunities for patients and staff to participate in innovative Clinical Research across the region. There is a large body of evidence that not only can individual patient outcomes be improved by inclusion in clinical trials but also that clinical outcomes across research active institutions are improved[17] [18]. Clinical trials can provide access to novel therapies that are not available through any other route and in addition to improved patient experience and outcome can lead to significant financial savings and efficiencies for NHS departments. A modern fit for purpose facility with a regional service model focussed on innovation and Clinical Research will encourage recruitment and retention of high quality staff across the professional disciplines who would like the opportunity to be part of cancer research and trials in the South East of Scotland.

[17] bmjopen.bmj.com/content/bmjopen/5/12/e009415.full.pdf

[18] Downing A, et al (2016). High Hospital Research Participation and Improved

Colorectal Cancer Survival Outcomes: A Population Based Study. Gut 0:1–8.

doi:10.1136/gutjnl-2015-311308.

A clinical trials facility with an adequate footprint will help to increase the capacity for clinical trials and in particular will help develop capability for a wider range of early phase studies which aren't currently possible as well as providing high quality clinical research training for trainees across the professional disciplines in order to support the next generation of clinical researchers in oncology and haematology.

To achieve this requires a service model which allows for efficient use of staff resource/time and an integrated approach to training as well as:

- Location which allows easy access for Consultants and research partners
- Co-located pharmacy
- Access to ITU beds (integrated with WGH critical care and high dependency provision)
- Ringfenced capacity within an Advanced Therapeutics Unit
- Diagnostic support (labs and radiology)
- Links to University

A dedicated Early Phase Trials unit would provide daycase and extended daybed capacity along with dedicated inpatient beds for lower risk patients to allow fast sample processing.

Development of a broader portfolio of Early Phase Clinical Trials would allow closer collaboration between the clinical and pre-clinical researchers and generate more commercial activity, particularly in some of the disease areas with most potential to recruit high patient numbers.

The ability to increase commercial activity will provide financial efficiencies and provide opportunities for local research institutions and commercial partners.These activities could generate intellectual property and new income for NHS Lothian,for partner institutions and for the wider economy, would result in recruitment and retention of new research staff posts. Commercial trials are also an important source of income and of cost avoidance on Cancer Medicines where patients receive standard treatments through a commercially funded Clinical Trial rather than directly from the NHS.

Development of a new facility would help to grow the reputation and build on the existing strengths and infrastructure of Scotland, the South East Region and the Edinburgh Cancer Centre,both for clinical research and for clinical excellence.It would ensure that the region continues to attract both the widest selection of clinical trialand research opportunities for patients but also ensure continued recruitment and retention of the highest calibre of staff. Wider benefits to the local economy are elaborated on in the sections above.

All of the above would enable strategic international partnerships with research and trials centres worldwide for reciprocal research opportunities.

3.3.1.8 Supportive Therapies Facilities

Requirement: A dedicated Supportive Therapy unit co-located beside the Haematology and Oncology Daycase units.

This will enable clear pathways to be developed for patients requiring Supportive Therapies (e.g. Blood Transfusion, IV Fluids etc) and ensure patients are being seen in the right setting for their care needs while releasing capacity in the SACT delivery unit.This may also include a Nurse Led Planned Procedure Unit.

Small numbers of patients post-procedure could also be accommodated in this area.

3.3.1.9 Emergency Village

Comprising of:

- Cancer Assessment Unit (CAU)
- Enhanced Supportive Care Clinic
- Cancer Treatment Helpline (CTH)/On Call Service Team Hub

3.3.1.10 CAU

Requirement: Adequate trolley space and short stay/assessment (e.g. 24 hour) beds in close proximity to Radiology.

The Cancer Assessment Unit (CAU) is primarly for patients (both Oncology & Haematology) who have developed acute problems while on active cancer treatment or who have recently completed therapy.

It is also the assessment area for those with acute problems of disease progression requiring specialist assessment and /or admission. Currently patients are referred in from across the SCAN region although, if they self-refer through the Cancer Treatment Helpline (CTH), they may be asked to attend a hospital closer to home rather than WGH if appropriate.

Other routes of referral into CAU include; from the treatment floors and outpatient clinics, by GP's, from SACT Daycase, CNS and also from other departments and hospitals, or self-referall through the CTH or haematology emergency line . Referrals are received into CAU out of hours. The patients are triaged, assessed and then treated and discharged, or admitted as appropriate.It is a service which has evolved and expanded over several years and is still being developed.

In the context of increasing cancer incidence and increasing patient activity the need for acute oncology will expand and the Oncology Service will need to further develop the acute oncology model of care to further enhance coordination of care and early decision making. Clear patient pathways are required in and out of the Cancer Centre to allow reactive care, rapid access and repatriation of patients to other centres where clinically appropriate.

Work is ongoing to review the different flows of patients through CAU with a view to stratifying patient pathways. This review requires an understanding of key performance measures (e.g. developing a predictor tool) to assess other ways to plan admissions and review performance against time from referral, admission and assessment.

There is also a requirement to understand the impact on admission rates in the context of increasing demand and activity and to consider the potential for virtual/remote assessment (based on the Call Mia model). The outcome of this work will shape the size and functionality of the CAU space.

Enhanced Supportive Care (ESC) Clinic

Requirement: Access to ESC and Acute Oncology multidisciplinary team with urgent outpatient clinic space.

The Enhanced Supportive Care (ESC) Model promotes the earlier integration of Palliative Care with Acute Oncology to avoid unnecessary admissions, diagnostics and aggressive treatments by providing early 'front door' urgent outpatient support for pain management, symptom control and Palliative Care.

Implementation of this model at The Christie Centre, Manchester is being measured against the following outcomes:

- Reduction in the number of patients who die within 30 days of their last SACT treatment
- Reduction in the number of patients in whom treatment is curtailed after 1 or2 cycles of a new line of chemotherapy
- Improved Patient and Carer Experience

- Reduced Hospital admission rate
- Reduced Length of hospital stay

3.3.1.11 Emergency Referral Pathway

Requirement: Continued working with the Cancer Treatment Helpline (CTH)

All emergency referrals to Oncology are managed by the nurse-led on-call team (Mon-Fri 9-5) and at other times by the on-call Registrar.

Patients who are receiving SACT or Radiotherapy treatment can contact the CTH during their treatment and for six weeks thereafter.

This is a national service which is open 24 hours and provides a triage assessment to patients who are receiving or have received specific cancer treatment when they feel unwell, ensuring that they access the most appropriate, effective and timely care if their condition is deteriorating.

Triaged calls are then re-directed to specialist staff on site for input when required. Currently in Lothian there is a Triage Team from 9am to 5pm, staff in the Cancer Assessment Unit take the calls from 5-9pm then the Hospital at Night Team (HAN) receives triaged calls overnight.

3.3.1.12 Outpatient Department

Requirement: Flexible, multi-purpose accommodation to support holistic needs (e.g. one stop diagnostic clinics, SACT pre-assessment clinics, virtual clinics, Oral SACT clinics, nurse or pharmacy led clinics, AHP clinics, palliative and enhanced supportive care clinics).

Availability of outreach clinics will be expanded to enable care to be provided closer to home where clinically appropriate and financially viable to do so.

The ambition is to have virtual clinics available for stable patients and to have an increasing number of joint clinics with other specialties to offer options and streamline pathways for patients wherever possible.

Growth in the one stop clinic model.

3.3.1.13 Radiotherapy Department

Requirement: An appropriate fleet of treatment machines including MR Linac, PET, CT Simulation and MRI Simulation for the purposes of pre-treatment planning. A Linac for Research purposes should also be considered.

**The future provision of Radiotherapy services is dependent upon the technology available at the time of design and construction.*

The availability of cutting edge technology will enhance Edinburgh's research capability and attract professionals to NHS Lothian and Scotland. Work will continue with University partners on joint venture acquisitions around new technology.

There is further scoping to be done regarding inclusion of a Radiotherapy Satellite Unit to establish the viability of this against patient demand data in the regional boards and the specialist staff resources that would be required.

A Proton Beam Therapy Unit will not be included as an option due to confirmation from the Scottish Government Cancer Policy Team in September 2019 that the results of data forecasting show insufficient patient throughput within Scotland to justify an economic case.

3.3.2 Delivery of Clinical Model - Workforce

As a South East of Scotland Development hosted and led by NHS Lothian on behalf of the SCAN region, full re-provision of the Edinburgh Cancer Centre is an opportunity to transform the way cancer services are delivered across the South East Region.

Opportunities for delivering more care closer to home are currently being scoped in the knowledge that workforce availability is a risk to the delivery of this proposed model of care as well as a risk to current service sustainability.

Alongside planning for a resilient and sustainable workforce for the future, this is also an opportunity to consider any benefits that advances/changes in technology could offer in terms of improving patient experience and maximising the use of the available workforce.

The regional workforce plan is ambitious and will require planning to start early in order to ensure we have a sustainable workforce with the right skills in place by the time a new Cancer Centre is operational.It is essential to develop this plan and ensure a sustainable workforce regardless of the re-provision to enable service continuity and resilience across the South East Region.

A planning horizon of five to seven years for the centre provides an adequate timeframe to develop and implement a workforce plan using the *Six Steps Methodology to Integrated Workforce Planning*.

As we go through this process, potentially there will be opportunities to gain short and medium term benefits around workforce as well as ensure that when the new centre opens its doors the necessary workforce is available.

3.3.2.1 Workforce Required

A re-provided Edinburgh Cancer Centre will provide specialised cancer care and a range of clinical trials for the patients of South East Scotland.

There is also the opportunity to provide Care Closer to Home and an expanded range of trials in outreach facilities and increased regional capacity through discussion with regional partners.

It is anticipated that increases in staff will be required due to:

- Increase in demand for cancer services across the region (due to increasing cancer incidence, forecast population growth and increase in treatment options/complexity of patients)
- Agreement on a regional model (both within and outwith Lothian)

Increase in number of single rooms requiring an increase in nursing establishment (0.29 WTE uplift per single room).

There has been work undertaken in recent years – e.g. Advanced Nurse Practitioner (ANP) and Clinical Nurse Specialist (CNS) role development etc – to enhance skill mix and transfer medical responsibilities to non medical personnel undertaking specialist and advanced practice roles.

Extending clinical roles or 'task shifting' involves changes to training, education and continuing professional development. These changes need to be clinically led, made on a large scale and co-ordinated nationally rather than introduced piecemeal locally. There is also a requirement to explore alternative staffing models and opportunities to develop new roles and modern apprenticeships.

Further engagement with management and clinical teams will take place to further define the workforce requirements and ensure an effective and efficient operational service.

As part of the development of an OBC,detailed work to establish the workforce requirements for a re-provided Edinburgh Cancer Centre (plus /minus regional services) will be required in order to calculate indicative revenue implications.

At IA stage, high level revenue modelling will be provided based on clearly articulated assumptions.

3.3.2.2 Workforce - Next Steps

Three key areas have been identified areas where work needs to progress workforce requirements as part of the development of an OBC:

1) Pipeline - Influencing training numbers as well as changes to training, education and continuing professional development and ensuring these where possible are co-ordinated nationally
2) Refining workforce requirements and options for regional service delivery model - potential regional impact on recruitment, retention and workforce sustainability. Potential regional ways of working to reduce sustainability risks.
3) Implementation of large scale recruitment (in line with RHCYP and DCN model)

Current uncertainty regarding these is a significant risk to delivery of the proposed clinical model within the IA.

3.3.3 Essential and Support Services

It has been recognised when developing a Clinical Model for the future that many of the cancer pathway transformations and service improvements are reliant on the essential and support services that are part of the patient's cancer journey.

Having proximity to these will allow the most efficient pathways for patients to be developed, as well as allow the development of these services for future sustainability.

In order to achieve the stated '*Investment Objectives'* the service must be designed around transformed models of cancer care with proximity to the key ***'Essential Services'*** below:

- Laboratories
- Imaging
- Nuclear Medicine Physics – NMP
- Critical Care capacity

A high level, strategic vision for inclusion of each of these in an ***'Essential Services Hub'*** has been developed with key representatives from each area to ensure relevant expertise has been incorporated and that plans are being developed in line with existing NHS Lothian strategy. The provision of these services will be designed in such a way as to support and benefit all services based on the Western General Hospital site.

Appendix 10 gives a high level overview of each of these ***Essential Services***.

The realisation of many of the Benefits as described in Section 2.5 of the IA are dependent on the development of the Essential Services Hub.Development of this as an enabler to the cancer centre also provides an opportunity to improve the cancer patients pathway across NHS Lothian and subsequently improve performance around cancer waiting times (CWT).

This proposal will be further scoped and developed in a separate Business Case.

Alongside the requirement for *Essential Services*,there is also the recognition that cancer patient pathway transformation also requires adjacency of other ***Support Services:***

- Allied Health Professionals (AHPs) – Physiotherapy, Occupational Therapy (OT), Speech and Language Therapy (SLT) and Dietetics.

Appendix 11 articulates a high level, strategic vision for each of these services which has been developed with key representatives from each area to ensure relevant expertise has been incorporated and that plans are being developed in line with existing NHS Lothian strategy.

Further development of AHP proposals will be completed as part of the Outline Business Case process.

The success of this model is also dependent upon the Western General Hospital remaining a viable 'hot' site with services including:

Table 32: Required Support Services On WGH Site

Viable ITU/Critical care	Labs	Palliative Medicine/ Supportive Care	Acute Medicine
Acute Receiving Unit	Hospital At Night	Abdominal & Pelvic Surgery	AHP Services - Physiotherapy, Occupational Therapy, Speech and Language Therapy and Dietetics
Cardiology	Frailty service	ID/Microbiology	Resuscitation
Respiratory	Endocrinology	Gastroenterology	Screening (symptomatic and asymptomatic)
Radiology (including interventional)	24/7 Haematology, Blood transfusion and Biochemistry laboratory services	Pharmacy	Surgical Services (inc Robotic Surgery, nephrostomies, scopes, stents and ERCP)
Medical Physics	Nuclear Medicine		Radiopharmacy

3.3.4 Rapid Diagnostic Centre

The concept of a Rapid Diagnostic Centre (RDC) or Multidisciplinary Diagnostic Centre (MDC) is an example of patient pathway transformation which aims to provide rapid access to a range of diagnostic tests for suspected cancer in one location and conducted on one visit (when clinically possible).

Examples from elsewhere in Europe (e.g. Sweden and Denmark), England and Wales have demonstrated that access to an RDC/MDC has streamlined the process and improved the timeliness and quality of care for patients allowing GPs to refer into a 'one stop' service .

It may also have the potential to reduce the number of diagnoses through emergency presentations (though there is currently no data available to assess this impact).

Figures referenced in the interim report from the ***Accelerate, Coordinate and Evaluate (ACE) Programme*** in England (April 2018) suggest that survival for some of the most common cancers is more than three times higher for patients when diagnosed early at Stages 1 and 2[19].

[19] Cancer Research UK 'Survival three time higher when cancer is diagnosed early' 10th August 2015

Cancers presenting with non-specific symptoms can be more difficult to diagnose than those with 'red flag' alarm symptoms and evidence from Denmark suggests that as many as 52% of patients present without recognised alarm symptoms[20].

Wave 1 of the ACE Programme explored ways of achieving earlier diagnosis for patients with non-specific symptoms and found that opportunities existed to improve the time to diagnosis for these patients by developing a non-specific symptoms based diagnostic pathway, providing planned and rapid access to appropriate tests and reporting[21].

Recommendation 21 of *Achieving World Class Cancer Outcomes*[22] calls for the trial and evaluation of Multidisciplinary Diagnostic Centres for non-specific symptoms as part of Wave 2 of the ACE programme which completed at the end of 2018.

Headline findings from the MDC Wave 2 evaluation (April 2019)[23] suggest that the MDC model:

- Has value as a cancer diagnostic pathway for patients presenting with non-specific but concerning symptoms
- Facilitate the diagnosis of a broad range of cancer types, including rare and less common cancers
- Should be considered as an approach to achieving earlier diagnoses of cancer for patients presenting with non-specific symptoms, given the types of cancer being detected
- Provides a broad diagnostic approach encompassing a range of cancer and non-cancer conditions
- Provides a planned and rapid pathway for patients with complex presentation

An NHSL Pilot requested by Scottish Government and national discussions currently underway will inform the development of this concept.Further scoping and modelling of potential patient catchment areas, referral pathways, Regional,Lothian and WGH whole site capacity requirements is required.

3.3.5 Holistic Patient Approach

Re-provision of the Edinburgh Cancer Centre is an opportunity to deliver services with a patient focused, holistic approach and to meet the aspiration of the refreshed Scottish Government Cancer Strategy ' *Beating Cancer:Ambition and Action (2016)*'[24] around '*best care and support for all people with and beyond cancer*'[25]

There are a wide range of Third Sector partners who currently provide vital support services for cancer patients.It is the ambition of the proposal that this support is strengthened in order to provide a holistic patient experience.

The NHS Lothian Third Sector Voluntary Services Manager has undertaken a mapping exercise of 3rd sector service provision to cancer patients across the South East Region.Once verified, the outputs of this exercise will be used to engage with Third Sector Partners (existing and potential future) to plan a regionally co-ordinated approach to Third Sector service provision with the overall aim of enhancing the patient experience.

This will be fully articulated as part of the OBC.

---

[20] M.L.Ingeman, M.B.Christensen, F.Bro et al 'Cancer suspicion in general practice, urgent referral and time to diagnosis: a population based GP survey and registry study' BMC Cancer, Volume 14, no.636, 2014
[21] ACE programme 'Improving diagnostic pathways for patients with vague symptoms, final report' 2017
[22] NHS England 'Achieving World Class Cancer Outcomes: a strategy for England 2015-2020'Independent Cancer Taskforce 2015
[23] https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/ace-programme/ace-programme-wave-two.html
[24] Refreshed in April 2020: An update: achievements, new action and testing change
[25] Beating Cancer:Ambition and Action (2016), refreshed in April 2020 p.13

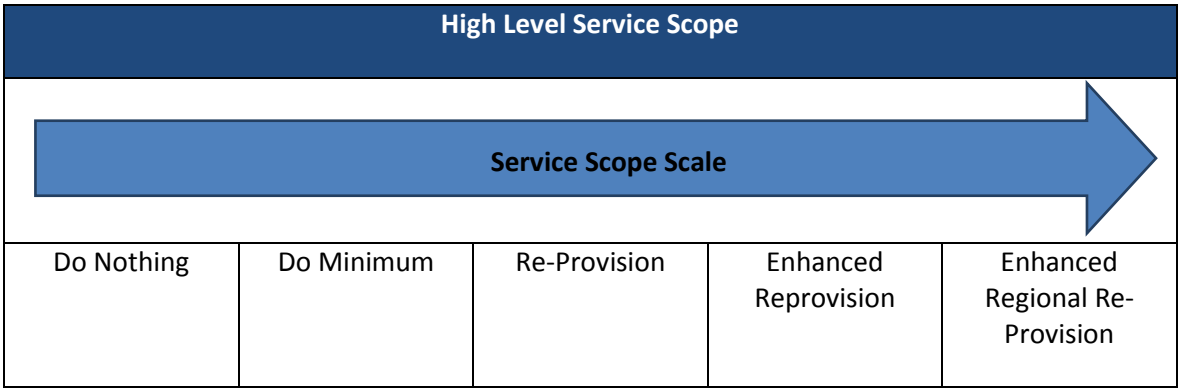
3.4 Long-listed Options

3.4.1 High Level Service Scope

Initial options were developed around the general shape of the service, taking account of varying ranges of the scope.

These options are summarised below:

Figure 19: Service Scope Scale



3.4.1.1 Do Nothing

The 'Do Nothing' option involves carrying on with the existing service with no change or improvement. This option has been deemed as not applicable as the 'Do Minimum' option is already in the process of being implemented in the form of the Oncology Enabling Programme of Works, Haematology and Clinical Trials projects.

3.4.1.2 Do Minimum

The 'Do Minimum' option relates to cancer services remaining at the WGH in their current location but with some upgrade works (Oncology Enabling, Haematology and Clinical Trials projects) to support service sustainability and resilience to ~2025 (based on modelling that commenced in 2015).

The above noted projects have received internal and external endorsement via separate Business Cases and are in the process of being implemented.

3.4.1.3 Re-Provision

The 'Re-Provision' option seeks to replicate the existing service provision providing core cancer services whilst allowing for adjustments in department areas to meet modern healthcare standards. This option does not seek to address future projected demand and capacity issues relating to the service.

3.4.1.4 Enhanced Re-provision

This option represents a purpose built *'Regional Specialist Cancer Centre'* with accommodation/infrastructure designed to meet current applicable clinical standards - including design and technical requirements and incorporating transformational redesign of patient pathways. In addition, the enhanced option would build upon the existing complement of services providing a wide range of specialist cancer therapies and providing enhanced clinical trials and research capacity.

3.4.1.5 Enhanced Regional re-provision

As the Enhanced Re-Provision option above but additionally seeks to integrate the service regionally through satellite and outreach facilities. As the proposal progresses towards OBC, ongoing regional discussions and collaboration will result in potential sustainable service delivery options being scoped and defined. Options will subsequently be refined and costed in more detail allowing an objective scored option appraisal to be undertaken with relevant stakeholders.

3.4.2 Delivery Model Scope

The high-level service scope options above were then considered alongside possible delivery model options as summarised in the table below.

Table 33: Delivery Model Options and Service Scope

Delivery Model Scope	Service Scope				
	Do nothing	Do minimum	Re-provision	Enhanced re-provision	Enhanced Regional re-provision
NA	✓C				
Limited refurbishment		✓C			
Refurbishment at WGH			✓D		
Part new-build and part refurbishment at WGH			✓D		
New-build at WGH			✓C	✓C	
Phased new-build at WGH			✓C	✓D	
New build at WGH with hub and regional spoke model			✓D	✓D	
New build at WGH with Regional satellite / outreach facilities					✓C
New-build facilities at another site (not WGH)			✓D	✓D	
New-build facilities at another site with Regional satellite / outreach facilities					✓D
Key C – Option carried forward D – Option discounted					

A process of qualitative option appraisal was conducted to consider the merits of each option against the established 'need for change'.

Options which generally failed to respond satisfactorily to the needs for change were discounted. In addition, options which were relatively similar were discounted to allow six shortlisted options to be carried forward.

There was also consideration of options which involved establishing the cancer centre at an alternative site, however these were discounted due to service delivery challenges, the requirement for the cancer centre to be on an acute hospital site and NHSL's strategic commitment to the Western General campus.

A more detailed analysis of the long list of options is located at Appendix 12.

3.5 Short-listed Options

The short list of options that emerged from the long list of options are described below. The strengths and weaknesses provided for each option are directly extracted from long list analysis provided at Appendix 13.

3.5.1 Option 1 – Do Nothing

The 'Do nothing' option involves carrying on with the existing service with no change or improvement. This option is not applicable as the 'Do minimum' option is already in the process of being implemented.

Table 34: Option 1 – Strengths/ Weaknesses

Strengths / Weaknesses	
Description	**Strength (S) Weakness (W) Improved (I)**
Facilities and capacity are not able to cope with projected demand	W
HAI patient safety issues	W
Poor patient experience	W
Workforce challenges - recruitment and retention	W
Wide range of cancer therapies	W
Opportunities to participate in a full programme of trials and research	W
Cost (capital/revenue)	S

3.5.2 Option 2 – Do Minimum

The 'Do minimum' option relates to cancer services remaining at the WGH in their current location but with some upgrade works (Oncology Enabling, Haematology and Clinical Trials projects) to support service sustainability and resilience to ~2025.

These works consist of:

- Refurbishment of Oncology inpatient wards 2-4
- Relocation of Cancer Assessment unit
- Expansion of pharmacy in Ward 1
- New build Linac bunkers and Admin block
- Haematology refurbishment of Wards 7 and 8 East/West
- Relocation of Clinical Trials Staff and expansion of Trials footprint

The above noted projects have received internal and external endorsement via separate Business Cases and are in the process of being implemented.

Table 35: Option 2 – Strengths/ Weaknesses

Strengths / Weaknesses	
Description	**Strength (S) Weakness (W) Improved (I)**
Facilities and capacity are not able to cope with projected demand	I
HAI patient safety issues	I
Poor patient experience	I
Workforce challenges - recruitment and retention	W
Wide range of cancer therapies	W
Opportunities to participate in a full programme of trials and research	W
Cost (capital/revenue)	S

3.5.3 Option 3 – Re-provision: new-build at WGH

A 'Re-provision' option seeks to replicate the existing service provision providing core cancer services whilst allowing for adjustments in department areas to meet modern healthcare standards. This option does not seek to address future projected demand and capacity issues relating to the service.

Table 36: Option 3 – Strengths/ Weaknesses

Strengths / Weaknesses	
Description	**Strength (S) Weakness (W) Improved (I)**
Facilities and capacity are not able to cope with projected demand	I
HAI patient safety issues	S
Poor patient experience	S
Workforce challenges - recruitment and retention	I
Wide range of cancer therapies	W
Opportunities to participate in a full programme of trials and research	W
Cost (capital/revenue)	I

3.5.4 Option 4 – Re-provision: phased new-build at WGH

Effectively the same as option 3 but allows for a long-term phased delivery strategy which may be beneficial from a cashflow perspective but would most likely lead to a compromised clinical model and given inflation etc may cost more overall.

Table 37: Option 4 – Strengths/ Weaknesses

Strengths / Weaknesses	
Description	**Strength (S) Weakness (W) Improved (I)**
Facilities and capacity are not able to cope with projected demand	I
HAI patient safety issues	S
Poor patient experience	S
Workforce challenges - recruitment and retention	I
Wide range of cancer therapies	W
Opportunities to participate in a full programme of trials and research	W
Cost (capital/revenue)	I

3.5.5 Option 5 – Enhanced re-provision: new-build at WGH

This option represents a purpose built *'Regional Specialist Cancer Centre'* with accommodation/infrastructure designed to meet current applicable clinical standards - including design and technical requirements and incorporating transformational redesign of patient pathways. In addition, the enhanced option would build upon the existing complement of services providing a wide range of specialist cancer therapies and providing enhanced clinical trials and research capacity.

Key characteristics

- Wide range of specialist cancer therapies available for the patients of South East Scotland
- Internationally leading Clinical Research and Trials providing most innovative cancer therapies for people of Scotland
- Essential Services Hub (potentially incorporated the Rapid Diagnostic Centre concept supporting transformation of cancer pathways (*components to be costed separately*)
- Innovation, role re-design and Workforce Development/training for staff regionally and nationally, potentially including a Centre for Cancer Education
- Support for patients living with and beyond cancer in managing long term conditions

Table 38: Option 5 – Strengths/ Weaknesses

Strengths / Weaknesses	
Description	**Strength (S) Weakness (W) Improved (I)**
Facilities and capacity are not able to cope with projected demand	S
HAI patient safety issues	S
Poor patient experience	S
Workforce challenges - recruitment and retention	S

Wide range of cancer therapies	S
Opportunities to participate in a full programme of trials and research	S
Cost (capital/revenue)	W

3.5.6 Option 6 – Enhanced Regional re-provision: New build at WGH with Regional satellite / outreach facilities

As Option 5 above but additionally seeks to integrate the service regionally through satellite and outreach facilities. As the proposal progresses towards OBC, ongoing regional discussions and collaboration will result in potential sustainable service delivery options being scoped and defined. Options will subsequently be refined and costed in more detail allowing an objective scored option appraisal to be undertaken with relevant stakeholders.

Table 39: Option 5 – Strengths/ Weaknesses

Strengths / Weaknesses	
Description	**Strength (S) Weakness (W) Improved (I)**
Facilities and capacity are not able to cope with projected demand	S
HAI patient safety issues	S
Poor patient experience	S
Workforce challenges - recruitment and retention	S
Wide range of cancer therapies	S
Opportunities to participate in a full programme of trials and research	S
Cost (capital/revenue)	W

3.5.7 Departmental Service Scope

The departmental service scope for each option has been developed allowing initial schedules of accommodation to be generated. These have supported generation of initial cost estimates for the options.

The departmental service scope for options 3 and 4 are the same; the only difference being that option 4 is delivered in a phased manner. The scope for options 5 and 6 are also similar at this stage due to the fact that the Regional satellite and outreach components inherent within option 6 are still being discussed and developed.

In order to provide a better understanding of the differences been the re-provision options (3 and 4) and the enhanced re-provision options (5 and 6) a detailed schedule of services has been created and is located at Appendix 14.

3.6 Assessment and identification of preferred solution(s)

Following the development of the short-list of options, an Initial Option Assessment Workshop was held on 30 April 2019. This was an initial high-level assessment by key stakeholders to review the advantages and disadvantages of each option.A follow up workshop to assess and score each option based on the benefits and cost criteria will be undertaken upon approval of this IA with the process and results articulated within the OBC.

Photo 19: Initial Option Assessment Workshop

At the workshop,the following process was followed:

1. Each shortlisted option was carefully explained to the participants enabling them to understand the potential scope of the option and the associated service arrangements.

2. The workshop Facilitators presented some pre-determined advantages and disadvantages associated with each option. Groups were the formed to consider any additional advantages and disadvantages.

3. Based on item 2, the groups then considered the Strengths Weaknesses Opportunities Threats (SWOT) analysis against assessment criteria for each option. The assessment criteria was effectively the Investment Objectives. The groups considered the merits of each option against the Investment Objectives through marking up an option assessment matrix. The scoring mechanism was high-level and included 'Discounted', 'Carried Forward / Less Attractive', 'Carried Forward / More Attractive' and 'Preferred'.

4. The Facilitators then combined the group scoring on a master option assessment matrix to illustrate the overall consensus. The option assessment workshop presentation and notes (including master option assessment matrix) are located at Appendix 14.

The tables below summarise the outputs from the option assessment workshop:

Table 40: Option SWOT Analysis

	Advantages (strengths & opportunities)	Disadvantages (weaknesses & threats)
Option 1 Do Nothing	- Requires no change - Requires no additional investment	- Service sustainability issues - Building issues - Facilities nearing max. life span - HAE issues - Poor patient experience - Reputational risk - More investment required in future years to remain viable
Option 2 Do Minimum	- Improves patient environment - Requires minimum investment	- Service sustainability issues - Building issues (derogations) - Min. service transformation - Facilities nearing max. life span - Sub-optimal patient experience - Patient safety - More investment required in future years to remain viable
Option 3 Re-provision	- Additional investment reasonable - Compliant accommodation - Improved patient experience	- Service sustainability issues - Limited service transformation - Core services only provided - Service targets may not be met - Adjacencies to other site services - Threat of being unable to provide a workforce model
Option 4 Phased Re-provision	- Additional investment reasonable (phased) - Compliant accommodation - Improved patient experience	- Service sustainability issues - Limited service transformation - Core services only provided - Service targets may not be met - Longer delivery timeframe affecting recruitment and retention, patient experience and workforce challenges to cope with detached services/buildings
Option 5 Enhanced re-provision	- Respond to service sustainability - Compliant accommodation - Allows service transformation - Recruitment and retention opportunities - Availability of specialist therapies - Integration and development of research and trials - Improved staff and patient experience - Future proofing of service - Training capability	- Substantial financial investment - Option does not integrate Region - Workforce availability
Option 6 Enhanced Regional re-	- All the advantages noted under option 5, plus: - Care closer to home	- Substantial financial investment - Potential workforce and transport issues relating to Regional work

	Advantages (strengths & opportunities)	Disadvantages (weaknesses & threats)
provision	-Improved access to clinical trials	- Workforce availability

Table 41: Option Summary Table

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
	Do Nothing	Do Minimum	Re-provision	Phased Re-provision	Enhanced Re-provision	Enhanced Regional Re-provision
Does it meet the Investment Objectives (Fully, Partially, No, n/a):						
Increase service capacity and sustainability to meet demand	No	No	Partially	Partially	Fully	Fully
Building designs will provide appropriate facilities for clinical care that meet all required standards	No	Partially	Fully	Fully	Fully	Fully
Opportunities available to ensure recruitment and retention of specialist staff	No	No	Partially	Partially	Fully	Fully
Offering a range of education and training for professional development	No	No	Partially	Partially	Fully	Fully
Wide range of specialist cancer therapies available for the patients of South East Scotland	No	No	No	No	Fully	Fully (Regional)
Clinical Research and Trials integrated with Cancer Services	No	No	Partially	Partially	Fully	Fully
Are the indicative costs likely to be affordable? (Yes, maybe/ unknown, no)						
Affordability	Yes	Yes	Maybe	Maybe	Unknown	Unknown
Discounted	X			X		
Carried forward / less attractive		X	X			
Carried forward / more attractive					X	
Preferred						X

3.6.1 Summary

The group consensus emerging from the option assessment workshop held on 20 April 2019 was that **Option 6 (Enhanced Regional Re-provision) was the preferred option**.

The balance of the options will be carried forward to the OBC stage for further assessment via a scored option appraisal method, with Option 1 discounted as the 'Do Minimum' option is now effectively Option 2 (Oncology Enabling works are underway).

It was also agreed that Option 4 could be discounted as it is merely a delivery option for Option 3.

In summary, Options 2, 3, 5 and 6 will be carried forward to OBC for further assessment.

3.6.2 Preferred way forward

The preferred way forward was determined to be Option 6.

Table 42: Preferred Way Forward

Strategic Scope of Option	Re-Provision and enhancement of the Cancer Centre [Fully integrated facility at the WGH/ At the WGH with satellite/outreach facilities across East Region]
Service provision	Purpose built 'Regional Specialist Cancer Centre' incorporating transformational redesign of patient pathways Wide range of specialist cancer therapies available for the patients of South East Scotland, enabling repatriation of patients from the SE and potentially across Scotland Scoping of a Rapid Diagnostics Centre and Essential Service Hub to support transformation of cancer care Internationally leading Clinical Research and Trials capability providing most innovative cancer therapies for people of Scotland
Service arrangements	The service will be delivered through a 'hub and spoke' model with specialist treatments available in the centre and expanded outreach capacity across the region to ensure equity of access to service and research across the region
Workforce arrangements	Robust regional workforce plan to be developed as Business Case progresses to ensure sustainability of regional services and attract high calibre specialist staff to Scotland Provide employment opportunities across the region, continued close engagment with Regional boards to ensure alignment with local Boards workforce planning Innovation, role re-design and Workforce Development/training for staff regionally and nationally to address training needs and retain/upskill specialist staff
Supporting assets	Purpose built facility incorporating cutting edge technology Scoping of a Rapid Diagnostics Centre and Essential Service Hub to support transformation of cancer care

Strategic Scope of Option	Re-Provision and enhancement of the Cancer Centre [Fully integrated facility at the WGH/ At the WGH with satellite/outreach facilities across East Region]
Public and service user expectations	Clinical standards met Holistic patient approach including support for patients living with and beyond cancer managing long term conditions

3.7 Indicative Costs

The table below details the indicative whole life costs associated with each of the shortlisted options. For further detail around the determination of the costs see Section 5 – Financial Case.

The additional assumptions associated with the calculation of the NPV of costs are:

- A discount rate of 3.5% has been used in line with Government guidance.
- The Net Present Value (NPV) of costs are calculated over a 30 year period. Inflation and VAT are excluded in line with SCIM guidance.
- Phasing of the costs reflect the useful life and the programme of works as identified in the timetable in the Commercial Case.

Table 43: Indicative Costs of Shortlisted Options (£m)

Cost – Mid Estimate(£m)	Option 2 Do minimum (mid)	Option 3 Re-provision: New build at WGH (mid)	Option 5 Enhanced re-provision: New build at WGH (mid)	Option 6 Enhanced regional re-provision: New build at WGH with regional satellite/outreach facilities (mid)
Whole life capital costs	61.8	252.5	363.1	373.6
Whole life operating costs	0.0	42.6	250.0	259.4
Estimated Net Present Value (NPV) of Costs	**61.8**	**295.1**	**613.1**	**633.0**

3.8 Design Quality Objectives

NHS Lothian is required to follow SCIM requirements for the NHS Scotland Design Assessment Process (NDAP) in the implementation of capital projects.

The approach of NHS Lothian is to achieve good design to support cost effective and future proof facilities that improve the patient experience. This can be achieved through good, cost effective design within its built environment and is committed to improving the quality of life for people who use its premises as patients, staff, visitors and the local community by enhancing and creating buildings and spaces that are healthy for present and future generations and environmentally sustainable.

NHSL wishes to get maximum benefit from its investments in healthcare facilities. The design of this redeveloped facility and its environment should promote best working practice, be welcoming and accessible to people from all walks of life and all abilities, and generate a sense of wellbeing, belonging, and place to all who use it. The building quality and materials should optimise whole life value and seek to minimise the environmental impact of the development and enhance the wellbeing of users.

A Design Statement has been prepared for this Initial Agreement stage to support the design assessment process which will take place at the Initial Agreement, Outline Business Case and Full Business Case stages of approval. This requirement is mandated through NHS CEL 19 (2010) and supported by the Scottish Government's Policy on Design Quality for NHSScotland. The Scottish Capital Investment Manual (SCIM) Design Statement is available upon request.

The resultant Achieving Excellence Design Evaluation Toolkit (AEDET) Benchmark and AEDET Target outputs are presented in Appendix 15.

The delivered project will also be specified to comply with relevant statutory and design and technical guidance documentation. Any proposed derogations from guidance will be reviewed as appropriate and accepted or not and with a clear audit trail of decision-making being required at every stage. Guidance will be sought from HFS as required. Documentation will be specified generally on the basis of the following table.

Table 44: Statutory, Design and Technical Guidance

Mandatory Requirements Design and Technical Guidance	
NHSScotland policy letters (DLs,CELs, CMOs)	Scottish Government: Health and Social Care; Chief Medical Officer directorates
Scottish Health Planning Notes (SHPN)	Health Facilities Scotland
Scottish Health Facilities Notes (SHFN)	Health Facilities Scotland
Scottish Health Technical Memoranda (SHTM)	Health Facilities Scotland
Health Building Notes (HBN)	Dept of Health (England)
Health Technical Memoranda (HTM)	Dept of Health (England)
Health Facilities Notes (HFN)	Dept of Health (England)
Other relevant design and technical guidance in support of the above or additional to it may be incorporated as relevant.	Procurement and Construction Policy note: NB: Construction quality in particular. HSE and other Health and Safety guidance CIBSE BRE Sustainability design and specification guidance. Dementia design and specification guidance. Others
Statutory Requirements	
	Planning permission Building Regulations compliance Equality Act compliance

Mandatory Requirements Design and Technical Guidance	
	Health and Safety Executive (HSE) compliance Construction (Design and Management) Regulations compliance
Other Mandatory Requirements	
	Activity Data Base (ADB) Achieving Excellence Design Evaluation Tool (AEDET) – As noted above. BREEAM Healthcare – as noted

3.9 Sustainability Objectives

Based on the core driver to deliver a new model of care and replace the existing accommodation in order to improve access to services, patient flow and efficiency, the sustainability objectives for the project are:

- To provide patients with a sustainable service in a fit for purpose and patient centred environment.
- To provide an environment that is sustainable in responding to different patient groups specific needs.
- To provide staff with a working environment conducive to delivering the best health care in a sustainable environment that also supports the long-term sustainability of the workforce in supporting recruitment and retention.
- To provide an easily maintained facility with good quality finishes and materials.
- Where feasible, to set criteria and standards surpassing those required by current regulations
- To challenge the market to provide innovative solutions that minimise the environmental impact of buildings
- To raise the awareness of the benefits of buildings with a reduced impact on the environment
- To support NHS Lothian's progress towards corporate environmental objectives
- To provide staff with digital technology that supports Agile working and overall productivity

The sustainability strategy for the project has included a review of compliance with CEL19(2010) based on all new build facilities above £2m in value are required to obtain a Building Research Establishment Environmental Assessment Method (BREEAM) Healthcare/ or equivalent 'Excellent' rating as a minimum.

Based on the above requirement and given that the project is for a new facility, it is clear that a BREEAM Assessment process is required. This will be reviewed early in OBC stage in collaboration with Health Facilities Scotland (HFS) and Architecture and Design Scotland (ADS) as required and a pre assessment will be carried out.

The following checklist will be used for the project based on BREEAM requirements:

- Commissioning
- Health and wellbeing
- Daylight
- Occupant thermal comfort
- Acoustics
- Indoor Air and Water quality
- Lighting
- Energy
- Transport
- Water

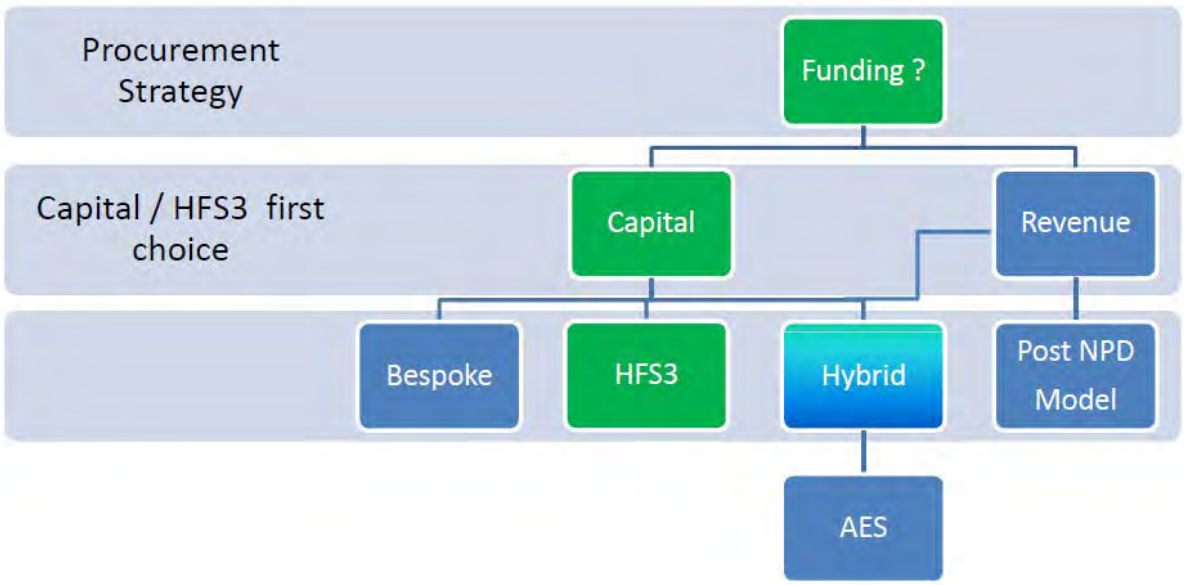
- Waste
- Pollution
- Land use and ecology
- Materials

4 The Commercial Case

4.1 Procurement Strategy (Constructor)

The funding mechanism will fundamentally determine the procurement route and selection of the constructor (Figure 21)

Figure 20: Procurement Route



Should a revenue funded route be selected the prevailing private financed model promoted by Scottish Futures Trust will prevail. The Board understand this to be the successor to the Non Profit Distribution Model (NPD) known as the Mutual Investment Model (MIM).

Three options present themselves should capital funds be available. The first, and the Board's preferred option, is the utilisation of Health Facilities Scotland Framework 3 (HFS3) to secure an established and pre selected constructor as a Principal Supply Chain Partner (PSCP) bringing a full supply chain of designers and cost consultants. It is envisaged that this route would facilitate the earliest construction start.

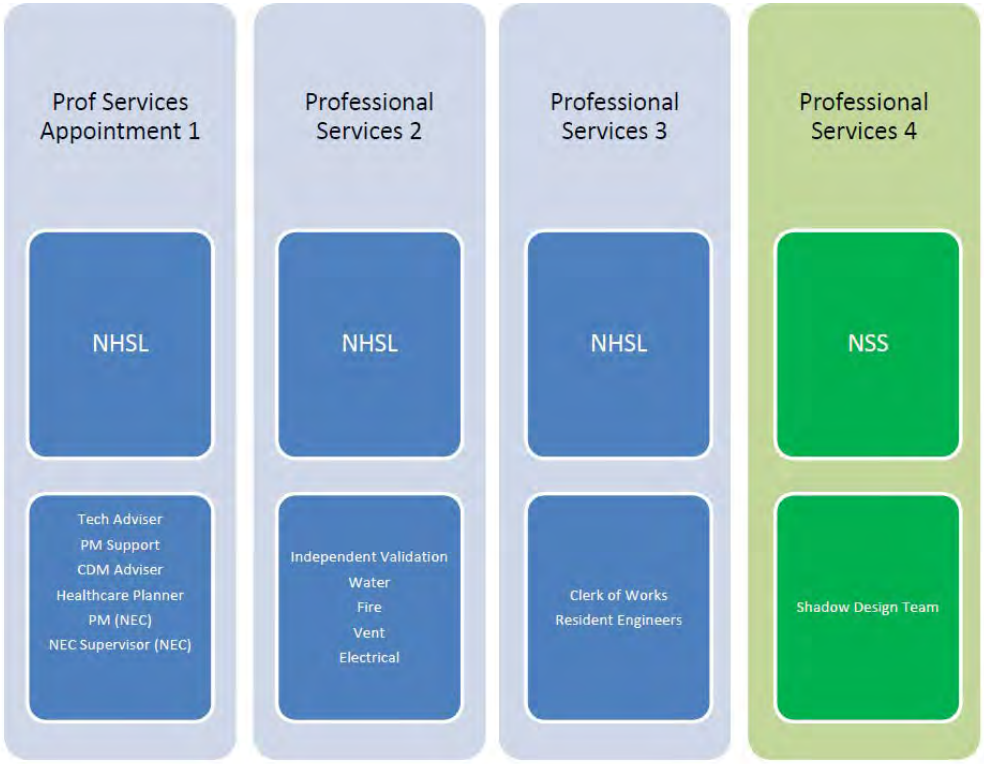
The second option is a bespoke approach through limited competition adhering to OJEU procedures with sub options in terms of actual building contract ranging from a traditional and fully billed approach through a two stage design manage and construct contract to design and build.

A possible third option is the leasing of floor space as an anchor tenant within a commercial development built to institutional investor specification. A feasibility study to explore the viability and test developer appetite is hopefully to be undertaken in the near future in relation to the Board's development requirements at the Edinburgh Bioquarter.

4.2 Procurement Strategy (Professional Services)

Three professional service appointments will be required through the HFS3 Framework as described in Figure 22 regardless of the procurement route selected for the constructor.

Figure 21: Professional Services



The first appointment to be made would be for a technical adviser, project management support, CDM adviser, healthcare planner and if a NEC construction contract is entered into (HFS3 Framework) a NEC project manager and supervisor.

Prior to the construction phase two other appointments will be necessary to ensure independent validations and clerk of works/resident engineer duties can be fulfilled. It is considered essential that this level of supervision and assurance is provided and that the integration of these duties begins early enough to fully inform the agreed testing and commissioning regimes. It is proposed that the Clerk of Works and Resident Engineer report directly to the SRO as client and operate independently but in liaison with the project team.

A fourth appointment of a shadow design team employed directly by National Services Scotland (NSS) will also be essential to provide independent assurance to the Board and Scottish Government inconjunction with Health Facilities Scotland (HFS) and Health Protection Scotland (HPS) engineers and infection control specialists.

4.3 Programme / Timetable

A detailed Project Plan and Programme will be produced for the OBC.

The table below shows key milestones:

Table 45: Key Milestones

Key Milestone / Activity (Dependent on Procurement Route Selected)	Date
Initial Agreement submitted & approved by SGCIG	October - December 2020
Development of Information (Clinical Brief / Technical Brief) for Lead Advisor / Technical Advisor Appointment	January to October 2021
Lead Advisor / Technical Advisor Procurement & Appointment	October to December 2020
Contractor Procurement (Assuming OJEU route) & Appointment	March 21 to March 2022
Outline Business Case submitted & approved by SGCIG	October to December 2022
Full Business Case submitted & approved by SGCIG	December 2023 to Feb 2024
Enabling Works (DCN Site Clearance / Infrastructure inc roads and car parking)	January 2021 to Feb 2024
Essential Services Centre	March 2025 to September 2028
Cancer Centre (Assuming no phasing)	Nov 24 to December 2027
Commissioning	January to September 2028
Service Migration	March 28 to March 2029

The above timescales are based upon a single construction phase. Should the works be broken down into different phases the programme would need to be adjusted accordingly.

5 The Financial Case

5.1 Capital Affordability

The estimated capital cost range associated with each of the four short listed options is detailed in the table below. Do minimum represents the baseline option, and assumes completion of the Oncology Enabling project.

The table presents the low, mid and high estimates derived for each of the option and indicates an estimated capital cost for the preferred option of £635 - £700m.

Table 46: Capital Cost Range (£m)

Capital Cost Range (£m)	Option 2 Do minimum	Option 3 Re-provision: New build at WGH	Option 5 Enhanced re-provision: New build at WGH	Option 6 Enhanced regional re-provision: New build at WGH with regional satellite/outreach facilities
Low	26	428	616	635
Mid	28	446	644	663
High	29	468	678	700

5.1.1 Mid Capital Cost Estimation

The mid capital cost was estimated using information provided by the cost advisors or lifecycle data from the NHS Lothian capital planning system (where relevant).

Table 47: Mid Capital Costs (£m)

Capital Cost (£m)	Option 2 Do minimum	Option 3 Re-provision: New build at WGH	Option 5 Enhanced re-provision: New build at WGH	Option 6 Enhanced regional re-provision: New build at WGH with regional satellite/outreach facilities
Construction	0	159	212	212
Professional Fees & NHS Project Team Fees	0	13	17	17
Other Costs (Surveys, IT, Estates)	0	3	5	5
Equipment	0	26	49	49
Inflation	0	59	82	82
Sustainability Uplift - Zero Carbon	0	19	25	25
Lifecycle	23	0	0	0

Optimism Bias	0	93	146	162
Total Cost (excl VAT)	**23**	**372**	**536**	**552**
VAT	5	74	108	111
Total Capital Cost	**28**	**446**	**644**	**663**

The assumptions made in the calculation of the capital costs are detailed below. These will all be continuously refined through the business case process.

5.1.1.1 Option 2: Do minimum

The do minimum option costs represent the outstanding works required to the cancer centre in order to bring it up to a 'satisfactory' condition. Initial data is extracted from the NHS Scotland Capital Planning System – based on NHS Lothian Estates data - with an additional allowance for fees, VAT, and additional costs associated with decant and working in a live environment, based on previous experience and advice from cost advisors. The assessment of the mid-point cost assumes 5% of outstanding requirements are already addressed/ funded through the NHS Lothian backlog maintenance program. This considers a timeframe to 2027 in line with the proposed completion of options 3, 5 and 6.

The capital costs associated with the ongoing projects as detailed in section 2.1.2 are not included in the 'do minimum' option above as these projects have been separately approved and funding already committed.

5.1.1.2 Options 3, 5 and 6

Capital cost estimates provided by the cost advisors have been prepared based on the developed Schedule of Accommodation as detailed in Appendix 9, and the details of what areas are included within the scope of this cost are included in this Appendix.

This Schedule of Accommodation was developed based on information provided by a Healthcare Planner on the facilities required to deliver the strategic service model considering a timeframe to circa 2039 for most services. The services in scope are as detailed in **Figure 1**, those services specifically required for the ECC. No costs are included for the development of the 'Essential Services Hub' or wider WGH site Masterplan, both of which will be considered as part of separate enabling Business Cases.

Detailed assumptions in the determination of the capital costs are noted below:

- Options 3, 5 and 6 are based on information provided by cost advisors and benchmarked against similar projects.
- Optimism bias has been calculated in line with SCIM guidance and is included at 32.9% for option 3, 37.3% for option 5 and 41.4% for option 6, following an optimism bias workshop that took place on 23rd July 2020.
- Sustainability uplift has been included at 12% for options 3, 5 and 6 as an estimate of the uplift required to meet carbon zero targets. This estimate is in line with the SFT funding for schools programme, as details of this requirement are not yet available.
- Equipment has been included at 15% of costs plus an allowance of c£14m for high value equipment requirements (e.g. Linacs) for options 5 and 6.
- It has been assumed that there will be no additional capital costs associated with regional delivery associated with option 6. The optimism bias has been increased (by c.£16m) to represent the uncertainty associated with this assumption/ option.

5.1.1.3 General assumptions

In addition to the above the below assumptions have been applied across all options:

- Inflation has been included in all options based on the proposed construction timetable(s).
- VAT has been included at 20% on all costs. No VAT recovery has been assumed. Working with VAT advisors, VAT recovery will be further assessed in the OBC following confirmation of the procurement route.

5.1.2 Lifecycle Replacement Costs

It is acknowledged that the mid capital costs detailed above do not consider lifecycle replacement costs that will need to be met in the years following completion of construction. These annual capital costs are estimated below.

Table 48: Lifecycle Replacement Costs (£k)

Annual Lifecycle Capital Cost (£k)	Option 2 Do minimum	Option 3 Re-provision: New build at WGH	Option 5 Enhanced re-provision: New build at WGH	Option 6 Enhanced regional re-provision: New build at WGH with regional satellite/outreach facilities
Lifecycle	3,090	770	1,029	1,029

5.1.2.1 Assumptions

- Option 2: Based on information from the Capital Planning System – determined as the average estimated lifecycle replacement cost per year over the period 2018-2027.
- Options 3, 5 and 6: Based on an estimate of £25/sqm based on experience from previous new build projects.

5.1.3 High/ Low Capital Cost Estimation

It is noted that the estimated capital costs associated with each of the short listed options are sensitive to factors that are subject to uncertainty. A sensitivity analysis has been completed for each option to determine the estimated high/ low capital cost.

The assumptions made in the calculation of the high/ low costs are detailed below:

5.1.3.1 Option 2: Do minimum

- High: No regular maintenance/ replacement undertaken until 2027.
- Low: Increase in regular maintenance/ replacement to 10% of outstanding requirements per year

5.1.3.2 Options 3, 5 and 6

- High: Upper bound Optimism Bias and inflation +4%
- Low: Optimism bias adjusted to reflect the possibility of a more stable policy environment and a greater robustness of the output specification and inflation -4%

5.2 Revenue Affordability

The estimated incremental recurring revenue costs associated with each of the short listed options are detailed in the table below. These represent the additional revenue costs when compared to the baseline 'Do Minimum' option when the ECC is operating at full capacity.

The table below presents the low, mid and high estimates derived for each of the option and indicates an estimated incremental recurring revenue cost for the preferred option of £19.5 to £33.1m when operating at full capacity.

Table 49: Incremental Revenue Cost Range (£k)

Incremental Recurring Revenue Cost/year (£k)	Option 2 Do minimum	Option 3 Re-provision: New build at WGH	Option 5 Enhanced re-provision: New build at WGH	Option 6 Enhanced regional re-provision: New build at WGH with regional satellite/outreach facilities
Low	-	3,570	18,750	19,542
Mid	-	3,570	20,969	21,760
High	-	5,454	32,074	33,117

5.2.1 Mid Revenue Cost Estimation

The table below shows a breakdown of the mid revenue costs. The assumptions made in the calculation of the revenue costs are detailed below. These will be continuously refined through the business case process as a detailed staffing model is developed and the building design is refined.

Table 50: Mid Incremental Revenue Costs (£k)

Incremental Recurring Revenue Cost/Year (£k)	Option 2 Do minimum	Option 3 Re-provision: New build at WGH	Option 5 Enhanced re-provision: New build at WGH	Option 6 Enhanced regional re-provision: New build at WGH with regional satellite/outreach facilities
Staffing	0	1,904	6,472	7,120
Facilities Staffing	0	891	1,443	1,586
Non-Pays	0	124	11,959	11,959
Facilities Non-Pays	0	565	980	980
eHealth	0	86	115	115
Total Incremental Revenue Cost/Year	**0**	**3,570**	**20,969**	**21,760**

The assumptions made in the calculation of the revenue costs are detailed below. These will all be continuously refined through the business case process.

5.2.1.1 Option 2: Do minimum

The revenue costs associated with the ongoing projects as detailed in section 2.1.2 are not included in the 'do minimum' option above as these projects have been separately approved and funding already committed. There are therefore no additional incremental revenue costs associated with the do minimum option.

5.2.1.2 Options 3, 5 and 6

The incremental revenue costs for Options 3, 5 and 6 are developed based on the strategic service model and the schedule of accommodation. The detail on services in scope, and associated staffing cohorts are included in **Figure 1**. As with the capital costs no costs are included for the development of the 'Essential Services Hub' or wider WGH site support services, both of which will be considered as part of separate business cases.

There are two key drivers behind the incremental revenue costs: activity growth and the increased capacity provided by the shortlisted options.

As noted above these costs represent the revenue cost when the reprovided ECC is operating at full capacity and all beds, chairs and theatres are utilised. These are based on activity data provided by NHS Lothian and subsequent modelling provided by the Healthcare Planner with a timeframe to circa 2039.

The detailed assumptions made in the calculation of the revenue costs are detailed below.

- Staffing cost increases are based on the greater capacity of a re-provided cancer centre such as inpatient beds, chairs and Linacs.
- Facilities staffing cost increases are based on the greater capacity noted above and also consider the anticipated increase in single rooms.
- An additional increase in clinical and facilities staffing costs for option 6 has been included at 10%, due to the regional aspects of this option and the additional costs that this will result in.
- The main driver of the non-pays increase noted is drug growth. This is based on the average growth seen over the last 5 years.
- Facilities non-pays cost growth is driven by the increased footprint offset by maintenance benefits of a new building, based on prior experience.
- Incremental eHealth revenue costs are calculated as 10% of anticipated capital costs. This is to be further assessed in the OBC.

Depreciation costs are not included in the table above but are estimated to be £12.0m annually for option 3, £19.4m annually for option 5 and £20.0m annually for option 6. Depreciation is based on a useful life of 60 years for buildings and 10 years for equipment. It is assumed to be funded from an additional Scottish Government non core allocation, to be confirmed through the OBC process.

As noted above the re-provided centre would not be operating at full capacity immediately, this would happen over time. The staffing cost increases noted are based on operating at full capacity. An assessment of the day 1 revenue costs is included in the section below.

5.2.2 Day 1 Revenue Costs

The incremental revenue costs associated with options 5 and 6 presented above reflect a timeframe to 2039 when the reprovided ECC is operating at full capacity.

The proposed opening of the ECC is planned to be 2028 therefore costs will increase incrementally from this point to full operation in 2039.

Day 1 opening incremental revenue costs for Options 5 and 6 will be worked through in more detail in advance of submission of this IA to the NHS Lothian Board, and Scottish Government CIG. This will seek to project:

- forecast increase in revenue expenditure in the current configuration through activity growth to 2029, to be managed through the financial planning process;
- forecast increase in 'day one' costs in the new facility, reflecting a larger facility and increase in activity through growth; and
- step increases in costs from day one to full capacity.

5.2.3 High/ Low Revenue Cost Estimation

It is noted that the estimated revenue costs associated with each of the short listed options are sensitive to factors that are subject to uncertainty. A sensitivity analysis has been completed for each option to determine the estimated high/ low revenue cost when the ECC is operating at full capacity.

The assumptions made in the calculation of the high/ low costs are detailed below:

5.2.3.1 Low:

- Drug growth will be in line with the lowest growth that has been seen over the last 5 years.
- Additional 2% saving on drugs as a result of research trials savings.

It is also noted that there may be additional efficiencies and associated revenue cost saving that may arise as a result of this project and the associated service transformation. These will be researched as the business case develops and quantified and included in the financial models where possible. Please see the benefits section for further details.

5.2.3.2 High:

- Drug growth will be in line with the highest growth that has been seen over the last 5 years.
- Inability to recruit resulting in the use of agency and locum staff for 25% of posts in year 1 and 10% of posts in year 2.
- Optimism bias at 19% following an optimism bias exercise on revenue costs.

The below table summarise the impact on revenue costs from each of the noted sensitivities:

Table 51: Low/ high revenue cost impact (£k)

Risk	Change - Low (£k)	Change - High (£k)
Drug Costs	(1,991)	
		2,080
Trials Drugs Savings	(227)	
Inability to Recruit		5,041
Optimism Bias		3,984
Total	**(2,218)**	**11,105**

Revenue costs will continue to be refined through the OBC and FBC process and funding remains to be identified.

5.2.4 Revenue cost allocation

Revenue costs associated with the reprovision of the ECC are proposed to be split between the partner boards: NHS Lothian, NHS Borders, NHS Fife and NHS Dumfries and Galloway.

The allocation of revenue costs between boards noted below is based on activity as identified and agreed in the Oncology Enabling Business Case – it is for indicative purposes only at this stage. These are based on the mid-cost estimated and require to be reviewed and agreed with regional partners as the detailed costings develop. A second scenario is detailed which excludes NHS Dumfries and Galloway pending clarity on the strategic direction of this board. These represent incremental revenue costs when the ECC is operating at full capacity.

Table 52: Revenue Cost Allocation – Including Dumfries and Galloway (£k)

Board Share Of Staffing Costs	%	£K
Lothian	79.1%	17,212
Fife	8.0%	1,741
Borders	6.3%	1,371
Dumfries & Galloway	6.6%	1,436
Total	**100.0%**	**21,760**

Table 53: Revenue Cost Allocation – Excluding Dumfries and Galloway (£k)

Board Share Of Staffing Costs	%	£K
Lothian	84.7%	18,431
Fife	8.6%	1,871
Borders	6.7%	1,458
Total	**100.0%**	**21,760**

5.3 Overall Affordability

The capital costs detailed above are predicted to be funded through traditional capital funding and it is anticipated this will be provided by a specific allocation from the Scottish Government.

The revenue costs shown in this section are high level estimates for indicative purposes, and the assumptions behind them are stated in section 1.2. The configuration of services, and supporting staff models, will be defined further through detailed options appraisal at OBC. Affordability will be a key consideration, and detailed engagement will take place through existing regional forums – SEAT DoFs Operational Group and Regional DoFs, with approval by these groups a mandatory part of the OBC Governance group.

This project has been prioritised by NHS Lothian and the estimated costs are included in the NHS Lothian Property and Asset Five Year Investment Plan. However capital affordability will be determined by availability of a Scottish Government funding source and procurement route.

All costs will continue to be refined through the OBC and FBC process.

5.3.1 Fundraising

The aim of the Edinburgh & Lothians Health Foundation (ELHF) is to improve the physical and mental health of the people of Scotland, in particular in Edinburgh and the Lothians.

The ELHF support activities and projects that are over and above core funding and priority areas of support are:

- Improving the patient experience
- Family and carer support
- State-of-the-art equipment and technologies
- Modern patient environments
- Pioneering clinical and patient-centred research
- Volunteering programmes
- Arts and greenspace in health and wellbeing
- Professional development of NHS staff

ELHF have previously supported the Edinburgh Cancer Centre in the above areas and commit to continuing to do so through utilising historic endowment funds and building strong relationships with a variety of donors who wish to support the Edinburgh Cancer Centre's current and future patients and staff.

Working in partnership with the Edinburgh Cancer Centre to show the impact of donors' support will give Edinburgh & Lothians Health Foundation a strong position to develop and launch an additive capital fundraising campaign that supports a new facility or resources in the future.

6 The Management Case

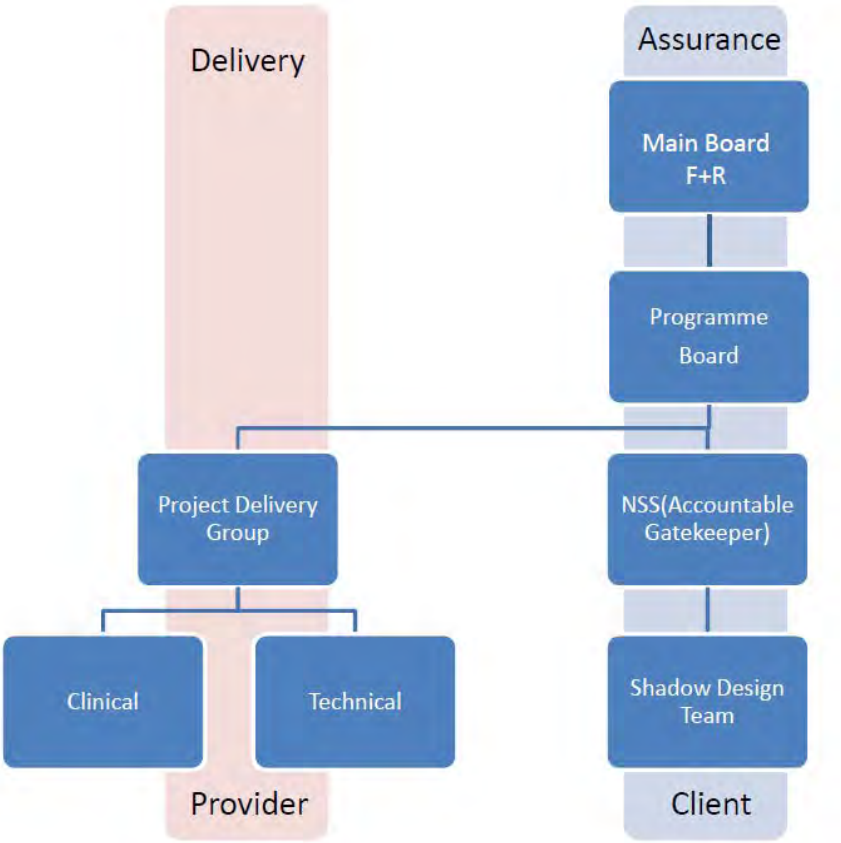
The purpose of the Management Case is to demonstrate that NHS Lothian is capable of successfully delivering the Edinburgh Cancer Centre Project.

The management and governance surrounding the project is of the utmost importance to NHS Lothian. Good governance, defined approval processes, robust project management and clear routes for escalating issues are essential as well as implementing lessons learned from previous capital projects across Scotland.

6.1 Reporting Structure and Governance Arrangements

A clear distinction will be made between the provider or deliverer and the client or receiver who will use the facility – Figure 23.

Figure 22: Reporting Structure



A shadow design team will be appointed by NSS to assist their Principal Engineer to provide independent assurance that the emerging design and finally executed facility is fully compliant with all current and relevant HFS and HPS requirements particularly all SHTM's.

Internal support to the Board's project team from within NHS Lothian from IPCT, Fire Officer, Health and Safety, eHealth and Estates and Facilities will liaise closely with NSS in respect to their individual disciplines.

The Project Delivery Group and NSS as the accountable gatekeeper will report directly to the Programme Board which will be chaired by the SRO as "client".

6.2 Project Governance

The project governance organogram show in Figure 23 has been developed to take the project forward at this stage. Each phase of the project will require different groups within the structure to perform specific roles. NHS Lothian may augment the structure with other relevant stakeholder as the project progresses.

6.2.1 Programme Board

The NHS Lothian Deputy Chief Executive is the Senior Responsible Officer (SRO) and "client" for the project and will have overall direction and leadership of the project. Final decision making authority on technical and contractual issues will also rest with the SRO.

The Edinburgh Cancer Centre Programme Board (ECCPB) is a strategic group responsible for ensuring that a dedicated, qualified and sufficiently resourced Project Team is in place to lead the delivery of the programme and that a robust project governance structure has been established that clearly links to the governance arrangements of the NHSL Board. The Director of Capital Planning, Director of Finance, Western General Hospital Site Director, Project Director, General Manager for Cancer Services, Associate Medical Director for Cancer Services and Strategic Programme Manager alongside other key stakeholders all have places on the Programme Board.

The NHS Lothian Board has considerable experience in the delivery of large value capital projects ranging from the Royal Hospital for Children and Young People (RHCYP + DCN) and East Lothian Community Hospital through to the Royal Infirmary Edinburgh. The NHS Lothian Board had also been heavily involved in the delivery of the Oncology Enabling projects at the Western General Hospital as well as the strategic Masterplan for the site.

The Cancer Capital Programme Board came into existence in June 2018 and meets every 2 months.

Table 54: Cancer Capital Programme Board Membership

Cancer Capital Programme Board Role	Individual	Capability and Experience
Deputy Chief Executive / SRO (Chair)	Jim Crombie	Executive Director with 35+ years of healthcare experience. SRO roles for major projects in last 10 years. Member of NHS Lothian Executive Leadership Team and NHS Board.
Site Director – Western General Hospital (Deputy Chair)	Chris Stirling	Senior NHS manager with 25 years experience in acute hospital management roles in NHS Scotland and NHS England. Experience of a variety of capital projects and service transformation and quality improvement programmes.
Project Director	Brian Currie	Construction professional, project manager and chartered architect with 40 years experience in the property and construction sectors in Scotland. Project Director for the RHCYP and DCN Capital Programme in Edinburgh since 2009.
Strategic Programme Manager	Lyndsay Cameron	MSP Qualified Programme Manager with several years of operational management experience and project delivery on the WGH site.

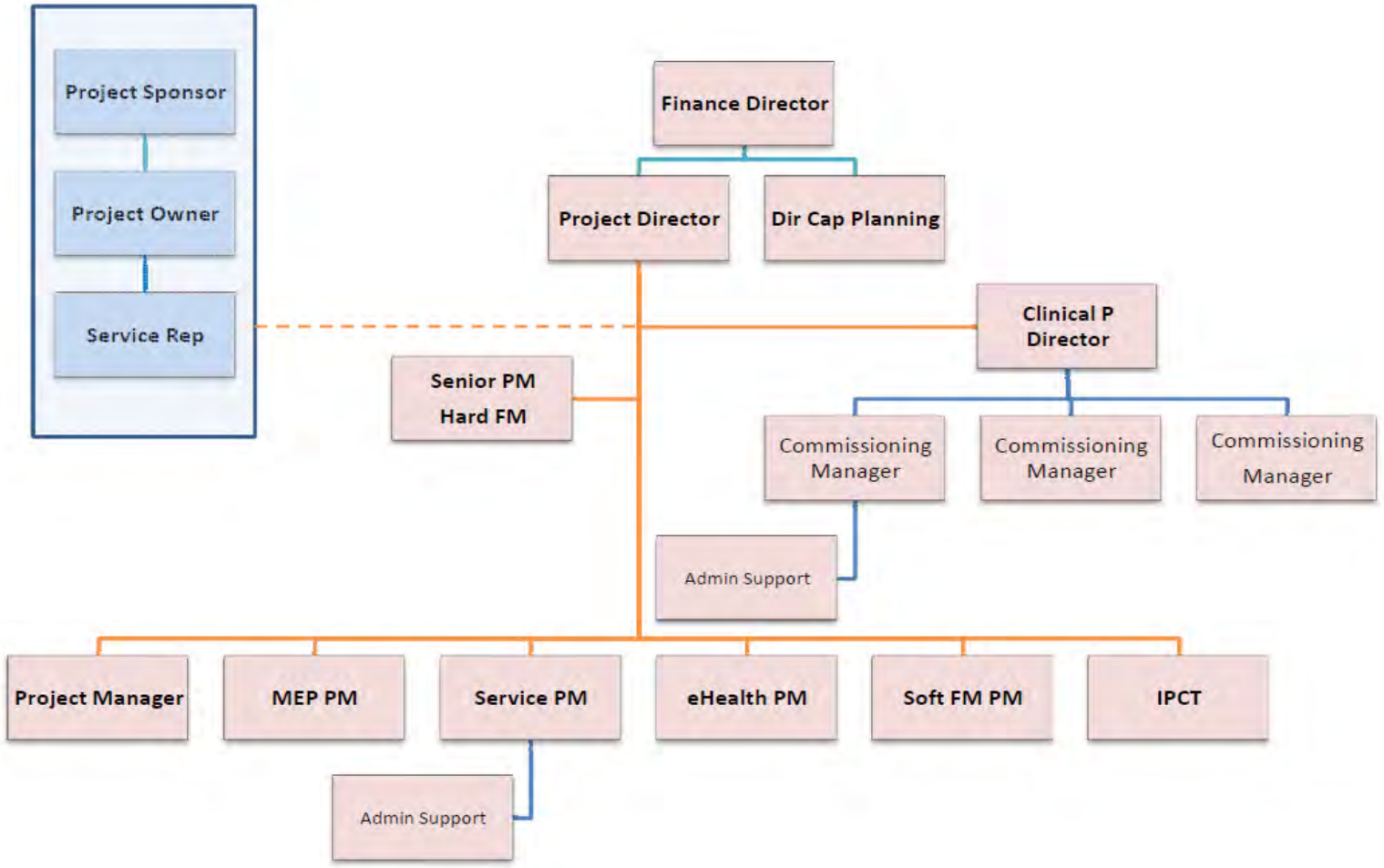
Cancer Capital Programme Board Role	Individual	Capability and Experience
General Manager, Cancer Services	Denise Calder	Senior NHS Manager with 16 years experience in acute hospitals management roles in NHS England and NHS Scotland. 7 years experience of managing Specialist Regional Cancer and Palliative Care Services. Experience of leading development of wide range of cancer facilities.
Associate Medical Director, Cancer Services	Larry Hayward, MBChB MRCP PhD DCO NRS Fellow	Consultant Medical Oncologist in Sarcoma and Breast Cancer with 15 years experience, Principal Investigator or Co-Investigator on multiple clinical trials. 3 years experience as Associate Medical Director Cancer Services NHS Lothian and formerly as Clinical Director Oncology, including as clinical lead on Oncology Enabling projects.
Clinical Leads	Steve Elliott, Clinical Nurse Manager	Senior Nurse with over 25 years experience in Acute sector, latterly within Cancer Services as a Clinical Nurse Manager. Experience in Patient Safety and Quality Improvement (Scottish Improvement Leader) initiatives across NHS Lothian.
	Linda Carruthers, Head of Oncology Physics	Medical Physicist with over 10 years experience of clinical and technical input into radiotherapy capital equipment and infrastructure projects.
	Heather Tait, Clinical Service Manager	Operational Service Manager for Oncology.
	Nicola McCloskey-Sellar, Clinical Service Manager	Operational Service Manager for Haematology.
	Catriona Mclean, Consultant Oncologist	Clinical Oncologist at ECC for 25 years, latterly with clinical ward management responsibilities (3 years).
	Oliver Young, Consultant Breast Surgeon	Consultant Breast Surgeon with 10 years experience and 5 years as Clinical Director of one of Europe's busiest breast units. Surgical lead for South East Scotland Breast

Cancer Capital Programme Board Role	Individual	Capability and Experience
	Angus Broom,Consultant Haematologist	Screening Programme. Haematologist at ECC for 9 years and Stem Cell Programme Director for South East Scotland for 7 years.
Director of Pharmacy	Melinda Cuthbert	Licensed pharmacist for over 26 years with 22 of these years in an acute hospital setting including cancer clinical pharmacy practice and SCAN Pharmacy Lead remit. Pharmacy Acute Service Lead with service redesign, quality improvement and smaller scale capital project experience.
Director of Capital Planning & Projects	Iain Graham	TBC
Director of Finance	Susan Goldsmith	A Director of Finance in the NHS in Scotland for the last 25 years. Significant experience of the oversight and delivery of capital projects and Lead Executive Director for the Board's Finance and Resources Committee.

6.2.2 Project Team

Using the recent RHCYP + DCN project as a model, the proposed structure of the project team is illustrated in Figure 24.

Figure 23: Proposed Project Team



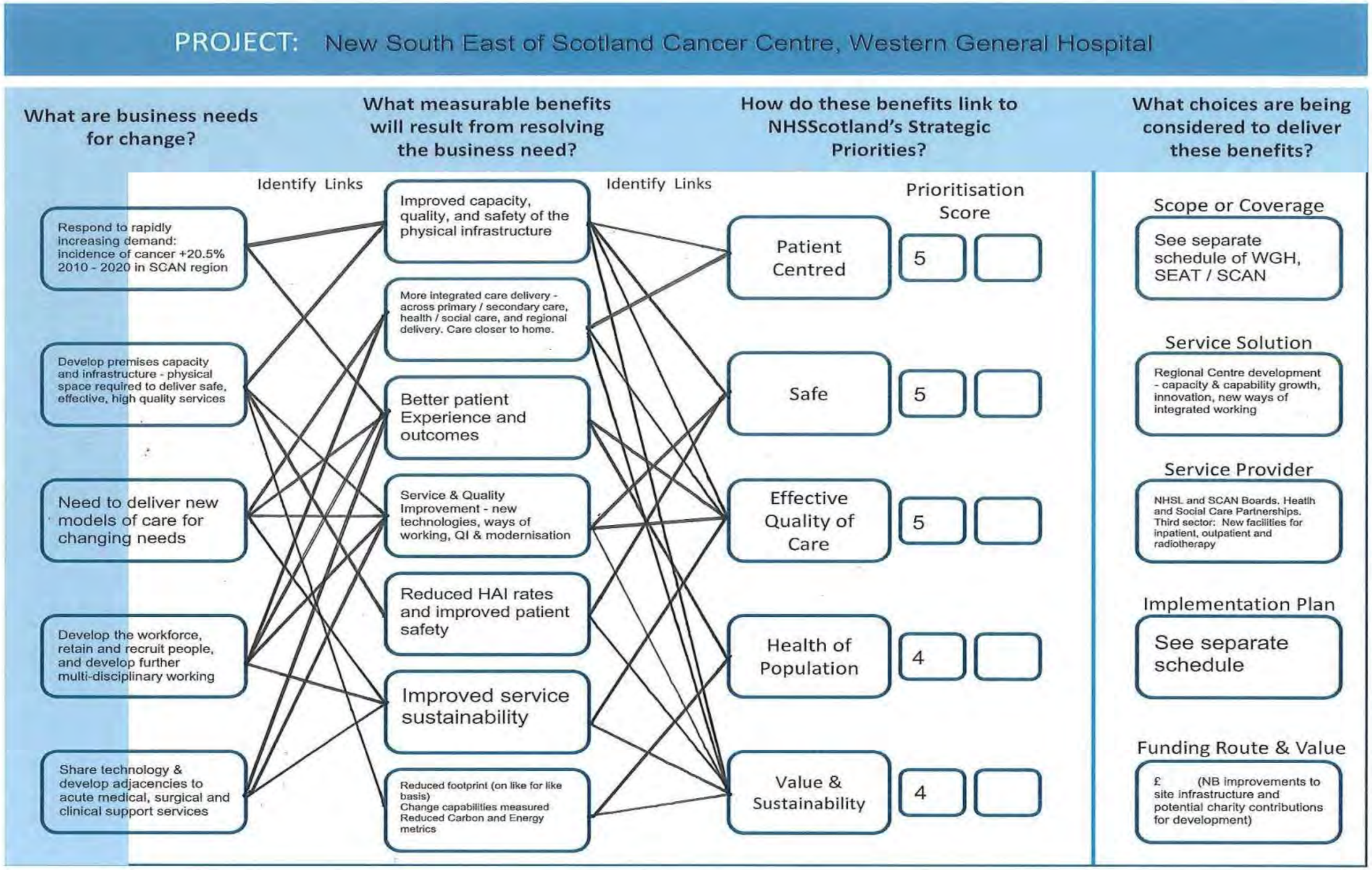
7 Conclusion

The Strategic Assessment for this proposal (included in Appendix 1) scored 23 (weighted score) out of a possible maximum score of 25.

The evidence base as contained in this IA confirms that this score remains valid.

The proposal has been prioritised by the relevant governance groups within NHS Lothian and the South East Region and identified as a priority for NHS Lothian and regional partners (NHS Fife, NHS Borders and NHS Dumfries and Galloway).

Appendix 1: Strategic Assessment



Appendix 2: Further Benefits Information

Table 55: Detail behind key benefits

#	Benefit	Details
1	Provision of **care closer to home** improves the **patient experience, reduces emissions, provides skilled employment opportunities in the region** and **reduces health inequalities**	Provision of care closer to home: provide an increased range of treatments in a patient's local area through regional delivery, provision of treatments not currently available in the SCAN region and use of technology to provide digital consultations. Provision of care closer to home reduces the distance that people have to travel - both within the local area and for some patients across the UK. This: - directly reduces emissions through less travel - reduces health inequalities by providing timely access to full range of specialty therapies and trials closer to home - benefits patients through a reduction in the time required to get to treatments and allowing patients to spend more time at home with families, in the community or at work - reduces inequalities by giving patients more options for treatment locally - lowering the cost to the patient of travel, time away from work or childcare - generates skilled jobs in the south east region area - supports flexible working for staff through the use of technology
2	An **improved environment for staff** results in improved **staff recruitment, retention** and **well being,** enhancing **economic participation**	An improved physical environment for staff including wellbeing spaces, technology to enable flexible working, collocation enabling collaboration: - benefits staff wellbeing - improved staff experience reflected in staff recruitment and retention and a reduction is sickness-related staff absence. - provides opportunities to engage with students/ young people - benefits staff recruitment including attracting national/ international talent - provides an environment to enable more training/ development opportunities - standardisation of design increasing staff efficiency and releasing time to focus on patient care
3	A flexible building that can be adapted to safely manage and treat different patient cohorts provides improved **service resilience** and supports a **transformed service model**	An adaptable building and skilled staff benefits service/ pandemic resilience: - highly skilled staff - flexible building suitable for segregation/ treatment of different patient cohorts - increased diagnostic capability
4	Increased ability to provide **precision medicine** through further collaboration with genomic services, building on University relationships and increasing clinical trials - resulting in **better**	Increased ability to provide precision medicine (tailored genetic treatments): - link to better patient data - better outcomes - build on link with IGMM (unit genetics) and Human genetic unit to develop and build new treatments to offer to patients and share wider - deepen collaboration with NHS Genomic Services (key link to Centre for Labs and Forensic Services (CLFS) business case)

#	Benefit	Details
	patient outcomes and clinical innovation	
5	Increased opportunities for **clinical trials** leading to **improved outcomes, equitable access ,better patient** and **staff experience** and **closer links between the NHS, academia and industry**	Increased trials capacity gives benefit of: - more patients being able to be involved in trials in different locations - a research active hospital delivers better outcomes for its patients - drives investment/collaboration - improves staff morale, retention and development - inward investment from pharmaceutical companies - both within and outwith the UK
6	**Collocating services** helps streamline patient pathways and aids staff collaboration improving the **patient experience** and **patient outcomes,** and provides synergies and adjacencies that optimise opportunities for research and innovation	The benefits of collocating services in a single area: - ease of collaboration between staff from different disciplines leading to better patient experience and outcomes - improvement in patient pathways by reducing length of wait through optimum service adjacencies - integrated care delivery
7	An **improved physical environment** for patients benefits **safety** and **the patient experience**	An improved physical environment for patients: - adequate space for safe treatment that meets applicable healthcare standards - improved inpatient experience protecting patient privacy and dignity, with provision for control of the personal environment, including reduced disturbance - a reduction in healthcare associated infection through modern design
8	More efficient buildings and reduced travel for treatment drives a **reduction in emissions**	Net zero emissions target: - an efficient building that minimises its impact on the environment and resources in terms of energy consumption and running costs, and its transport strategy - less travel by patients and staff through care closer to home
9	A national infrastructure project drives increased **skilled job opportunities** in the region from construction, R&D and clinical trials activity and associated innovative business growth	Job market benefits will be accrued throughout the project lifecycle: - promoting local employment and capabilities, particularly in the construction phase, through training and placement opportunities - engagement with small and medium sized enterprises and social enterprises - demand for local, national and international skilled staff to develop the clinical trials and R&D offerings - improved socio economic opportunities across the SCAN region by provision of a range of diverse jobs

#	Benefit	Details
10	An increase in **research and development** provides opportunities which **attract staff, drive economic innovation** and provide innovative treatments that **benefit patient experience and outcomes**	An increase in opportunities for Research and Development: - attracts staff locally, nationally and internationally - promotes collaborative working with higher education, in particular the University of Edinburgh through co-location with the IGMM and GMU at the WGH site - benefits patients through innovative treatments - provide staff with more training and development opportunities - benefits the economy through R&D activity supporting innovative companies
11	Future proofed **sustainable service** with capacity to provide **equitable access to healthcare**	Future proofed service with improved service capacity able to provide a sustainable service with a service model built to match demand: - reduction in waiting times (improved access for all) - improved service sustainability (ability to respond to growth) - Improved clinical outcomes through reduced waiting times and fewer cancellations
12	Redesigned patient pathways **improve the patient experience** and **clinical outcomes** and provide **unique opportunities for science and bench to bedside medicine.**	An integrated model of care: - providing access to early diagnostics, detection and treatment through an integrated service model - where possible, providing care as daycase/outpatient (rather than inpatient) to benefit the patient by allowing them to return home during or after their treatment, increasing the time they can spend with family - allowing patients the opportunity to self care in a non-clinical environment where possible, whilst having the support of the service should they require it
13	Ability to use **data driven innovation** to improve patient experience and outcomes through a more linked up data driven service model and provide **innovative business development opportunities**	Incorporation of the use of better data in to the model of care: - link between machines and their data developed to enhance the flow of clinical information between primary and secondary care, and between secondary care providers to reduce duplication of tests and loss of information - use data to expedite the correct decisions for a patient and improve their experience and outcomes. - use data regionally to more rapidly allow peripheral boards and hospitals to access the expertise needed from people in a different physical place - improve efficiency and benefit for patient care - pioneering data driven innovation in the UK/world to drive inward investment and attract staff

Table 56: Further detail on benefits mapping to SG National Performance Framework Outcome and indicators

#	Benefit	Mapping to SG Performance Framework National Outcome/ Indicator										
		Children and Young People	Communities	Culture	Economy	Education	Environment	Fair Work and Business	Health	Human Rights	International	Poverty
1	Provision of **care closer to home** improves the **patient experience, reduces emissions, provides skilled employment opportunities in the region** and **reduces health inequalities**	Provision of care closer to home allows parents to spend more time with their children and reduces travel costs they incur: Child wellbeing and happiness Child material deprivation			Reduced travel will result in reduced emissions: Carbon footprint Greenhouse gas emissions	Care closer to home reduces the disruption to young people's education and employment: Young People's participation		Care closer to home allows patients to reduce the time away from employment and provides skilled jobs across the region: Economic participation	Care closer to home provides more opportunities for active travel: Journeys by active travel	Care closer to home responds to the individual patients requirements: Public services treat people with dignity and respect Quality of public services		Care closer to home reduces travel costs they incur and disruption to their employment: Relative poverty after housing costs Wealth Inequality
2	An **improved environment for staff** results in improved **staff recruitment, retention** and **well being,** enhancing **economic participation**		Incorporation of green space into a reprovision benefits staff and patients physically and mentally: Access to green and blue space	Inclusion of artworks in a reprovided ECC: Attendance at cultural events or places of culture		An improved environment offers more opportunities and space from staff training and development: Work place learning Skill profile of the population	Alternative energy sources considered in building design: Energy from renewable sources		An improved environment for benefits staff wellbeing: Work related ill health	An improved physical environment provide staff with the space and facilities they need for their health and wellbeing: Public services treat people with dignity and respect		
3	A flexible building that can be adapted to safely manage and treat different patient cohorts provides improved **service resilience** and supports a **transformed service model**	Improved service resilience allows parents to spend more time with their children: Child wellbeing and happiness			Improved service resilience allows patients to reduce the time away from employment: Income inequality Economic growth			Improved service resilience allows patients to reduce the time away from employment: Economic participation	Improved service resilience can help save lives in pandemic events and provide comfort to communities that resilience is there: Healthy life expectancy Mental wellbeing Premature mortality			

#	Benefit	Mapping to SG Performance Framework National Outcome/ Indicator										
		Children and Young People	Communities	Culture	Economy	Education	Environment	Fair Work and Business	Health	Human Rights	International	Poverty
4	Increased ability to provide **precision medicine** through further collaboration with genomic services, building on University relationships and increasing clinical trials - resulting in **better patient outcomes and clinical innovation**	Reducing time in hospital and treatments required benefits children's mental health: Child wellbeing and happiness			Improved outcomes and timely access to treatment allows patients to reduce the time away from employment: Income inequality Economic growth	The use of data and research into new treatments gives staff opportunities to wider their knowledge and skills: Work place learning Skill profile of the population		Improved treatments and outcome allows patients to engage more in the economy: Economic participation	Increased genetic focussed treatments can benefit outcomes and reduce time spent in hospital: Healthy life expectancy Mental wellbeing Premature mortality	Precision medicine responds to the individual patients requirements: Public services treat people with dignity and respect Quality of public services		
5	Increased opportunities for **clinical trials** leading to **improved outcomes, equitable access ,better patient** and **staff experience** and **closer links between the NHS, academia and industry**				Increase opportunities for R&D and collaboration: Spend on research and development	The use of clinical trials to research new treatments gives staff opportunities to wider their knowledge and skills: Work place learning Skill profile of the population		Increase clinical trials portfolio and collaboration between NHS, Uni and private sector: Innovative businesses High growth businesses Economic participation Contractually secure work	Clinical trials involvement can benefit outcomes and provide wider access to innovative treatments: Healthy life expectancy Premature mortality		Clinical trials activity increases the NHS and SCAN area's profile internationally: Scotland's reputation Trust in public organisations International networks	Clinical trials involvement can provide wider access to innovative treatments: Wealth Inequality
6	**Collocating services** helps streamline patient pathways and aids staff collaboration improving the **patient experience** and **patient outcomes,** and provides synergies and adjacencies that optimise opportunities for research and innovation		Provision of care closer to home to help support and develop local areas: Perceptions of local area		Improved outcomes and timely access to treatment allows patients to reduce the time away from employment: Income inequality Economic growth	Collocation of services increases the opportunities for collaboration and staff development: Work place learning		Improved treatments and outcome allows patients to engage more in the economy: Economic participation	Increased genetic focussed treatments can benefit outcomes and reduce time spent in hospital: Healthy life expectancy Mental wellbeing Premature mortality			

#	Benefit	Mapping to SG Performance Framework National Outcome/ Indicator										
		Children and Young People	Communities	Culture	Economy	Education	Environment	Fair Work and Business	Health	Human Rights	International	Poverty
7	An **improved physical environment** for patients benefits **safety** and **the patient experience**	Provision an improved environment benefits children and parents through increased privacy and comfort: Child wellbeing and happiness	Incorporation of green space into a reprovision benefits staff and patients physically and mentally: Access to green and blue space	Inclusion of artworks in a reprovided ECC: Attendance at cultural events or places of culture			Alternative energy sources considered in building design: Energy from renewable sources		An improved environment for benefits patient wellbeing: Mental wellbeing	An improved physical environment provides patients with the space and facilities for privacy and dignity: Public services treat people with dignity and respect Quality of public services		
8	More efficient buildings and reduced travel for treatment drives a **reduction in emissions**		Reducing emission will improve air quality: Perceptions of local area		An efficient building can result in net zero emissions: Carbon footprint Greenhouse gas emissions				Reducing emissions can benefits on the populations health: Healthy life expectancy Premature mortality			
9	A national infrastructure project drives increased **skilled job opportunities** in the region from construction, R&D and clinical trials activity and associated innovative business growth	Provision on well paid jobs can provide children with a more stable environment and reduce poverty: Child wellbeing and happiness Child material deprivation	A growth in the job market provide opportunities to local communities: Social Capital		Creation of skilled jobs will drive growth in the economy and improve income equality Income inequality Economic growth	A growth in the job market can provide opportunities for young people: Young people's participation		Reprovision of cancer services will provide job opportunities throughout the project lifecycle - particularly construction and operation: Economic participation Employees on the living wage Contractually secure work	An improved job market can improve opportunities in the community: Mental wellbeing			Skilled job opportunities improves the job market: Relative poverty after housing costs Wealth Inequality

#	Benefit	Mapping to SG Performance Framework National Outcome/ Indicator										
		Children and Young People	Communities	Culture	Economy	Education	Environment	Fair Work and Business	Health	Human Rights	International	Poverty
10	An increase in **research and development** provides opportunities which **attract staff, drive economic innovation** and provide innovative treatments that **benefit patient experience and outcomes**				Increase opportunities for R&D and collaboration between NHS, Uni and Businesses: Spend on research and development Economic growth	Increase R&D activity provides additional opportunities for staff development: Work place learning		Increase opportunities for R&D and collaboration between NHS, Uni and businesses: Innovative businesses High growth businesses Economic participation Contractually secure work	R&D can benefit outcomes and provide wider access to innovative treatments: Healthy life expectancy Premature mortality		R&D activity increases the NHS and SCAN area's profile internationally: Scotland's reputation Trust in public organisations International networks	Skilled job opportunities improves the job market: Relative poverty after housing costs Wealth Inequality
11	Future proofed **sustainable service** with capacity to provide **equitable access to healthcare**		Equitable access to healthcare enhances cohesion in communities: Social capital		Improved timely access to treatment allows patients to reduce the time away from employment: Income inequality Economic growth			Improved treatments and outcome allows patients to engage more in the economy: Economic participation	A sustainable service with the required capacity can allow equitable, timely access to treatment: Healthy life expectancy Mental wellbeing Premature mortality	A sustainable service can provide timely equitable access: Public services treat people with dignity and respect Quality of public services		
12	Redesigned patient pathways **improve the patient experience** and **clinical outcomes** and provide **unique opportunities for science and bench to bedside medicine.**	Reducing time in hospital and treatments required benefits children's mental health: Child wellbeing and happiness			Improved outcomes allows patients to reduce the time away from employment: Income inequality Economic growth			Improved treatments and outcome allows patients to engage more in the economy: Economic participation	Streamlined pathways will help provide timely access to treatment: Healthy life expectancy Mental wellbeing Premature mortality	Redesigned pathways respond to the individual patients requirements: Public services treat people with dignity and respect Quality of public services		

#	Benefit	Mapping to SG Performance Framework National Outcome/ Indicator										
		Children and Young People	Communities	Culture	Economy	Education	Environment	Fair Work and Business	Health	Human Rights	International	Poverty
13	Ability to use **data driven innovation** to improve patient experience and outcomes through a more linked up data driven service model and provide **innovative business development opportunities**	Reducing time in hospital and treatments required benefits children's mental health: Child wellbeing and happiness			Improved outcomes and timely access to treatment allows patients to reduce the time away from employment: Income inequality Economic growth	Data driven innovation provides additional opportunities for staff development: Work place learning		Data driven innovation provides opportunities for businesses: Innovative businesses High growth businesses	Data driven pathways will help provide timely access to treatment: Healthy life expectancy Mental wellbeing Premature mortality	Data driven pathways respond to the individual patients requirements: Public services treat people with dignity and respect Quality of public services	Data driven innovation increases the NHS and SCAN area's profile internationally: Scotland's reputation Trust in public organisations International networks	

Table 57: Draft Benefits Register

1. Benefits Register						*2. Prioritisation*
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**
1	Provision of **care closer to home** improves the **patient experience, reduces emissions, provides skilled employment opportunities in the region** and **reduces health inequalities**	Qualitatively and Quantitatively	5. Change in number of remote consultations 6. Change in service provision throughout the Region 7. Change in number and distance of patient journeys for treatment 8. Patient satisfaction audits before and after reprovision			
2	An **improved environment for staff** results in improved **staff recruitment, retention** and **well being,** enhancing **economic participation**	Qualitatively and Quantitatively	1. Staff absence, turnover and bank and agency usage 2. Staff satisfaction audits before and after reprovision 3. Monitor environmental / facilities complaints before and after reprovision 4. SG National Indicator: Education/ Work place learning			
3	A flexible building that can be adapted to safely manage and treat different patient cohorts provides improved **service resilience** and supports a **transformed service model**	Qualitatively and Quantitatively	1. Diagnostic capacity and capability 2. Building flexibility (single rooms and adaptable wards)			
4	Increased ability to provide **precision medicine** through further collaboration with genomic services, building on University relationships and increasing clinical trials - resulting in **better patient outcomes and clinical innovation**	Qualitatively and Quantitatively	4. Specialities using genetic treatments and target cellular therapies 5. Offering access to novel treatment options through expansion of early phase trials programme 6. Change in patient outcomes for those treated using precision medicine			
5	Increased opportunities for **clinical trials** leading to **improved outcomes, equitable access ,better patient** and **staff experience** and **closer links between the NHS, academia and industry**	Quantitatively	1. Increase in number of clinical trials undertaken at ECC and across the region 2. Increase in number of NHS patients taking part in clinical trials 3. External investment received before and after reprovision			
6	**Collocating services** helps streamline patient pathways and aids staff collaboration improving the **patient experience** and **patient outcomes,** and provides synergies and adjacencies that optimise opportunities for research and innovation	Qualitatively and Quantitatively	1. Impact on waiting times performance 2. Impact in pathways involving multiple disciplines			
7	An **improved physical environment** for patients benefits **safety** and **the patient experience**	Qualitatively and Quantitatively	1. Reduction in DATIX incidents 2. Patient satisfaction audits before and after reprovision 3. Compliance with HEI and other relevant standards 4. Comparative levels of Healthcare Associated			

1. Benefits Register						2. Prioritisation
Ref No.	**Benefit**	**Assessment**	**As measured by**	**Baseline Value**	**Target Value**	**Relative Importance**
			Infection (HAI) – Infection Control Reports and Audits			
8	More efficient buildings and reduced travel for treatment drives a **reduction in emissions**	Quantitatively	1. SG National Indicator: Economy/ Carbon footprint 2. SG National Indicator: Economy/ Greenhouse gas emissions 3. Reduction in building energy usage 4. Reduction in patient journeys			
9	A national infrastructure project drives increased **skilled job opportunities** in the region from construction, R&D and clinical trials activity and associated innovative business growth	Quantitatively	1. SG National Indicator: Fair work and business/ Economic participation 2. Increase in skilled roles			
10	An increase in **research and development** provides opportunities which **attract staff, drive economic innovation** and provide innovative treatments that **benefit patient experience and outcomes**	Quantitatively	1. SG National Indicator: Fair work and business/ High growth businesses 2. SG National Indicator: Fair work and business/ Innovative Businesses 3. SG National Indicator: Economy/ Spend on Research and Development 4. Cancer Services research portfolio			
11	Future proofed **sustainable service** with capacity to provide **equitable access to healthcare**	Qualitatively and Quantitatively	1. Impact on waiting times performance 2. Reduced number of appointment cancellations			
12	Redesigned patient pathways **improve the patient experience** and **clinical outcomes** and provide **unique opportunities for science and bench to bedside medicine.**	Qualitatively and Quantitatively	1. Patient satisfaction audits before and after reprovision 2. Impact on length of stay an number of treatments delivered as in/ outpatient			
13	Ability to use **data driven innovation** to improve patient experience and outcomes through a more linked up data driven service model and provide **innovative business development opportunities**	Qualitatively and Quantitatively	1. Change in patient outcomes 2. Change in time to progress through patient pathway			

Appendix 3: Risk Register

WGH Cancer Centre
Risk Register - DRAFT
07 September 2020 - Rev. 3

Ref No:	Risk Type	Risk Description	Risk Rating: Probability (1-5)	Risk Rating: Impact (1-5)	Risk Rating (1-25)	Mitigation	Comments
	Pre-construction						
1	Client / Business Risk	The project disrupts day to day business operations for Cancer Services/WGH site wide	5	4	20	Undertake feasibility study to understand services, isolations and demolitions in order to clear the site. Develop construction phase planning via dedicated workshops in due course.	
2	Client / Business Risk	Client doesn't have the capacity or capability to deliver the project	3	4	12	Develop appropriate governance arrangements and develop a competent project team using internal and external resources. Backfill allowance to allow clinical staff to attend. Ensure staff turnaround review and comments for deadlines.	Lessons to be learned from issues encountered during the Department of Clinical Neurosciences (DCN) and Royal Hospital for Children and Young people (RHCYP) capital projects alongside the findings/recommendations from the Queen Elizabeth University Hospital (QEUH) enquiry. Some of the same internal project team is likely to be responsible for delivering the Edinburgh Cancer Centre and will ensure these lessons are learned.
3	Client / Business Risk	The clinical need for change and expected outcomes isn't clearly defined. Difficulty in predicting the future needs.	2	4	8	Set out a plan to engage with service providers to fully understand the service based need for change and the expected outcome from investment. Articulate in business case. Design to ensure flexibility for future changes.	
4	Client / Business Risk	Poor stakeholder involvement results in a lack of support for the project	3	4	12	Prepare and implement an appropriate communication plan which engages with all appropriate stakeholders at appropriate stages of the project. Early engagement vs. Engagement Fatigue. Regional participation could be impacted by various factors.	Funding allocated to NHS Fife and Borders to enable appropriate strategic input into the programme as it develops.
5	Client / Business Risk	Adverse publicity occurs due to an issue with the project	4	4	16	Review the reputational impact of all risks in this register and take action. Communication. Robust and realistic planning/programming. Learn from other projects (e.g. Department of Clinical Neurosciences (DCN) and Royal Hospital for Children and Young people (RHCYP) capital projects)	
6	Client / Business Risk	Capacity - rapidly growing and ageing population, increase in cancer incidence and increase in treatment options exacerbating service pressures Demand for the service does not match the levels planned, projected or presumed.	3	4	12	Plan using national indicators. Implement internal and external engagement sessions to ensure alignment. Commission an external peer review. Regular modelling updated with real time inputs. Differences between cancer types and treatment type. Flexibility within the design. Benchmark against other areas.	Review of population forecasts, both size and age would impact the planned levels.
7	Client / Business Risk	Planned facilities do not meet stakeholder expectations.	3	4	12	Develop design statement and ensure ongoing engagement via AEDET etc measuring the proposals against the brief. Management of expectations. Correct media for engagement. Ensure aspirational expectations - not settling. Acknowledgement that you can't meet everybody's expectations. Communication.	

8	Client / Business Risk	Workforce: 1. Availability of workforce across various professional groups across the South East Region. 2. No timely increase in training places for certain professions and any changes will take time to feed through. 3. Transformed models of care reliant on recruitment and retention of specialist staff across the South East Region.	4	5	20	1. Clearly outline the workforce required identifying current challenges. 2. Develop a comprehensive risk assessed regional workforce plan as part of the outline business case 3. Provide staff training and education facilities	
9	Client / Business Risk	Existing Stakeholder (Edinburgh University) lease arrangements may constrain the proposed master-plan including timing/sequencing.	3	3	9	Arrange regular dialogue meetings to discuss, share and agree plans. Workshop to review alignment of goals - agreed to be scheduled.	
10	Client / Business Risk	Internal and external approvals processes may delay the programme.	3	3	9	Take account of approval processes within the master programme. Early and ongoing engagement and communication.	
11	Client / Business Risk	Availability and experience of a suitable/reliable contractor and supply chain to undertake this size of project in the local market.	3	4	12	To be considered as part of the commercial case within the IA.	
12	Client / Business Risk	Regions unwilling to accept the preferred option or unable to articulate their future requirements impacting upon the scope and success of the Regional model.	3	5	15	Continuous dialogue and colaboration with Regional Partners to ensure agreement on plans proposed.	
13	Client / Business Risk	Lack of ambition results in the loss of potential revenue.	3	3	9	Review the brief with a view for maximising future revenue streams	
14	Client / Business Risk	Failure of IA to gain approval due to: - understatement of socio-economic impact; or - articulating full vision.	2	5	10	Early and regular review of IA between cross section of stakeholders.	
15	Client / Business Risk	COVID-19 - impact on future arrangements and provision.	4	4	16	Engage internally and externally to understand long-term future requirements and adjust the briefing to suit.	
16	Planning / Design Risk	Local community objects to the project	3	4	12	Liaise with planning. Undertake early and ongoing community engagement sessions as part of the planning process.	
17	Planning / Design Risk	Statutory Consents. May fail to acquire or delay in obtaining.	3	4	12	Place brief for planning in place. Ongoing engagement with planning and statutory authorities.	
18	Planning / Design Risk	Information used as part of the strategic & project brief is unpredictable or subject to change.	3	4	12	Commission an external peer review. Develop the clinical and technical briefs as separate workstreams. Implement internal and external engagement sessions to ensure alignment.	
19	Planning / Design Risk	New clinical pathways still not tested which may impact on schedule of accommodation.	4	4	16	Ensure SoA is robust/flexible enough to cope with some change. Start development of new operational policies for clinical brief. Continuous feedback loop.	
20	Planning / Design Risk	The design does not meet the Design Assessment expectations	3	3	9	Undertake self assessments. Resolve any issues arising.	
21	Planning / Design Risk	Failure to design in accordance with statutory requirements and appropriate healthcare guidance. Derogations are not signed off - disagreement with SHTM/HTM.	2	5	10	Appoint a professional and experienced team of designers and contractors. Checking process.	
22	Planning / Design Risk	The design may not reflect the brief and requirements.	2	4	8	Appoint a professional and experienced team of designers and contractors. Carry out design reviews at key stages. Capture comments and resolve prior to entering a subsequent design stage. Exemplar design/reference design. Continuity and appropriateness of reviewers	The potential for all single rooms was discussed,if this was to be implemented day rooms would be required to allow patients the ability to leave their rooms and socialise.
23	Planning / Design Risk	The master-plan may not support the optimum site location for the building - decant of DCN.	3	4	12	Engage with the WGH/NHSL master-planning group.	
24	Planning / Design Risk	Site infrastructure may not be able to support the project's requirements.	3	5	15	Engage with the Infrastructure project. Advise what supplies and services the Cancer Centre will require. Discuss and agree timelines.	

25	Planning / Design Risk	The facilities do not have flexibility to respond to future service needs.	3	4	12	Capture flexibility as a key principle within the briefing. Assess this at key design review stages.	
26	Planning / Design Risk	The new design fails to meet carbon/green targets	3	4	12	Engage with the Infrastructure project. Identify carbon/green targets at an early stage.	
27	Planning / Design Risk	The new Cancer Centre fails to link with other services due to location i.e. critical care.	3	3	9	Review of location of services within Cancer Centre and proximity to other services located elsewhere on site.	
28	Construction / Property Risk	Site condition risks.	3	4	12	Collate existing site information. Commission a feasibility study. Commission surveys and investigations as required to mitigate risk.	
29	Construction / Property Risk	Risk associated with working in a live environment.	4	4	16	Undertake feasibility study to understand services, isolations and demolitions in order to clear the site. Develop construction phase planning via dedicated workshops in due course.	
30	Construction / Property Risk	Estates request an onerous level of asset management	3	3	9	Ensure that the level of asset recorded is suitable for a project of this size and complexity.	
31	Finance Risks	The project estimate is poorly prepared and inaccurate	3	4	12	Develop robust SoA - use Lead Advisor / Cost Advisor to prepare initial cost plan using current benchmarking and inflation allowances. Allow for appropriate optimism bias at this early stage in the process.	
32	Finance Risks	The project becomes unaffordable: - Capital funding not approved by SG - Revenue funding not approved by NHS Lothian	4	5	20	Initial Agreement clearly articulating the value of a world class cancer facility in Edinburgh. Transformed ways of working to show best use of public monies. Transformed services based on most efficient use of workforce to demonstrate value for money.	
33	Finance Risks	Inflation costs rise above those projected	4	4	16	Optimism bias at IA and risk register at OBC should help to mitigate this risk.	
34	Finance Risks	Changes in legislation or tax rules increase project costs	4	4	16	Optimism bias at IA and risk register at OBC should help to mitigate this risk.	
35	Finance Risks	Equipment budget is insufficient	4	3	12	Liaise with HFS to agree a realistic equipment budget for the project. Departmental reviews.	
36	Finance Risks	Uncontrolled changes may lead to affordability issues.	3	4	12	Ensure that the project is structured properly with good governance and project management. Communication from stakeholders - robust consultation and IA.	
37	Finance Risks	Revenue costs may be understated.	3	4	12	Engage early with NHSL finance. Ensure that they are involved in developing the financial case for IA. Understanding the design and it's impact on revenue (single rooms vs multi bed - issues).	
38	External Risks	Changes to policy affects project cost or progress	3	3	9	Managed with risk allowances. Governance to confirm changes to be implemented as a result of external factors.	
39	External Risks	There are uncertainties over future policy changes	3	3	9	Managed with risk allowances. Governance to confirm changes to be implemented as a result of external factors.	
40	External Risks	The project does not align with Scottish Government cancer strategy.	3	3	9	Refresh of Beating Cancer Ambition and Action 2016 has been released (March 2020) and the Proposed Clinical Model specifically addresses key aspects of this strategy, alongside key aspects of several other local and national strategies.	
41	External Risks	Brexit/IndyRef2/Political Risks	4	4	16		It was noted that we are currently experiencing unprecedented political uncertainty and that this could impact the project in a number of different ways.

Appendix 4: Stakeholders List

Internal Stakeholders	External Stakeholders
All NHS Lothian staff (Everyone) Clinical, administrative & support staff	Patients and Patients' relatives
Staff on the WGH site	The public including neighbourhood and local community groups
Medical Staff Committee	Carers
Site Management Team	Patient Councils
Acute Senior Manager Team	Patient Public Forums Cancer patient group
Regional and Scottish Ambulance Service Managers (Planning)	Stakeholder groups with specific interests
Finance Department	Voluntary and third sector organisations – Edinburgh and the Lothians Health Foundation (ELHF) Maggies Edinburgh (presence on site) Macmillan Cancer (presence on site) Welcome Trust (presence on site) Cancer Research UK Scottish Cancer Foundation Breast Cancer Now Kidney Research UK Diabetes UK A recent Third Sector Audit has identified over 50 Third Sector organisations that currently provide services to Cancer Centre patients.

Quality Improvement Department	Volunteers
Human Resources Department	Members of the public (not in other groups categorised)
Communications Department	Politicians (community council, council, Scottish Government)
	The media (print, broadcast, online and social)
Lothian Partnership Forum	National NHS Boards : National Service Scotland (including NHS National Specialist and Screening Services Division (NSD)) NHS 24 NHS Health Scotland Healthcare Improvement Scotland (Send to each Board and let them cascade appropriately)
Lothian NHS Board	Key decision makers and opinion formers
Strategic Planning Department & Strategic Planning Committee	Edinburgh Integration Joint Board Mid Lothian Integration Joint Board East Lothian Integration Joint Board West Lothian Integration Joint Board (Primary Care – GPs, Dentists, Pharmacists – local practiced and/or Area Committees)
Finance and Resources Committee	Edinburgh Health and Social Care Partnership Mid Lothian Health and Social Care Partnership East Lothian Health and Social Care Partnership

	West Lothian Health and Social Care Partnership
Lothian Capital Investment Group	Police
Cancer Capital Programme Board	Armed Services
WGH Energy Programme Board	Scottish Fire and Rescue
Renal Project Group	University of Edinburgh: on site, Corporate and Estates
RHSC & DCN Programme Board	Health Facilities Scotland
Cancer Enabling & Haematology Project Working Groups	Architecture & Design Scotland
	Scottish Health Service Centre

Appendix 5: Design Principles

Co-Design Team One

Group members (names redacted for GDPR purposes)
MacMillan Information & Support Manager
Carer
Patient
NHS Lothian Clinical Service Manager for Cancer Services (Facilitator)
SCAN Patient Involvement
Cancer Services, Project Support Officer
NHS Lothian Public Involvement and Engagement Manager

Holistic wellbeing for everyone

1. **Design of the building should be welcoming and friendly**
   - 1.1. From the outside, as well as inside, dimensions should be "human" in scale
   - 1.2. Airy, warm and bright with natural daylight
   - 1.3. Outside green space availability with easy access and easily visible from the inside
   - 1.4. Building design should not be intimidating or imposing

2. **A clear main entrance including a welcome hub with orientation aids**
   - 2.1. Clear wayfinding help
   - 2.2. Easy to understand signage
   - 2.3. Designed to recognise that people arriving may be in a stressed state
   - 2.4. Consider zoning for ease of wayfinding

3. **The building should be designed to respect patients and staff privacy**
   - 3.1. Consideration given to pathways through the hospital and as far as possible avoid the movement of patients (ie. in beds/trolleys) through busy public areas
   - 3.2. Waiting areas not in corridors
   - 3.3. Mixture of waiting areas to allow privacy for patients who require it
   - 3.4. Include non-clinical rooms for counselling, quiet space, discussion near to clinical areas and easy to access

4. **Protect privacy and dignity of patients and staff when bad news is related to patients**
   - 4.1. Appropriate areas within clinical spaces for bad news
   - 4.2. Break out areas for staff (away from patients and visitors)
   - 4.3. Consideration of patient location and pathway after receipt of bad news
   - 4.4. Bereavement suite

5. **The building should be designed to respect patients and staff dignity**
   - 5.1. Accessible and convenient spiritual place for use by staff, patients and visitors
   - 5.2. Signage, wayfinding and information in variety of languages
   - 5.3. Appropriate number of toilets for patients and staff, convenient, within easy access and clearly signposted
   - 5.4. Specific consideration should be given to supporting end of life care

5.5. Appropriate number of changing facilities and showers for staff
5.6. Designated wheelchair areas at entrances to building, with properly maintained wheelchairs

6. **The design should include high quality facilities for staff and patients with children**
   6.1. On site nursery
   6.2. Play areas for children
   6.3. Breast feeding area
   6.4. Changing facilities for babies
   6.5. Gender neutral

7. **Supportive services should be centralised, accessible, welcoming and encourage usage**
   7.1. 3rd sector partners visible and accessible to encourage use
   7.2. Carers hub providing specific support to carers
   7.3. Hub for inpatients/outpatients providing clear and accessible information upon arrival and during visits/stays

8. **The design needs to include hotel quality accommodation for patients from rural areas and those travelling long distances for their treatment**
   8.1. Separate, quality accommodation with opportunities for social interaction among those using this form of accommodation
   8.2. Self catering facilities

9. **Facilities for staff should be enhanced and fit for purpose**
   9.1. Meeting/training rooms
   9.2. Changing facilities and showers close to places of work
   9.3. Toilets
   9.4. Break out rooms
   9.5. Lunch and break facilities and private space

Co-Design Team Two

Group members(names redacted for GDPR purposes)
Cancer Services Clinical Nurse Manager
Oncology Ward Senior Charge Nurse
Patient
Cancer Services Programme Manager (Facilitator)
Strategic Programme Manager, Cancer Services
Service Change Advisor for Scottish Health Council
FACE representative

Access, environment and technology

10. **A range of options for improving transport links should be included**
    - 10.1. Shuttle bus from local transport hubs
    - 10.2. Drop off/pick up zones with wheelchair access
    - 10.3. Multiple bus stops through the site
    - 10.4. Clear zones to improve patient journey should be implemented (e.g. red zone for outpatients, yellow zone for oncology day unit)
    - 10.5. User friendly electronic updates of transport
    - 10.6. Safe path for walking around the site for staff and patients to enjoy

11. **The design of the building and surroundings should be accessible and user friendly**
    - 11.1. Appropriate access to accommodate all abilities
    - 11.2. Up to date with dementia standards
    - 11.3. Clear signage
    - 11.4. Be mindful that not all disability is visible

12. **The design of the entrance should provide personalised and friendly information and wayfinding**
    - 12.1. Member of staff to greet people if possible
    - 12.2. Volunteers to assist with wayfinding

13. **The design should make use of latest technology and supporting infrastructure to support the patient experience**
    - 13.1. Up to date, future-proofed IT
    - 13.2. Safe and protocolised IT systems
    - 13.3. Increased digital profile of the information for patients and visitors
    - 13.4. Supporting online consultations
    - 13.5. Social media friendly and positive online presence

14. **The design of the space should be mindful about natural light and maximise access to it**

15. **Patient rooms should be spacious, single occupancy and family friendly**
    - 15.1. Space for family/carers should be incorporated

16. **The design should demonstrate consistent branding with possibility of variety of colours to differentiate specialities**

17. **The building should include some flexible space to allow room for growth of the services**

18. **The design should include a variety of car parking and parking should be adequate.**
    18.1. Off site but safe and easily accessible (shuttle bus)
    18.2. On site, close distance to entrance
    18.3. Clear instructions on parking should be issued with joining instructions to avoid stressing patients
    18.4. A range of options should be available for staff to retain current staff and encourage staff to work at WGH

19. **The design of the building should include adequate and safe storage for each area including for patient's belonging**

20. **The design of the building should incorporate:**
    20.1. Buzzer access to wards within strict but clearly advertised visiting hours
    20.2. Fire safety
    20.3. ID cards access for staff
    20.4. Confidentiality
    20.5. CCTV
    20.6. Catering should meet the needs of patients and staff
    20.7. Supportive, holistic services connected to main treatment areas
    20.8. Social spaces both together and option for staff to have separate space

Appendix 6: Option Assessment

WGH Cancer Centre Option Assessment 30.04.19

	Option	2						3						4						5						6					
	Table	1	2	3	4	5	Summary	1	2	3	4	5	Summary	1	2	3	4	5	Summary	1	2	3	4	5	Summary	1	2	3	4	5	Summary
Assessment Criteria																															
Increased service capacity and sustainability to meet rapidly increasing demand																															
Building designed to provide appropriate facilities to deliver safe and effective, high quality clinical care that meets all applicable healthcare building standards																															
Opportunities available to ensure recruitment and retention of specialist																															
Provide Care Closer to Home where clinically appropriate and financially viable																															
Full range of specialist cancer therapies available for the patients of South East Scotland (where UK best practice and specialist commissioning criteria can be met)																															
Integration of Clinical Research and Trials																															

Discount – only if clearly unfeasible - D
Carry Forward – Less attractive - CFL
Carry Forward – More attractive - CFM
Preferred - P

Appendix 7: IIA Action Plan

Integrated Impact Assessment: Summary Report Template

Each of the numbered sections below must be completed

Interim report	✓	Final report		(Tick as appropriate)

1. Title of plan, policy or strategy being assessed

Re-Provision of the Edinburgh Cancer Centre

2. What will change as a result of this proposal?

Re-provision of the Edinburgh Cancer Centre is an opportunity to transform the way cancer services are delivered and to construct a purpose built facility for cancer patients based upon transformed patient pathways.

3. Briefly describe public involvement in this proposal to date and planned

There have been a wide range of Stakeholder Engagement activities to date which are due to continue in order to shape and inform the development of the Initial Agreement (IA). More detail on these can be found in s3.2 of the IA

4. Date of Integrated Impact Assessment (IIA)

28th November 2019

5. Who was present at the IIA? Identify facilitator, Lead Officer, report writer and any partnership representative present and main stakeholder (e.g. NHS, Council)

Name	**Job Title**	**Date of IIA training**
names redacted for GDPR purposes	Lead on Equalities and Human Rights, NHS Lothian Strategic Programme Manager, Cancer Services, NHS Lothian Patient Involvement Manager, SCAN, NHS Lothian Patient Engagement and Involvement Manager, NHS Lothian Clinical Service Manager, Cancer Services, NHS Lothian	November 2017 November 2018 2018

	Assistant Finance Manager, Capital Finance, NHS Lothian Macmillan Programme Manager, NHS D&G Patient Associate Medical Director, Cancer Services, NHS Lothian Carer Service Change Advisor, Scottish Health Council Head of Oncology Physics, NHS Lothian Patient Directorate Assistant, Cancer Services, NHS Lothian Assistant Service Manager, NHS Borders Project Support Officer, NHS Lothian Project Development Worker for Equality and Rights Network GP Lead, NHS Lothian Capital Finance Manager, NHS Lothian Partnership Lead, Western General Hospital	

6. Evidence available at the time of the IIA

Evidence	Available?	Comments: what does the evidence tell you?
Data on populations in need	Yes	NHS Lothian is part of the South-East Scotland Cancer Network (SCAN) and works collaboratively with NHS Borders, NHS Fife, and NHS Dumfries and Galloway to plan and deliver cancer services across the South East of Scotland. The centre provides a regional service which serves a population of almost 1.5

Evidence	Available?	Comments: what does the evidence tell you?
		million in South East Scotland. All highly specialist cancer care is provided to SCAN Region patients in NHS Lothian. Where possible, assessment and diagnosis is undertaken locally in the NHS Board of the patients residence however some regional patients will be referred to NHS Lothian for clinical assessment and diagnosis of suspected cancer. Some treatment services (such as radiotherapy and complex chemotherapy provision) are exclusively provided by NHS Lothian. The proposal relates to service users in the South East region that use the service. Demand for Cancer services is rising annually in response to a number of key drivers: - Aging demographic - Increasing population within Lothian and the SCAN region which is expected to continue - Increased cancer incidence across the SCAN region - Improved diagnostics - Increased screening/early cancer detection - Increased number of effective treatment options licensed and Scottish Medical Council (SMC) approved. - Increased use of multiple lines of Systemic Anti-Cancer Therapy (SACT) Many more people are living with and beyond cancer resulting in a need to focus on early prevention and detection to meet the challenge of cancer as well as adding a complexity to care planning and delivery for those who are living with the consequences of cancer or cancer treatment.
Data on service uptake/access	Some	NHS Lothian carried out an engagement process in preparing an Equality Outcomes document for 2018-2021; those consulted

Evidence	Available?	Comments: what does the evidence tell you?
		told us that there are four important Outcomes to focus on. These are • Better Access • More Compassion • More Participation • Justice **Access** The Scottish Government Cancer Strategy Beating Cancer; Ambition and Action (March 016) states that health inequalities in cancer outcomes will be improved by taking action to help more equitable access to screening, earlier diagnosis, support for health literacy and access to services to support people who are living with cancer that are aimed directly at hard-to reach groups. Health inequalities across Scotland mean that cancer incidence is more common in the most deprived areas of Scotland - incidence rates have typically been 30% to 50% higher in the most deprived compared to the least deprived areas. There are a number of reasons for this including lifestyle choices and variations in screening uptake which ultimately have an impact on cancer survival for some types of cancer. Health inequalities can also be found in cancer mortality rates. Of people in the 45 to 74 year age group, those living in most deprived areas are more than twice as likely to die of cancer than those in the least deprived areas. The gap between least and most deprived areas is projected to continue to widen. Action needs to be taken to reverse this by firstly understanding what this means within the context of the South East Region and planning proactively as to how we can address this.
Data on equality outcomes	Some	In the Scottish Government Cancer Strategy Beating Cancer; Ambition and Action (March 2016) it highlights evidence that shows people from deprived communities are more likely to have

Evidence	Available?	Comments: what does the evidence tell you?
		poorer health outcomes and they also use acute services more than the population as a whole. The Health Promoting Health Service ethos provides an opportunity to address inequalities and the Scottish Government are supporting NHS Boards to ensure that routine enquiry for vulnerability is built into person-centered care and, therefore, those at risk of poverty and inequality attain the best possible health outcomes. We must continue to develop this ethos as the proposal develops. **Transforming Care After Treatment (TCAT),** a five year programme funded by Macmillan Cancer Support Scotland, is a partnership between the Scottish Government, Macmillan Cancer Support, NHS Scotland, local authorities and third sector organisations that focuses on the care and support of people after treatment for cancer. A TCAT pilot in Lothian for patients with breast, gynecological, anal, rectal and lung cancer highlighted the benefit of offering care after cancer treatment based around an assessment of individual needs. By identifying issues that were important to a person's health and wellbeing, and jointly working with them to manage their recovery through shared planning, patients reported a return of confidence and sense of control. Additionally, having a single point of staff contact was hugely beneficial to many participants, which helped them feel 'less alone'. This programme is an example of the benefits gained by focusing on outcomes based on individual needs.
Research/literature evidence	In progress	Evidence of effectiveness - the need to consider how effective our services are for the different population groups we serve. The concepts of compassion (we will always seek the best for the people we

Evidence	Available?	Comments: what does the evidence tell you?
		work with - both our patients and their families and communities, and our own staff), participation (the right to have a say in decisions that affect us - "nothing about me without me") and justice (the duty of NHS Lothian to understand the impact of its policies, procedures and services on different groups within the population) will underpin this evidence. A summary sentence for each of the main patient groups - will be added to this table in due course.
Public/patient/client experience information	Yes	There has been a version of Experience Based Co-Design undertaken with a variety of patients as part of the IA Development process. This includes a patient video which can be seen here: https://vimeo.com/318729227 Using the following password: CodesignECC And a range of other activities including compiling a Design Statement, an Options Assessment event and discussion of the proposed Clinical Model. Further information on this process is available upon request.
Evidence of inclusive engagement of service users and involvement findings	In progress	We are keen to involve as wide representation from service users as possible as the project develops. As described above, a series of workshops have occurred as part of the development of the Initial Agreement however we also plan to launch a wider communications strategy as the programme progresses to gather as many opinions as possible.
Evidence of unmet need	Yes	Currently, there are delays at different points on the pathway for cancer patients. NHS Lothian's performance is below the 95% compliance rate for the 31(days from decision to treat to treatment) and 62

Evidence	Available?	Comments: what does the evidence tell you?
		(days from referral to treatment) day national standards. Continuous growth in demand for Inpatient, Outpatient, Systemic Anti Cancer Treatment (SACT) and Radiotherapy has also led to overcrowding in current facilities. This has been acknowledged by an investment of £18 million by the Scottish Government for Oncology Enabling works however this will only sustain service demand for the next five years and a new solution is required post 2025.
Good practice guidelines	In progress	A review of current clinical guidelines is required, in particular to look at whether they refer to equalities and equity of outcomes, whether they should and how we ensure equity of care.
Environmental data	No	Energy costs - to be added when the design process is further advanced.
Risk from cumulative impacts	Yes	Growing demand exceeds what the service can cope with within existing building infrastructure - without any action this will lead to delayed treatment. Further deterioration of the building could potentially cause service disruption or expenditure on backlog maintenance. The Oncology Enabling programme of work will allow for immediate issues to be addresses however as the demand for cancer services continues to increase a long term solution is essential.
Other (please specify)		
Additional evidence required		

7. In summary, what impacts were identified and which groups will they affect?

Equality, Health and Wellbeing and Human Rights	Affected populations
Positive Care closer to home – decreased travel time and distance	All but particularly elderly,

required to travel New build: • Fit for purpose facilities which are compliant with all applicable standards • Improved technology allowing multi-language Information, way finding and decreasing social anxiety • Improved signage to reduce anxiety • Improved access with easy way finding. Well described patient, visitor and staff pathways • Inclusive, accessible toilet facilities for staff and patients • Improved staff training and education facilities • Childcare and breastfeeding facilities **Negative** Access to wellbeing and holistic services post treatment may not be equal to everyone due to social and economic status. Need to ensure that Care Closer to Home does not negatively impact patients by not allowing them the right to choose the location of their treatment.	disabled people Disabled people Ethnic minority and disable people All All All, including Trans and non-binary people Staff Staff and carers, young people and children Homeless people, those involved in the criminal justice system People from rural/semi rural communities

Environment and Sustainability	**Affected populations**
Positive Care closer to home: • reduced travel/reduced carbon footprint New build: • Comprehensive recycling • Built in sustainable measures • Robust disposal procedures • Enhanced public safety due to new build options providing reduction in infection risks • Nursery on site for staff would decrease travel Incorporating green spaces into original design: • Enhanced biodiversity by supporting wildlife **Negative** Some design elements (e.g. single rooms) could potentially be resource inefficient	People from rural and semi rural communities All Staff Patients, carers, visitors and staff All

Economic	Affected populations
Positive Care closer to home: • Decrease in travel time and costs	Staff, people with protected characteristics and rural communities
New build providing nursery and child care facilities on site decreasing childcare costs and travel	Staff, children and young people, carers
Transforming cancer care service by focusing on prehabilitation of patients awaiting their treatment to reduce hospital length of stay	Self-employed, single parents, carers,
Centralised Social Care - access to charities	Older and disabled people, veterans, single parents, carers, vulnerable families
Negative Providing services closer to home could have a negative impact on service sustainability in some areas due to staff working in other locations.	Staff

8. **Is any part of this policy/ service to be carried out wholly or partly by contractors and how will equality, human rights including children's rights, environmental and sustainability issues be addressed?**

   Any contractors selected by NHS Lothian will be required to demonstrate compliance with all applicable standards, taking account of equality, human rights including children's rights, environmental and sustainability issues.

   NHS Lothian will work alongside the contractors to ensure any negative impact on the local community during the construction time is minimised, including:
   - Increase in noise, traffic, pollution
   - Decreased car parking on the hospital site.

9. **Consider how you will communicate information about this policy/ service change to children and young people and those affected by sensory impairment, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language? Please provide a summary of the communications plan.**

   A communications plan will be developed as the proposal progresses, taking into account children and young people and those affected by sensory impairment, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language.

10. **Does the policy concern agriculture, forestry, fisheries, energy, industry, transport, waste management, water management, telecommunications, tourism, town and country planning or land use?** If yes, a Strategic Environmental Assessment (SEA) should be completed as part of the design phase of the project, and the impacts identified in the IIA should be included in this.

    SEA to be completed

11. **Additional Information and Evidence Required**

    If further evidence is required, please note how it will be gathered. If appropriate, mark this report as interim and submit updated final report once further evidence has been gathered.

    No further evidence required at this stage.

12. **Recommendations (these should be drawn from 6 – 11 above)**

    Gender equality – Plan required for how best to support patients going through gender transition and how to approach treatment during transition

    Further discussions recommended with the LGBTQ community about what an inclusive environment consists of for them.

    Consistent / equal help should be offered to all patients regardless of their cancer type. Require resources to establish a patient profile and revise the Hospital Passport model (currently used for children within cancer services) so it can be used by adults to access and manage their health record.

    Proposal must take into consideration patient choice and maximise self-care and independence. (Realistic Medicine)

    Resource efficiency should be maximised (recycling, etc) by improvement of culture and education.

13. **Specific to this IIA only, what actions have been, or will be, undertaken and by when? Please complete:**

Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)	**Who will take them forward (name and contact details)**	**Deadline for progressing**	**Review date**
Gender Equality Plan required	Project Team with specialist input when required	During development of OBC	TBC
Further discussions with LGBTQ community	Project Team with specialist input when required	During development of OBC	TBC

Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)	Who will take them forward (name and contact details)	Deadline for progressing	Review date
Resources to be designed based on patient profile	Project Team with specialist input when required	During development of OBC	TBC
Use of Hospital Passport to be investigated	Project Team with specialist input when required	During development of OBC	TBC
Maximisation of resource efficiency	Project Team with specialist input when required	During development of OBC	TBC

14. How will you monitor how this policy, plan or strategy affects different groups, including people with protected characteristics?

Stakeholder Engagement will continue as the proposal develops to ensure that all impacts on people with protected characteristics are considered.

15. Sign off by Head of Service/ Project Lead

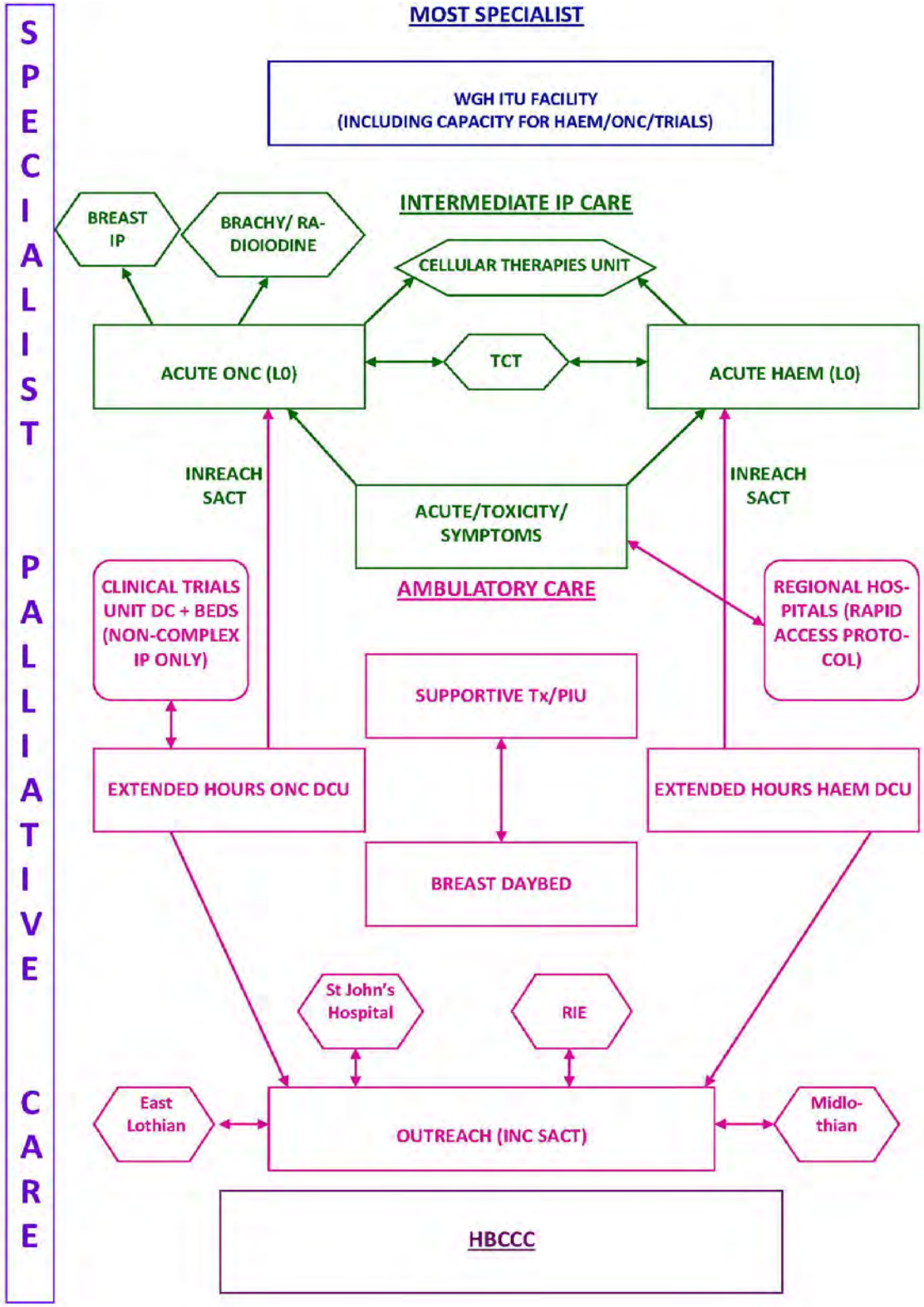
Name

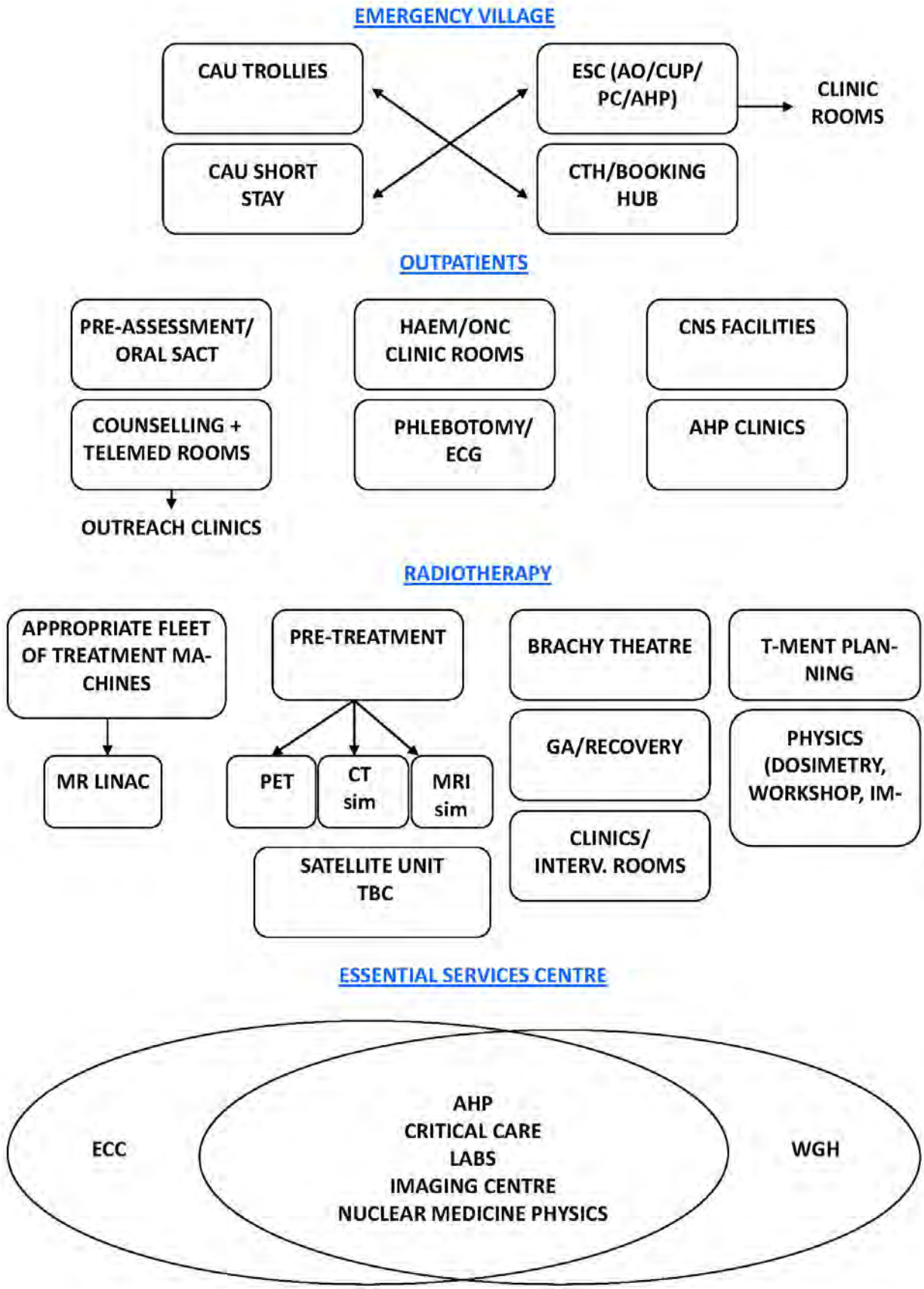
Date

16. Publication

Send completed IIA for publication on the relevant website for your organisation. See Section 5 for contacts

Appendix 8: Proposed Clinical Model Diagram




EMERGENCY VILLAGE
CAU TROLLIES
CAU SHORT STAY
ESC (AO/CUP/ PC/AHP)
CTH/BOOKING HUB
CLINIC ROOMS
OUTPATIENTS
PRE-ASSESSMENT/ ORAL SACT
COUNSELLING + TELEMED ROOMS
OUTREACH CLINICS
HAEM/ONC CLINIC ROOMS
PHLEBOTOMY/ ECG
CNS FACILITIES
AHP CLINICS
RADIOTHERAPY
APPROPRIATE FLEET OF TREATMENT MA-CHINES
MR LINAC
PRE-TREATMENT
PET
CT sim
MRI sim
SATELLITE UNIT TBC
BRACHY THEATRE
GA/RECOVERY
CLINICS/ INTERV. ROOMS
T-MENT PLAN-NING
PHYSICS (DOSIMETRY, WORKSHOP, IM-
ESSENTIAL SERVICES CENTRE
ECC
AHP
CRITICAL CARE
LABS
IMAGING CENTRE
NUCLEAR MEDICINE PHYSICS
WGH

STAFF FACILITIES

- OFFICES (MIXTURE OF OPEN PLAN/SMALLER SPACES)
- SEMINAR ROOMS WITH VIDEO CONFERENCE
- CHANGING FACILITIES ON EACH FLOOR
- NURSERY
- STAFF ROOM + LOCKERS AT EACH UNIT
- GYM
- CANTEEN (STAFF)
- BIKE SHEDS
- SHUTTLE BUS

WELLNESS CENTRE

- BENEFITS ADVICE
- COFFEE LOUNGE
- HOLISTIC AND COMPLEMENTARY THERAPIES
- TRAINING "LIVING WITH & BEYOND CANCER"
- COUNSELLING

RECEPTION/MAIN ENTRANCE

- WAY FINDING
- RETAIL
- CHARITY SHOP
- CANCER INFORMATION + SUPPORT
- CANTEEN (PUBLIC)
- WIGS SERVICES ETC.
- MULTI STOREY CAR PARK

ACCOMMODATION

- STUDIO EN-SUITES/W KITCHENETTES
- COMMUNAL DAY ROOM
- COMPANION ACCOMMODATION
- PAEDIATRIC ACCOMMODATION TBC

TRANSPORT SERVICE HUB

- CHARITABLE FOR THOSE ON ACTIVE TREATMENT

Abbreviations List

AHP	Allied Health Professional
AO	Acute Oncology
CAU	Cancer Assessment Unit
CTH	Cancer Treatment Hospital
CUP	Cancer of Unknown Primary
DCU	Daycase Unit
ECC	Edinburgh Cancer Centre
ESC	Enhanced Supportive Care
HDU	High Dependency Unit
IR	Interventional Radiology
L0	Level 0
ITU	Intensive Therapy Unit
PC	Palliative Care
PIU	Procedural Investigation Unit
TCT	Teenage Cancer Trust
WGH	Western General Hospital
HBCCC	Hospital Based Complex Clinical Care

Appendix 9: Schedule of Accommodation

Background

A Draft Schedule of Accommodation for the proposed new Edinburgh Cancer Centre was initially developed in 2015 to principally inform work being progressed on the Western General Hospital Site Masterplan. This scheduling was based on the re-provision of existing facilities to meet current design and technical guidance, with uplift to meet projected increased activity where that information was available – SACT and Radiotherapy principally.

From May 2019 this scheduling was more robustly developed (Rev E) in conjunction with more detailed work being undertaken around the shortlisted options for re-provision which included an "Enhanced" Edinburgh Cancer Centre with Regional Outreach provision.

The development initially used the NHS Lothian data available for each clinical area alongside clinical input and incorporated briefings previously developed for the Oncology Enabling and Haematology capital projects to inform numbers of clinical treatment areas: Inpatient Beds, SACT & Haematology Chairs, Outpatient consulting rooms etc.

Healthcare Planner Input

Independent healthcare planning advice was sought through the appointed Lead Advisor team to review the emerging brief and provide a high-level overview of relevant gaps and associated risks.

An initial review by the Healthcare Planner identified gaps in the data provided and based on that, further work was done around data collation and analysis to inform the refinement of the Schedule of Accommodation. In conjunction with this there were further stakeholder meetings including an adjacency workshop with key departments to further define the associated clinical relationships.

This further data collation and analysis was subsequently reviewed by the Healthcare Planner.

A key element of this second review was to understand whether or not the existing draft schedules of accommodation were fit for purpose from a high level perspective based on the data and clinical assumptions available. This required the review team to:

- Review all of the existing historical/baseline data available
- Identify (and attempt to fill with documented assumptions) gaps in the available data
- Suggest how capacity required may change over time
- Identify a 'planning window' for future projections
- Relate available data/projections to scheduled spaces in order to ensure a clear and identifiable relationship between capacity required and the spaces scheduled to deliver it

The team worked on the high-level principal that all schedules of accommodation have 2 core types of accommodation in scheduled planning terms that they defined as:

- Primary delivery areas
- Secondary support spaces

'Primary delivery areas' are those key rooms/spaces that deliver core service functions. They include areas such as consulting rooms; imaging rooms; operating theatres and other spaces/locations where capacity calculations are essential to understand numbers required.

'Secondary support spaces' also require modelling to schedule appropriately, although this tends to be directly related to the number of 'primary delivery areas' required and practical decisions around how

we expect them to operate and relate to each other (e.g. clean utility rooms, DSR's or theatre recovery spaces).

In this way it was possible to understand, at a high-level, the overall impact on area of changing the number of 'primary clinical delivery areas' based on an understanding of the relationships between these and the support areas they require to operate.

For this high-level review, the team concentrated on reviewing primary clinical delivery areas, in the understanding that:

- These are key to support the development of a high level schedule of accommodation with a more robust clinical brief to be developed for the Outline Business Case;
- These schedules of accommodation can be further refined around the identified primary clinical areas based on relevant health building notes, supplemented with experience from similar projects;
- This approach is sufficient to understand basic area requirements in support of masterplanning activity;
- Further work is required at OBC stage to verify the support areas currently provided. For every clinical delivery space there is an impact on waiting area, WCs, storage, dirty/ clean utility/other support and staff areas that requires to be considered alongside circulation and plant.

Assumptions

The main assumptions made are outlined below:

Primary Clinical Delivery Area	Assumption
CAU	Bed and trolley figures are based on the agreed model for Oncology Enabling. Due to changes in service delivery, there is little useful historical data to verify future modelling.
SACT (Chairs)	Growth rates were estimated at 5% over 5 years based on cancer incidence and adopted from similar projects in other areas.
Haematology (Bays)	Growth rates were estimated at 5% over 5 years based on cancer incidence and adopted from similar projects in other areas.
Radiotherapy	Modelling completed to show 8 Linacs required by 2025, operating at 81% capacity – 9 Linacs (plus one bunker for maintenance swaps) currently scheduled for new ECC with further modelling required to define requirement for satellite.
Outpatients	Growth rates were set based on historical overall out-patient growth based on the data provided - average of 14% over five years.
Inpatient Beds	Bed numbers are based on current model due to data showing decreasing length of stay and opportunities to delivery care differently in the future. Impact of increased throughputs for daycase surgery and CAU to be further analysed to verify estimates for future bed number modelling.

It is acknowledged that the assumptions above are high level and require further verification through development and agreement of regional service models (which may influence the location of service delivery) during the Outline Business Case stage.

It was specifically noted that activity analysis and associated assumptions generally supported the proposed Schedule of Accommodation provisions for Haematology, SACT, Outpatients and Radiotherapy 'primary clinical delivery area' numbers (boxes coloured green on the SoA Summary below). More development of the clinical brief is required at OBC stage to deliver the clarity required on bed and trolley numbers (CAU) in the context of the developing overall model of care.

The findings were presented to NHS Lothian on this basis by the adviser team and it was agreed that the proposed activity analysis and associated Schedule of Accommodation were acceptable to proceed with at this stage of the process.

Output

The Schedule of Accommodation (now at Rev K) and associated adjustments for re-provision and enhancement options has been used as the basis for the high level costings included in this Initial Agreement.

It has been developed in line with further refinement of the clinical model, ensuring that space is designated to support relevant functional requirements.

A key consideration within the Schedule of Accommodation and the clinical and non-clinical functional relationships is how these work within a wider supporting campus facility and also relate to wider NHS Lothian requirements.

A key part of the masterplan is to balance the requirements of the site as a whole while providing the most cancer dependent services and facilities within the proposed new Edinburgh Cancer Centre brief.

Essential and Supporting Services

The Essential Services that are required to support the vision of delivering transformed models of care include Imaging, Laboratories, Critical Care and Pharmacy along with other support functions such as Allied Health Professionals (AHP).

Currently the Schedule of Accommodation for the Cancer Centre includes imaging that is required principally for cancer diagnosis and treatment and a WGH Campus Integrated Pharmacy Department.

Further work is required to scope the requirements for an Essential Services Hub, which could potentially include the concept of a Rapid Diagnostic Centre. It is envisaged that these elements will be seen as an 'enabler' to the Edinburgh Cancer Centre reprovision and be taken forward as part of a separate Business Case.

It should be noted that there are currently other associated workstreams, including business cases in development for:

- A new laboratory block at Little France – the CLIFs Project - though specific new lab facilities will still be required to support services at the WGH including cancer services.
- Imaging services pan Lothian- this will include new facilities at the WGH.
- Critical Care – a short term solution is currently required with a longer term solution being reviewed in the context of masterplan proposals.

Future Strategy – Next Steps

The further development of the Schedule of Accommodation will be dependent on a more detailed clinical briefing process including;

- Full review of activity data and area requirements with clinical teams alongside a healthcare planner and design team;
- Multi service co-ordination to identify where efficiencies can be realised in the sharing of common support and administration areas;
- Technological research for Pharmacy and Radiotherapy services in particular;
- Refinement of the proposed inpatient model through articulation if future service models;
- Refinement of future staff models for wellness, administration and other supporting accommodation;
- Full review of all "Essential Services" accommodation to identify how services will be provided for:
    - Imaging
    - Critical Care
    - Laboratories
    - Pharmacy
- Horizon scanning to refine future services, for example the development of a Rapid Diagnostic Service and Cellular Therapies Unit.
- Further refinement of Training/Education Centre provision;
- Further definition of the other support required on the WGH site including; café and social support areas for staff rest/wellbeing, patient and relative 'aparthotel' accommodation, nursery/childcare and provision for Third Sector support services.
- More detailed FM and Engineering inputs.
-

Department	Net Area/ 'Functional Area'	Gross Department Area
Main Entrance	696.5	973
Training/Education Centre	140	196
Admissions / Cancer Assessment Unit; CAU (Ward 11)	515	735
Chemotherapy Day Case	1093.75	1527
Haematology including Day Case	664	927
Radiotherapy	4860.75	6788
Out-patients	782	1117
WGH Campus Integrated Pharmacy	1195.7	1670
Inpatients- "generic" wards (98 beds)	3057.25	4366
Teenage Cancer Trust (TCT - 4 Beds)	389	564
Ward support clusters	328	458
Mammography & Breast Screening	1253.4	1790
Breast Clinics & Consultant Offices	819.5	1170

Breast Theatres	1085.5	1516
SES SCRN	1131	1579
Admin and support (in addition to areas scheduled within departments)	611.52	874
Macmillan	61.5	86
Palliative Care (Admin and support)	39	51
Staff Welfare Hubs	1570.6	2111
Staff WC Hubs	0	0
FM Hub	464.5	624
Data Centre (see estimated Calcs below)	197.4	282
Radiopharmacy	tbc	270
Patient accommodation	346	494
Sub-total	20892	**29595**
Distributed plant @ 20%		5919
Sub total		35514
Communication @ 10%		3551
Total		**39065**

ECC Indicative "Primary Clinical Delivery Areas" by Scheduled Zone and Room Type

	Beds	Trolleys	Exam/Con/Inter'	Tx Chairs/Rooms	Op Rooms	PET	CT	Linacs	Ultrasound	Mammo	MRI	Meet/Sem	Desks
CAU													
6 x Bedrooms	6												
10 x Trolleys		10											
2 x Triage Rooms		2											
CHEMOTHERAPY													
4 x examination/physical therapy rooms			4										
4 x consulting/examination rooms			4										
35 x treatment chairs				35									
6 x treatment rooms				6									
HAEMATOLOGY													
2 x procedure rooms				2									
15 x treatment bays				15									
3 x isolation rooms				3									
RADIOTHERAPY													
1 x PET Scanner						1							
2 x CT Scanners							2						
11 x On treatment review rooms			11										
9 x Linacs								9					
10 x Bunkers													
1 x superficial room													
1 x brachy room													
OUT-PATIENTS													
2 x Physical Measurement Rooms			2										
24 x General Consulting/Exam Rooms			24										
4 x Emergency Village Consulting/Exam Rooms			4										
2 x Treatment Rooms				2									
TCT WARD & TREATMENT													
4 x Bedrooms	4												
1 x 40m2 "Activity hub"													
1 x 28m2 "Chemo lounge"													
IN-PATIENTS													
96 x Bedrooms (4 x 28 bed wards?)	96												
THEATRES													
2 x Operating Theatres					2								
2 x Anaesthetic Rooms													
6 x recovery bays													
10 x recovery rooms (with en-suites?)													
6 x further trolley spaces?													
MAMMOGRAPHY & BREAST SCREENING													
5 x Ultrasound									5				
9 x Mammography										9			
1 x MRI											1		
10 x Clinic Rooms			10										
BREAST CLINICS													
4 x Interview			4										
12 x Consulting			12										
2 x treatment				2									
2 x pre-operative assessment			2										
SCRN													
20 x "Chair spaces"				20									
4 x interview rooms			4										
3 x examination rooms			3										
TRAINING/EDUCATION													
12 x meeting/seminar rooms (various sizes)												12	
OFFICE/ADMIN/DESK SPACE													
Circa. 230 x defined offices or desk spaces													230
OVERALL TOTALS	106	12	84	85	2	1	2	9	5	9	1	12	230
Indicative "Multiplier" (Total m2/PCDA)	50		65	50	700			900					7.5
Indicative "Risk" (Total m2)	5300		5460	4250	1400			8100					1725

Level of confidence relating to masterplanning PCDA number requirements based on data reviewed:

High	Scheduled PCDA numbers appear to be wholly/largely supported by the data/variable assumptions presented
Medium	Scheduled PCDA numbers appear to be partially supported by the data/variable assumptions presented
Low	Scheduled PCDA numbers do not appear to be/cannot currently be supported by the data/variable assumptions

07/07/2020

Appendix 10: Essential Services Hub

It has been recognised when developing a Clinical Model for the future that many of the pathway transformations and service improvements are reliant on the essential services that are part of the patient's cancer journey.

Having proximity to these will allow the most efficient pathways for patients to be developed, as well as allow the development of these services for future sustainability.

In order to achieve the stated '*Investment Objectives'* the service must be designed around transformed models of cancer care with proximity to the key ***'Essential Services'*** below:

- Critical Care capacity
- Laboratories
- Imaging
- Nuclear Medicine Physics – NMP

The high level, strategic vision for inclusion of each of these in an ***'Essential Services Hub'*** has been developed with key representatives from each area to ensure relevant expertise has been incorporated and that plans are being developed in line with existing NHS Lothian strategy.

The provision of these services will be designed in such a way as to support and benefit all services based on the Western General Hospital site and a scoping exercise is required to ascertain the demand on each of these services across all specialities on the WGH site which will be completed as part of the Outline Business Case process.

An Integrated Pharmacy for WGH (including Radiopharmacy) has been included within the scope of the Edinburgh Cancer Centre proposal as integral to delivery of the proposed clinical model however will also be considered as part of the Essential Services Hub proposal if this would result in greater service efficiencies.

Pharmacy

Re-provision of the Edinburgh Cancer Centre (ECC) provides an opportunity to design one purpose built, central pharmacy that would support the delivery of cancer services alongside all of the specialties on the Western General Hospital (WGH) site.

Existing Arrangements

Pharmacy services are currently provided from two separate areas on the WGH site;

1/ The pharmacy in the Alexander Donald Building (ADB) provides a dispensing service for discharge medicines for all inpatients, and outpatients for all areas except for cancer services; a distribution service providing ward medicines stock for all areas; aseptic service proving parenteral nutrition; IV additives and non-cytotoxic supportive medicines to all areas on the site; and parenteral SACT dispensing on a Saturday and Sunday.

2/ The pharmacy in ECC (situated in Ward 1) dispenses all systemic anti-cancer therapy (SACT) (oral and parenteral including clinical trials medicines) for in-patients, day-case and out-patients and selected oral supportive therapies to day-case and out-patient cancer patients Monday to Friday.

This split site working does not maximise efficient utilisation of staff or premises and is potentially confusing to patients who may arrive at the wrong dispensary or have to visit both dispensaries in order to obtain all their medicines.

Drivers for change

- Combination of two aseptic units into one - recommendation of the NHS Scotland National Review of Aseptic Services.
- Currently one aseptic unit in Edinburgh Cancer Centre (ECC) and one in Alexander Donald Building (ADB), which have a lifecycle requirement for replacement approximately every 15 years. It is likely that by the time a new Cancer Centre is delivered, the ADB aseptic unit will be >12 years old and would require replacement at a cost in excess of £2M.
- Allow the provision of the required space to develop an aseptic unit containing the specified Biosafety Hazard 2 rooms needed to provide ATMP products that will become a priority for Clinical Trials delivery in the next 10 years and facilitate the introduction of new medicines technologies.
- Integration of workforce that currently function as two separate departments and, due to severe space constraints both in the ADB pharmacy and Ward 1, are working from multiple satellite office spaces across the WGH campus. Integration would result in more efficient, shared working and increase resilience of pharmacy workforce capacity.
- Opportunity for a more holistic management of cancer patients with multi-morbidity from co-location of specialist/Advanced Pharmacists working in MOE/Acute Medicine and Cancer services (i.e. currently all other WGH pharmacists are located in a separate department)
- Efficiency of shared working elimination of duplicate roles and some activities (e.g. administrative support in dispensary, decrease in the number of printers and office equipment).
- Economy of scale for purchasing medicines would allow for 1 order instead of 2; and 1 area for controlled drugs further reducing requirements for duplication in effort and team members time to undertake. In addition, an increase in efficiency for receipt of medicines by removing need for orders to be assembled and transported between ADB Pharmacy and ECC pharmacy department.
- Efficiency of eliminating the requirement of portering of medicines between the two pharmacy premises.

- Need for improved storage space for medicines required for the hospital site with resultant decrease in associated current H&S risks.
- Improved cold room storage space would decrease the number of cold rooms required for refrigerated medicines from 4 to 3; and improve efficiency in associated maintenance contracts. There would also be a reduced requirement for free standing fridges.
- Need for improved staff experience with adequate facilities for changing, lockers, staff room and common departmental spaces to support team working. The current pharmacy department does not have any of these available for staff.
- Eliminate confusion for patients looking for pharmacy services

Future Vision

The future vision for Pharmacy on the WGH site would include:

- One licensed Aseptic Unit
- One dispensary providing a service for the whole of the WGH site
- Medicines store (Distribution Service) for supply of medicines to all wards on the WGH site
- Integrated Radiopharmacy (currently located on the RIE site) that makes Radiopharmaceuticals for nine sites (however 48% of products prepared come to WGH)
- Flexible accommodation to accommodate future growth – including service areas and expanding workforce accommodation
- Service designed to support alternative models of delivery of medicines to patients closer to home (e.g. medicines homecare, community based dispensing of prescriptions, etc)

Essential components of this include:

- Licensed Aseptic Unit (combine from two to one);
    - Include ATMP's and clinical trials service as well as SACT, TPN, IV, other.
    - Biohazard Unit for gene therapy
    - Controlled temperature & refrigerated storage
    - Potential for revenue generation by supplying aseptically prepared medicines to other boards
    - Consider and scope introduction of robotic solution for batch manufacturing of products (e.g. SACT, monoclonal antibodies)

- Dispensary (combine for Inpatient and Daycase /Outpatient)
    - Controlled temperature & refrigeration storage required.
    - Patient waiting areas and counselling rooms to facilitate private consultations
    - Consider and scope introduction of robotic solutions to aid dispensing

- Radiopharmacy (move from RIE site)
    - SIRT supplied to vascular patients at RIE, time critical (currently only 10 patients annually)
    - Gallium Imaging (NSS service) used in PET scanning for cancer
    - Cyclotron located with PET Scanner in UOE building at RIE – 70% usage for NHS patients, lifespan of 10-15 years
    - Require a laminar flow cabinet and gallium cabinet
    - Requires close links with imaging and nuclear medicine
    - Radiopharmaceutical developments in pipeline for cancer treatment

- Distribution (store)
    - Access for suppliers deliveries,
    - Large storage and distribution area requirement but consideration and scoping of robotic solutions to decrease floor footprint requirements

- Controlled temperature and refrigeration storage within stores

- Accommodation for clinical teams, administrative and staff facilities

Service Provision

The future vision is to provide a seven day clinical service using automation as much as possible –for example robots for dispensary and aseptic filling and delivery of medicines via pneumatic tube system/ robots.

Future horizon scanning includes continued growth in medicines developments, use of prefilled SACT where possible, CIVAS plus service, clinical trials expansion in all clinical areas, introduction of advanced therapy medicinal products and gene therapies and parenteral nutrition changes. The introduction of a more integrated regional service to the provision of therapies will result in changes to the pharmacy requirements.

Changes in dispensing models are likely to include medicines provision as close to home as possible with community dispensing of HBPs for different specialist areas , and home delivery of medicines once patient has been discharged, to take advantage of community hub and spoke model of medicines provision (this would have an impact on community pharmacy capacity that would need to be considered/resourced).

In addition the roll out of medicines homecare will also change the way in which medicines are dispensed. Changes in supply models require investment in resource to ensure an adequate amount of expert advice and administrative support is available to facilitate this. This is likely to lead to a need for expansion in the pharmacy workforce.

The use of more automation in pharmacy and the introduction of electronic prescribing will change how wards and areas, order and store medicines. This will include the use of automated systems (such as the Omincell Supply Management System)which allows automated inventory management system and integration into automated medication dispensing system.

Challenges

- Current workforce challenges plus an increase in priority 1 patients requiring clinical pharmacy intervention highlights the importance of automation where possible to maximise effective use of pharmacist time.
- Required space for storage of medicines is likely to increase due to a need to hold increased stock levels to mitigate against medicines shortages.
- Plans for changes to services delivered on the WGH campus in the future and the increased demand for treatments in many clinical areas, including cancer services, is projected to continue.
- There is a need to ensure that the new integrated pharmacy department is able to meet the needs of the whole site in the future.

Critical Care

The concept of an 'Essential Services Hub' provides an opportunity to re-provide a Critical Care facility of the highest standard on the Western General Hospital site which would continue to support the needs of services on the site and be designed with enough capacity to accommodate the predicted increase in Cancer services patients who require care in a high dependency unit.

As included in the proposed Clinical Model there will be a requirement for Level 3 ITU and Level 2 HDU capacity for Haematology/Oncology/Breast Surgery patients integrated with WGH critical care and high dependency provision in the future.

Over the next few years, a predicted increase in Advanced Therapeutics such as CAR-T (and potentially others) in Cancer services the number of Level 3 and 2 beds required by Haematology and Oncology patients is likely to increase, over and above that already provided by the existing Stem Cell Transplant, High Dependency and Critical Care Facilities.

Data produced during the Western General Hospital Dependency Audit (May-June 2018) will be factored into the review of future high dependency capacity requirements for Cancer Services.

During discussions with the NHS Lothian Critical Care Team regarding how best to provide a critical care facility on site the following needs must be met:

- The need to ensure patients requiring multi-organ support and specialist care are cared for by appropriately experienced staff. It was agreed that this should remain the remit of Intensivists and critical care experienced nursing staff. Given the national shortfalls of anaesthetists and nursing staff, it is important that the critical mass is retained in a single service.
- High Dependency (HDU) facilities suitable to the provision of Stem Cell Transplant services and Advanced Therapeutics (bone marrow – single organ failure), should be managed by specialty services, as at present, with access to Level 3 Critical Care remaining adjacent and on site.
- Location of Intensive Treatment Unit (ITU)/High Dependency Unit (HDU) facilities in a central location. All relevant adjacencies will be taken into consideration at planning stage.

Some upgrade work is planned to the current ITU/HDU facilities on the Western General Hospital site which will happen in the short term, to be completed in 2021/22 at the earliest.

Any further re-provision of facilities will be discussed and consulted upon with relevant teams as the business case progresses.

Laboratories

The concept of an 'Essential Services Hub' provides an opportunity to re-provide the blood Sciences Lab on the WGH site.

Existing Arrangements

Blood Sciences (Biochemistry, Haematology and Blood Transfusion) on the WGH site is currently provided in 50 year old portakabin accommodation which is no longer fit for purpose. There are also Blood Sciences services provided at RIE and SJH.

The CLIFS capital project (Initial Agreement currently in development) proposes the re-provision and centralisation of histopathology and genetics on the Royal infirmary Site.

Microbiology is split between RIE and the SJH sites with the larger lab located at the RIE site.

Genetic services are provided on both the RIE and WGH site.

Drivers for change

There will be no proposed change to the services provided on each site due to the requirement of specialist equipment, IT programmes and staff which makes de-centralisation an unattractive option.

Rapid access to blood sciences is an essential component in the monitoring and treatment of cancer patients. The Blood Sciences Lab at WGH currently receives 50% of its workload from GP practices and the other 50% from the WGH site.

Future Vision

The future vision for the laboratory service includes:

- A purpose built Blood Sciences Lab with accommodation for flexible use as the options for automation in blood sciences develops
- Lab to service GPs as is currently the arrangement (and could potentially grow) as well as the WGH site
- Would require proximity to the Cancer Centre to allow timely delivery of SACT.
- Would required proximity to serve the rest of WGH site.

Service Provision

Cancer treatment services will primarily require monitoring from Blood Sciences and Blood transfusion services on site. Centralised genetics, microbiology and histopathology services at the proposed RIE will have no day to day impact on cancer centre service delivery.

Challenges

- Transport across the city
- Staffing for potential activity increases
- Recruitment to some specialist roles (currently a national shortage of Histopathologists)
- Pressure from potential of increased screening – increasing uptake rates and introduction of new screening programmes

Imaging

The concept of an 'Essential Services Hub' provides an opportunity to design a new Imaging Department which would maximise staffing efficiencies and economies of scale in order to adequately support the needs of services on the Western General Hospital site.

Drivers for Change

- Waiting times as short or non-existent if possible, with patient centred booking
- Sufficient time available for patient to feel valued
- Real time reporting
- More time for staff Continued Personal Development which should ultimately lead to increased quality of imaging and improved patient experience

Future Vision

In order to achieve these aims the requirements are;

- Increase scanning capacity by opening up additional sessions on current equipment – weekend and evening working -Include contrast imaging for cancer patients
- Increase number of CT/MR scanners to build in a buffer so scanners run at optimum capacity (never over 100% capacity) and to allow room to cope with breakdowns and peaks in demand
- Improve reporting system -alert when scans have been reported rather than relying on a paper copy or manual searching.

In order to move this forward, the Radiology team will;

- Focus on work force planning
- Submit a Business Case for additional scan resource in the short term (to be included in the Edinburgh Cancer Centre OBC for the future)
- Allow staff to attend MDTs for educational purposes (when staffing allows)
- Look at ways to increase the study budget for post grad education
- Review pathways so patients can be sent for immediate scanning where possible
- Implement Patient Focussed Booking (PFB) when immediate scanning not possible (RTS project)
- Implement a robust system for patients being scanned locally to ensure referrals are received in the right place in a timely manner
- Investigate a way to identify that scans are completed when performed out with Lothian and ensure radiology reports for these patients are available
- Use electronic paper record (Trak) to flag up verification of reports against a list of patients

Nuclear Medicine Physics – NMP

The concept of an 'Essential Services Hub' provides an opportunity to co-locate the Nuclear Medicine Physics (NMP) service with Cancer Services, Radiology and Radiopharmacy. This would improve the patient experience and allow efficient utilisation of a specialist staff group.

Existing arrangements

The current NMP service is located in the original Outpatients building at the WGH; due to the physical condition of the building further radioactive therapies for cancer services cannot be provided.

The service is part of the pan-Lothian Medical Physics Department who provide services across NHS Lothian. The clinical services provided by the NMP team at WGH include:

- Inpatient radioiodine ablation therapy (^{131}I – thyroid cancer), currently performed on ward 2 (CAU) by NMP clinical technologists (approximately 60 patients p.a.)
- Outpatient radioiodine therapy (^{131}I) for overactive thyroid, currently performed in the NMP section in outpatients (approximately (200 p.a.)
- Castration resistant metastatic prostate cancer therapy (using ^{223}Ra), currently performed in the NMP section in outpatients (approximately (40 p.a.)
- Treatment of myeloproliferative neoplasms such as polycythaemia vera using ^{32}P, currently performed in the NMP section in outpatients (approximately 6 p.a.)
- Radioactive Glomerular Filtration Rate (GFR) tests for chemotherapy dosing, performed in NMP in outpatients and nuclear medicine imaging (radiology Ann Ferguson) (approximately 100 p.a.)
- DEXA scanning for bone density (approximately 10,000 p.a.)

The NMP service provides the following clinical services at RIE:

- Support and provision of ^{90}Y SIR Spheres for treatment of liver tumours (approximately 12 p.a.)
- Radioactive GFR tests for chemotherapy dosing including paediatric service (approximately 50 p.a.)

Medical Physics Expert (MPE) services are provided to:

- Nuclear imaging departments at WGH, RIE, RHCYP, NHS Fife and Borders
- EIF-QMRI (formally CRIC) to ensure the operation of the NHS PET-CT scanner and two research scanners (PET-CT and PET_MR)
- Various theatres using gamma probes for sentinel lymph node biopsy for the cancer surgeries including; breast, penile, vulval, head and neck, and melanoma.

Drivers

The facilities for outpatient therapies do not allow new advanced therapies to be offered. An example of this includes ^{177}Lu for treatment of relapsed non-Hodgkin's lymphoma, neuroendocrine tumours and metastatic castration-resistant prostate cancer. This is in part due to the lack of a dedicated radioactive toilet and waiting area.

Inpatient facilities on ward 2 do not meet HEI standards with regards to room sizes which also means that MIBG therapy for neuroendocrine tumours cannot be offered.

New facilities designed for the intended purpose of delivery of radiopharmacy would mean NHSL can offer patients a greater variety of radionuclide therapies whilst meeting legislative requirements.

Having the NMP section co-located next to cancer services and the radiopharmacy would mean that the NMP team would not have to carry radioactive sources across the site. This will improve efficiency of staff, reduce staff dose, and minimise the potential for an incident.

PET-CT relies on radiotracers produced from a cyclotron. The cyclotron which currently provides tracer to the University of Edinburgh and NHSL is operated by the University of Edinburgh.

Having nuclear medicine imaging (SPECT-CT and PET) located in the same vicinity as the NMP section would mean that a specialist staff group is in one place, and where needed, resources can be pooled. Radiation labs and source stores could to some extent be shared. These could also be shared with the Radiotherapy sealed source therapies. This gives redundancy and efficiency around specialist equipment such as contamination monitors, calibrators etc.

Therefore, ideally a PET-CT service would be located at WGH. PET-CT (or PET-MR) is used for fully staging cancers and prevents overtreatment of advanced disease undetectable by other means, and can be also used for radiotherapy treatment planning purposes.

NMP provides a range of services from therapeutic cancer treatment to DEXA scanning. Being co-located (in close proximity, not directly in) to radiology and oncology would also provide a better patient experience.

Future Vision

- Purpose built facility for radioactive outpatients and inpatients
- Co-located next to oncology services, inpatient ward, radiopharmacy, radiology nuclear imaging
- Move DEXA scanners and all NMP services (including offices etc), radiation labs, radioactive stores etc.
- PET-CT at WGH
- Cyclotron located at WGH mainly for FDG production etc
- Improved integration with nuclear imaging, cancer service team (particularly for inpatient therapies) and radiopharmacy

Appendix 11: Support Services

Alongside the requirement for *Essential Services* as described in Appendix 10, there is also the recognition that cancer patient pathway transformation is reliant on fit for purpose *Support Services*.

These key support services include:

- AHP Services – Physiotherapy, Occupational Therapy, Speech and Language Therapy and Dietetics

The high level, strategic vision for inclusion of each of these as below has been developed with key representatives from each area to ensure relevant expertise has been incorporated and that plans are being developed in line with existing NHS Lothian strategy.

Further development of proposals for each of these will be completed as part of the Outline Business Case process.

Physiotherapy

Re-provision of the Edinburgh Cancer Centre (ECC) provides an opportunity to develop a world class physiotherapy service which addresses the needs of people at all stages of their cancer journey.

Existing Arrangements

Permanent funding for 3.9 WTE is available to provide services to all inpatients within the Edinburgh Cancer Centre (ECC) as well as a limited number of outpatient services.

These include a cancer-related lymphoedema service to patients living in Edinburgh. A small number of other outpatient services are also provided including a service to patients with limited shoulder range of motion following breast cancer treatment who require urgent physiotherapy to enable them to get into position for radiotherapy. The therapists also manage patients with cording after breast cancer treatment and provide ad hoc services to outpatient areas (e.g. for walking aid provision to prevent admission).

Drivers for change

- Recent benchmarking with several other cancer specialist hospitals in the UK revealed significantly higher ratio of staff to beds than ECC and a number of specialist posts. The specialist posts include services for specific cancer types and services which promote and assist people to become more physically active at different stages of the cancer journey. This is in line with the growing body of evidence that physical activity can help to reduce morbidity and mortality for people with cancer.
- Aging population and increasing frailty. Haematology Older Persons Service, which includes a B4 Rehabilitation Assistant, has been established to help manage needs of frail patients over aged 65 but permanent funding has not yet been secured.
- Increasing number of people living with and beyond cancer and dealing with the consequences of treatment such as fatigue, reduced range of motion and strength but lack of resource to address these needs for patients in an outpatient setting.
- No investment in staffing for more than 10 years despite increased services pressures, including expansion and development of new services within ECC and increased acuity, dependency and complexity of patients. The inpatient service uses a criteria-led prioritisation system as the caseload exceeds capacity with patients often being seen less regularly than what is considered optimal. Lack of ability to provide rehabilitation and treatment focused on discharge planning. Waiting time delays for new outpatients and review outpatient appointments. The targeted 5/7 day physiotherapy service at the Western General has an impact on the oncology service

with specialist staff's days during the week being provided by generalists and coverage not always being available as backfill staff often have cover more than one clinical area.

Future Vision

Key Points

- Development of specialist physiotherapy posts to address complex needs of patients (similar to CNS model and model observed in other centres of excellence) with specialists in different cancer types.
- ECC centre specialist physiotherapists providing expert care and linking in with other satellite and community- based services.
- Comprehensive inpatient and outpatient services but anticipating move towards more outpatient-based services.
- Access to physiotherapy at all stages of cancer journey and including pre-habilitation, during cancer treatment and cancer rehabilitation services to help patients living with and beyond cancer. Access should be available when required by the patient.
- Involvement in promotion of healthy lifestyle and secondary prevention through physical activity programmes and education e.g through health and wellbeing events.
- Environmental considerations including inpatient and outpatient gym space and lymphoedema room with consideration for optimal locations within the ECC.
- Post-graduate training and workforce planning to develop oncology physiotherapy knowledge and skills.
- Considerations for frailty with aging population, management of various cancer types as chronic conditions and the potential for services to change with advances in treatments.
- Review of lymphoedema services in Lothian and potential for reorganising of services.
- Access to innovative technology for communication, information sharing with patients and for treatment modalities.

Core Services

- Tailored physiotherapy services will address the needs of patients at all stages of their cancer journey and will be provided in both the inpatient and outpatient settings.
- The majority of patients will likely be managed in an outpatient setting, with those requiring specialist physiotherapy services attending the ECC or satellite cancer centres and others being managed in the community.
- ECC services will be provided by advanced practitioner physiotherapists, specialist physiotherapists, physiotherapists, physiotherapy assistant practitioners and exercise practitioners

Wider Services

- Patients requiring generalist intervention would be managed by the community and non-specialist outpatient physiotherapy services. Timely access to these services is important.
- Consider the long-term development plans for hospice and community palliative care physiotherapists and the scope of their involvement in providing specialist community services for patients with advanced disease.
- Ensure access to specialist inpatient rehabilitation services for patients with complex needs and that they are appropriately skilled to manage patients with life limiting conditions e.g. malignant spinal cord compression/brain tumours.

- Patients from other parts of SCAN region would require access to physiotherapy specialist (including lymphoedema services) and generalist services to allow patients to be appropriately managed in their local area.

Treatment

Physiotherapy will be tailored to needs of the individual with consideration for the type of cancer and stage of cancer from diagnosis, during treatment, after treatment and in palliative stages.

- Pre-treatment: Pre-habilitation to ensure patients strength and function are optimised prior to treatment (Likely multidisciplinary approach). Involvement of physiotherapy also in prevention of admission.
- During treatment: Promote physical activity, self-management and address problems arising from treatment
- Cancer rehabilitation: Address and optimise patients' recovery from cancer treatment (not just focusing on curing the disease!) Consider many patients living with cancer as chronic conditions.
- Survivorship, wellness and promotion of healthy lifestyle for secondary prevention: Develop a culture which promotes physical activity as a means of reducing morbidity during and after treatment and reduce mortality in certain types of cancer. Provide physical activity advice 1:1 or as part of health and wellbeing events, tailored exercise programmes and develop links with community-based exercise programmes such as Move More.
- Lymphoedema Services: Ensure ongoing close links between ECC lymphoedema practitioners and Lothian Lymphoedema Service which provides services to other parts of Lothian and practitioners in other areas of SCAN region. Consider potential for reorganising Lothian lymphoedema services into one hub and spoke service.

Workforce

- Develop highly skilled, specialised physiotherapists and advanced practitioners with in depth knowledge of cancer
- Development of specialist posts, similar to the clinical nurse specialist model, with in depth diagnosis-specific physiotherapy expertise to help patients manage the sequence of treatment specific to their cancer-type and treatment (e.g. a breast cancer specialist can provide lymphoedema management, help improve range of motion, scar mobility, strength and aid patients back into physical activity to reduce weight gain and combat fatigue).
- Recent increased growth in advanced practice roles and the changing picture within the community with the developments within health and social care partnerships means that there is a need for additional undergraduate and post graduate physiotherapy training in Scotland. This has been recognised by the Scottish government who are increasing training places in Higher Education Institutions (HEI's) and are supporting the development of practice placement availability.
- Develop frailty services to manage increasing elderly population receiving treatment. This has been initiated through the Haematology Older Person's Service but permanent funding still to be secured and scope to expand this service to outpatient areas and oncology.

Environment

- Inpatient physiotherapy gym space(s) with a range of exercise equipment and located close to /on the wards
- Recommend an outpatient physiotherapy gym space in ambulatory care area.
- A lymphoedema treatment room with suitable space, equipment and attention to environment to ensure comfort and privacy.

Education

- Post graduate training and development of staff should be seen as an integral role of the Cancer Centre with this being delivered in partnership with HEI's and 3rd sector (e.g. Macmillan).
- Undergraduate education and exposure to cancer is limited. Need to consider if this should be more widely available in undergraduate education programmes.
- Community and regional based physiotherapy staff will require upskilling to support management of patients in these settings.
- Education, lifestyle management and support for both patients and family/carers is also seen to be integral to the management of cancer patients. Facilities required will include single rooms and rooms for group sessions.
- Education and information will be provided using a variety of models including 1:1 sessions, group sessions and directing patients to a web site or mobile phone apps.

Innovative Technology

- Patients and physiotherapy staff will be able to access innovative technology (e.g. websites and apps for communication and self-management)

Challenges

- Workforce - Current service capacity limitations and lack of scope for development without investment in staff. Recruitment and training staff for specific roles
- Training –Availability of undergraduate and postgraduate training places
- IT –Must be able to support service changes
- Facilities – Availability of space to provide treatment and carry out administrative tasks

Occupational Therapy (OT)

Re-provision of the Edinburgh Cancer Centre (ECC) provides an opportunity to transform the OT service by developing a specialist OT service for cancer patients to access at any point in their care pathway.

Existing Arrangements

Currently, the WGH Oncology/ Haem OT Team consists of:

- 1 WTE B7 Highly Specialist OT
- 0.6 WTE B6 Specialist OT
- 1 WTE B5 Static OT
- 0.6 B3 OT Assistant

The service is funded to provide a 42 week service to cover all inpatients in the Oncology and Haematology wards at the WGH.

HOPP (Haematology Older Peoples Service)

This service is for over 65's and is funded for 42 weeks per annum.

- O.5 WTE B4 OT Practitioner

There is also a B7/6 OT who provides Specialist Advice/Support in managing complex palliative and end of life care.

The OT service is provided to all patients over 16 years of age.

Current service provision consists of:

- Completing an assessment to establish the patient's needs and any potential difficulties with daily activities and function.
- Providing advice and coping strategies to facilitate self management of physical symptoms such as fatigue, pain or weakness
- Providing advice and coping strategies to facilitate self management of psychological and cognitive deficits such as anxiety, body image, low mood, changes in confidence levels or memory/ higher executive functioning difficulties
- Offering advice on equipment provision or adaptation of activities/environment to make it easier for patients to manage daily activities
- Referring/liaising with community services after treatment for further support if indicated following our assessment
- Engaging and supporting family with patients challenges for going home.

Drivers for Change

Rehabilitation is a crucial element of cancer care. The need for rehabilitation starts at the point of diagnosis (prehabilitation) and an OT service should deliver services from this point onwards for patients.

Equitable services should be delivered regardless of where a patient lives in South East Scotland. OT has a key role in providing rehabilitation and patients' should be able to access OT services at all stages of the cancer journey.

It is currently a challenge to meet the demand of the service in a timely manner -our standard is to start assessment with all patients within 24 hours of referral to OT – however we are not always able to meet this target.

Timing of referrals – patients are not always identified at point of admission for OT intervention as not all admissions are screened therefore this creates a delay in the referral process which can impact on length of stay.

Service is only currently funded for 42 weeks per year.

Inability to assess and treat patients when they require it most, this applies to both inpatient and outpatient. Also, no service currently provided in the Cancer Assessment Unit (CAU).

No resource to provide palliative care rehabilitation as demonstrated in the HOPPS project.

Palliative /end of life patients in other wards and specialities at WGH do not currently have access to our Oncology specialist services.

Future Vision

Re-provision of the Edinburgh Cancer Centre (ECC) provides an opportunity to transform the OT service by enabling the service to provide an equitable and consistent standard of OT service throughout South East Scotland as well as enable;

- Patients to access occupational therapy as and when they need it – rather than crisis management
- Providing screening at clinics to identify this need as early as possible
- Provision of a fully funded OT service for out-patients – currently there is no outpatient service provision for patients requiring occupational therapy.
- Flexible flow arrangements (out patients, in patients, and after care) with in-reach and outreach of therapy.

- 'Roving' oncology team including AHPs to treat patients with a cancer diagnosis in other wards within the hospital.
- Rehabilitation Department (similar to that in the Christie) to provide both rehab and prehab, this needs to contain:
    - Physiotherapy Gym and treatment rooms
    - Occupational Therapy activities of daily living suite.
    - Quiet rooms
    - Access to large space for education sessions / relaxation sessions etc
    - Outdoor space
    - Office accommodation
    - Storage for equipment etc.
- Improve flow between the regional areas. Patients admitted from other regions need to have a bed to return to, otherwise arranging ongoing community services can be difficult.
- Engagement with AHP services in other regional centres (Dumfries and Galloway, Fife, Borders, and the rest of NHS Lothian)
- All areas must be adequately staffed. This would require a significant increase in WGH AHP staffing.
- Providing access to Vocational Rehabilitation Services.

Challenges

In order to achieve this vision the service would require:

Staffing Resource – this would need to increase significantly with more specialist OT staff skilled in managing Oncology/Haematology conditions as well as training posts to up-skill staff. This would allow the opportunity to provide a service not only to inpatients but outpatients. It would enable an in/outreach model of care within the local community as well as non cancer wards.

Facilities including a purpose build Activities of Daily Living (ADL) suite to deliver OT services in order to provide rehabilitation for patients at all stages of their condition.

Training opportunities need to be available for staff to maintain specialist skills in line with development of cancer services.

Speech and Language Therapy

Re-provision of the Edinburgh Cancer Centre (ECC) provides an opportunity to develop a Speech and Language Therapy service which addresses the needs of people at all stages of their cancer journey.

Future Vision

A new Cancer Centre provides an opportunity to provide a service model based on the model at the MD Anderson Cancer Centre in Houston, Texas, which is currently the world leader for SLT service provision and innovative evidence-based practice.

Clinical service and pathways

- Sufficient staffing to develop SLT pathways for lung, thyroid and skin cancer patients
- Frailty model (already in haematology) as people live longer with the effects of cancer
- Continuity of level of SLT service (hospital / home / local SLT) with equity of access to services, within WGH or wherever patients live within SCAN region
- Multidisciplinary pre-, post- and on-treatment clinics for head & neck cancer patients
- Access to pre-treatment and post-treatment instrumental swallow assessment as standard
- Standard outcome data collection at pre-treatment, post-treatment, 6m and 12m points

Research, audit and education

- Sufficient staffing and IT support to collect clinical data for ongoing service evaluation and development
- Links between universities and third sector (eg Macmillan) for post grad education and funding for projects
- Potential to carry out research projects and participate in national trials
- Access to medical library/librarian
- Potential to use expertise to provide postgraduate SLT training at a national level
- Sufficient staffing to provide regular undergraduate student placements
- Regular opportunities for offering training to SCAN region SLTs to maintain and develop skills (eg training days, onsite visits)

Accommodation

- SLT –specific admin and clinical rooms available to provide daily outpatient sessions including FEES instrumental swallow assessment
- Accommodation within xray to provide weekly videofluoroscopy clinic with multiple appointment slots
- Sufficient accommodation to allow evidence-based prehabilitation and rehabilitation clinics including intensive intervention such as the McNeill Dysphagia Therapy Program

Staffing/training/workforce

- A workforce with appropriate training, knowledge, expertise, with provision made for succession planning and career progression
- Consultative role to community SLT staff and SLTs within the SCAN region – facilitating SLT input closer to home for patients where appropriate
- Development of advanced practice roles (eg prescribing)
- Sufficient staffing to allow evidence-based prehabilitation, on-treatment and rehabilitation clinics including intensive intervention
- Sufficient A&C support to facilitate the above

Administration and equipment

- Technology –use of apps, telehealth, electronic messaging, new tech eg sEMG
- Access to xray suite for videofluoroscopy instrumental swallow assessment
- Access to nasendocopy stack for FEES instrumental swallow assessment
- Access to voice recording equipment for speech work
- Budget for equipment items such as Therabites, EMST units
- Sufficient PC access including scanning and printing

Challenges

- Workforce – Challenge to recruit and train staff for specific roles
- IT –Must be able to support service changes
- Facilities – Availability of space to provide treatment and carry out administrative tasks.

Dietetics

A new Cancer Centre provides an opportunity to transform the Dietetic service providing improved access for patients and specialist services for all tumour sites.

Existing Arrangements

NHSL Dietetics is a single system covering all hospital and community sites. Although the Edinburgh Cancer Centre (ECC) is the primary site for delivering cancer treatment,many Dietetic teams across NHSL are involved in providing care to people living with cancer.

The WGH Oncology Dietetic Team consists of 3 wte staff who provide assessment and management of people with disease-related malnutrition to all in patients within the ECC. In addition Dietetics provides 4 specialist clinics per week which are Head & Neck tumour site specific with 1 specialist clinic for all other tumour sites (i.e. for patients requiring enteral tube feeding, dysphagia management and specialist therapeutic advice to manage GI symptoms). Specialist Dietitians provide the clinical input to these 5 clinics. A graduate Dietitian post within this team is rotational (annual) and predominantly provides the inpatient care. The team supports clinical placements from Dietetics.

It is well documented that early nutritional therapy improves outcomes for patients with cancer, the benefits from Dietetic intervention are summarized below:

Clinical – **Management of malnutrition**	• Education and support to promote nutritional self care strategies to optimise well being, with a digital first approach. • Specialist assessment of nutritional status • Specialist therapeutic dietary advice and education • Assess and manage symptoms impacting on nutritional status e.g dysphagia, bowel obstruction, malabsorption, pancreatic enzyme replacement therapy • Initiation, management and monitoring of artificial feeding (enteral tube feeding and intravenous parenteral nutrition) • Advising and managing the supply of oral nutritional supplements for IP and OP.
Continuity/co-ordination **of care**	• Core role within the MDT • Co-ordinated nutrition care pathways for all tumour sites
Quality	• Support/expert information/advice: reduces anxiety/promotes patient confidence, rehabilitation and ability to 'self manage' • Symptom management reduces unplanned admission and helps people to avoid hospital admission and remain in their community
Education and Training	• To support self care for patient and/or carer, including patient Groups • To participate in the Oncology MDT training at ECC and beyond • Dietetic clinical placements
Patient Safety	• Early intervention: reduce complications and unplanned admissions e.g. aspiration risk, dehydration, renal failure, food safety for neutropenia

Efficiency	• Facilitate achieving cancer targets e.g prophylactic gastrostomy insertion • Supporting patients to complete treatment programmes with reduced interruptions for radiotherapy • Reduction in complications and prevention of unplanned admission working with our locality community Dietetic teams, SCAN colleagues. • Prepares patients for complex treatment
Economic Benefits	• Improve malnutrition care pathway management prescribing costs for ONS and symptom management and prescribing costs. • Support patient reviews and follow-up with self management using TEC and skillmix.

Drivers for change

- Increased Lothian population and increased incidence of cancer.
- An aging population with increasing frailty and co morbidities is leading to an increased prevalence of cancer.
- More people living with and beyond cancer leading to a growing demand for prehabilitation, rehabilitation and self care nutritional strategies.
- Disease related malnutrition is prevalent in cancer (30-80% incidence) and it is now well recognised that under-nutrition adversely affects clinical outcome.
- New developments in the treatment of cancer, in particular multimodality SACT have created significant increased demands for the Dietetic service to manage the nutritional consequences and symptoms – the nutritional challenges of these treatments require use of specialised diets, oral nutritional supplements and artificial feeding (enteral tube-feeding and intravenous parenteral nutrition).
- Enteral tube feeding rates have escalated over the last 8 years (75% increase) and have now become an integral component of cancer management. Circa 130 new patients per year are discharged on enteral feeding requiring acute and community input in addition to those who live longer with enteral feeding requiring long term review.
- The inpatient service uses a criteria-led prioritisation system as the caseload exceeds capacity with patients often discharged prior to dietetic assessment and patients often being seen less often than is optimal.
- Nutritional issues span all tumour sites but Head & Neck Oncology and Upper GI have a specific QPI related to nutrition. Gynaecology and Lung are also currently identifying significant nutritional issues and a gap in service provision. Haematology utilises the service with national standards for nutritional care in place for being a transplant centre.
- To improve clinical outcomes, promote rehabilitation, prevent hospital admission, promote shorter length of stay and enhance patient experience , the current capacity of the dietetic service remains a concern. There has been no additional investment in Dietetic services since 2012. A business case for additional resources was submitted to the Cancer Services Management Team in June 2020.

Future Vision

Clinical Service & Pathways

- Development of additional specialist dietetic posts (ranging from Band 3 to Band 8a) to create an Oncology Dietetic Team that has a critical mass to integrate into the ECC. This would aim to address complex needs of patients (similar to CNS model and model observed in other centres of excellence) with specialists in different tumour types.
- A comprehensive Dietetic Service that provides access for IP, OP and Day Case care.

- Attendance at all MDT's and ward rounds.
- A responsive service (over 7 days, outwith core hours) that increases access to nutritional care at the right time, in the right place by the right person.
- Timely access to dietetics at all stages of the cancer journey including pre-habilitation, rehabilitation and cancer survivorship.
- Staff to support an increasing number of patients to access complex nutrition therapies, enteral and parenteral feeding, at home and within palliative care.
- Joint clinics with CNS, other specialist AHP's and Pharmacists to reduce pressure on consultant time.
- Creating Dietitians with extended roles (e.g prescribers and care of enteral feeding tubes).
- Making strong links with the Integrated Cancer Journey (ICJ) programme to address nutritional issues and management of symptoms, which are widely reported in the top 10 concerns for patients and their carers.
- Working with colleagues to promote primary and secondary prevention through healthy diet, maintain a healthy weight, lifestyle programmes and self management strategies.

Accommodation

- Access to appropriate clinical space within ECC to assess, counsel and educate patients (e.g. enteral tube feeding) is required - this could be a dedicated AHP hub with storage space for enteral feeding supplies and equipment.
- Dedicated space for patients who require to administer enteral feeding, fluids and medication during their visit to ECC (e.g a private room with handwashing facilities) is also desirable.

Education, training & research

- Attendance at all MDT's and ward rounds to provide education on complex nutrition care.
- Post-graduate training and workforce planning to develop oncology nutritional knowledge and skills.
- Upskilling of community and regional based dietetic staff to support patient care.
- Involvement in research & QI projects, training other AHPs and links with universities.

Technology

- Access to innovative technology for communication, information sharing with patients and for treatment modalities (e.g. laptops, use of Near Me, ability to email patients with treatment plans and dietary advice, patient reported measures-Healthcall).

Challenges

- 3 WTE staff limits the ability to integrate with all tumour site pathways.
- Competing clinical demands of inpatient/outpatient/daycase compromise the service ability to provide equitable, timely & safe care.
- Unable to provide 7 day working with current level of staffing.
- No dedicated clinic room for Dietetics within IP/OP services in current ECC.
- Require equitable resource across the SE Region (within acute and community services) to allow a consistent Nutrition & Dietetic pathway for every patient attending ECC.

Appendix 12: Long-listed Options

Cancer Centre Initial Agreement
Option Appraisal · Long List of Options

Long list of delivery options

09 September 2020 - Rev. 7

Ref.	Option	Option Description	Strengths / Weaknesses: Description	Strength (S) Weakness (W) Improved (I)	Preferred Possible Discounted	Carry to shortlist (yes/no)?
1	Do nothing	Continue with the existing service at WGH and Regionally. This option is no longer possible as the "do minimum option" in terms of the Oncology enabling projects is underway.	Facilities and capacity are not able to cope with projected demand.	W	Discounted	Yes - carry forward to allow comparison. Short-list option 1
			HAI patient safety issues.	W		
			Poor patient experience	W		
			Workforce challenges - recruitment and retention.	W		
			Wide range of cancer therapies.	W		
			Opportunities to participate in a full programme of trials and research.	W		
			Cost (capital/revenue)	S		
2	Do minimum	This option relates to the Oncology enabling projects. Cancer services remain in their existing accommodation with upgrade work completed (Oncology enabling and Haematology projects). These works deal to some degree with building condition and capacity related issues, however the enabling works are viewed as a 10 year max. plan to support cancer treatments until a new cancer centre is ready.	Facilities and capacity are not able to cope with projected demand.	I	Discounted	Yes - carry forward to allow comparison. Shot-list option 2
			HAI patient safety issues.	I		
			Poor patient experience	I		
			Workforce challenges - recruitment and retention.	W		
			Wide range of cancer therapies.	W		
			Opportunities to participate in a full programme of trials and research.	W		
			Cost (capital/revenue)	S		
3	Re-provision: WGH hub and Regional spoke model.	New-build and/or refurbishment at WGH to create a hub. This would in turn allow Regional spokes to be formed helping to balance care between WGH and the Region. This option would decentralise the cancer centre to an extent providing more service within the Region. Potential issues with patient and staff flows. Staff recruitment and retention may be a challenge generally under this option and a international centre of excellence would not be created.	Facilities and capacity are not able to cope with projected demand.	I	Discounted	No
			HAI patient safety issues.	S		
			Poor patient experience	S		
			Workforce challenges - recruitment and retention.	W		
			Wide range of cancer therapies.	W		
			Opportunities to participate in a full programme of trials and research.	W		
			Cost (capital/revenue)	I		
4	Re-provision: new-build at WGH	Current services re-provided at the WGH in a new build facility.	Facilities and capacity are not able to cope with projected demand.	I	Possible	Yes Short-list option 3
			HAI patient safety issues.	S		
			Poor patient experience	S		
			Workforce challenges - recruitment and retention.	I		
			Wide range of cancer therapies.	W		
			Opportunities to participate in a full programme of trials and research.	W		
			Cost (capital/revenue)	I		
5	Re-provision: phased new-build at WGH	Current services re-provided at the WGH in a new build facility. Delivered in a phased manner. Ability to spread investment over a longer timeframe helping cashflow. With inflation, although cashflow will be improved this option will cost more overall compared to option 4. It will however take longer to make the necessary changes and realise the benefits of the investment. There are likely to be site compromises in terms of adjacencies over a longer time period under this option also.	Facilities and capacity are not able to cope with projected demand.	I	Possible	Yes Short-list option 4
			HAI patient safety issues.	S		
			Poor patient experience	S		
			Workforce challenges - recruitment and retention.	I		
			Wide range of cancer therapies.	W		
			Opportunities to participate in a full programme of trials and research.	W		
			Cost (capital/revenue)	I		
6	Re-provision: refurbishment at WGH	Current services re-provided at the WGH in refurbished accommodation. Option is very unlikely to be feasible based on space constraints, site adjacencies and general building condition.	Facilities and capacity are not able to cope with projected demand.	I	Discounted	No
			HAI patient safety issues.	I		
			Poor patient experience	I		
			Workforce challenges - recruitment and retention.	I		
			Wide range of cancer therapies.	W		
			Opportunities to participate in a full programme of trials and research.	W		
			Cost (capital/revenue)	I		
7	Re-provision: part new-build and part refurbishment at WGH.	Current services re-provided at the WGH in a smaller new-build and refurbished accommodation. This could include retaining some facilities - i.e. radiotherapy. More feasible than option 6, however site adjacencies and compromises over space standards and building condition would still exist.	Facilities and capacity are not able to cope with projected demand.	I	Discounted	No
			HAI patient safety issues.	I		
			Poor patient experience	I		
			Workforce challenges - recruitment and retention.	I		
			Wide range of cancer therapies.	W		
			Opportunities to participate in a full programme of trials and research.	W		
			Cost (capital/revenue)	I		

8	Re-provision: new-build facilities at another site (in Edinburgh, Lothians or Regionally).	Current services re-provided at another site in Edinburgh/Lothians/Regionally. Availability of appropriate sites are likely to be limited. Land purchase may also be a factor. As other non cancer related services would remain at the WGH this option has the potential to disrupt patient and staff flows/efficiencies. In addition this option is not aligned with NHS Lothian's Clinical Strategy which commits to the long-term future of the WGH site.	Facilities and capacity are not able to cope with projected demand. HAI patient safety issues. Poor patient experience Workforce challenges - recruitment and retention. Wide range of cancer therapies. Opportunities to participate in a full programme of trials and research. Cost (capital/revenue)		Possible	No
9	Re-Provision and enhancement of the Cancer Centre: new-build facilities at WGH.	Enhanced new-build facilities at WGH helping to achieve all of the needs for change. The disadvantages with this option are cost and the lack of Regional synergy.	Facilities and capacity are not able to cope with projected demand. HAI patient safety issues. Poor patient experience Workforce challenges - recruitment and retention. Wide range of cancer therapies. Opportunities to participate in a full programme of trials and research. Cost (capital/revenue)		Possible	Yes Short-list option 5
10	Re-Provision and enhancement of the Cancer Centre: enhanced new-build facilities at another site (in Edinburgh, Lothians or Regionally).	Enhanced new-build facilities at an alternate site helping to achieve all of the needs for change. The disadvantages with this option are cost and lack of Regional synergy. There is also potentially workforce challenges with this option. In addition NHS Lothian have committed to cancer services at the WGH site over the longer-term within their clinical strategy. As other non cancer related services would remain at the WGH this option has the potential to disrupt patient and staff flows/efficiencies and the viability of the site longer term.	Facilities and capacity are not able to cope with projected demand. HAI patient safety issues. Poor patient experience Workforce challenges - recruitment and retention. Wide range of cancer therapies. Opportunities to participate in a full programme of trials and research. Cost (capital/revenue)		Possible	No
11	Re-Provision and enhancement of the Cancer Centre: enhanced new-build hub at WGH with Regional spokes.	Enhanced new-build facilities at WGH with an appropriate balance of care shifting to Regional spokes. This option would decentralise the cancer centre to an extent providing more services within the Region. Potential issues with patient and staff flows. Staff recruitment and retention may be a challenge generally under this option and a international centre of excellence would not be created.	Facilities and capacity are not able to cope with projected demand. HAI patient safety issues. Poor patient experience Workforce challenges - recruitment and retention. Wide range of cancer therapies. Opportunities to participate in a full programme of trials and research. Cost (capital/revenue)		Possible	No
12	Re-Provision and enhancement of the Cancer Centre: Re-provision at WGH + Regional satellite / outreach facilities	Enhanced new-build facilities at the WGH with Regional satellite and outreach facilities. This option helps to achieve all the needs for change creating a core centre of excellence at the WGH whilst establishing appropriate local facilities, helping to treat people locally as far as practical. The disadvantages of this option are cost and potential workforce issues in managing Regional requirements.	Facilities and capacity are not able to cope with projected demand. HAI patient safety issues. Poor patient experience Workforce challenges - recruitment and retention. Wide range of cancer therapies. Opportunities to participate in a full programme of trials and research. Cost (capital/revenue)		Preferred	Yes Short-list option 6
13	Re-Provision and enhancement of the Cancer Centre: at another site (in Edinburgh, Lothians or Regionally) + Regional satellite / outreach facilities	Enhanced new-build facilities at another site (in Edinburgh, Lothians or Regionally) + Regional satellite / outreach facilities. This option is similar to option 12, however site availability/cost could be potential issues. Workforce challenges are likely to be greater for this option especially if the core centre is out with Edinburgh. As with other options that look at moving off the WGH site, this goes against NHS Lothian's clinical strategy and is likely to stagnate the WGH site over the longer term.	Facilities and capacity are not able to cope with projected demand. HAI patient safety issues. Poor patient experience Workforce challenges - recruitment and retention. Wide range of cancer therapies. Opportunities to participate in a full programme of trials and research. Cost (capital/revenue)		Possible	No
14	Re-Provision and enhancement of the Cancer Centre: Regional approach	This option would have less reliance on a dominant central hub and service would be distributed via key hubs Regionally. Potential issues with staff and patient flows in respect to this option. Likely to be less efficient having a series of hubs. The loss of a core cancer centre reduces the likelihood of achieving an international centre of excellence and the benefits of staff recruitment that this would facilitate.	Facilities and capacity are not able to cope with projected demand. HAI patient safety issues. Poor patient experience Workforce challenges - recruitment and retention. Wide range of cancer therapies. Opportunities to participate in a full programme of trials and research. Cost (capital/revenue)		Possible	No

Appendix 13: Short-listed Options

Cancer Centre Initial Agreement
Option Appraisal - Long List of Options

Definitions & Option Descriptions

09 September 2020 - Rev. 7

Definitions

Satellite	- facility provided and managed by NHS Lothian in NHS Lothian's estate.
Regional	- services which are provided in Lothian by NHS Lothian and outwith Lothian by other Boards.
Re-provision	• Accommodation/ infrastructure designed to meet current applicable clinical standards (including design and technical requirements). • Provide core services for cancer services as are currently provided. NB: Provision of single main entrance.
Re-provision and enhancement	• Purpose built 'Regional Specialist Cancer Centre' (Accommodation/infrastructure designed to meet current applicable clinical standards - including design and technical requirements) and incorporating transformational redesign of patient pathways; • Wide range of specialist cancer therapies available for the patients of South East Scotland, enabling repatriation of patients from the SE and potentially across Scotland; • Rapid Diagnostics Centre and Essential Service Hub supporting transformation of cancer care • Single integrated outreach service model for region • Internationally leading Clinical Research and Trials capability providing most innovative cancer therapies for people of Scotland Centre for Cancer Education, • Innovation, role re-design and Workforce Development/training for staff - For staff across region and across Scotland - For patients living with and beyond cancer managing long term conditions NB: Area uplifts as relevant in line with projected growth.
Option 1:	Do Nothing
Option 2:	Do minimum - Enabling Projects
Option 3:	Re-provision of the Cancer Centre (Single New Build)
Option 4:	Re-provision of the Cancer Centre (Longer term phased solution)
Option 5:	Re-Provision and enhancement of the Cancer Centre (Fully integrated facility at the WGH)
Option 6:	Re-Provision and enhancement of the Edinburgh Cancer Centre (At the WGH with satellite/outreach facilities across East Region)

Appendix 14: Services – Evaluation Matrix for Options

Cancer Centre Initial Agreement
Option Appraisal - Long List of Options

Long list of services filtered into short list of delivery options

17 July 2020 - Rev. 4

Key: Preferred (green) / Possible (amber) / [illegible] (red)

Services	Services Solutions: Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Short listed Options for Assessment: Feasibility / notes
Main Entrance	Green	Red	Red	Red	Red	Required only if New Build Cancer Centre is provided
Wellness Centre						
Benefits Advice	Green	Amber	Amber	Red	Amber	Dedicated service for the new Cancer Centre. Could be provided in another new adjacent building or via the retained estate if required (not preferred).
Coffee Lounge	Green	Amber	Amber	Red	Amber	As above.
Holistic and Complementary Therapies	Green	Amber	Amber	Red	Amber	As above.
Training "Living With and Beyond Cancer"	Green	Amber	Amber	Red	Amber	As above.
Counselling	Green	Amber	Amber	Red	Amber	As above.
Training & Education Centre	Green	Amber	Amber	Red	Red	
Admissions/ Cancer Assessment						
CAU (trolleys & short stay)	Green	Red	Red	Red	Red	A dedicated service for the new cancer centre.
Enhanced Supportive Care Clinic	Green	Red	Red	Red	Red	A dedicated service for the new cancer centre.
Cancer Treatment Helpline/Booking Hub	Green	Red	Red	Red	Red	Currently provided national service that would continue to be provided within a new cancer centre.
Companion Accommodation	Amber	Amber	Amber	Red	Red	Replacing Pentland lodge accommodation in Options 3 & 4 - may be located within WGH site or nearby. Includes immediately adjacent relatives accommodation within CAU and 'aparthotel' accommodation within Options 5 & 6. Aparthotel - see "Overnight & Support" for regional patients below.
Chemotherapy Day Case	Green	Red	Red	Green	Green	New Cancer Centre with an NHS Lothian satellite facilities is the preference. There may also be opportunities for expansion of Regional capacity however these would require to be scoped out in detail to ensure efficient patient flows and sustainable staffing models could be provided without any negative impact on the ambition for the centre and specialist staff recruitment/retention.
Haematology including Day Case	Green	Red	Red	Green	Green	As above.
Radiotherapy Department (including Brachytherapy)	Green	Red	Red	Amber	Amber	New Cancer Centre is the preference. There may also be opportunities for satellite facilities (in Lothian or in Region) however these would require to be scoped out in detail to ensure efficient patient flows and sustainable staffing models could be provided without any negative impact on the ambition for the centre and specialist staff recruitment/retention.
Radiopharmacy	Amber	Green	Amber	Red	Red	Radiopharmacy is currently provided at RIE however 60% of medicines produced come to WGH
Outpatient department	Green	Red	Amber	Amber	Green	The preference is for Cancer Centre provision and Regional clinics offering access to outpatient services throughout the Region. There are alternative possible options as noted, however these are not preferred. All OP facilities to be designed flexibly to allow for use of technology, remote clinics etc.
Supportive Therapies Facilities	Green	Red	Red	Amber	Green	The preference is for Cancer Centre provision and Regional capacity offering access to Supportive Therapies throughout the Region.
HEBA Clinic	Green	Red	Red	Red	Red	It is considered that this service would be provided as part of the outpatient capacity within the new Cancer Centre

Services	Option 1 – Do nothing: WGH	Satellite	Regional	Option 2 – Do Minimum: Wider WGH Campus	Satellite	Regional	Option 3 – Re-provision, cancer new-build: Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Option 4 – As option 3 but phased: Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Option 5 – Re-provision and enhancement: Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Option 6 – Re-provision and enhancement + regional: Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional
Main Entrance							✓					✓					✓					✓				
Wellness Centre																										
Benefits Advice	✓			✓			✓					✓					✓					✓				✓
Coffee Lounge	✓			✓													✓					✓				✓
Holistic and Complementary Therapies	✓			✓													✓					✓				✓
Training "Living With and Beyond Cancer"	✓			✓													✓					✓				✓
Counselling	✓			✓			✓					✓					✓					✓				✓
Training & Education Centre																	✓					✓				
Admissions/ Cancer Assessment																										
CAU (trolleys & short stay)	✓			✓			✓					✓					✓					✓				
Enhanced Supportive Care Clinic																	✓					✓				
Cancer Treatment Helpline/Booking Hub	✓			✓			✓					✓					✓					✓				
Companion Accommodation	✓			✓			✓	✓	✓			✓	✓	✓			✓					✓				
Chemotherapy Day Case	✓	✓	✓	✓	✓	✓	✓					✓					✓			✓		✓			✓	
Haematology including Day Case	✓	✓	✓	✓	✓	✓	✓					✓					✓					✓				
Radiotherapy Department (including Brachytherapy)	✓			✓			✓					✓					✓					✓			✓	
Radiopharmacy								✓					✓				✓					✓				
Outpatient department	✓	✓	✓	✓	✓	✓	✓				✓	✓				✓	✓				✓	✓				✓
Supportive Therapies Facilities	✓	✓	✓	✓	✓	✓	✓				✓	✓				✓	✓				✓	✓				✓
HEBA Clinic	✓			✓			✓					✓					✓					✓				

	Services Solutions						Short listed Options for Assessment	Option 1			Option 2			Option 3					Option 4					Option 5					Option 6				
								Do nothing			Do Minimum			Re-provision, cancer new-build					As option 3 but phased					Re-provision and enhancement					Re-provision and enhancement + regional				
Services	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional		Feasibility / notes	WGH	Satellite	Regional	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional
Pharmacy (ECC provision)							Pharmacy facility will be provided to current design standards and integral to any new build options. Note that New build adjacent to ECC or the wider WGH campus would require good immediate links and adjacencies to ECC, particularly for SACT delivery.	✓			✓			✓					✓					✓					✓					✓				
Pharmacy - Combined site facility							Pharmacy requires good adjacencies to the Cancer Centre and the rest of the WGH site. The preference is for this service to be delivered via a new single fully integrated facility at WGH combining pharmacy services for the cancer centre and the wider site. Other options are available as noted however these are not preferred. Note Option 2 "Do Minimum" - area available for Pharmacy Services is compromised.	✓			✓			✓						✓					✓	✓				✓					✓				
Inpatient beds																																
Acute Oncology Inpatient Beds							New Cancer Centre is the preference. There may also be opportunities for specific Oncology/Haematology capacity in the region, however this requires to be scoped out in detail to fully understand current arrangements and ensure efficient patient flows and sustainable staffing models could be provided without any negative impact on the ambition for the centre and specialist staff recruitment/retention.	✓			✓			✓						✓					✓					✓					✓				
Breast Surgical Inpatient Beds							The only IP beds provided regionally are for Breast Surgery patients. All other Onc and Haem patients are managed within general wards.	✓	✓	✓	✓	✓	✓	✓					✓					✓					✓				
Acute Haematology Inpatient Beds							As above.	✓			✓			✓					✓					✓					✓				
Clinical Trials Inpatient Beds							As above.	✓			✓			✓					✓					✓					✓				
Teenage Cancer Trust (TCT)																																
Teenage and Young Adult Inpatient Beds							The only IP beds provided regionally are for Breast Surgery patients. All other Onc and Haem patients are managed within general wards.	✓			✓			✓					✓					✓					✓				
Teenage and Young Adult Services							New Cancer Centre is the preference.	✓			✓			✓					✓					✓					✓				
Breast services:																																
Breast screening & Mammography							The preference is for co-location of the Screening Centre with the new Cancer Centre due to efficiencies in equipment use and staff utilisation. Mobile screening would continue to offer access to patients throughout Lothian and the South East Region.	✓	✓	✓	✓	✓	✓			✓	✓			✓	✓				✓	✓					✓	✓			✓	✓
Breast Clinics & Consultant Offices							New Cancer Centre is the preference. Wider WGH campus is a possibility via a refurb option however optimum flows and adjacencies may be compromised. Some outpatient services are already offered regionally, there may also be opportunities for additional regional capacity, however these would require to be scoped out in detail. All OP facilities to be designed flexibly to allow for use of technology, remote clinics etc	✓	✓	✓	✓	✓	✓	✓						✓					✓					✓					✓				
Breast Theatres							As above.	✓	✓	✓	✓	✓	✓	✓					✓					✓					✓				
Breast Daybed Unit							New Cancer Centre is the preference. Breast Surgery is also carried out regionally at the moment however specialist procedures come to WGH - assumption is this arrangement would continue in the future.	✓	✓	✓	✓	✓	✓	✓					✓					✓					✓				
SESCRN							New Cancer Centre is the preference. There may also be opportunities for Regional research and trials capacity, however these would require to be scoped out in detail to ensure efficient patient flows and sustainable staffing models could be provided without any negative impact on the ambition for the centre and specialist staff recruitment/retention.	✓			✓			✓						✓					✓					✓					✓				
Admin & Support																																
Offices - Administrative/management (Agile working)							Dedicated to a new Cancer Centre. Could be provided in another new adjacent building or via the retained estate if required (not preferred).	✓			✓			✓					✓					✓					✓				
Offices - Clinical (Agile working)							As above.	✓			✓			✓					✓					✓					✓				
Seminar rooms							As above.	✓			✓			✓					✓					✓					✓				
Macmillan																																
Palliative Care							This relates to office space only and the preference is for this service to be provided via the new Cancer Centre and in the Region. The service could be provided via the retained estate at the WGH if required.	✓			✓			✓						✓					✓					✓					✓				✓
Staff Welfare Hubs																																
Changing facilities &WCs							Dedicated to a new Cancer Centre. Could be provided in another new adjacent building or via the retained estate if required (not preferred).	✓			✓			✓					✓					✓					✓				
Staff Restrooms							As above.	✓			✓			✓					✓					✓					✓				
FM Hub							Site wide strategies indicate that with the proximity to the Clock Tower, FM services associated with the Cancer centre should be integated in a new build option.							✓					✓					✓					✓				
Data Centre							IT Strategy indicates requirement for suitable facility within new build options.																											

	Services Solutions							Option 1			Option 2			Option 3					Option 4					Option 5					Option 6				
							Short listed Options for Assessment	Do nothing			Do Minimum			Re-provision, cancer new-build					As option 3 but phased					Re-provision and enhancement					Re-provision and enhancement + regional				
Services	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional		Feasibility / notes	WGH	Satellite	Regional	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional	Cancer Centre (new build)	New build adjacent to CC	Wider WGH Campus	Satellite	Regional
Overnight and Support Accommodation																																
Regional Patient							Flexible opportunities for provision of this service. Preferred model "Aparthotel" concept.	✓			✓			✓					✓					✓					✓				
Communal Day Room							As above.	✓			✓			✓					✓					✓					✓				
Other Support Accommodation, including site wide essential services & Rapid Diagnostic Centre Model																																
Rapid Diagnostic Centre							Site wide services to be provided from retained estate and new accommodation in conjunction with new ECC.	✓			✓			✓	✓	✓			✓	✓	✓			✓	✓	✓			✓	✓	✓		
Labs							As above.	✓			✓														✓					✓			
Critical Care							Requires good adjacencies to the Cancer Centre and the rest of the WGH site therefore the preference is for this service to be delivered via a new adjacent facility at the WGH. Other options are available as noted however these are not preferred.	✓			✓														✓					✓				✓
Imaging							An Imaging Centre requires good adjacencies to the Cancer Centre and the rest of the WGH site. The preference is for this service to be delivered via a new adjacent facility at the WGH. Other options are available as noted however these are not preferred.	✓			✓														✓					✓				
AHP							AHP services requires good adjacencies to the Cancer Centre, however do not necessarily require to be located within the Cancer Centre. The preference is for this service to be delivered via a new adjacent facility at the WGH. Other options are available as noted however these are not preferred. Opportunities to provided rehabilitation services within the "Ward Support Clusters" multi-purpose room, and in the development of the brief for the Wellness Centre.	✓			✓		✓				✓				✓				✓				✓				✓				✓
Social Work							As above.	✓			✓		✓				✓					✓			✓				✓				✓
Nursery							This facility is not currently provided, but would complement the overall Cancer Centre offering. It could be provided in new facilities, however as its not essential the preference is for the retained estate to be used.																			✓					✓			
Gym							As above.																			✓					✓			

Appendix 15: AEDET Matrix

HFS 20200818 AEDET Refresh Edin Cancer Centre IA v0_2 .xlsx

Benchmark **Edinburgh Cancer Centre** **AEDET Refresh** v1.2 Mar 2016

Functionality

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1		YES
A.02	The design facilitates the care model	2		YES
A.03	Overall the design is capable of handling the projected throughput	1		NO
A.04	Work flows and logistics are arranged optimally	1		
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2		YES
A.06	Where possible spaces are standardised and flexible in use patterns	1		
A.07	The design facilitates both security and supervision	1		YES
A.08	The design facilitates health promotion and equality for staff, patients and local community	1		YES
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1		YES
A.10	The benchmarks in the Design Statement in relation to building USE are met	0		

	Access	Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	1	3	YES
B.02	There is adequate parking for visitors/ staff cars/ disabled people	2		YES
B.03	The approach and access for ambulances is appropriately provided	1	3	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	2	YES
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	2		YES
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	2	YES
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1		YES
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	3	YES
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	0		

	Space	Weight	Score	Notes
C.01	The design achieves appropriate space standards	1		
C.02	The ratio of usable space to total area is good	1		
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	2		
C.04	Any necessary isolation and segregation of spaces is achieved	1		
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	2		
C.06	There is adequate storage space	1		
C.07	The grounds provided spaces for informal / formal therapeutic health activities	1	2	
C.08	The relationships between internal spaces and the outdoor environment work well	2		
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	0		

Build Quality

	Performance	Weight	Score	Notes
D.01	The building and grounds are easy to operate	1		
D.02	The building and grounds are easy to clean and maintain	1		
D.03	The building and grounds have appropriately durable finishes and components	1		
D.04	The building and grounds will weather and age well	1		
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1		
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1		
D.07	The design minimises maintenance and simplifies this where it will be required	1		
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	0		

	Engineering	Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1		
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1		
E.03	The engineering systems are energy efficient	1		
E.04	There are emergency backup systems that are designed to minimise disruption	1		
E.05	During construction disruption to essential services is minimised	1		
E.06	During maintenance disruption to essential healthcare services is minimised	1		
E.07	The design layout contributes to efficient zoning and energy use reduction	1		

	Construction	Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	0		
F.02	Temporary construction work is minimised	0		
F.03	The impact of the building process on continuing healthcare provision is minimised	0		
F.04	The building and grounds can be readily maintained	0		
F.05	The construction is robust	0		
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	0		
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	0		
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	0		
F.09	The construction contributes to being a good neighbour	0		
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	0		

Impact

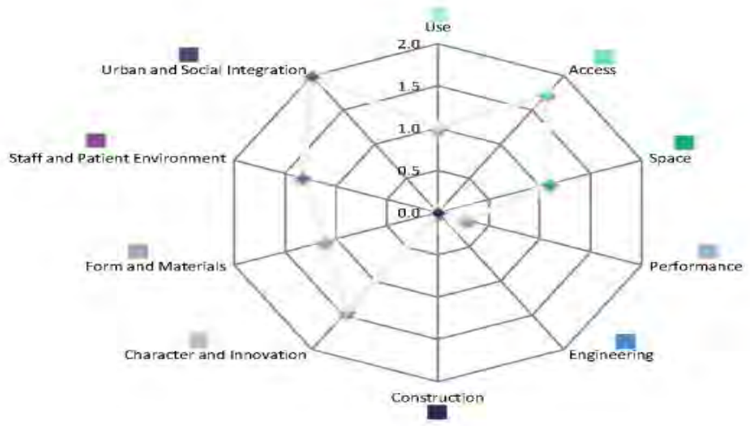
	Character and Innovation	Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1		
G.02	The building and grounds are interesting to look at and move around in	1	-2	yes
G.03	The building, grounds and arts design contribute to the local setting	1		yes
G.04	The design appropriately expresses the values of the NHS	1		yes
G.05	The project is likely to influence future designs	1	-2	
G.06	The design provides a clear strategy for future adaptation and expansion	2		
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	2	-2	YES
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	0		

	Form and Materials	Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	-2	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1		
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	2		
H.04	The external materials and detailing appear to be of high quality and are maintainable	2		
H.05	The external colours and textures seem appropriate and attractive for the local setting	1		yes
H.06	The design maximises the site opportunities and enhances a sense of place	2		
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	0		

	Staff and Patient Environment	Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2		
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	2	-2	yes
I.03	The design maximises the opportunities for access to usable outdoor space	1	-2	
I.04	There are high levels of both comfort and control of comfort	1		
I.05	The design is clearly understandable and wayfinding is intuitive	1		
I.06	The interior of the building is attractive in appearance	1		
I.07	There are good bath/ toilet and other facilities for patients	1		
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2		
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	-2	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENT are met	0		

	Urban and Social Integration	Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	3	
J.02	The facility contributes positively to its locality	2	-3	
J.03	The hard and soft landscape contribute positively to the locality	1	3	
J.04	The overall design contributes positively to neighbourhood and is sensitive to passers-by	1	-2	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	2		
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	0		

AEDET Refresh Benchmark Summary



	Benchmark
Use	1.0
Access	1.7
Space	1.3
Performance	0.3
Engineering	0.0
Construction	0.0
Character and Innovation	1.4
Form and Materials	1.3
Staff and Patient Environment	1.3
Urban and Social Integration	2.0

Weighting	=	Target
2	=>	5 - 6
1	>	3 - 4
0	<	3

NHS National Services Scotland

Health Facilities Scotland

HFS 20200818 AEDET Refresh Edin Cancer Centre IA v0_2 .xlsx

AEDET Refresh v1.2 Mar 2016

Edinburgh Cancer Centre

Benchmark

Ref	Note
A.01	Fragmented services. Pharmacy unable to deliver service. Radiotherapy average, but no clinical rooms - Score '3.' Clinical Trials '1' - can't deliver service.
A.02	Reception waiting areas Ward 1 'miserable.' No space for Palliative Care, contemplative, peaceful etc.
A.03	Fragmented services mean care model can't be delivered. Patient: good service but pressure mounting on staff to deliver same standard of care.
A.04	Fragmented services throughout whole of WGH campus. Inpatient areas distal to CC services. Staff have to work harder to deliver the service.
A.05	Lack of physical space, both current and potential future expansions. Reached limit. Infrastructure will not support any more expansion in this area.
A.06	
A.07	RIE warnings to 'Keep possessions Close' & locking door while procedures are being performed - alarming that this is necessary. See original recorded notes.
A.08	Ward 1 waiting area unwelcoming, bare, insufficient which availability. Patient using whchs they are not familiar with. Sensory impairment considers e.g. lighting.
A.09	No Wifi in Ward 1 - although some treatment chairs do now have ports.
A.10	Facilitating the enablement of new treatments is fundamental to future service. Futuring-proofing from 'expansion' perspective also. Flexibility in use of space.
B.01	Site reasonably well served by public transport - if transport is available. Travelling from Fife and Border regions can be expensive. See original recorded notes.
B.02	1' unanimous. Quantity and access to parking poor: Staff parking £5.20/day. Staff parking stressful - selective what staff can use the parking available on site.
B.03	Very tight spaces for ambulances and there is a fragmentation of services. e.g. patients dropped off at in-patient wards instead of Cancer Centre.
B.04	EM problems in Outpatients in particular – no segregation and can be disruptive to the service.
B.05	Fragmented services, poor wayfinding/ signage, complex levels. Pavements either non existant or only on one side of the road.
B.06	Most outdoor spaces used for carparking. Patient: benches and tubs of flowers nice outside CC but not private, with traffic passing constantly.
B.07	No secure bicycle storage, showers etc to encourage staff. No safe cycle routes.
B.08	Entrances to Radiotherapy and Ward 1 are situated on the road and also directly opposite each other and can get congested. See original recorded notes.
B.09	Fragmented services - lone works raising security concerns. Ward 11 - monitoring extremely difficult. See original recorded notes.
C.01	
C.02	
C.03	
C.04	
C.05	
C.06	
C.07	Face Garden' most used spaces by patients because it is visible and easily accessible. 'Spiritual' Care: dank, miserable, smells.
C.08	Fragmentation especially over different levels across services. Difficulties in using wheelchairs across site.
C.09	
D.01	Not asked
D.02	Not asked
D.03	Not asked
D.04	Not asked
D.05	Just being able to see daylight is beneficial. Too many long dim corridors. Important to staff as well as patients.
D.06	Improved policies and implementation req. Use and disposal of domestic plastics a particular concern. Concerns as to how this is achieved in majority of rooms.
D.07	Not asked
D.08	Not prioritised as all questions were not scored/ discussed.
E.01	IT complesely out of date. Frequent problems with overheating and can't relieve this fans due to Infect Control. Air Con has been installed but has never worked.
E.02	
E.03	
E.04	
E.05	
E.06	One lift to access services - needs long detour if it is not working.
E.07	
F.01	
F.02	
F.03	
F.04	
F.05	
F.06	
F.07	
F.08	
F.09	
F.10	
G.01	No clarity.
G.02	Clock tower and similar building character appreciated.
G.03	Depends which side you approach from the site from. Mature trees of great value. Anything of value needs to be properly maintained.
G.04	Some of views from the wards are stunning to city of Edinburgh/ castle.
G.05	Complimentary therapies and garden spaces that have been created should be promoted. TCT should be a good example of how other services are run.
G.06	
G.07	Tiny elements are there, but not predominant in the service/ environment.
G.08	
H.01	Small elements work. Entrance to OPD - fair. Ward 1 - needs much improvement.
H.02	
H.03	
H.04	
H.05	Breast Unit balconies a good feature.
H.06	
H.07	
I.01	Generally good design of toilets; accessible for patients. Quantity an issue.
I.02	Small elements work - eg Face Garden. Wards have large windows but prone to overheating. Staff experiences & some patient journeys can be quite dismal.
I.03	Wards can access outdoor space allbeit on different level. Breast Unit balconies.
I.04	
I.05	
I.06	
I.07	Ward 2 no space in medical emergencies, e.g. bathrooms.
I.08	Not enough WCs etc for patients. Staff wellbeing facilities not fit for purpose. This is a priority for rriorale and encouraging staff retainment and recruitment.
I.09	Some small elements. Spaces are there but not enough facilities.
J.10	
J.01	
J.02	Parking often in front of local residents' property is a problem. Mature Trees a 'plus.'
J.03	
J.04	
J.05	See previous comments. The evolution of site - there is now no clarity in the design. Varying levels, complex wayfinding.
J.06	

Weighting

High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring

Strongly Agree (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Strongly Disagree (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this.
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed
	A.07 Consider what can be done now with regards to security:			
	(A.07 continued) - lone working, panic button provision.			
	A.08 Combatting health inequalities. e.g. lack of single bedrooms.			

Health Facilities Scotland

AEDET-IA Benchmark

NHS National Services Scotland

HFS 20200818 AEDET Refresh Edin Cancer Centre IA v0_2 .xlsx

Target | **Edinburgh Cancer Centre** | **AEDET Refresh** v1.1 Feb 2016

Functionality

Use

		Weight	Score	Notes
A.01	The prime functional requirements of the brief are satisfied	1	4	
A.02	The design facilitates the care model	2	5	
A.03	Overall the design is capable of handling the projected throughput	1	4	
A.04	Work flows and logistics are arranged optimally	1	4	
A.05	The design is sufficiently flexible to respond to clinical /service change and to enable expansion	2	5	
A.06	Where possible spaces are standardised and flexible in use patterns	1	4	
A.07	The design facilitates both security and supervision	1	4	
A.08	The design facilitates health promotion and equality for staff, patients and local community	1	4	
A.09	The design is sufficiently adaptatable to external changes e.g. Climate, Technology	1	4	
A.10	The benchmarks in the Design Statement in relation to building USE are met	2	5	

Access

		Weight	Score	Notes
B.01	There is good access from available public transport including any on- site roads	2	5	
B.02	There is adequate parking for visitors/ staff cars/ disabled people	2	5	
B.03	The approach and access for ambulances is appropriately provided	1	4	
B.04	Service vehicle circulation is well considered and does not inappropriately impact on users and staff	1	4	
B.05	Pedestrian access is obvious, pleasant and suitable for wheelchair/ disabled/ impaired sight patients	2	5	
B.06	Outdoor spaces wherever appropriate are usable, with safe lighting indicating paths, ramps, steps etc.	1	4	
B.07	Active travel is encouraged and connections to local green routes and spaces enhanced	1	4	
B.08	Car parking and drop-off should not visually dominate entrances or green routes	1	4	
B.09	The benchmarks in the Design Statement in relation to building ACCESS are met	2	5	

Space

		Weight	Score	Notes
C.01	The design achieves appropriate space standards	1	4	
C.02	The ratio of usable space to total area is good	1	4	
C.03	The circulation distances travelled by staff, patients and visitors is minimised by the layout	1	4	
C.04	Any necessary isolation and segregation of spaces is achieved	1	4	
C.05	The design maximises opportunities for space to encourage informal social interaction & wellbeing	2	5	
C.06	There is adequate storage space	1	4	
C.07	The grounds provided spaces for informal/ formal therapeutic health activities	1	4	
C.08	The relationships between internal spaces and the outdoor environment work well	1	4	
C.09	The benchmarks in the Design Statement in relation to building SPACE are met	2	5	

Build Quality

Performance

		Weight	Score	Notes
D.01	The building and grounds are easy to operate	1	4	
D.02	The building and grounds are easy to clean and maintain	1	4	
D.03	The building and grounds have appropriately durable finishes and components	1	4	
D.04	The building and grounds will weather and age well	1	4	
D.05	Access to daylight, views of nature and outdoor space are robustly detailed	1	4	
D.06	The design maximises the opportunities for sustainability e.g. waste reduction and biodiversity	1	4	
D.07	The design minimises maintenance and simplifies this where it will be required	1	4	
D.08	The benchmarks in the Design Statement in relation to PERFORMANCE are met	2	5	

Engineering

		Weight	Score	Notes
E.01	The engineering systems are well designed, flexible and efficient in use	1	4	
E.02	The engineering systems exploit any benefits from standardisation and prefabrication where relevant	1	4	
E.03	The engineering systems are energy efficient	1	4	
E.04	There are emergency backup systems that are designed to minimise disruption	1	4	
E.05	During construction disruption to essential services is minimised	1	4	
E.06	During maintenance disruption to essential healthcare services is minimised	1	4	
E.07	The design layout contributes to efficient zoning and energy use reduction	1	4	

Construction

		Weight	Score	Notes
F.01	If phased planning and construction are necessary the various stages are well organised	1	4	
F.02	Temporary construction work is minimised	1	4	
F.03	The impact of the building process on continuing healthcare provision is minimised	1	4	
F.04	The building and grounds can be readily maintained	1	4	
F.05	The construction is robust	1	4	
F.06	Construction allows easy access to engineering systems for maintenance, replacement & expansion	1	4	
F.07	The construction exploits opportunities from standardisation and prefabrication where relevant	1	4	
F.08	The construction maximises the opportunities for sustainability e.g. waste and traffic reduction	1	4	
F.09	The construction contributes to being a good neighbour	1	4	
F.10	Infection control risks for options, design and construction recorded/ minimised using HAI Scribe	1	4	

Impact

Character and Innovation

		Weight	Score	Notes
G.01	There are clear ideas behind the design of the building and grounds	1	4	
G.02	The building and grounds are interesting to look at and move around in	1	4	
G.03	The building, grounds and arts design contribute to the local setting	1	4	
G.04	The design appropriately expresses the values of the NHS	1	4	
G.05	The project is likely to influence future designs	1	4	
G.06	The design provides a clear strategy for future adaptation and expansion	2	5	
G.07	The building, grounds and arts design contribute to well being and a sustainable therapeutic strategy	2	5	
G.08	The benchmarks in the Design Statement in relation to CHARACTER & INNOVATION are met	2	5	

Form and Materials

		Weight	Score	Notes
H.01	The design has a human scale and feels welcoming	1	4	
H.02	The design contributes to local microclimate, maximising sunlight and shelter from prevailing winds	1	4	
H.03	Entrances are obvious and logical in relation to likely points of arrival on site	2	5	
H.04	The external materials and detailing appear to be of high quality and are maintainable	2	5	
H.05	The external colours and textures seem appropriate and attractive for the local setting	1	4	
H.06	The design maximises the site opportunities and enhances a sense of place	2	5	
H.07	The benchmarks in the Design Statement in relation to FORM & MATERIALS are met	2	5	

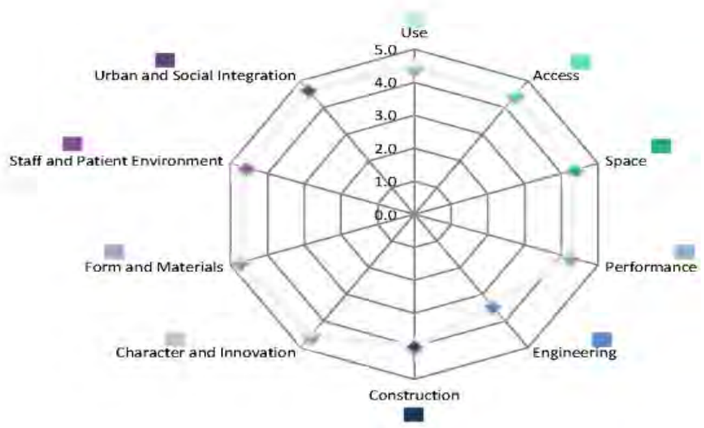
Staff and Patient Environment

		Weight	Score	Notes
I.01	The design reflects the dignity of patients and allows for appropriate levels of privacy	2	5	
I.02	The design maximises the opportunities for daylight/ views of green natural landscape or elements	2	5	
I.03	The design maximises the opportunities for access to usable outdoor space	1	4	
I.04	There are high levels of both comfort and control of comfort	1	4	
I.05	The design is clearly understandable and wayfinding is intuitive	1	4	
I.06	The interior of the building is attractive in appearance	1	4	
I.07	There are good bath/ toilet and other facilities for patients	1	4	
I.08	There are good facilities for staff with convenient places to work and relax without being on demand	2	5	
I.09	There are good opportunities for staff, patients, visitors to use outdoors to recuperate/ relax	1	4	
I.10	The benchmarks in the Design Statement in relation to STAFF & PATIENT ENVIRONMENTare met	2	5	

Urban and Social Integration

		Weight	Score	Notes
J.01	The height, volume and skyline of the building relate well to the surrounding environment	1	4	
J.02	The facility contributes positively to its locality	2	5	
J.03	The hard and soft landscape contribute positively to the locality	1	4	
J.04	The design contributes to being a good neighbour and is sensitive to neighbours and passers-by	1	4	
J.05	There is a clear vision behind the design, its setting and outdoor spaces	2	5	
J.06	The benchmarks in the Design Statement in relation to INTEGRATION are met	2	5	

AEDET Refresh Target Summary



	Target
Use	4.5
Access	4.5
Space	4.4
Performance	4.2
Engineering	3.4
Construction	4.0
Character and Innovation	4.5
Form and Materials	4.7
Staff and Patient Environment	4.6
Urban and Social Integration	4.7

Weighting	=	Target
2	= >	5 - 6
1	>	3 - 4
0	<	3

AEDET-IA Target

HFS 20200818 AEDET Refresh Edin Cancer Centre IA v0_2 .xlsx

AEDET Refresh v1.1 Feb 2016

Edinburgh Cancer Centre

Target

	Ref	Note
	A.01	
	A.02	
	A.03	
	A.04	
	A.05	
	A.06	
	A.07	
	A.08	
	A.09	
	B.01	
	B.02	
	B.03	
	B.04	
	B.05	
	B.06	
	B.07	
	B.08	
	B.09	
	C.01	
	C.02	
	C.03	
	C.04	
	C.05	
	C.06	
	C.07	
	C.08	
	C.09	
	D.01	
	D.02	
	D.03	
	D.04	
	D.05	
	D.06	
	D.07	
	D.08	
	E.01	
	E.02	
	E.03	
	E.04	
	E.05	
	E.06	
	E.07	
	F.01	
	F.02	
	F.03	
	F.04	
	F.05	
	F.06	
	F.07	
	F.08	
	F.09	
	F.10	
	G.01	
	G.02	
	G.03	
	G.04	
	G.05	
	G.06	
	G.07	
	G.08	
	H.01	
	H.02	
	H.03	
	H.04	
	H.05	
	H.06	
	H.07	
	I.01	
	I.02	
	I.03	
	I.04	
	I.05	
	I.06	
	I.07	
	I.08	
	I.09	
	I.10	
	J.01	
	J.02	
	J.03	
	J.04	
	J.05	
	J.06	

Health Facilities Scotland

Weighting
High = High Priority to the Project (2)
Normal = Desirable (1)
Zero = Not Applicable (0)

Scoring
Virtually Total Agreement (6)
Strong Agreement (5)
Fair Agreement (4)
Little Agreement (3)
Hardly Any Agreement (2)
Virtually No Agreement (1)
Unable to Score (0)

Guidance for Initial Agreement Stage

1 AEDET Target (& Benchmark) to be set at IA Stage and must be submitted for NDAP as ANNEX 1 to the Design Statement
2 The OBC and FBC Stage AEDET reviews will be monitored against IA Stage. Boards will require to provide an explanation of the reason for deviation from the IA Target
3 The note section to be completed to provide further briefing information
4 If any of the criteria is weighted as zero (not applicable) a note should state the reason for this
5 Boards may add project specific criteria. A note must be provided stating the reason for this.
6 Key actions arising from AEDET discussions to be recorded

Ref	Actions	by date	Owner	Completed

NHS National Services Scotland

AEDET-IA Target

Edinburgh Cancer Centre Western General Hospital

v.41 Oct 2020

HFS 20200818 AEDET Refresh Edin Cancer Centre IA v0_2 .xlsx

AEDET Refresh v1.1 Feb 2016

Edinburgh Cancer Centre

Summary

Category	Benchmark	Target	OBC	FBC	POE
Use	1.0	4.5	0.0	0.0	0.0
Access	1.7	4.5	0.0	0.0	0.0
Space	1.1	4.4	0.0	0.0	0.0
Performance	0.3	4.2	0.0	0.0	0.0
Engineering	0.0	3.4	0.0	0.0	0.0
Construction	0.0	4.0	0.0	0.0	0.0
Character and Innovation	1.4	4.5	0.0	0.0	0.0
Form and Materials	1.1	4.7	0.0	0.0	0.0
Staff and Patient Environment	1.3	4.6	0.0	0.0	0.0
Urban and Social Integration	2.0	4.7	0.0	0.0	0.0

NHS National Services Scotland

Health Facilities Scotland

Summary Progress

Appendix 16: Glossary

Initial Agreement Glossary

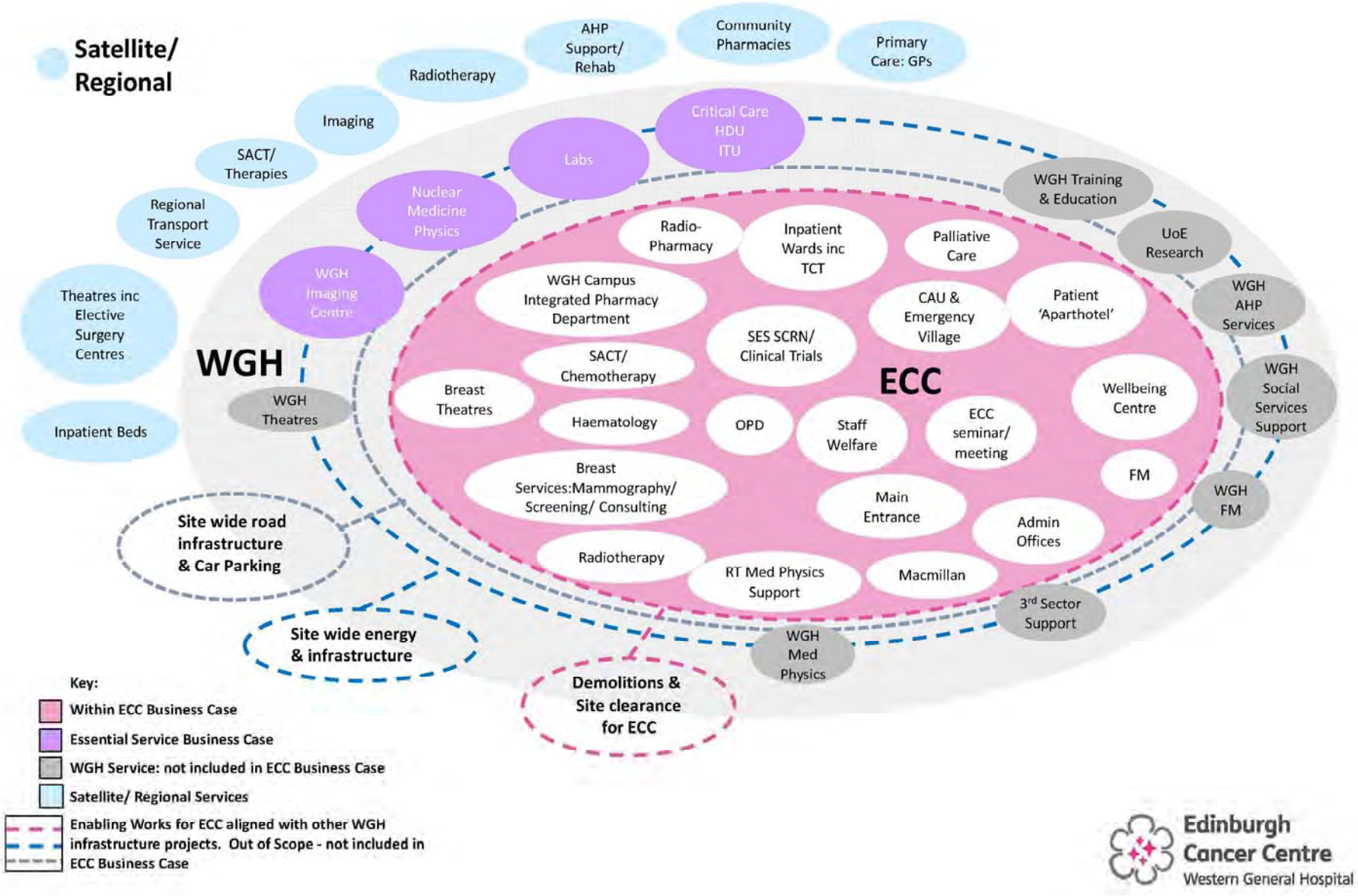
Acronym	Meaning
ADB	Alexander Donald Building
ADL	Activities of Daily Living
ADS	Architecture and Design Scotland
AEDET	Achieving Excellence Design Evaluation Toolkit
AES	Adaptable Estates Strategy
AFB	Anne Ferguson Building
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
AO	Acute Oncology
ATMP	Advanced Therapy Medicinal Product
Cancer CMT	Cancer Clinical Management Team
CAR-T	Chimeric antigen receptor T
CAU	Cancer Assessment Unit
CCPB	Cancer Capital Programme Board
CIG	Capital Investment Group
CLFS	Centre for Labs and Forensic Services
CNS	Clinical Nurse Specialist
COPD	Chronic obstructive pulmonary disease
CPD	Continued Professional Development
CPS	Capital Planning Strategy
CRUK	Cancer Research UK
CSO	Chief Scientist's Office
CT	Computerized tomography
CTH	Cancer Treatment Helpline
CUP	Cancer of Unknown Primary
CVADS	Central Venous Access Devices
DCN	Department of Clinical Neuroscience
DEXA	Dual-energy X-ray absorptiometry
DoFs	Directors of Finance
EAMS	Estates and Asset Management System
EBCD	Experience Based Co-Design
EBU	Edinburgh Breast Unit
ECC	Edinburgh Cancer Centre
ELCH	East Lothian Community Hospital
ELHF	Edinburgh and Lothian Health Foundation
EMST	Expiratory Muscle Strength Trainer
ENT	Ear, Nose, Throat
ERCP	Endoscopic retrograde cholangiopancreatography
ESC	Enhanced Supportive Care
FACE	Fight Against Cancer Edinburgh
FBC	Full Business Case
FDG	Fluorodeoxyglucose
FEES	Fiberoptic Endoscopic Evaluation of Swallowing
FM	Facilities Management
GFR	Glomerular Filtration Rate
GI	Gastrointestinal

GP	General Practitioner
H&S	Health and Safety
HAI	Healthcare Associated Infection
HAN	Hospital at Night Team
HBN	Health Building Notes
HDR	High Dose Radiation
HDU	High Dependency Unit
HEI	Healthcare Environment Inspectorate
HFN	Health Facilities Notes
HFS	Health Facilities Scotland
HFS3	Health Facilities Scotland Framework
HGU	Human Genetics Unit
HOPP	Haematology Older Persons Project
HPS	Health Protection Scotland
HSPCS	Hospital Specialist Palliative Care Support
HTM	Health Technical Memoranda
IA	Initial Agreement
ICJ	Integrated Cancer Journal
ICU	Intensive Care Unit
IGMM	Institute of Genetics and Molecular Medicine
IIA	Integrated Impact Assessment
IMRT	Intensity-modulated radiation therapy
IP	Inpatient
IPCT	Infection Control and Protection Team
ISD	Information Services Division
IT	Information Technology
ITU	Intensive Therapy Unit
IV	Intravenous
KPIs	Key Performance Indicators
LDR	Low Dose Radiation
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning
LHP	Lothian Hospital Plan
LOS	Length of Stay
MDC	Multidisciplinary Diagnostic Centre
MDT	Multi Disciplinary Team
MOE	Medicine of Elderly
MPE	Medical Physics Expert
MRI	Magnetic resonance imaging
NDAP	NHS Scotland Design Assessment Process
NEC	New Engineering Contract
NHS D&G	NHS Dumfries and Galloway
NMP	Nuclear Medicine Physics
NPD	Non-profit distributing
NPV	Net Present Value
NRS	NHS Research Scotland
NSD	National Screening Division
NSS	National Services Scotland
OBC	Outline Business Case
OJEU	Official Journal of the European Union
ONS	Oral Nutritional Supplement
OP	Outpatient

OPD	Outpatient Department
OT	Occupational Therapy
PAMS	Property and Asset Management Strategy
PET	Positron emission tomography
PET CT	Positron emission tomography–computed tomography
PET MR	Positron emission tomography–magnetic resonance
PFB	Patient Focused Booking
PICC	Peripherally Inserted Central Catheter
PIR	passive infrared
PPE	Post Project Evaluation
PSCP	Principal Supply Chain Partner
QI	Quality Improvement
R&D	Research and Development
RAI Room	Radioactive Iodine Room
RARP	Robotic Assisted Radical Prostatectomy
RDC	Rapid Diagnostic Centre
RHCYP	Royal Hospital for Children and Young People
RHSC	Royal Hospital for Sick Children
RIBA	Royal Institute for British Architects
RIE	Royal Infirmary of Edinburgh
RT	Radiotherapy
RTS	Radiotherapy Services
RVB	Royal Victoria Building
SA	Strategic Assessment
SABR	Stereotactic Ablative Radiotherapy
SACT	Systemic Anti Cancer Therapy
SBRT	Stereotactic Body Radiotherapy Treatment
SCAN	South-East Scotland Cancer Network
SCIM	Scottish Capital Investment Manual
SEA	Strategic Environmental Assessment
SEAT	South East and Tayside
SES SCRN	South-East Scotland Cancer Research Network
SG	Scottish Government
SGCIG	Scottish Government Capital Investment Group
SHFN	Scottish Health Facilities Notes
SHPN	Scottish Health Planning Notes
SHSC	Scottish Health Service Centre
SHTM	Scottish Health Technical Memoranda
SIRT	Selective Internal Radiation Therapy
SJH	St John's Hospital
SLT	Speech and Language Therapy
SMC	Scottish Medical Council
SNBTS	Scottish National Blood Transfusion Services
SoA	Schedule of Accommodation
SPC	Strategic Planning Committee
SPECT-CT	Single-photon emission computed tomography
SPSP	Scottish Patient Safety Programme
SRO	Senior Responsible Officer
SWOT	Strengths, Weakness, Opportunities and Threats
TCAT	Transforming Care After Treatment
TCT	Teenage Cancer Trust

TEC	Technology Enabled Care
TPN	Total parenteral nutrition
TYAC	Teenage and Young Adults
UGI	Upper Gastrointestinal
UOE	University of Edinburgh
WGH	Western General Hospital
WSP	Accepted name of a company
WTE	Whole Time Equivalent

ECC, proposed Essential Services , and wider WGH & Satellite/ Regional Departments and Services Detail:



Edinburgh Cancer Centre
Western General Hospital

NHS LOTHIAN

Board Meeting
14th October 2020

Director of Finance

AUGUST 2020 FINANCIAL POSITION AND QUARTER ONE FINANCIAL FORECAST

1 Purpose of the Report

1.1 This paper provides an update to the Board on the financial position at Period 5 for NHS Lothian and the Quarter 1 forecast.

1.2 This paper also sets out the financial impact from Covid-19 to-date.

1.3 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 The Board is asked to:

- **Accept** as a source of significant assurance that the Finance & Resources Committee (F&R) has considered the month 5 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

Financial Position as at August 2020

3.1 At its meeting of the 23rd of September, members of the F&R committee received a report on the NHS Lothian financial position for the first five months of the year. This showed an in-month overspend of £2.1m brining the year to date position to a £29.2m overspend against the Revenue Resource Limit. A summary of the position is shown in Table 1 below.

Table 1: Financial Position to 31st August 2020

	Mth 1 £000	Mth 2 £000	Mth 3 £000	Mth 4 £000	Mth 5 £000	YTD £000
Pay	(5,079)	(4,631)	(4,463)	(2,281)	(2,192)	(18,646)
Non Pays	(1,079)	(801)	(4,078)	(6,015)	(177)	(12,150)
Income	513	10	239	569	241	1,572
In Month Total	**(5,646)**	**(5,422)**	**(8,301)**	**(7,727)**	**(2,128)**	**(29,224)**

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 projected and expenditure is not consistent with previous years' trends.

3.3 The Financial Plan endorsed by the Board in April 2020 showed a projected deficit for the year ahead of £10.8m. Assuming this as a baseline allows for the estimation of the level of offsets within the system. Currently the level of offsets, based on reduced activity but including other variation from the financial plan, is estimated at £18.4m as shown in Table 2 below.

Table 2: Breakdown of Financial Position to 31st August 2020

	YTD £'000
FP Expected Pressure	(4,525)
Covid Costs	(45,211)
Covid Funding Received	2,127
Reduced Expenditure/Offsets	18,385
Reported Variance	**(29,224)**

Financial Impact of Covid-19

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

3.5 The latest review of Covid-19 related costs up to the end of August 2020 shows that NHS Lothian has incurred an estimated £45m of additional costs with some Scottish Government funding being received for specific elements (£2.1m) to date. The breakdown of these costs is shown in table 3.

Table 3: Breakdown of Covid-19 Costs Incurred & Funding Received

YTD Position	YTD Variance £000's	YTD Covid-19 Costs £000's
Medical & Dental	(6,340)	3,629
Nursing	(9,745)	18,152
Support Services	(3,190)	2,946
Other Pay	631	2,837
Total Pay	**(18,645)**	**27,565**
Medical Supplies	4,959	756
Equipment Costs	(3,827)	1,934
Pharmaceuticals	(2,316)	2,992
GMS Exp	(3,569)	3,364
Other Non-Pay	(7,398)	3,676
Total Non-Pay	**(12,151)**	**12,722**
Income	**1,572**	**2,798**
Flexibility & Reserves	**0**	**0**
Total	**(29,224)**	**43,084**

3.6 The Scottish Government is assessing all NHS Boards' Covid-19 costs, both in absolute and relative terms, as part of a Quarter 1 exercise. Some allocations have been made by the Government to offset specific costs incurred but there is an expectation that significant funds will begin to flow from next month following further submission of cost information.

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 across Set Aside, Hosted and Core areas, and this is compounded by the centralisation of significant cost elements as noted earlier in this paper. It is likely that a proper assessment of the IJB variances will only be possible following the confirmation of additional resources from the SG into Lothian.

Quarter 1 Forecast

3.8 The F+R Committee considered the year-end forecast at its meeting. The forecast has been split into two elements to assist with interpretation of financial performance. It includes:

- The **Core** financial position which can be compared against the Annual Operation Plan (AOP) projection of a £10.8m overspend;
- The **Covid** related position which draws an assessment of the costs attributable to Covid-19, including offsets from activity reductions elsewhere.

3.9 In total, the forecast outturn position for this financial year (before further allocations for Covid) is estimated at just under £107m. Table 4 below summarises the key elements of the year end outturn.

Table 4: Summary of Year end Outturn

Cost Group	£k	£k
Core Costs	**(4,789)**	**(4,789)**
Covid Costs:		
Mobilisation/Re-mobilisation in place	(86,145)	
Re-mobilisation Decision Awaited	(29,664)	
Gross Covid Cost	**(115,809)**	
Offsets due to Covid	13,779	
Net Covid Cost	**(102,030)**	**(102,030)**
Q1 Forecast Variance		**(106,818)**

Core position

3.10 Forecasting this year requires judgement about what are core cost pressures, and what is Covid related. A best assessment has been made which shows that NHS Lothian would be presenting a forecast outturn of £4.8m at this stage had Covid not impacted. At period 5 the estimated core year end overspend reported was £6.6m.

3.11 Clearly there is an improvement on the estimated outturn of £10.8m at the time of the Financial Plan. Table 5 below contrasts the core position now against this initial estimate.

Table 5 – Comparison between latest Core variance and AOP

	20/21 AOP	Core Q1 Forecast	Movement
	£k	£k	£k
Acute Services Division	**(20,303)**	**(21,028)**	**(726)**
REAS	(2,439)	768	3,208
Edinburgh Partnership	(492)	2,244	2,736
East Lothian Partnership	(296)	(125)	171
Directorate of Primary Care	(682)	177	859
Midlothian Partnership	(152)	59	211
West Lothian Partnership	(444)	1,094	1,537
Facilities And Consort	(6,771)	(8,975)	(2,204)
Corporate Services	**(532)**	**1,715**	**2,247**
Inc + Assoc Hlthcare Purchases	5,219	4,514	(705)
Research & Teaching	(1,109)	(366)	742
Strategic Services	5,517	6,178	661
Operational Position	**(22,483)**	**(13,746)**	**8,737**
Reserves	11,622	8,957	(2,665)
NHS Lothian Position	**(10,861)**	**(4,789)**	**6,072**

3.12 The Committee were informed that at this stage we are confident a balanced position can be achieved in the core position by year end with continued work to identify flexibility and manage costs.

Covid Forecast

3.13 The additional cost of Covid equates to **£102m** as noted above and breaks down as follows:

- Those costs relating to the mobilisation effort at the beginning of the financial year and subsequent planned decisions agreed as part of remobilisation – totalling **£86m**;
- Decisions still to be taken around remobilisation plans, including waiting times recovery – estimated at **£30m**;
- Those offsets identified arising from cost reductions from activity falling, particularly in the early months of the year – estimated at circa **£14m**.

3.14 The F&R committee received detail on the key elements within the Covid costs above.

3.15 The recurring element of the Covid costs is currently being worked through. The Board will receive an update next month on the five-year Financial Plan which will include the recurring financial implications from decisions either already taken or planned this year relating to Covid.

Funding allocations for Covid

3.16 A key issue remains the arrangements for funding Covid costs. All health boards have been in ongoing dialogue with the Scottish Government about the distribution of Covid related resources to support expenditure locally. Detailed discussions have taken place to ensure that there is equity and transparency in the methodology to support expenditure within the health boards. A Peer Review programme has been set up to ensure territorial

boards in particular are taking a consistent approach to the identification and calculation of Covid related costs, and are treating these discretely from underlying costs within the core position which are not Covid related. This distinction is particularly important where health boards have a significant imbalance in their Financial Plan.

3.17 The key assumption is the expectation that all Covid related costs are fully funded. There is a concomitant risk that the cost of Covid across Scotland exceeds resources available to the SG, and by default an element of cost is passed to boards to manage. We will work closely with other Boards and with the SG to ensure this risk does not materialise for Lothian.

3.18 Since the F&R Committee consideration of the financial position, NHS Lothian received formal communication from the Scottish Government (29th September) on the first allocation to meet ongoing Covid related costs. In total, the letter confirmed circa £78m of revenue funding and £6.2m of capital resource to offset costs incurred. The allocation is an interim arrangement, with a further allocation expected later in the year. The key principles of this allocation include the following:

- *The allocation uses information provided by health boards in the returns to the SG on the 14th of August;*
- *The allocation considers all costs incurred in the first quarter of this year. It is partially calculated an actual costs incurred, with an element of funding on an NRAC basis. Some board costs (including Lothian) are slightly higher than the NRAC share;*
- *Costs for efficiency savings lost have not been included in the allocation due to the level of disparity between boards. Further discussion will be required with those outlying boards;*
- *The SG has not adjusted downwards for offsetting benefits (e.g. cost reductions in medicines and clinical supplies arising from a fall in activity). This allows Boards to retain an element of benefit at this stage, although this will be reviewed as part of any final allocation;*
- *For those future costs, an allocation has been made for 70% of the estimated costs. A review will be undertaken in January to assess further funding requirements;*

3.19 Covid related costs will continue to evolve in the coming months. Further allocations will be made by the SG in due course, and we will report the latest additional cost pressures (including ongoing changes arising from expansion in areas like Test and Protect) that we expect funding for. Our assumption that all Covid related cost pressures will be fully funded remains in place.

3.20 We will work with colleagues across the health board and IJBs to agree appropriate allocation arrangements for this resource. An update will be provided through the F&R Committee in October.

4 Key Risks

4.1 The key risks relating to the delivery of a breakeven position include the following:

- As noted above, the achievement of financial balance is dependent on receiving full financial support from the SG to meet addition Covid related costs. At this stage the allocation of resources to health boards has not yet been made;

- The impact of Brexit is unknown – and assumed to be cost neutral in estimates to the year end. Any additional Brexit-related costs have no additional funding allocations attached to them at this stage;
- The estimates for the year end outturn are predicated on the assumption that Covid related activity levels remain broadly consistent with where it is today. Any material deviation from this may impact on the ability for the health board to achieve a balanced outturn;
- Delivery of Financial Recovery Plans by individual Business Units to the level identified in the Financial Plan remains a key assumption which impacts on the achievement of Core performance.

5 Risk Register

5.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

5.2 The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

7.1 The implementation of the financial plan and the delivery of a breakeven outturn may require service changes. As this paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith
Director of Finance
30th September 2020
susan.goldsmith@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board
14 October 2020

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on the NHS Lothian's Corporate Risk Register for assurance.

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

2 Recommendations

The Board is recommended to:

2.1 Accept reinstatement of the risk associated with the exit from the European Union (EU) (Brexit) onto the corporate risk register.

2.2 Accept the risk assurance table, as set out in Appendix 1, as a summary of all risks including levels of assurance and grading, as agreed by the relevant committee.

3 Discussion of Key Issues

3.1 The Board is asked to reinstate the risk associated with Brexit (4693) on the corporate risk register.

Risk description
The consequences of EU Exit are expected to be substantial and far reaching, although specific impacts will depend on the type of agreement (if any) reached between UK Government and EU and any other trade agreement and regulatory changes.

There is a risk that patient experience and outcome care may be compromised due to uncertainty relating to EU Exit.

The areas that require close observation and require risk assessment and mitigation identified include:-

- Workforce
- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Supply of non-clinical consumables, goods and services

- Covid related medicines and consumables
- Impacts on care homes.

Committee assurance

Healthcare Governance Committee will be the primary committee for assurance.

Grading – Very high (20)

There is a significant level of uncertainty at local and national level including the political agenda which impacts on the ability to manage the risk at a local and national level.

3.2 **Risk Register Update**

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 21 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

3.3 **Maximising NHS Lothian's Risk Management System**

3.3.1 A programme of work was initiated in late 2018 which aimed to put in place a reliable, data-driven Risk Management Assurance process informed by NHS Lothian's Corporate Objectives (now Priorities for Continuous Improvement). The programme objectives included:

- Assurance committees to review allocated risk, progress actions and escalate to the Board as appropriate
- The risks and associated plans set out explicit measures to illustrate impact of risk mitigation
- The data is visible from floor to Board and informs escalation and effectiveness of plans to mitigate the risk

- Levels of assurance informs risk grading and inclusion on the Corporate Risk Register

3.3.2 In order to achieve the programme's aim and objectives, a number of key building blocks had to be developed and mechanisms put in place to establish a consistent approach across the governance committees of the Board these are described below.

3.3.3 The Board in April 2019 agreed NHS Lothian's Strategic Risk Framework, which replaced NHS Lothian risk appetite statement. This stated that all NHS Lothian plans to mitigate corporate risk and associated controls will consider the following:-

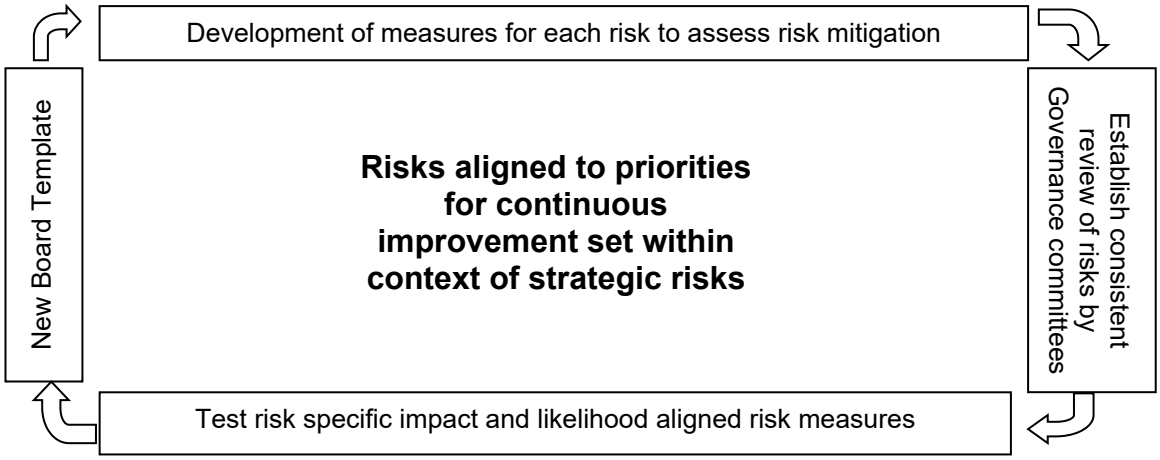
- New models of Health & Social Care
- How it seeks to improve and innovate
- Mechanisms for collaborative and joint working
- Engagement with the public and patients.

3.3.4 In September 2019, a new risk template was approved by the Board supported by training for Owners and Handlers, and aligned with internal audit recommendations. The new template set out the relationship between risks, a measurement framework to assess the risk, the impact of mitigation plans and assurance grading. The measures for individual risk are being developed over the coming year.

3.3.5 Governance Committees were allocated risks and work is ongoing to embed reliable assessment of risk associated plans and the alignment of assurance levels and grading.

3.3.6 The Finance & Resources Committee in June 2020 agreed to test a risk specific approach to defining likelihood and impact, starting with 'Facilities Fit for Purpose', based on the explicit measures set out in the new template to inform grading and associated plans.

The diagram below summarises this programme:-



3.4 A high level review of risks on the corporate risk register is now taking place to ensure the risks are fit for purpose.

3.5 At an operational level, responsibility for risk management is aligned to operational management structures. The NHS Lothian Risk Management Architecture illustrates operational risk registers captured on the Datix system, as set out in Appendix 2

3.5.1 Work was previously undertaken with the acute services senior management team to agree the risk management process and to review the acute services risk register. This included training for risk owners and handlers and follow up support to review their risks. This approach was cascaded to the site/service clinical management teams.

3.5.2 The focus of the team to support risk management across Lothian has been on adverse event management, which has been a national and local priority over the last 18 months. This includes, establishing and implementing new processes for the introduction of the statutory organisational Duty of Candour (DoC) and a new national reporting system for significant adverse event reviews.

3.5.3 QIST staff are re-engaging with Acute SMT and sites/services to examine the degree to which the risk management process have been implemented as intended and whether any changes are required, given that both structures and personnel have changed since the initial exercise.

3.5.4 A piece of work was also undertaken with Health and Social Care Partnerships Chief Officers and a forum established with staff involved in risk management across health and social care to examine common risks across the system and how they were being managed through health and council risk management processes. It was agreed that this group would continue to meet twice a year.

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 Inequality, Including Health Inequalities

6.1 Not applicable.

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

7.1 This paper does not consider developing, planning and/or designing services, policies and strategies.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

Jo Bennett
Associate Director for Quality Improvement & Safety
30 September 2020
jo.bennett@nhslothian.scot.nhs.uk

Sue Gibbs
Quality & Safety Assurance Lead
sue.gibbs@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Risk Assurance Table
Appendix 2: NHS Lothian Risk Register Architecture

Appendix 1

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. A standing item on the HCG Agenda	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	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
		in the new facility. July 2020- F&R agreed risk remains very high					
3600	Finance Update provided July 2020	<u>Finance & Resources Committee (F&R)</u> 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) Update provided July 2020	<u>Healthcare Governance Committee (HCG)</u> HCG Jan 2019 update accepted moderate assurance re plan in place to improve 4 hour performance and safety at RIE. Plan subject to external scrutiny.	High 10	Very High 20	Very High 20	Very High 20	Very High 20
4688	Patient safety in RIE ED Update provided July 2020	<u>HCG Committee</u> 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	<u>HCG Committee</u> 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	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
	2020	sustainability.					
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. Agenda item for Nov 2020	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) Update provided July 2020	HCG Committee September 2019 HCG accepted moderate assurance on the management of clinical risk related to cancer waiting times. Agenda item for Nov HCG	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
4693	Brexit Update provided January 2020 **(CLOSED 09/04/2020,) work now re insteaded**	HCG Committee Agreement to keep under review pending discussions on trade agreements. Risk to now go live.	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.	Very High 20		High 12	High 12	High 12

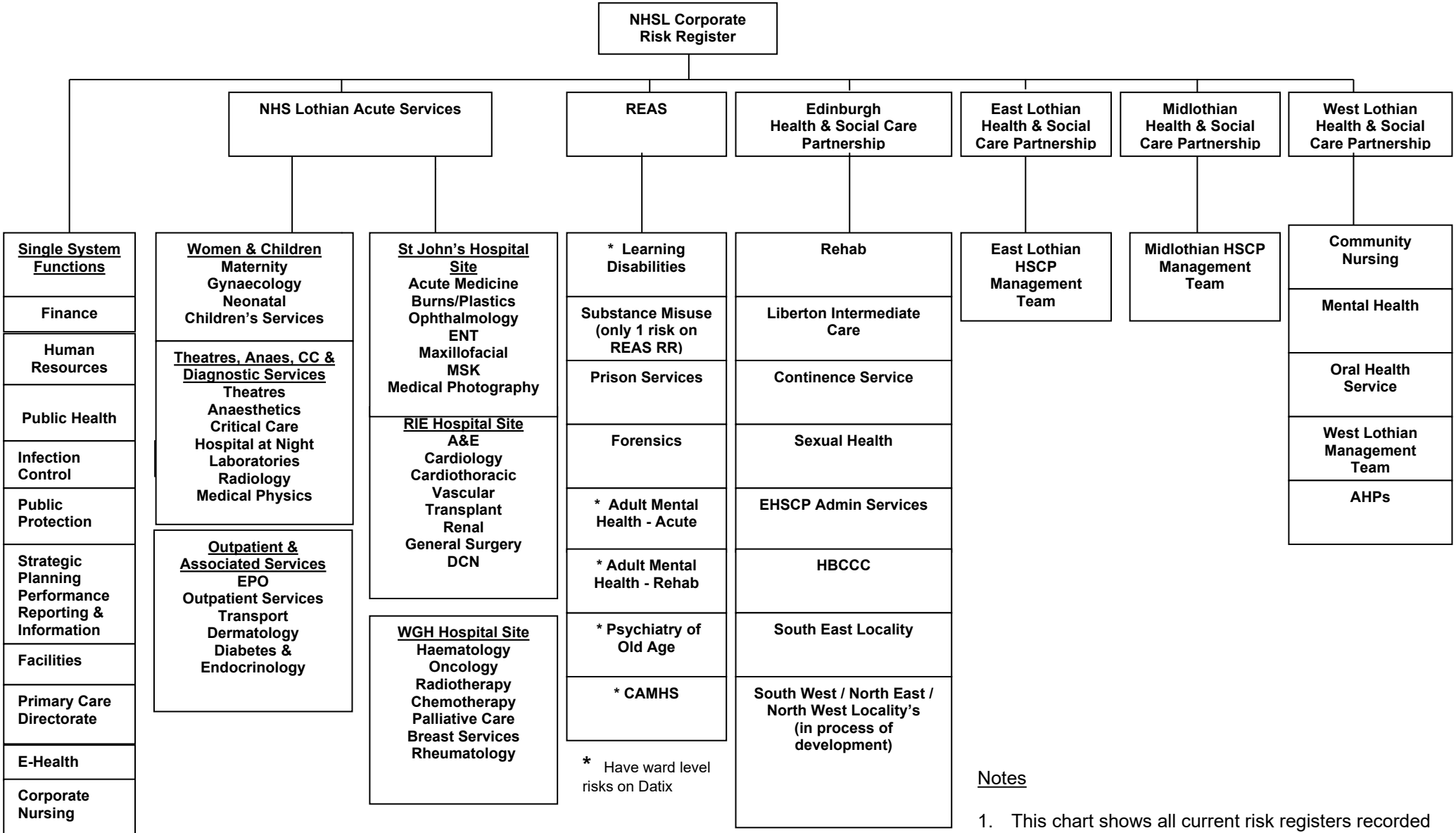
Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
		Process with Scot gov paused, acknowledgement of need for substantial review of plans/metrics in view of Covid-19					
4921	Bed Capacity in Acute Mental Health Update provided July 2020	Healthcare Governance Committee Jan 2020 - accepted moderate assurance. Discussed at HCG on adult inpatient services September 2020 moderate assurance .	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
5034	Care Homes New risk –approved by Board 12 August 2020	Healthcare Governance Committee July 2020 – moderate assurance accepted that governance infrastructure in place to deliver the enhanced professional oversight. Limited assurance in respect of the 4 aspects of care for which Exec nurse director given accountabie	High 12				
5020	Legionella	Healthcare Governance Committee	High 12				

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
	New risk –approved by Board 12 August 2020						
3454	Learning from Complaints Update provided July 2020	HCG Committee July 2020 – Moderate assurance accepted. September Moderate assurance	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 patient safety and quality of care.	High 16	High 16	High 16	High 16	High 16
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) On agenda for further review Jan 2021	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	Staff Governance Committee July 2020- limited assurance accepted	High 12	High 12	High 12	High 12	High 12

Datix ID	Risk Title	Committee Assurance Review Date	Initial Risk Level	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020
	December 2015) (Reported at H&S Committee). Update provided January 2020						
1076	Healthcare Associated Infection Update provided July 2020	<u>HCG Committee</u> 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	<u>Staff Governance Committee</u> July 2020 - increase in grading from 6 to 12 Significant assurance that there is a robust mobilisation plan and mechanism to co-ordinate the responses across the nursing and midwifery workforce. Limited assurance that there is sufficient capacity in the event the pandemic requires that the Board delivers a full surge plan in acute and community, including supporting the NHS Louisa Jordan	High 12	Med 6	Med 6	Med 6	High 12

Appendix 2

NHS Lothian Risk Management Architecture (Existing Structure) (see note 1)



Notes

1. This chart shows all current risk registers recorded on DATIX

NHS LOTHIAN

Board
14 October 2020

Chief Executive

Proposal for a Planning, Performance and Development Committee

1 Purpose of the Report

1.1 Lothian NHS Board's Standing Orders state that the establishment and terms of reference of all committees, and the appointment of committee members, is a matter reserved to the Board. This report is presented so that the Board may consider a proposal to establish a new committee which will replace the Strategic Planning Committee and Board development sessions.

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

2 Recommendations

The Board is recommended to:

2.1 Agree to disband the Strategic Planning Committee.
2.2 Review and approve the establishment of, and terms of reference of the Planning, Performance and Development Committee.
2.3 Appoint Esther Roberton as the Chair of the Planning, Performance and Development Committee.

3 Discussion of Key Issues

3.1 The Board has for some time trying to find the correct approach for it to oversee performance at Board meetings, recognising that committees carry out detailed oversight on matters of performance and risk related to their remits. Additionally the members have fed back that there is a need to improve on the current arrangements for the Strategic Planning Committee. The health and social care system naturally creates a considerable volume of complex and inter-related issues. This challenge is made more difficult by the complexity of the governance structures in health and social care in Lothian (Scottish Government, health board, four local authorities, four integration joint boards), the increasing volume of law and national policy/ directions, and the immediate pressures which all NHS Boards have to deal with. In this context it is essential that Board members have a space to discuss how the whole system is performing, and to plan for the future.

3.2 The proposed Planning, Performance and Development Committee is designed to create this space. The committee will not repeat what other committees or executive management are/ should be doing. As an example, the terms of reference of the Strategic Planning Committee set out in considerable detail the assurance needs related to working with integration joint boards and observing the associated law. A governance committee does not need to get into this level of detail. However a committee can reasonably expect to receive assurance from executive management on their systems, for example, that all IJB directions are systematically captured and

implemented. The Committee's approach to overseeing the implementation of agreed plans and delivery of outcomes should allow it to evaluate the effectiveness of the whole system of planning and performance.

3.3 The Head of Corporate Governance circulated a first draft of the terms of reference to members or comment. This generated feedback which informed the development of a substantively re-drafted version which is at Appendix 1.

3.4 Once the Committee is up and running, it can determine how it will carry out its role, and how it will engage with other committees. For that reason the terms of reference have been drafted in a manner so that they are not prescriptive, or attempt to answer all questions as to how things will work.

4 Key Risks

4.1 All of the Board members do not have an opportunity to be involved and engaged in the development of plans, leading to the plans not being informed by the knowledge, skills, and experience of the collective membership.

4.2 The business which the Board and other committee meetings have to routinely carry out is dominated by immediate concerns. This does not give the Board members the opportunity to properly consider the medium-to-long term, and how the whole system is operating.

5 Risk Register

5.1 The Committee should help the Board respond to all of its corporate risks.

6 Impact on Inequality, Including Health Inequalities

6.1 This report sets out an administrative change which does not relate to a specific proposal which has an impact on an identifiable group of people. However improving the approach to planning and performance management should assist with the overall goal of addressing inequalities.

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 specific decisions that would significantly affect groups of people. Consequently public involvement is not required.

8 Resource Implications

8.1 The Planning, Performance and Development Committee is scheduled to have fewer meetings than would have been the case if the Board continued with the Strategic Planning Committee and Board development sessions. There is the potential to make more effective use of the time at Board meetings, as a consequence of the discussions held at the committee.

8.2 The Committee's remit may mean that executive management is required to produce different information from that which would normally be prepared. This may or may not require additional resources to service the Committee's requirements, and management will monitor this.

8.3 The Director of Strategic Planning keeps the resources for the strategic planning function under regular review, and can report any issues to the Committee as and when required.

Alan Payne
Head of Corporate Governance
6 October 2020
alan.payne@nhslothian.scot.nhs.uk

Colin Briggs
Director of Strategic Planning
6 October 2020
colin.briggs@nhslothian.scot.nhs.uk

PLANNING, PERFORMANCE AND DEVELOPMENT COMMITTEE

1. REMIT

The committee provides all Board members an opportunity to:

- consider and discuss complex issues which have implications for the whole system of health and social care;
- develop the medium to long-term direction and plans of NHS Lothian, and the approach to sustainably delivering the associated outcomes; and
- discuss the continuous development and improvement of NHS Lothian.

The committee will take a whole-system approach to consider, and make recommendations to the Board on:

1) What is NHS Lothian trying to accomplish?
2) How will NHS Lothian know if a change is an improvement?
3) What changes shall we make that will result in improvement?

The answers to the first two questions should inform how the Board, the other committees, and management approach question 3).

This committee does not alter the 'Matters Reserved to the Board' (as set out in the Board's Standing Orders). Additionally the committee does not alter the remit and functions of other Board committees, which will continue to carry out their detailed responsibilities for assurance, performance and risk management. The committee's work should assist and facilitate the work of the Board and the other committees, but not duplicate it. This approach should ensure that as part of taking forward agreed medium-long term aims, there is active and continuous consideration of any operational and workforce issues.

The committee will be predominately focused on the medium to long term; however it may consider reports and information from the current period to allow members to understand the performance of the organisation. It is likely that the volume of material presented to members will be less than that traditionally received at other committees.

2. CORE FUNCTIONS

- To contribute to and oversee the co-ordination and development of the Board's priorities and overall intended outcomes. The committee will seek assurance that the priorities and outcomes take into account anything the Scottish Government or integration joint boards want the Board to do, and any legal requirements. As part of this process, ensure that the development process effectively involves and engages key stakeholders, and that NHS Lothian effectively communicates its interests to stakeholders. Refer the product of this activity to the NHS Board for approval.

- To seek assurance from management that there is a system to ensure that there are robust and feasible implementation plans in place to deliver whatever the Board has agreed to do.

- To consider how the Board's system of governance monitors performance and the delivery of its plans and outcomes, and make recommendations to the Board and other committees. The committee may instruct further reports on any topic or service as part of carrying out its remit.

- To review progress against the agreed medium to long-term outcomes at the agreed milestones within the plans, and make recommendations to the Board and other committees.

3. MEMBERSHIP

All of the non-executive Board members will be the members of the committee. The Board will appoint the chair of the committee.

The executive Board members are not members of the committee but will be expected to routinely attend. The Chief Officers of the four integration joint boards and other members of the Corporate Management Team will also be expected to routinely attend. Other managers and staff may also be asked to attend.

4. QUORUM

The quorum is one third of the whole number of non-executive Board members, including at least two who are not employees of a NHS Board.

5. FREQUENCY OF MEETINGS

The committee will normally meet five times in a year, but may elect to have further meetings.

6. REPORTING ARRANGEMENTS

The Committee will report to the Board through its chair, and by submitting its approved minutes to the Board. The Committee Chair will also provide an annual report on the Committee's activities to the Audit & Risk Committee, to inform the preparation and review of the Board's Governance Statement.

7. DATE OF APPROVAL OF THESE TERMS OF REFERENCE

[This will be updated when the Board approves the terms]

8. REVIEW DATE

Two years from the above date of approval, or earlier if the Board requires.

NHS LOTHIAN

Board
14 October 2020

Chair

2021 Schedule of Board and Committee Meetings

1 Purpose of the Report

1.1 Lothian NHS Board's Standing Orders state: 'The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates'. This report is presented for that purpose.

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

2 Recommendations

The Board is recommended to:

2.1 Approve the schedule of Board and committee meeting dates.

3 Discussion of Key Issues

3.1 It is a challenging process to prepare this schedule due to the various competing demands on members' time, e.g. integration joint boards, national and local management meetings. The proposed timetable at Appendix 1 avoids clashes as far as is possible, and schedules the required six meetings of the NHS Board.

3.2 The Board and its committees all require a quorum to be achieved. This provides a control to ensure that there is always an adequate number of members present before business can proceed.

3.3 A key difference from 2019 is the proposal to have a Planning, Performance & Development Committee (which is discussed in a separate report). This will replace the Board development sessions and the Strategic Planning Committee.

3.4 Members have previously expressed a preference for meetings to always be held on a limited number of days in the week. This schedule provides that all governance meetings will be held on either a Tuesday or a Wednesday. The exception is that the Audit & Risk Committee meetings are on Mondays.

4 Key Risks

4.1 The Board or one of its committees 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 schedule of meetings means that the members cannot carry out their responsibilities in other roles that they may have.

4.3 The need to respond to emerging events as they emerge may lead to the need for

additional meetings, which not all members may be able to attend.

5 Risk Register

5.1 There is no need to add anything to the 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. As part of the process of developing the timetable, we have taken into account the published timetable of board meetings of integration joint boards. However due to the complexity, the process did not consider the scheduling of any integration joint board committees or sub-groups.

8 Resource Implications

8.1 The key currency is members' time and the availability of suitable calendar slots. This schedule assists on managing the demand in the following ways:

- The Board was meeting on a monthly basis in 2019. This schedule continues with the recent decision to revert to bi-monthly meetings.
- The Finance & Resources Committee introduced monthly meetings in 2019. This schedule re-introduces a 6-weekly meeting cycle.
- The Planning, Performance & Development Committee will meet less frequently than what it replaces (the Board development sessions and the Strategic Planning Committee meetings).

8.2 There is currently a process underway to appoint three new members to the NHS Board. Once those new members are in place, there will be a holistic review of the membership of committees and integration joint boards. This will also give an opportunity to review how many members are appointed to committees, which in turn may reduce the total demand on Board members' time.

Alan Payne
Head of Corporate Governance
25 September 2020
alan.payne@nhslothian.scot.nhs.uk

2021

BOARD AND COMMITTEE DATES

LOTHIAN NHS BOARD
9:30 am – 1:00pm

WEDNESDAY MORNINGS

Board Meetings	Deadline
03 February 2021	21 January 2021
07 April 2021	25 March 2021
23 June 2021 *	10 June 2021
04 August 2021	22 July 2021
06 October 2021	23 September 2021
01 December 2021	18 November 2021

** Annual Accounts Meeting*

FINANCE & RESOURCES COMMITTEE
9:30 am – 1:00pm

WEDNESDAY MORNINGS

Date of Meeting	Deadline for Final Paper Submission
27 January 2021	14 January 2021
10 March 2021	25 February 2021
21 April 2021	8 April 2021
2 June 2021	20 May 2021
14 July 2021	1 July 2021
25 August 2021	12 August 2021
6 October 2021	23 September 2021
17 November 2021	4 November 2021

PLANNING, PERFORMANCE & DEVELOPMENT COMMITTEE
9:30 am – 1:00pm

WEDNESDAY MORNINGS

Date of Meetings	Deadline for Final Paper Submission
06 January 2021	24 December 2020
03 March 2021	18 February 2021
05 May 2021	22 April 2021
01 September 2021	19 August 2021
03 November 2021	21 October 2021

LOTHIAN PARTNERSHIP FORUM
(10am premeet) 12:00pm – 3:00pm

TUESDAY AFTERNOONS

Date of Meetings	Deadline for Final Paper Submission
23 February 2021	10 February 2021
27 April 2021	14 April 2021
22 June 2021	9 June 2021
24 August 2021	11 August 2021
26 October 2021	13 October 2021
21 December 2021	8 December 2021

HEALTHCARE GOVERNANCE COMMITTEE
1 – 4pm

TUESDAY AFTERNOONS

Date of Meeting	Deadline for Final Paper Submission
12 January 2021	? December
23 March 2021	10 March 2021
25 May 2021	12 May 2021
27 July 2021	14 July 2021
7 September 2021	26 August 2021
9 November 2021	29 October 2021

INFORMATION GOVERNANCE SUB-COMMITTEE
2:00pm – 5:00pm

TUESDAY AFTERNOONS

Date of Meeting	Deadline for Final Paper Submission
26 January 2021	13 January 2021
13 April 2021 ***(Annual Report)***	31 March 2021
24 August 2021	11 August 2021
26 October 2021	13 October 2021

AUDIT & RISK COMMITTEE
9:00am – 12:30pm

MONDAY MORNINGS

Date of Meetings	Deadline for Final Paper Submission
22 February 2021	9 February 2021
26 April 2021	13 April 2021
21 June 2021	8 June 2021
23 August 2021	10 August 2021
22 November 2021	9 November 2021

REMUNERATION COMMITTEE
2:00pm – 4:00pm

TUESDAY AFTERNOONS

Date of Meetings	Deadline for Final Paper Submission
16 February 2021	3 February 2021
20 April 2021	07 April 2021
20 July 2021	07 July 2021
19 October 2021	06 October 2021
21 December 2021	8 December 2021

STAFF GOVERNANCE COMMITTEE
9.30am – 1:00pm

WEDNESDAY MORNINGS

Date of Meetings	Deadline for Final Paper Submission
17 February 2021	4 February 2021
26 May 2021	13 May 2021
28 July 2021	15 July 2021
20 October 2021	07 October 2021
15 December 2021	02 December 2021